Exploring Community Treatment Orders:

An Institutional Ethnographic Study

by

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Abstract

Community Treatment Orders (CTOs) involve mandated community treatment for individuals with severe, persistent mental disorders. The use of CTO legislation in Newfoundland and Labrador (NL), Canada is explored in this study through institutional ethnography (IE). This method is used by researchers seeking to elucidate everyday life experiences that occur within an institution. According to IE, the everyday work of individuals is coordinated and organized by social structures and discourses known as ruling relations that are inherent within an institution. These ruling relations exist often without our overt knowledge or awareness.

One of the main findings in this study is that CTOs are socially organized to focus on legal issues of public safety and accountability. Worries about the possible risks to the public of severe, persistent mental illness supersede the therapeutic implications of the CTO. While health professionals' activation of the CTO proceeds as though it is focused on treatment and recovery, the therapeutic interests are subordinate to the politico-legal interests of government.

Informants in this study included family members, nurses and other healthcare team staff, managers, bureaucrats, and legal experts who had experience with CTOs. Data were collected through interviews and document review and examined for evidence of the social web of practices (ruling relations). The actual process of using the CTO legislation was mapped, highlighting the many points at which decisions were being made based on varying interpretations of the legislation. A number of disjunctures, or moments of incongruousness, were found. What the informants described as actually happening with the use of CTO legislation was sometimes in conflict with what they expected to happen, or with what the legislation identified as “suppose to happen”. Nurses’ professional ideology was also challenged in that nurses’ “therapeutic” actions often resulted in practices organized by the legislation that were at odds with the interests of patients and their families.

The results of this study offer important insights about the use of CTOs in NL and should be of considerable interest to nurses and other health professionals, advocacy groups, families, and individuals with mental health concerns. It is hoped that increasing awareness to these social structures and disjunctures will foster a greater understanding of the challenges facing mental health nursing practice.

Key words: Community treatment orders, institutional ethnography, mental health nursing

Preface

This dissertation is an original work by Nicole Snow. The research project, of which this dissertation is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name "*Using Institutional Ethnography to Explore Community Treatment Orders*", Pro. 00021542, June 6, 2011 and Health Research Ethics Board, Newfoundland and Labrador, Reference # 11.066, July 12, 2011.

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be possible without these individuals taking the time to speak with me. I learned so much from talking to them about the realities in which they live, and the challenges they face in their everyday work, be it paid or unpaid. I hope this dissertation and the discussions it stimulates will ripple through the status quo in how mandatory care is conceptualized in mental health nursing practice to create an expanded awareness of what is actually happening in the everyday.

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CHAPTER 1

INTRODUCTION

Community treatment orders (CTOs) are a contentious topic in mental health practice. CTOs mandate patients to engage in community treatment against their will (Canadian Mental Health Association (CMHA, 1998, ¶ 4). Individuals considered for a CTO usually have a severe, persistent mental illness, a history of treatment non-adherence, and the potential to become violent when unwell. There is considerable ambivalence regarding the use of CTOs. They are criticized as paternalistic and coercive in nature as they are viewed as providing a means for those in positions of power to exert control over vulnerable persons (Trueman, 2003). The considerable power imbalances between individuals with mental illness and healthcare providers potentially lead to inequalities in the therapeutic relationship (Lützén, Evertzon & Nordin, 1997). Concerns exist, as well, that using CTOs suppresses individual patients' rights to exert their own power and make their own choices, raising questions regarding respect for autonomy and the human rights of the patient. Coinciding with such concerns is the recognition that the person with severe mental illness may need to be protected from potential harm to self and others (Jenkins & Coffey, 2002), protection that inaction will not provide. Families who have witnessed the mental decline of their loved ones have been particularly vocal in supporting this position. From this vantage point, the delivery of care becomes paramount, given that it will provide protection from harm for a person made vulnerable by severe mental illness, as well as for others (i.e., the greatest good for the greatest number of people). Given the complexity of individual and family situations and the ethical concerns regarding CTOs, there is a need to explore what happens in their use.

This research was conducted within the socio-cultural context of mental health and illness, one that is laden with many issues, including those pertaining to ethics. Ethical issues surrounding CTOs are also representative of more widespread concern inherent within mental health care delivery and even within society itself (Snow & Austin, 2009). Individuals with mental illness experience stigma that can influence their access to, and experiences with, health care. This stigma extends to those who informally and formally care for individuals with mental illness. Mental illness continues to be viewed as something to be feared and controlled. These societal perceptions have deep roots, stemming back through the centuries and colour the manner in which mental illness and those who experience it are treated and viewed. This stigma exists not only in the general populace, but also in the systems that are established to aid persons living with mental illness when they are most vulnerable. Professionals, such as nurses who are influenced by personal, professional, and societal beliefs, act as the agents of these systems. In doing so, they co-create a system that reflects these perceptions.

Historically, ethical practice in mental health has been criticized as not being given its due attention (Fulford & Hope, 1994). However, the convoluted web of interaction influencing persons involved in the mental health system (whether persons with a mental illness, family members, or healthcare providers) is challenging to examine. This complexity is exemplified in the examination of the everyday realities and larger social influences that shape mental health practice in the care of people with severe persistent mental illness who are mandated to a CTO. In particular, it is important to understand how ideological debates about ethical practice and nurses' roles in it are being played out in the actual development and implementation of CTOs.

The purpose of this research study was to identify and map the social processes that concert in the implementation and consideration of CTOs, particularly from the standpoint of the registered nurse working with people subject to CTOs. This was accomplished through the use of institutional ethnography (IE). This method highlights how knowledge and practices are socially constructed through social relations that may be outside of immediate individual, everyday experiences and awareness. People do not necessarily realize how societal institutions, their organization, power structure, and practices influence ordinary lives and everyday work. In conducting research by this method, researchers are able to learn how to see, hear and understand what people are doing in their everyday life and can “piece together” how separate everyday occurrences are coordinated by common external forces. This overarching social organization, known as “ruling relations”, concerts the activities of people in a variety of separate yet interconnected settings (Turner, 2006). Ruling relations include those “forms of consciousness and organization that are objectified in the sense that they are constituted externally to particular people and places” (Smith, 2005, p. 13). People act to co-create these social and ruling relations. Social relations are “people’s doings in particular social settings” that are “articulated to sequences of action that hook them up to what others are or have been doing elsewhere and elsewhen” (p. 228). Activities I perform in my everyday life are connected to other activities I have performed in other locations and different times. They are connected through texts, such as provincial laws, which guide expectations and provide boundaries regarding my behaviour anywhere in the province at any time. In this way, ruling relations act to *coordinate* social activities over time and space.

However, what we do, how we do it, and how it is socially organized by ruling relations is usually not given much conscious thought (Campbell & Gregor, 2002). In making these relations, or the "socially-organized exercise of power that shapes people's actions and their lives" (p. 32) visible, we can see what is influencing the social organization of what we do. IE seeks to elucidate and map these "unseen" relationships, so that they can be methodologically explored (Smith, 2005). Fostering an understanding of how greater social forces, in areas such as health care and justice, influence and permeate everyday mental health nursing practice is important for mental health nurses, patients, and families. There is a need to develop a reflexive practice that results from mental health nurses giving due consideration to and analysis of why we act in the manner we do.

Personal Context

The choice of using IE to explore CTOs came from my experiences as a mental health nurse working with individuals with severe persistent mental illness. I have witnessed many people living with their mental illness while facing daily challenges and stigma, quite often without support. I have seen families feeling strained by the desire to care for their loved one and yet incredibly frustrated with the difficulties they face in doing so. I have also seen many individuals discharged from acute mental health care return to their home communities, often without necessary supports, only to be readmitted a short time later. This "revolving door patient" is a reality in mental health care. In addition, concerns with mental status deterioration and safety for the individual and others are paramount. As a mental health nurse, I, too, felt frustrated by what was happening to persons with mental illness and their families. I wondered: "What is being done for them?” “What could be done for them?” and “Why is it not being done for them?” “How are choices regarding supports and services made for individuals who need them?” For me, these are questions that need to be considered in mental health nursing practice.

These questions are also grounded in my ideological conceptualizations of words such as good, competent, compassionate, ethical care, which are guided, in part, by the Canadian Nurses’ Association’s *Code of Ethics* (2008). These terms are value laden in nursing. I have been left reeling at times when these “ideological concepts”[1] collide with the realities of actual situations in which individuals with mental illness live, become unwell, recover, and relapse. It has led me to wonder, “What is really happening here?” I have questioned, “How is it that my practice does not always “fit” my understanding of ethical nursing?” This lack of fit occurs even after giving the available options and responsibilities due consideration and taking the needs and wishes of the patient into account as I attempt to do the best I can in a given situation. I have also pondered, “Why am I so often left with doubts and worries about what my (and others’) nursing practice is accomplishing?” This uncertainty is extremely challenging given the way my ideological ethical principles are frequently intertwined with legislation and the threat of litigation.

The pivotal point for deciding to explore CTO use occurred a few years ago when I participated in my nursing association’s consultation process for the drafting of a response to proposed mental health legislation changes. When the discussion came to the possible inclusion of CTOs, many of the nurses in the room, including myself, let out a

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[1] Ideology refers to “taken for granted assumptions, beliefs, and value systems which are shared collectively by social groups”. An ideology is said to be dominant when it is “mediated through powerful political and social institutions like the government, the law and the medical procession” (Simpson, 1993, p. 5).

collective sigh. We knew of CTOs being used elsewhere in Canada and the world. We were aware of many of the ethical concerns involved with forcing people into treatment in the community. However, we also knew that CTOs could provide hope for individuals for whom recovery and mental stability were serious issues. We discussed the pros and cons of including such provisions in our legislation. We debated the ethical concerns with such measures. Since that time, we have seen the implementation of the CTO legislation in the province and the debate it has sparked. I question, "What is the 'bigger picture' of CTOs that many mental health nurses and patients may be missing?" I want to better understand what is influencing the manifestation of the everyday challenges, successes, and events that impact on the treatment of those with mental illness who are considered for or mandated to a CTO.

Aim of Study

This study explored the ruling relations influencing mental health nursing practice that involved CTOs. To accomplish this, the following broad areas were considered:

- What are the processes involved in considering a patient for a CTO?
- What are the everyday experiences (or work) of mental health nurses in working with individuals with or being considered for CTOs?
- How do mental health nurses describe their activities in conducting this work?
- What is the social organization of "ethics" as it arises within activities of mental health discourse and practice?[2]

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[2] This evolved from purely being ethics to the clashes in the ideological conceptualizations regarding mental health nursing practice and what is actually happening.

- What are the social relations influencing how mental health nurses are involved in this process?

Dissertation Overview

This document is the culmination of an intensive examination of the use of CTOs in Newfoundland and Labrador through the use of IE. Chapter 2 outlines the literature I reviewed in the preparation for and during the conduct of this work. Chapter 3 provides an overview of the method used to collect and analyze data. Here, I also discuss IE's theoretical underpinnings that informed how I approached this research process with IE's particular emphasis on document review. In chapter 4, I have included a review of the various documents that were of greatest pertinence to this research. My analysis is located in chapters 5, 6, and 7. These chapters take the reader through an examination of what is happening in CTO use from a local, everyday level with individuals who are directly affected by its use. The broader social forces evident in the CTO implementation are explicated. Chapter 8 provides a discussion of this analysis. Additionally in this chapter, I conclude the dissertation and summarize the work conducted. This dissertation is very descriptive in nature. My goal is to give the reader an account of the everyday lives of those who are impacted by legislated mandatory community mental health care. In doing so, I plan to explicate the often unseen "dimensions of the social", namely the ruling relations, that "transcend the local" experiences and work (Smith, 2006b, p. 3) that is inherent in the use of CTOs.

CHAPTER 2

LITERATURE REVIEW

There are different approaches to conducting a literature review in qualitative research. First, the researcher may choose not to consult the literature ahead of conducting data collection. This is to avoid any possible influence the literature may have upon the researcher's ability to engage in "unbiased" research (Glaser, 1978). A second approach is to unearth as much literature as possible about the topic being explored. All of the major literature sources are then incorporated into the literature review. A third approach is to critically examine the literature and selectively use what is found. This literature then acts as a guide to aiding the researcher in the analysis of the data collected (Morse & Field, 1995). Institutional ethnography (IE) is most closely aligned with the third approach in terms of selectively "using" the literature. IE deviates slightly insofar as the literature is considered data.

To start, the researcher conducts a review of the literature in the "conventional sense" (Campbell & Gregor, 2002, p. 51) as a means of gaining a sense of the scope and breadth of the knowledge of, and research conducted on, the topic of interest. The "selective" use of the literature is based on what arises during data collection. In this way, the literature review is iterative and carried out reflexively throughout the conduct of the study. The researcher discovers things in participants' talk and practices that lead back into the literature. Moreover, there may be aspects of the initial literature review that are not relevant to what is discovered in the field, and thus some topics are dropped. An IE approach to a literature review demands that the researcher pays attention to their own "conversation" with the literature as she reads. This provides the tools for the researcher to situate her understanding of the topic. A researcher familiar with the field of study pays attention to the dominant ideas that others may “gloss over”. As an individual who has mental health experience, I had in the literature review presented here, to consider the stance I hold regarding my knowledge of CTOs within the dominant discourse of literature available regarding them and their use (Campbell & Gregor).

In this way, conducting a literature review for an IE study is similar to conducting a preliminary discourse analysis[3]. It is designed to alert the researcher to dominating or marginalized ideas. It supports a cursory view into how this domination or marginalization is constructed within published papers and grey literature. Thus, when the researcher enters the field, the familiarity with the literature supports the researcher to “notice” how theories or postulates organize knowledge and practices. This is how the literature becomes data that can be used to provide evidence about how a topic (and people’s activity in relation to that topic) is constructed within socially organized practices of knowledge.

Mental Illness

Mental illnesses manifest themselves as changes in mood, affect, behavior, and thinking that impact a person’s ability to function in their day to day living (Austin, 2015). The nature and causes of mental illnesses are not well understood and their treatment and management can be rather complex. Severe and persistent mental illnesses (SPMI), such as schizophrenia, are chronic “brain disorders… that are neither preventable nor curable, but are treatable and manageable with combination of medication, supportive

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[3] Discourse refers to written and spoken communication. Definitions of discourse analysis vary from exploring the use of language to a more critical perspective in exploring the “broad conglomeration of linguistic and nonlinguistic social practices and ideological assumptions” (Schiffrin, Tannen & Hamilton, 2003, ¶ 2) that aid in constructing the concept the word comes to represent.

counseling, and community support services, including appropriate education and vocational training" (National Alliance on Mental Illness (NAMI), 2006, p. 5).

Mental illness significantly impacts the lives of many people and the estimated number of persons affected is increasing. One in five Canadians live with a mental illness or mental health problem each year. These 6.7 million individuals grossly outnumber those with other illnesses such as type-two diabetes (2.2 million) (Mental Health Commission of Canada (MHCC), 2013). According to Pearson, Janz, and Ali (2012), one in three Canadians (~ 9.1 million) meet the criteria for mental illness or substance abuse disorders. The remainder of the population will know of or care for someone with a mental illness (Alberta Mental Health Board (AMHB) and The Institute of Health Economics (IHE), 2006).

The considerable prevalence of mental health issues in Canada and around the world, as well as the challenges in delivering appropriate and timely health care services, is a pressing concern. Statistics Canada (2012) reported that for 2009 to 2010, 25.5% of all hospital stays involved a patient with a mental illness as a primary or secondary diagnosis. In the same report, it was identified these hospital stays were attributed to less than one percent of the total population. In Canada, there is an alarming rate of hospital readmissions for individuals with mental illness; 11.5% of individuals discharged will be readmitted within 30 days (Canadian Institute for Health Information (CIHI), 2013a), a rate similar to that found in Newfoundland and Labrador (NL) (11.2%) (CIHI, 2013b). The rates of frequent hospitalization (three or more admissions in one year) are also disconcerting. In Canada, 11% of those with mental illness were readmitted to hospital three or more times in 2012-2013. In NL, it was 13.8% (CIHI, 2015). Individuals who have a mental illness tend to stay in hospital far longer than those who do not (Statistics Canada, 2012). This risk increases with age and according to the diagnosis. For example, individuals with schizophrenia are particularly at risk for longer hospital stays and frequent readmissions (CIHI, 2005). The economic burden of mental illness is also increasing. Health Canada (2002) reported that in 1993 the economic burden associated with mental illness amounted to $7.331 billion. More recent estimates place this burden at $51 billion per year. This includes costs in health care, lowered productivity, and quality of life (MHCC, n.d.; Lim, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2008). This staggering amount represents 2.8% of Canada's gross domestic product (GDP) in 2011 (MHCC, n.d.).

Historically, individuals with mental illness experienced lengthy hospital admissions for exacerbations of their illness. Prior to the advent of active treatment, such as pharmacotherapy, in the early to mid-1900s, individuals suffering from SPMIs were often detained for indefinite periods of time in mental institutions. For some, the institution became their home and there was little hope of release back into the community. Over the past few decades, however, mental health care has shifted from an institutional focus to one of community integration. This has been facilitated through treatment advancements, evolving societal beliefs, changing fiscal management in health care, and influence from the patient advocacy movement (Morrow, Smith, Pederson, Battersby & Lesage, 2006). While this shift away from institutionalization has been largely beneficial, the advancement of community mental health care has lagged behind many other areas in health care delivery. This is evidenced by a lack of proportional, comprehensive, and appropriate resources in place before and during this time of deinstitutionalization (Trueman, 2003). As a result, many individuals with severe mental illness are left on the margins of existence. All too often, individuals decompensate to a severely compromised state before intervention is offered or accessed (Graham, 2006).

In recent years, the Canadian Federal Government (through Health Canada) has provided funding for a Mental Health Commission of Canada (MHCC) based on recommendations from *Out of the Shadows at Last* (The Standing Senate Committee on Social Affairs, Science and Technology, 2006), a report produced from the first pan-Canadian study of mental health. The MHCC is described as the following:

> … a catalyst for improving the mental health system and changing the attitudes and behaviours of Canadians around mental health issues. Through its unique mandate from Health Canada, the MHCC brings together leaders and organizations from across the country to accelerate these changes (MHCC, 2015b, ¶ 1).

The MHCC has identified six strategic directions for its work. These involve the areas of: promoting mental health across the lifespan; fostering recovery; providing access to services; reducing disparities in risk factors and service access; working with First Nations, Inuit, and Métis communities; and fostering leadership, knowledge, and collaboration (MHCC, 2012, see p. 11). The targets of these strategic directions taken by the MHCC are reflected in much of the literature reviewed here regarding living with mental illness.

Community Treatment Orders

Mental Health Legislation: A Backgrounder

The *Canadian Constitution* (Government of Canada, 1867/1982) supersedes all other legislation in Canada, seconded by *Canadian Charter of Rights and Freedoms* (1982) (henceforth referred to as the *Charter*). All mental health legislation in Canada must be in accordance with the *Charter*. Any existing law that violates the *Charter* is open to court challenge. If such a challenge was successful, the law would require government amendment, and any subsequent new legislation must be created in accordance with the *Charter*.

Most mental health acts in Canada have their beginnings in British Law, with Quebec's legislation being influenced, as well, by French law (Gray, Shone & Liddle, 2008). More recently, there has been a noted influence from changes made, not only in British mental health legislation, but also in American, Australian, and New Zealand mental health legislation. In Canada, mental health law involves three types of legislation: the mental health act of each province and territory; the federal *Criminal Code of Canada* (Government of Canada, 1985b); and provincial and territorial consent to treatment, adult guardianship, and adult protection legislation (Gray et al.). Mental health acts generally address the following: voluntary admission procedures and criteria; involuntary admission procedures and criteria; treatment authorization and refusal; rights and safeguards; assisted community treatment (including leave and CTOs); mandated services; and other provisions such as confidentiality and restraint (Gray et al., 2008, pp. 19-20).

CTOs are a form of mandatory outpatient treatment (MOT). MOT involves "legal provisions that require individuals with a mental illness to comply with a treatment plan while living in the community" (O'Reilly et al., 2009, p.1). Therefore, in legally mandating mental health care, a CTO is not treatment in and of itself (Canadian Mental Health Association (CMHA), 2012). A CTO may be enacted under a variety of conditions. These include situations in which persons with SPMI frequently become mentally unwell to the point of posing a safety risk to themselves or others, often due to treatment non-adherence, and who therefore require frequent readmission to treatment facilities (Centre for Addiction and Mental Health (CAMH) & CMHA, 2005; Elfstrom, 2002; Heffern & Austin, 1999; Jobling, 2014; Munetz, Galon & Frese, 2003; Trueman, 2003). Other reasons given for community treatment laws include: assisting with integration into the community; decreasing admissions and length of hospital stays and thereby reducing costs and making hospital beds available to others; improving prognosis by decreasing periods of untreated psychosis; decreasing traumatic aspects of hospitalization (Gray et al., 2008, p. 270), and concerns regarding public safety (Jobling). Schizophrenia is frequently cited as the diagnosis of individuals who are placed on CTOs (McLeod, 2012).

Proponents of CTOs describe these measures as less restrictive than mandatory inpatient admissions and are therefore in accordance with legal and *Charter* principles (Gray et al., 2008). The Canadian Psychiatric Association's position paper in support of MOT (O'Reilly et al., 2009) states that:

> … when a patient has demonstrated a pattern of repeated nonadherence to treatment followed by decompensation to a level that requires involuntary patient admission, it may be clinically and ethically appropriate to take a preemptive approach to reduce the risk of serious harm to the patient and, although less common, to others. Mental health legislation should be

> structured in a way that ensures that these clinical and ethical considerations are met (p. 2).

While many national and provincial associations, such as the Schizophrenia Society of Canada, are generally supportive of the use of CTOs, there is varied support from provincial branches of CMHA (Gray et al., 2008). The national branch of CMHA has identified the following arguments against mandating community treatment:

- It is a further erosion of individual rights and diminishes the ability of consumers to be in control of their lives.
- If an adequate mental health system were in place, community committal would not be needed.
- Forced treatment can jeopardize long-term relationships with caregivers (CMHA, 2012, ¶ 3).

Some of the literature describes CTOs as either diversionary or preventative in nature. Diversionary measures keep individuals, who would otherwise qualify for hospital admission, in the least restrictive community environment. Preventative measures act to promote an individual's level of well-being in the community so that they do not become unwell and pose a risk to self or others (Cullen-Drill & Schilling, 2008). The process of achieving these goals can arrive from various approaches. For example, CTOs involve requiring individuals to be released from an institution on the condition that they will adhere to the treatment program and not become dangerous. The patient's symptoms may (and indeed, in many provinces, must) fit institutional admission criteria, but for whatever reason, the person could be treated in the community (Wales & Hiday, 2006). Treatments may involve mandatory medication compliance, attendance for appointments or individual or group therapy, or any other treatment deemed appropriate (CMHA, 1998). Individuals may also be required to live in certain areas and have their ability to travel restricted (Campbell, Brophy, Healy & O'Brien, 2006). This can impact on a person's ability to maintain social relationships and avail of supports that were in place prior to the CTO. If a person steps outside these parameters, she[4] risks being readmitted to a treatment facility.

All Canadian provinces have mental health acts that identify circumstances in which an individual may be involuntarily admitted to a hospital for treatment (CMHA, 2012). Not all, however, have such provisos for involuntary community treatment (Kent-Wilkinson, 2015). Some mental health acts refer to short leaves from hospital. In Canada, Saskatchewan (Government of Saskatchewan, 2004), Ontario (Government of Ontario, 1990), Nova Scotia (Government of Nova Scotia, 2004), NL (Government of Newfoundland and Labrador, 2006a), and Alberta (Government of Alberta, 2009) include CTOs within their mental health act legislation. Saskatchewan was the first province to do so in 1995 (Trueman, 2003). British Columbia (Government of British Columbia, 1996), Manitoba (Government of Manitoba, 1998), and Prince Edward Island (Government of Prince Edward Island, 2013) have provisos in their legislation for extended leave from hospital, while New Brunswick (Government of New Brunswick, 1973) and the three territories (Northwest Territories, Nunavut, and Yukon) do not have any stipulations for hospital leave or CTOs (Kent-Wilkinson)[5]. All CTOs in Canada contain the following: committal criteria; psychiatric history criteria; a treatment plan; identification of available services; verification that rights advice has been given; and

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[4] In this dissertation, I have chosen to use feminine pronouns.

[5] See Appendix A for a summary of CTOs in Canadian mental health acts.

notification that consent or authorization for the order has been obtained (Gray et al., 2008).

In the case of NL, for example, the new *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) provides guidelines as to when and under what circumstances a person can be subjected to a CTO. The individual must have a history of mental illness and require ongoing treatment or supervision in the community. If such care was not provided, there must be an identifiable risk that the person would become harmful to self or others. The person, because of her severe mental illness, would have to demonstrate a lack of insight or understanding into its nature and need for treatment and therefore, she would be unlikely to voluntarily agree to treatment. As well, if the person does not avail of such services, then her mental status and level of functioning will continue to deteriorate. To be eligible, a person is required to have at least three involuntary admissions to a mental health facility in the past two years, or have previously been on a CTO.

Mental health acts in Canada that have options for mandated community treatment are similar in basic assumptions and criteria, although their implementation details may vary. For example, in Saskatchewan, CTOs are valid for three months (Government of Saskatchewan, 2004) versus the six months outlined by NL, Nova Scotia and Alberta (Government of Alberta, 2009; Government of Newfoundland and Labrador, 2006a; Government of Nova Scotia, 2004). Some acts, such as those in Alberta and Nova Scotia do not explicitly outline limitations on how many times a CTO can be renewed (Government of Alberta, 2009; Government of Nova Scotia, 2004). Therefore, in these provinces, it is plausible that a person could be on a CTO for a lengthy period of time, possibly indefinitely. As well, the Alberta and NL mental health legislation identify the "reasonable measures" that peace officers can take in remanding individuals to psychiatric assessment if they break the terms of their CTO, including entering homes and using physical restraint (Government of Alberta, 2009; Government of Newfoundland and Labrador, 2006a).

CTO legislation is present in many countries and was first used in Australia in 1986 (Russell, 2011). Beyond Australia and Canada, they are in effect in the United States (Kent-Wilkinson & Boyd, 2006), New Zealand (Ministry of Health New Zealand, n.d.), and the United Kingdom (Department of Health, 2007). In some jurisdictions, the patient does not have to be in hospital in order to have the CTO initiated nor does she necessarily have to meet the same criteria as an involuntarily admitted patient (Gray & O'Reilly, 2001). The frequency of enacting CTOs also varies among different countries. For example, in Saskatchewan, Canada, the rates of use were approximately 2 per 100,000 when first implemented (Lawton-Smith, 2005a). In Australia, the rates geographically vary. In Tasmania, their use is 30.2 per 100,000, whereas in Victoria, they are per 98.8 per100, 000[6] (Light, Kerridge, Ryan, & Robertson, 2012). There have been steady increases in CTO implementation since their first inception in many countries. For example, in New York State, the CTO rates have increased to 15.2 per 100,000 (New York State Office of Mental Health, 2012). In England, CTO use increased from 3325 to 4291 (29.1%) between March 2010 and March 2011 (O'Dowd, 2011). In some jurisdictions, such as Australia (with the exclusion of Tasmania), the rate of CTO use has exceeded all previous expectations (Light et al.). This is also the case in England and Wales. There, Lawton-Smith (2005b) predicted substantial increases in CTO use,

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[6] Australia has some of the highest rates of CTO use in the world (Light et al., 2012).

cautioning health services to plan, not for increases numbering in the hundreds, but the "thousands" (p. 24).

The impetus for the demand and creation of legislation related to CTOs has often been reactionary in nature. CTOs have been measures in response to horrific incidents involving individuals with mental illness (Erickson, 2005; Snow & Austin, 2009). The Ontario, Canada legislation, known as Brian's Law (Ontario Ministry of Health and Long Term Care, 2000), is named after an Ottawa sportscaster, Brian Smith, who was killed by an individual with mental illness ("Brian's Law Gets Hearing in Ottawa", 2000). In New York State, Kendra's Law is named for a young woman, Kendra Webdale, who, in 1999, was pushed in front of a subway train by an individual who had schizophrenia (McFadden, 1999). The creation of legislation in response to such tragedies unfortunately moves the focus (at least for the public) from the need for mandated health care for some persons with SPMI to the protection of the public from a mentally ill attacker (Kent-Wilkinson & Boyd, 2006). In NL, the push for CTO legislation in mental health legislation grew strength after police killed two individuals with mental illness in 2000 (Luther, 2003). A similar situation occurred in Alberta in 2004 where a man was fatally shot by police after killing a Royal Canadian Mounted Police (RCMP) officer (Cormier, 2006). In all instances, it was identified that closer psychiatric follow-up, possibly through the use of CTOs, would have helped these individuals.

Variances in Research Findings

While proponents of CTOs have previously lauded their use as an exemplar of "sound policy" (Geller & Stanley, 2005), their use is not without controversy. There is inconsistent evidence regarding the success of CTOs (Dawson, Romans, Gibbs & Ratter, 2003; Mullen, Dawson & Gibbs, 2006). Some research indicates that CTOs contribute to lower hospital readmission rates (Hunt, daSilva, Lurie, & Goldbloom, 2007; Kallapiran, Sankaranarayanan, & Lewin, 2010; Segal & Burgess, 2006b,c) but this is inconclusive, as researchers have also found no difference in studies with CTO and comparison groups (Segal, 2006c). There have been inconsistent research results exploring reductions in lengths of stay for individuals who are being placed on CTOs (Hunt et al.; Kallapiran et al.; Kisely, Xiao & Preston, 2004; Segal & Burgess, 2006a,c). There is some indication that individuals who are on CTOs have increased time in the community between hospital admissions (Frank, Perry, Kean, Maxine, & Geagea, 2005) and fewer readmissions overall (Segal & Burgess, 2008). In addition, it is suggested that individuals who are on CTOs are more likely to access community services. However, this access is most likely compelled by the CTO as little difference has been identified in those accessing services after a CTO has been completed and those who are not on CTOs (Segal & Burgess, 2006c).

A further factor is the challenge related to ethically designing intervention studies, such as randomized control trials (RCTs), in order to determine the efficacy of CTOs. According to a Cochrane Review by Kisely and Campbell (2014), only three RCTs have been completed and published (Burns et al., 2013; Steadman et al., 2001; Swartz, Swanson, Wagner, Burns, Hiday & Borum, 1999). The first RCT, conducted in North Carolina, found that mandatory outpatient treatment contributed to reductions in hospitalizations, lengths of stay, victimization, and violent behavior (Swartz, Swanson, Hiday, Wagner, Burns, & Borum, 2001). Further, it found that to accomplish this, sustained and intensive treatment was needed for individuals subjected to CTOs (Swartz et al., 1999).

These results notably vary from the other two RCTs. Steadman et al. (2001) conducted their RCT with individuals who were involved with a three-year pilot outpatient commitment program based at Bellevue Hospital in New York City. Individuals were randomly assigned to a group receiving court ordered treatment or to a group with enhanced community services. No statistically significant results were found between the two groups. The most recent and largest RCT study from Burns et al. (2013) utilized a non-blinded parallel-arm RCT in England and Wales. Involuntarily admitted patients were randomly assigned to a CTO or a Section 17 leave of absence from the hospital[7]. After twelve months, there was no significant difference between the two groups in terms of the number of readmissions to hospitals. Patients did tend to stay longer on CTOs than on a hospital leave of absence but the amount of self-reported contact with services did not differ.

Other empirical results are, for the most part, based on conflicting correlational research that cannot reveal causality. For example, medication adherence appears to be positively correlated with the amount of time one is on a CTO (Maughan, Molodynski, Rugkåsa & Burns, 2014). Other work by Van Dorn et al. (2010) found that individuals who were on CTOs for less than six months had decreased medication compliance rates, while individuals who were on CTOs for longer than six months had higher adherence rates once the CTO was completed. The reasons for these differences could only be speculated. Another study by Awara, Jaffar, and Roberts (2013) followed 34 patients who

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[7] This leave of absence allows individuals to leave the hospital for extend periods of time with the possibility of being recalled back (Burns et al., 2013).

were on CTOs. These researchers found that there was a reduction in hospital admission days after being on a CTO ($\bar{x} = 24$ days) when compared with the mean number of days in hospital while on a CTO ($\bar{x} = 37$ days) and with the days of admission in the year before the CTO ($\bar{x} = 263$ days). Despite the lack of randomization or control groups, the authors determined that CTOs were effective in lowering hospital admissions.

Based on existing evidence, there is no certainty that invoking a CTO will result in improved outcomes in all patient cases. The manner in which CTO research has been conducted makes it challenging to determine CTO effectiveness. Considerable variability is evident in the indicators used to denote effectiveness, the patients who are included as participants, and the outcomes that are measured (O'Reilly, 2004). Those who do improve and maintain their well-being may do so from enhanced access to community support, more consistent and close follow-up, and improved quality of care; not solely from the treatment being mandated (Vaughan, McConaghy, Wolf, Myhr, & Black, 2000). Romans, Dawson, Mullen, and Gibbs (2004) also support this observation; regardless of a service being mandated or voluntary, it is the nature, "quality and extent" of the service that is important in their study (p. 840).

Legal-Ethical Concerns Related to CTOs

Ricoeur (1992) defined ethics as "aiming at the 'good life' with and for others in just institutions" (p.192). The manner in which we interact with and relate to one another is based on social norms regarding what is "right or wrong." Within any given society, there can be considerable variations among the populace as to what constitutes ethical behavior. The notion of CTOs, a measure to force a person into mental health treatment and services against her will, fuels substantial ethical and legal debate.

Human rights. First, there is concern that CTOs violate human rights. The United Nations' *Declaration of Human Rights,* in part, supports the argument against CTOs by identifying people's right to life, liberty, and security of person (Article 3) without undue interference (Article 12) (United Nations, 1948). However, Article 25 of the *Declaration* highlights people's right to an adequate standard of living that includes health, food, security, and shelter. This paradoxically supports the use of CTOs through facilitating the ability of individuals with SMPI to live in the community (CMHA, 1998) regardless of their social and personal circumstances, including illness or disability (United Nations).

The United Nations (UN) General Assembly has also ratified the *UN Convention of the Rights of Persons with Disabilities* (2007), which is aimed at protecting the rights and equality of individuals with disabilities. Depending on the nature and severity of their mental illness, individuals can be considered as disabled, thus requiring assurances this UN document provides. Like the *Declaration of Human Rights* (United Nations, 1948), the articles within the *Convention* document can be interpreted to either support or refute CTO use. For example, Article 16 identifies that individuals with disabilities have a right to be free from exploitation, violence and abuse. It can be argued that many individuals, because of their mental illness, are at an increased risk of being victimized, providing a rationale for enacting means, such as treatment, to reduce their vulnerability to such threats. Articles 19 and 28 focus on the living situations of individuals, including community inclusion, freedom to choose their living arrangements, and a reasonable standard of living. CTOs infringe upon these liberties in the sense that patients can be directed to live in certain areas where services are available. While the act of forcing someone to move is not desirable, in accessing services and facilitating mental health recovery, the person is more likely to attain and maintain a good living standard. Finally, Article 9 focuses on individuals' ability to live independently and be active participants in their lives. While CTOs can be restrictive in dictating what a person can or cannot do, with whom, when, and under what circumstances, by mandating treatment, CTOs can be a means of ensuring the person accesses treatment that can foster her ability of a person to be a full and active participant in society.

As previously noted, all Canadian law must be in accordance with the *Canadian Charter of Rights and Freedoms* (1982). There are a number of sections in the *Charter* that pertain to CTO legislation. Section 1 identifies the *Charter* as guaranteeing "the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society". In Section 2, the *Charter* identifies everyone as having "fundamental freedoms" such as freedom of conscience, thoughts, beliefs, opinions, and association. Any type of involuntary treatment, including CTOs, restricts, in some way, these freedoms. Criticism that CTOs restrict liberty and freedom, however, can be challenged in that "the purpose of CTOs is to restore true liberty and autonomy by treating mental illness that is responsible for interfering with liberty, freedom of thought, and true autonomy" (Gray et al., 2008, p. 312-313).

Competency and capacity. The ethical principle of autonomy, also known as a person's ability to make independent decisions (Beauchamp & Childress, 2009), is the focus of much of the debate regarding CTOs. Concerns with autonomy stem from the actual, and perceived, lack of capacity and competence of some individuals with mental illness. Capacity and competency are related terms. Capacity refers to having the ability to understand, appreciate, and reason decisions in the decision-making process for oneself and to communicate this decision to others (Applebaum & Grisso, 1995). This differs from competency, which is a legal term that denotes being able to understand an issue or life circumstance to the point where one can make a decision regarding it, and understand its consequences (Kent-Wilkinson & Boyd, 2006). Competency and capacity are not static states; they can fluctuate with time and circumstances. Therefore, “incapacity in one legal area does not necessarily imply incapacity in another” (Robertson, 1994, p. 46). While there are times that individuals may be suffering from the effects of a mental illness such that they cannot make independent decisions regarding their care, all individuals do not experience this level of deterioration, nor does this reduced competency remain constant (Robertson).

A mental status assessment is an examination of a person’s appearance, affect, behaviour, and cognition *at a point in time* (Lasiuk & Hegadoren, 2015) and the results of which can be situation-specific (O’Brien, 2010). Therefore, assessments are not writ in stone and one’s mental state can fluctuate. Any designation of permanent incapacity would thus contravene this reality (Kaiser, 2002). In the CTO literature, there is debate regarding how long a CTO should be in place as patients could be living with a CTO long after their psychiatric symptoms are stabilized (Segal & Burgess, 2006c). Such a possibility creates serious concern, as a patient may not be permanently mentally incapacitated.

Ironically, competency is usually a non-issue in health care unless the individual or family refuses any part of a recommended treatment; only then does the health care provider determine it to be of concern (Snow & Austin, 2009). There is also fear that a person who would be considered legally competent in a court of law may, in fact, face having a CTO involuntarily invoked (Erickson, 2005). The potential for error in mandating treatment for those who do not require such “heavy-handed” approaches is very real (McKinney, 2006).

In acute mental health care, questions of competency can arise during admission to a health facility, resulting in a voluntary or involuntary designation for the patient. Voluntary admissions usually involve the patient consenting or requesting admission, whereas involuntary admissions occur when the patient is mentally ill to the point of being at risk for harming self or others, and is assessed as being unable to make autonomous decisions. It is possible for patients to be admitted voluntarily to a facility even though their mental status is such that they do not have the capacity to consent (Robertson, 1994). Because they did not refuse admission when offered, they did not require the “incompetent” designation in order to be coerced into entering the facility. However, from a legal perspective, voluntary admissions, consent to admission, and treatment must be given by a competent person (Kaiser, 2002).

Patients subjected to CTOs often have a history of frequent relapses in their mental status that were determined to require mandated mental health treatment. While the patient might not be mentally incompetent in all areas of decision-making at the time a CTO is enacted, they must demonstrate deficiency in the area of treatment decision-making. These considerations relate back to the previous description of preventative versus diversionary CTOs. With preventative CTOs, a patient does not need to be incompetent at the time of CTO use. It is based on the concern that this patient, when unwell, is at significant risk of harming self or others. With diversionary CTOs, a patient is diverted to the community, as opposed to being admitted to a facility. However, the patient is deemed incompetent to make treatment decisions at this time.

With respect to treatment decision-making, the patient should have "an ability to appreciate the nature and consequences of the decision" (Robertson, 1994, p. 467-468). There is evidence to support that individuals on CTOs do have issues in this area. In a study by Milne, O'Brien, and McKenna (2009), the majority of individuals who were on a CTO demonstrated a deficit when tested on decision-making abilities. However, as previously stated, incompetence does not automatically infer that an individual is unable to make *any* decision. Instead, there is a consideration of the attributes of the person, along with the nature of the decision to be made (Kaiser, 2002).

These discrepancies in the use of incompetence as a determinant for CTO use are confusing at best. They also highlight gaps in mental health act legislation. Take for example, the conditions under which a CTO can be used as outlined in the *Newfoundland and Labrador Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a). These include the patient having at least three involuntary admissions or being on a CTO in the preceding two-year period. Potentially, there could be patients in the mental health system who have a lengthy history of poorly managed mental illness but, because they do not have the requisite number of involuntary admissions during the stipulated time frame, are considered ineligible for a CTO.

Coercion. Health care professionals, including nurses, attempt to balance the individual's right to make independent decisions with the desire to protect the person and others from harm. In doing so, the health care professional can be seen to behave in a paternalistic manner (Playle & Keeley, 1998). Paternalism involves a person acting on behalf of and against the wishes of another with the goal of doing good (beneficence) or avoiding harm (non-maleficence) (Beauchamp & Childress, 2009). Paternalistic measures can take a subtle or overt approach to coercing an individual, who may be deemed incompetent to make such decisions, to engage in treatment against his or her will.

Coercion is "the power to force compliance with authority using the threat of sanctions, including physical punishment, deprivation of liberty, financial penalty, or some other undesirable consequence" (Geller, Fisher, Grudzinskas, Clayfield & Lawlor, 2006, p. 551). There is a range in the coercive measures that can be implemented within a health care context. Szmukler and Appelbaum (2008) identify (ranging in least coercive to most): persuasion; interpersonal leverage; inducements; treats; and compulsory treatment. CTOs fall within the most coercive category under this classification. The authors note that such measures may be necessary when the health interests of the patient or the protection of others is at stake.

The term "power" refers to the capacity to act in a certain manner or exert physical strength or force. Stating that one has power means that one has authority or influence resulting in the ability to control. It also refers to the person, organization, practice, or belief wielding such capacity. Interactions with health care professionals, family, friends, and the public are among the many avenues through which power can be exerted over people with mental illness (Foucault, 1995). Much of the criticism regarding professional power comes from the paternalistic role of the health care professional as the "definers of health/illness and proper treatment" (Playle & Keeley, 1998, p. 306). Under this premise, the professional's role is to treat while the role of the patient is to comply.

Simply stated, compliance occurs when "patients [do] what the health care professionals want them to do" (Fletcher, 1989, p. 453) with patients who do not comply sometimes considered as incompetent or lacking understanding into their illness (Graham, 2006). To overcome the problematic nature of compliance, mental health nurses learn how to exert their will with greater subtly and with manipulation that is disguised as therapeutic (Playle & Keeley, 1998), leading to an approach known as "benevolent coercion" (Stevenson & Cutcliffe, 2006).

Justice. The principle of justice involves giving due diligence to what is considered to be fair. This can involve the allocation of sparse resources and services (Beauchamp & Childress, 2009). What is just and what is fair needs to be considered from the individual, family, health care professional, health system, and public perspectives. Treatment and support for individuals with mental illness needs to be timely, available and accessible, yet also fiscally responsible. The special needs and circumstances of individuals and families must be respected and addressed fairly by those in the health and judicial systems. Likewise, the representatives of these systems need adequate preparation and the ability to engage in meeting the needs of those with mental health concerns. Linked with justice is the concept of reciprocity, which refers to the fact that people have both the right to fair treatment as well as the responsibility to treat others fairly (Beauchamp & Childress). If individuals are to have certain civil liberties removed from them, such as in the case with CTOs, then there has to be certain benefits to having, for example, mandatory engagement in a treatment plan and access to services (O'Reilly, et al., 2009).

There is some concern that individuals in compulsory treatment plans may siphon services from those voluntarily taking part in community mental health care. This concern was explored by Swanson et al. (2010) who found, in the beginnings of a newly minted compulsory assertive community treatment program, that there was evidence of some individuals, especially those newly placed in treatment, “skipping the line” to access community services (as compared to those who were voluntary). However, these patterns changed with usage rates becoming more even as the program progressed.

Risk. A considerable amount of the discourse surrounding CTOs is on the concept of risk. A quick search for a definition for the word yields descriptors such as being exposed to danger or a threat, and that the likelihood of experiencing harm from such exposure is high (Oxford Dictionary, 2015). In mental health legislation, the term risk is associated with protecting someone from harm. Generally, when one is doing this, the priority is to first protect them from physical harm and, secondly from psychological and emotional harm (Robertson, 1994). The target of this protection can be the individual with a mental illness whose mental illness can render her cognitively, emotionally, spiritually, and physically depleted and vulnerable. It can also be directed towards others with whom the individual associates, such as family members and friends, or the public at large.

Legally, the risk for harm or death to one’s person or to others is the strongest motivator for coercive intervention (Kaiser, 2002). From a utilitarian perspective (Beauchamp & Childress, 2009), risk is examined considering what would provide the greatest amount of safety and security for the greatest number of people. Infringing on the rights of the few, such as those individuals who are placed on CTOs, is argued to be beneficial for the many. The argument for using coercive measures to protect others is criticized as being too broad, especially when the risk of being severely harmed by a person with mental illness is low (Szmuckler & Appelbaum, 2008). Such a focus on the protection of the public perpetuates the image of the dangerous mental patient who is a threat to society. Societal perceptions greatly affect the manner in which individuals with SPMI are treated and their risk for harm appraised. With media portrayal of people with mental illness as attackers and murders (CMHA, 1998), there is an outcry for greater control of individuals in mental health care. However, when community care was introduced in the United Kingdom, there was a decrease in the number of homicides committed (Taylor & Gunn, 1999). Despite these statistics, there is a documented association with CTO and the risk for an individual to engage in harm to others. Using logistic regression analysis of Mental Health and Offender Databases, Xiao, Preston and Kisely (2004) compared 265 patients on CTOs with a group of 265 individuals who had been discharged from inpatient care or from a CTO. One of the significant predictors of CTO use was a history of violence towards others.[8] Causality could not be determined in this study and therefore "it was difficult to say whether compulsory community treatment really protects patients from self-harm or harm to others" (p. 617).

The fact that the development of CTO legislation is often based in murderous acts committed by a person with mental illness does absolutely nothing for the perception of mental health in the public realm. In addition, this criminalization of mental illness (Geller et al, 2006; O'Reilly, Keegan, Corring, Shrikhande & Natarajan, 2006) further adds to the stigma. This vilification of the mental health patient is not new but causes

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[8] The other significant predictors of CTO use included previous use of health services, placement in after-care, a history of mental illness (particularly schizophrenia), and being in a relationship (Xiao et al., 2004).

great concern. It is difficult to determine “the precise moment when a person’s illness makes dangerousness likely” (O’Reilly et al., 2009, p. 2). Assessing risk considers the individual’s history and current mental status in relation to the organization’s concerns. This is done using professional knowledge and clinical judgment while also considering statistical risk. There is concern that the assessment and ranking of risk is a form of codification and a means of further exercising control over individuals in mental health care. This codification process becomes no longer in the interest of the patient but in the institution that requires risk for harm to be communicated in a standardized manner to others (Crowe & Carlyle, 2003), and might not be fully reflective of the contextual considerations inherent in each patient situation.

Risk assessment is a mental health-nursing role (Kudless & White, 2007). Mental health nurses often engage in overt expressions of their professional power if there is a perceived risk for harm occurring to either the patient or the public. Mandatory treatment, such as community treatment orders (CTOs), exemplify how mental health nurses, through their professional position, have at their disposal legislation and policies allowing them to forcibly treat an individual under certain circumstances. As a result, mental health nurses act as agents of social control (Szasz, 1970), a position with which they are not entirely comfortable (Hannigan & Cutcliffe, 2002). In acting for the greater good of society, patients’ individual rights are compromised.

However, in keeping with reciprocity (Beauchamp & Childress, 2009), the loss of a person’s rights in placing her on a CTO is bartered against the opportunity to live in the community and avoid re-hospitalization. The goal of community care is to support the patient in the least restrictive setting possible (Geller et al, 2006). Grey et al. (2008)

contend that assisted community treatment, including CTOs, is less restrictive of a person’s liberty in comparison to an inpatient admission. However, with more people with SPMI living in the community and experiencing more severe exacerbations of their mental health symptoms (Geller et al., 2006; Graham, 2006), there is a desire to protect the public from the perceived potential dangers of an individual with mental illness (Geller et al.; Oberle & Tenmore, 2000).

Relational ethics. The consideration and use of CTOs in current mental health nursing practice result in complex situations that require a multi-factorial approach. Mental illnesses influence a person’s physical, mental, family, and social health, sometimes without the person’s full understanding or awareness of the potential for this harm (Healey-Ogden, 2006). This can also influence capacity to provide consent for treatment and being competent to understand the outcomes of decisions. As previously examined, the fluctuating nature of capacity and competency (Robertson, 1994) further results in considerable ambiguities in determining mental status and how to include the patient in treatment decision-making. Engaging the patient and her family requires a building of trust and commitment to understanding the individual concerns and social contexts these people have.

These ethically laden patient circumstances require a response that embraces the complex, contextual nature of mental illness and the lives of those experiencing it. Relational ethics emphasizes the ethical importance of the relationships in which people engage. It is defined by Austin, Bergum and Dossetor (2003) as being “an ethic that is grounded in our commitments to each other” (p. 46). In order to act ethically, one must make the effort to become familiar with the other. The knowledge gained from this engagement forms the basis of ethical practice. Relational ethics values individualized approaches to exploring ethical concerns. The use of ethical principles and codes, while helpful, are often not sufficient to guide acting fittingly in response to the needs of all people in all situations (Austin, Bergum & Dossetor; Gadow, 1999; Thompson, 2002).

Relational ethics holds, as core elements, mutual respect, the effort to engage with each other on a meaningful level, and the acceptance of the interdependent nature of this relationship (Austin et al., 2003). There is an understanding of, and willingness to work within, the uncertain nature of relationships and life circumstances. People are unique individuals who have within them an embodied knowledge and understanding of their lives that must be respected. There is also consideration of the complex environment in which this relationship takes place (Austin et al.; Bergum & Dossetor, 2005). For example, there are myriad variances in how people respond to seeking or avoiding treatment. A person could be frightened by a self-awareness that she is mentally ill and choose not to seek out assistance. The possibility of being labeled and stigmatized in making her illness known is worse than managing the symptoms of the illness itself (Corrigan & Wassel, 2008). People may fear being forced into treatment and having their rights taken (Cullen-Drill & Schilling, 2008). It is in knowing these valid concerns, the context in which the person believes in and holds these ideas, and in exploring with the individual how to best approach them, that a respectful relationship can develop.

Considerations of Those Affected by CTOs

Individuals with Mental Illness

There are numerous pragmatic issues with the use of CTOs. For instance, many individuals with a CTO have difficulties adhering to the mandated treatment regimes.

This can be due to such factors as adverse medication effects that make taking a particular medication uncomfortable or undesirable. While education and support regarding medications and other treatments is necessary for all patients, it becomes crucial for assisting patients with mandated treatments to sustain their compliance with them. While services and supports must be available in the community, accessing them may be a problem for the person on a CTO. Patients may, for instance, have difficulty in attending appointments due to transportation or childcare issues. It may be that their struggles with managing day-to-day crises and challenges, such as living in poverty and being homeless, may take precedence over attending an appointment (Trueman, 2003). Follow-up care that comes to the individual's homes can be an important strategy.

Individuals with mental health concerns offer conflicting information regarding their perceptions of CTOs (Munetz et al., 2003). Some patients perceive CTOs as coercive (Canvin, Bartlett, & Pinfold, 2002; Gibbs, Dawson, Ansley, & Mullen, 2005) and are dissatisfied with their treatment (Wynn & Myklebust, 2006), while others are more accepting of their use (O'Reilly et al., 2006; Riley, Høyer, & Lorem 2014). Riley et al. used a narrative approach to explore the experiences of coercion by individuals who were subjected to outpatient commitment in Norway. Individuals described a number of positive aspects of being on mandated community treatment (such as having a home, access to services, and more social benefits); however, a there were a number of negative experiences described. Beyond the fear of readmission and the need for mandated medication administration, there was the description of "one's living room [becoming] an institution outside the institution" (p. 510).

The legal system, which is tied to the medical system in enforcing the CTO, can be viewed as adversarial (Gault, 2009). Some patients have articulated their ambivalence regarding the benefits of being on a CTO and have been described as being “volunteers for compulsion” (Gibbs, Dawson & Mullen, 2005, p. 1093) or as begrudgingly “playing the game” (Gault, p. 509) in order to stay out of hospital. In this sense, the CTO can bring both “freedom and a lack of freedom, help and hindrance, restriction and liberty” and can act as a safeguard in case the person’s mental health status declined (Gibbs et al., p. 1096).

The patient’s development of insight or understanding of her mental illness, and its subsequent effect on treatment compliance appears to be a factor in determining the duration of a CTO (Dawson & Mullen, 2008). In medical terms, those who are identified as having a lack of insight are assessed as having a challenge in identifying one’s own thoughts and feelings as “unusual or abnormal” in comparison to others or when the individual is feeling well (Lasiuk & Hegadoren, 2015, p. 161). Concerns with insight are most often identified when a patient disagrees with a health care professional regarding a recommended course of treatment (Dawson & Mullen).

In a study conducted by Dawson and Mullen (2008), patients and psychiatrists were interviewed about their experiences with CTOs. Psychiatrists identified a lack of patient insight as a reason for prolonging a CTO, while developing insight was a reason for discontinuing a CTO. The rationale for this was the link between insight and treatment compliance. There is a belief that individuals with greater insight are more likely to engage in treatment. Patients described having some understanding of their illness but were still apprehensive regarding the need to take medications, giving rise to the possibility that insight is not a unified concept. There were various layers of what individuals understood in terms of having an illness, to needing treatment, to the outcomes of treatment compliance and noncompliance. Interviewed patients were generally agreeable to continue with the CTO in order to avoid the negative repercussions of noncompliance, being mainly hospitalization and having the police notified of any noncompliance.

The fear of being forced to engage in treatment, however, can act as a deterrent for patients seeking assistance (Van Dorn, Elbogen, Redlich, Swanson, Swartz & Mustillo, 2006; Zartaloudi & Madianos, 2010). This is supported by Galon and Wineman (2011), who explored the experiences individuals with SPMI had with coercion. Overall, the participants in mandated treatment reported a threefold increase in their perception of being coerced. There is also worry that coercion will prevent people from developing their own self-care, health maintenance and coping mechanisms (CMHA, 1998). Despite these documented fears, there is a tendency for health care professionals to make determinations regarding insight solely from their own perspectives, and not to fully consider the contexts that form the patients' perspectives. In assessing insight, health care professionals must be aware of the stance they are taking in making their observations (Dawson & Mullen, 2008).

Debate exists regarding the effectiveness of CTOs. Those that purport the benefits of CTOs state that there are reductions in hospitalizations, victimization, homelessness, violence, arrests, and incarceration. There are improvements in day-to-day functioning and in engaging in treatment and recovery. Both psychiatrists and mental health patients have identified these benefits (Gray et al., 2008). However, as previously discussed, the evidence supporting this varies. There is evidence that CTOs do not reduce hospital admission rates (Kisely, Smith, Preston & Xiao, 2006) and do not reduce the incidence of the “revolving door patient” (Kisely & Campbell, 2007). However, CTOs may assist with early intervention and reduced lengths of stay. In a large Canadian CTO study, Hunt et al. (2007) found that individuals with a CTO had less cumulative days in hospital, and postulated that patient commitment with case management and other support services can be facilitated as a result. Other identified benefits of CTOs for patients include having access to services, available community supports, a clear plan of care with projected patient outcomes, and an understanding into illness and treatment (CAMH and CMHA, 2005).

Conversely, in light of the previous review of literature pertaining to the legal and ethical concerns regarding CTOs, there is uncertainty that patients on CTOs are sufficiently informed of their rights while subjected to the legislation. Rolfe, Sheehan, and Davidson (2008) surveyed individuals on CTOs and obtained some disconcerting results. Sizable portions of those who responded reported they do not have enough information about CTOs (33%), that clinicians did not provide enough information as to what being on a CTO meant (39%), they were unaware of the right to a second opinion (44%), they were not informed about the treatment plan (55.5%), and they were not given the CTO form (23%). The ambiguity surrounding the “proper use” and effectiveness of CTOs for individuals with SPMI, a *legal* measure that jurisdictions have *detailed legislation and policies* surrounding, is tremendously disconcerting.

Families of those with Mental Illness

Families have been amongst the leading proponents for the use of CTOs. They frequently provide support for family members with severe mental illness and act to fill in the gaps that exist in the health care system (CMHA, 1998). According to Statistics Canada (2012), 7.6% of family caregivers are doing so with a family member with mental illness. These individuals have various responsibilities that require their attention. Health Canada (2002) reported that 70% of those who are providing care for individuals with a serious illness are women and 60% of this group are employed. A large minority of these individuals (20%) also provide care for another person who is ill or disabled. In addition, almost half of these family caregivers (47%) have been providing this assistance for over five years. It has been estimated that the informal work that families provide in caring for someone with a mental illness was equivalent to 12.8 billion dollars (CARP, 2008, p. 2).

This work is not bounded by the hours in the day or the days of the week. Individuals perform many functions beyond emotional and financial support. They are involved with ensuring that basic activities of daily living are performed and that their loved one is safe. Some provide care to their grandchildren when their adult children are unable (MacCourt, Family Caregivers Advisory Committee, and Mental Health Commission of Canada, 2013). In addition, family members are often the first to see early signs of relapse, such as personality changes, in the individual with mental illness. However, they feel this insight is often ignored (Hallam, 2007).

Being a support person for an individual with a chronic illness can take its toll. Statistics Canada (2012) identified that 16.5% of those family caregivers surveyed found their experiences to be "very stressful".[9] Angermeyer, Kilian, Wilms, and Wittmund (2006) found a significant association between the functional level of a person with mental illness and the self-reported quality of life of those family members and spouses caring for her. These caregivers reported lower levels of quality of life, psychological wellbeing, and social relationships, compared to the general population. The researchers also found an inverse relationship between the loved one's level of impairment and the caregiver's quality of life. Compounding this is the likelihood that family members feel powerless, isolated, unrecognized, undervalued, and in need of creating partnerships with health care professionals involved in care provision (Wilkinson & McAndrew, 2008). When this exclusion occurs, family members experience increased levels of stress (Gavois, Paulsson & Fridlund, 2006). Many family members also live in fear of what will happen to their loved one when she is mentally unwell (Hallam, 2007; O'Reilly et al., 2006) and view CTOs as providing a "safety net" (Stroud, Banks, & Doughty, 2015, p. 89) for those mandated to treatment. In this sense, CTOs are viewed as providing some assurance that patients will have their issues addressed and if not, at least they will be in receipt of inpatient care if the stipulations of the CTO are not followed.

Family support is an important factor in the recovery of those with mental illness (Gault, 2009), and their needs must also be addressed. They, themselves, are in need of support and education with respect to what their loved one is experiencing, particularly in the area of managing potentially violent exacerbations of the illness (Hallam, 2007). Studies such as those conducted by Chow et al. (2010) suggest the benefits of including family psycho-education support can lead, not only to a greater understanding of mental

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[9] The vast majority of these respondents reported stress on a rage from "somewhat" to "very" (Statistics Canada, 2012).

illness, but also to reduced caregiver burden, hostility, and conflicts, and increased overall well being. They must also be included in the discussions as to how to change the views of mental illness and of mental health care delivery in Canada and elsewhere. This stance is quite evident in the MHCC's document *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (2012), with the inclusion, in some form, of families in every one of its six strategic directions to "improv[e] mental health outcomes for all Canadians" (p. 9).

Mental Health Nurses

Mental health nursing practice is guided by the Canadian Federation of Mental Health Nurses (CFMHN) *Standards of Practice* which include: providing competent professional care through the development of the therapeutic relationship; performing and refining client assessments through the diagnostic and monitoring function; administering and monitoring therapeutic interventions; effectively managing rapidly changing situations; intervening through the teaching-coaching function; monitoring and ensuring the quality of health care practices; and practicing effectively within organizational and work-role functions (CFMHN, 2014). These standards reflect the necessary knowledge and performance expectations for nurses working within mental health care environments. A further guide for practice is the *Code of Ethics for Registered Nurses* (Canadian Nurses Association, 2008), which identifies the ethical values of nurses and their commitment to persons with health needs and/or receiving care. According to the *Code*, the ethical responsibilities of nursing are to: provide safe, compassionate, competent and ethical care; promote health and well-being; promote and respect informed decision making; preserve dignity; maintain privacy and confidentiality; promote justice;

and be accountable. There is recognition within both the *Standards of Practice* and *the Code of Ethics* that the societal context of nursing, which is constantly changing, has a strong influence on practice.

Mental health services are delivered in a variety of acute and community care settings and changes in health care delivery, health system funding, scopes of practice, and societal beliefs contribute to ongoing nursing challenges. Such challenges create tension for nurses working to deliver safe, compassionate, and ethical care for the patients, families, and communities with whom they engage. Within the context of CTOs, the challenge for nurses can be the considerable amount of monitoring and coordination involved with CTO, to the extent that some nurses feel overworked and less able to spend adequate amounts of time with all of their patients (Happell, Hoey, & Gaskin, 2012; Haque, Nolan, Dyke, & Khan, 2002; Henderson, Willis, Walter, & Toffoli, 2008; Muir-Cochrane, 2001) within an environment of staff shortages (Henderson, et al.). The realities of the health care system and, in particular, of community mental health care, can compromise individualized attentive care and follow-up (Henderson et al.; Perkins, Hudson, Gray & Stewart, 1998; Roberts, Battaglia & Epstein, 1999; Timms & Borrell, 2001; Winefield & Burnett, 1996). There can be additional challenges if the necessary services are not in place for a patient (Mullen et al., 2006) in terms of meeting their individual needs. At times, nurses can find themselves working outside of their "traditional scope of responsibility" in order to meet the complexity of their patients' needs (Elsom, Happell & Manias, 2007, p. 418), giving rise to concerns of liability and litigation (Elsom et al.).

Mental health nurses hold conflicting views of CTOs. While it is well established that patient treatment noncompliance is associated with a poor quality of life (O'Reilly et al., 2006) and that CTOs can aid in medication compliance (Coffey & Jenkins, 2002) and managing harmful behaviors (Jenkins & Coffey, 2002), nurses tend to be accepting of coercion only if they find it clearly benefits the patient (Hurley & Linsley, 2007; Lützén, 1998). Nurses and other health care professionals can have concerns with their role in the implementation of CTOs if they view it as one of "enforcer" and not "care provider" (CMHA, 1998). When this is the case, the therapeutic relationship, the crux of the professional interaction between a health care provider and a patient, is viewed as being seriously compromised (CMHA; Hannigan & Cutcliffe, 2002; Haque et al., 2002; Jenkins & Coffey, 2002; Mullen et al., 2006; O'Reilly et al., 2006; Patel, 2008). The primary reason why individuals are placed on CTOs is due to medication noncompliance, which can be viewed as a "bad" decision by nurses. It can be quite challenging to maintain the therapeutic relationship while patients make choices that do not lead to the most positive health outcomes. Despite these differences, nurses are morally and professionally obliged to maintain a professional demeanor with patients and continue to provide support for them (Magnusson & Lützén, 1999; Magnusson, Severinsson, & Lützén, 2002).

As previously described, the concept of risk is closely associated with the use of CTOs. There is concern that, with increased nursing responsibilities in CTOs and a lack of other resources, there will be an increased focus of risk assessment for nurses in supervised community mental health care (Gilbert & Plant, 2010). This heightened focus on risk management, and not on what is ideologically seen as "therapeutic", is also feared to have a negative result on the therapeutic relationship. Research in this area has explored such concerns and there is some evidence that the therapeutic relationship can be strengthened with the long-term use of CTOs (Romans et al., 2004). Arguably, this might be more so due to the increased amounts of time and knowledge spent in getting to know the patient (Addis & Gamble, 2004; Hurley & Linsley, 2007) versus the fact the person is on a CTO.

The challenge for nurses is finding a delicate balance between the desire for positive patient outcomes and harm reduction, and respect for patient autonomy (Hess, 1996; O'Brien, 2000). This balancing act may prove to be quite a formidable task, given the system constraints, the stigma associated with mental illness, and dearth of appropriate social supports and services. It is a further strain for nurses already working in complex community mental health environments with multifaceted and demanding responsibilities (Henderson et al., 2008).

The Public's Interest

Individuals in Canada have a right to access health are services, which the Federal Government funds, in part, with grants to the provincial governments. The *Canada Health Act* is a piece of legislation that pertains to these "cash contributions by Canada" and the "criteria and conditions in respect of insured health services and extended health care services" (Government of Canada, 1985a, ¶ 1). This legislation is based, in part, on the belief that Canadians "desire a system of health services that will promote physical and mental health protection against disease" (¶ 5). In this sense, from a federal level, there is a commitment to the provision of mental health services. In NL, there has been an increased interest in addressing mental health issues in the province. In the spring of 2015, the provincial government formed an All-Party Committee on Mental Health and Addictions to conduct "province-wide consultations, a review of current services, [and] presentations from experts, stakeholders, and regional health authorities" (All-Party Committee on Mental Health and Addictions , 2015, ¶ 1). These consultations have begun with responses to questions, asked at community fora, being posted on the *Be Heard NL* website (All Party Committee on Mental Health and Addictions). While there were a number of issues identified, such as the need for services, dealing with stigma, and challenges with daily living, there was very little feedback regarding the ACT teams and none regarding the use of CTOs in the province.

From a cost of service perspective, the care of individuals who experience SPMI significantly contributes to the overall use of mental health services and the burden of disease. For example, according to George et al. (1999), the economic burden of health care, administration, lost productivity, and incarceration costs associated with schizophrenia amounted to $2.35 billion in 1996. The authors postulated the indirect costs related to this illness were an additional $2 billion. Staggeringly, Murray and Lopez (1996) estimated that schizophrenia contributes to 3% of the global burden of disease. This is disproportionate to its prevalence rate of 1% of the population (Health Canada, 2002; National Institute of Mental Health, 2015). With approximately one fifth of the Canadian population having a mental health problem or illness, and taking into consideration the number of people without an illness who know someone who does, the issue of mental health affects everyone (MHCC, 2013).

With the changing shift of treatment for SPMI moving to the community setting and the increased use of mandatory community treatment in many jurisdictions (Light et al., 2012; New York State Office of Mental Health, 2012; O'Dowd, 2011), it is possible the public will become more aware of or have dealings with individuals whose lives are impacted by CTOs. This can increase the possibility of the public becoming more knowledgeable regarding this legislation. However, there is a concern that stigmatizing actions and attitudes will prevail. There is evidence to suggest that public contact with individuals with mental illness can positively change attitudes, particularly if the individuals are more closely known to one another. The nature of the contact, however, can also have an effect and seems to be linked with the emotions one feels when encountering a person with mental illness. If members of the public have an increased fear reaction to dealings with individuals with mental illness, it is more likely their attitudes will be negative (Pattyn, Verhaneghe & Bracke, 2013).

Related to this attitude formation is the propensity to vilify individuals with SPMI and see them as perpetrators of violent acts (CMHA, 1998). The fear that this incurs further contributes to the marginalization experienced by those with mental illness. While there may be societal pressure to control those with SPMI at risk of harming others, measures such as CTOs have been considered actions for which “no ordinary citizen” would stand (Geller et al., 2006, p. 553). Individuals with mental illness who are perceived as requiring additional monitoring may be considered deviant (Foucault, 1995) and negatively labeled (Crowe, 2000), doing little for promoting treatment compliance and seeking assistance. While it is imperative that the public has confidence in mental health services provided (Robertson & Collinson, 2011), they might fear the presence of those who have SPMI in the community. Given the considerable stigma that is endured by those with SPMI, the negative attention mental illness often receives does not act to better inform the public concerning mental illness, nor does it act to reduce society’s misperceptions of it.

In summary, there is textual evidence of a commitment to mental health and illness concerns in the actions of federal and provincial governments. How this commitment is actualized is debatable given the unfaltering challenges to the mental health system and to the lives of those who live with mental illness. Those who are subjected to CTOs tend to be individuals who have had significant health system use. In a publically funded health care system such as we have in Canada, this service use is of interest to the members of the public in questioning how effective are these services and how can care be best delivered. In addition, mental health and illness are impacted, in part, by larger societal concerns, such as employment, access to safe housing, and social support, all of which are of direct concern to the general public.

Summary

While, theoretically, CTOs can offer some stability to patients and their families, their use fosters considerable ethical concern and impacts how healthcare professionals, in particular nurses, care for and interact with those affected. CTOs often appear to be a better option when compared to others such as hospitalization, incarceration, and poor health status (Dawson & Mullen, 2008; Snow & Austin, 2009). There is realistic concern, however, that with the lack of experimental evidence to support their use, it is difficult to deem CTOs as ethical (Burns & Dawson, 2009) or effective (Kisely & Campbell, 2014). Given the pull between respecting the individual’s right to self-determination and doing what is best for the greater good of all involved, there is a need to thoughtfully consider how to best balance these concerns. However, before such strategizing begins, researchers must first explore what is concerting and influencing the social realities that shape the disconnect between CTO legislation, its implementation, and its effects on both mental health nursing practice and the lives of those impacted by CTO use. One means to undertake such an investigation is through the use of institutional ethnography. The following chapter outlines this method of investigation and research.

CHAPTER 3

METHODOLOGY AND METHODS

In this chapter, the theoretical underpinnings of institutional ethnography (IE) are briefly described, an overview of IE as a research method is provided, and the method of the current study delineated. The latter includes the study's problematic and aims, its setting, and the data collection processes that involved informants and selected documents. Rigor and the ethical considerations related to the study are also addressed.

Methodology

IE, as developed by sociologist Dorothy E. Smith, is the ethnographic exploration of institutional processes. It is premised on the belief that knowledge is socially organized (Smith, 2005). Smith, an early feminist scholar in sociology, was interested in the social constructions of women's knowledge. She observed that there was a mismatch between her "everyday world" (Smith, 1987) and the sociological knowledge that claimed to explain the social world in which she functioned as a woman, a single parent, and a lone female academic in a faculty dominated by men. During Smith's academic career, she guided the evolution of IE beyond its use for feminist critique to its present form as a means of questioning the hegemonic structures of knowledge (Campbell, 2003).

Theoretical Underpinnings of Institutional Ethnography

IE, while it does have its theoretical influences, does not seek to be theoretical in nature in that "institutional ethnography's project of inquiry and discovery rejects the dominance of theory" (Smith, 2005, p. 49). The goal of inquiry is to emerge from ideological discourse that clouds practices to observe what is actually happening in the everyday. As such, the purpose of IE is "to explore everyday life, not to theorize it"

(Campbell & Gregor, 2002, p. 50). Therefore, the results of IE research are not examined in terms of finding a conceptual framework that “regulates how data will be interpreted” (Smith, 2005, p. 50). The results can, however, be linked to other data sources for comparison and identification of any common threads or differences that exist.

While IE does not seek to theorize the everyday, it was developed from a number of different theories that influenced Smith throughout her graduate and professional experiences. These included Marxism, feminist standpoint theory, symbolic interactionism, and ethnomethodology. Smith was driven to examine her life experiences and those of other women in a manner that deviated from what was being done in male-dominated sociological research at the time. Smith later saw IE’s potential for exploring the social relations influencing the lives of others who have had their voices repressed, and not solely women (Doran, 1993). In doing so, IE has become “a sociology for people” (Smith, 2005). The following provides a brief overview of these theoretical influences that stimulated Dorothy Smith’s thinking in developing this research method.

Marxism. Dorothy Smith’s conceptualization of ruling relations emanates from her reading and selective uptake of the work of Karl Marx who explored the nature of social structure. In Marxism, social classes are differentiated by the material and social conditions in which people find themselves, and are further differentiated by the relations involved in the production of goods and services. The proletariat, or working class, are believed to have interests that are truly reflective of the interests of humanity. The struggle between the proletariat and the bourgeoisie, or ruling wealthy class, is foundational to social changes in Westernized societies and, because of this, Marxism seeks to establish public ownership of goods and services. While there are various forms of Marxism, most hold these as common beliefs (Encyclopedia Britannia, 2008).

Marx focused on relations in society, economics, and modes of production and conceptualized capitalist social relations as favoring the ruling class who enjoy the spoils of the labor of the working class (Carroll, 2006; Marx & Engels, 1998; Smith, 2004). Marx believed that treating labor as a commodity exemplified the reification of the individual (Kinsman, 2006). In this sense, labor, while essentially intangible, is something to be bought and sold. Dorothy Smith saw many parallels between the place of the proletariat (working class) in capitalist societies with the place of women. Women's experiences were excluded from knowledge development in science and academia and their work not valued. Yet, women's work was instrumental to maintaining the home, child rearing, and supporting males who worked outside the home and whose experiences and knowledge were recognized and valued (Smith, 1990).

One must also consider the context in which Marxism was developed. Marxist thought emerged in Europe and North America during the late 19th century in response to social and economic changes occurring with the production of goods and the use of human capital. The manner in which ruling was perpetuated at this time (and continues to be) evolved with the introduction and expansion of mass production of print technologies and other forms of communication. In capitalist societies, behaviour and production are concerted or managed from a centralized location, over a large area, in a number of settings, and among individuals who often will never meet (DeVault & McCoy, 2006). This is the premise for how translocal ruling relations impact local activities in a variety of different areas and at different times. Ruling relations exist outside of the individual local, everyday context and span many different local contexts. Defined by Smith (1993), ruling relations are:

> … the complex of extra-local relations that provide in contemporary societies a specialization of organization, control and initiative. They are those forms that we know as bureaucracy, administration, management, professional organization, and the media. They include also the complex of discourses, scientific, technical, and cultural, that intersect, interpenetrate, and coordinate the multiple sites of ruling (p. 6).

The study of ruling relations seeks to examine how people enact upon them, how people know how to do this, and what is in place to maintain their (the ruling relations') influence.

The process of ruling involves the use of power in a socially organized manner to influence the actions of others (Campbell & Gregor, 2002; Smith, 1993; 2005). People's everyday lives are shaped and organized by the considerable influence wielded by these relations of ruling (Mykhalovskiy & McCoy, 2002). A centralized location, authority, organization, or text (such as a policy document) is instrumental in shaping our everyday activities over a number of different work locations, communities, and even countries. These texts, especially in today's society, can be easily replicated and distributed over a great span of space and time. It connects far spread locales with the distant ruling centre (Smith, 1999). Despite the breadth of influence held by ruling relations, people often do not understand or are unaware of the social forces that influence their daily lives (Smith, 2005). IE seeks to elucidate these unseen factors as part of the inquiry. Likewise, the connections between ruling relations are not theoretically postulated. They exist and exert their influence in the everyday lives of people (Campbell & Gregor), and these empirical features of how people's work is linked and coordinated can be diagrammatically represented.

There is an emancipatory element to Marxist thought and different versions of Marxism focus on this to greater or lesser extents. Marx viewed the revelation of truth as a catalyst for social self-understanding and change. This finding of truth did not occur from detached observation of what was occurring in society but came from knowledge generated from being an active part of the social formation (Carroll, 2006). This was accomplished from "penetrating the ideological, surface level realities of bourgeois society, to show how an unjust social organization betrays the promises of liberal humanism" (p. 235). The goal of such an endeavor is not just to interpret or understand what is occurring but also to change it. To accomplish this, one must consider how the concern of interest is connected to other social issues (Carroll). IE, in emphasizing the idea of social connections and not interpersonal relationships, is drawing on Marx in this regard (DeVault, 2006).

Marx believed that people's consciousness and their real life activity could not be separated. A parallel with ethnomethodology (to be discussed later) is evident here in that the institutional ethnographer is interested in actual people and what they actually do in their activities of daily living (Dowling, 2006). Our consciousness exists through language, embodied ideas, principles, law, moralities, and religious beliefs that are created in the context of our actual social existence. In this sense, our consciousness is "in the world, not separated from it" (Smith, 2004, p. 449). As capitalism developed, consciousness became organized within ruling relations that coordinate and objectify it (Smith, 2005).

Marxism also addresses the influence of ideology in social relations. Ideology refers to a body of beliefs that guide individuals, classes, or cultures. These beliefs can be political or social in nature (Sargent, 2009). Smith's (2004) reading of Marx relies on Marx's analysis of ideology and how it is expressed in social and ruling relations. This is followed by a critique of formulations about ideological conceptualizations that are "biased or distorted," while social science is "objectively truthful" (Campbell, 2003, p. 8). When all knowledge is considered to be developed within ideological practices then *everything* becomes organized within particular interests. No knowledge is neutral. According to Smith (2004), while "ideology may begin with the real world, it proceeds by constructing a concept or theory that supplants the original and treats the original actualities as expressions or effects of the concept or theory" (p. 453). This colonial nature of ideology, as practices that organize knowledge and experiences, exemplifies ruling relations.

Marx's materiality made the linkages between ideology, capitalism, and ruling evident. Capitalism, with its dominating practices of power or influence, organizes and controls local activities (Smith, 1999). Today we are, even more so than in Marx's time, influenced by those in power who are unknown to and greatly distanced from us (Smith, 2005). This is where Smith cautions the practice of creating "theories [that sever] the categories or forms of thought from the actual social relations they reflect" (p. 458). IE, in establishing its focus in the everyday, seeks to reveal this knowledge that is often lost by the intelligentsia.

Feminist standpoint theory. Dorothy Smith's work is greatly influenced by early feminist thought. Dismayed by information purporting to be about and for women, Smith sought to develop a means of examining the everyday activities of women from the standpoint of women. Smith's use of the term standpoint references "a point of entry into discovering the social that does not subordinate the knowing subject to objectified forms of knowledge of society or political economy" (Smith, 2005, p. 10). It contends, "knowledge is always socially situated" (Harding, 2004, p. 7). Standpoint provides a way to understand how "some perspectives on society from which, however well-intentioned one may be, the real relations of humans with each other and with the natural world are not visible" (Hartsock, 1987, p. 159).

IE research begins from the standpoint or context of the person or persons in their everyday actualities who are "located" within a particular place within the social and ruling relations that coordinate that location (Campbell, 2003). The institutional ethnographer, in conducting the research, seeks to gain insight into the nature of ruling relations that might be hidden from the immediate awareness of those acting within it (Carroll, 2006). In IE, the goal is to uncover what is happening at a local level, with the everyday descriptions and standpoint of those living through the work and experiences, which can often be overshadowed by more dominant discourses.

Symbolic interactionism. During her graduate studies, Smith, as noted in Campbell (2003), explored the language work of George Herbert Mead, who is known for his contributions to symbolic interactionism. There are three main considerations in symbolic interactionism. Firstly, the meaning ascribed to things such as objects or experiences influence the manner in which people will act towards them. Secondly, such meaning is developed by people socially interacting with others. Finally, these meanings are "handled or modified through an interpretive process used by the person in dealing with the things they encounter" (Blumer, 1969, p. 2). From these basic constructs, Smith began to consider how to corporealize the nature of language from being an abstract concept into something that can be studied empirically.

According to Mead (1962), language does not just symbolize a "situation or object which is already there in advance" but makes possible "the existence or appearance of that situation or object" (p. 78). Therefore, language extends beyond the idea that a situation or object is symbolized through a word, as without the word, the situation or object would not exist (Mead). Because of this, people's realities and consciousness are mediated through language (Smith, 2006b) and, in this sense, language becomes a coordinator of people's knowledgeable practice.

There is a space within which the word is uttered by an individual (the speaker), and received by another (the hearer). Smith (2005) draws upon the work of Vološinov (1973) in describing this interindividual territory in which words are found. The word can be uttered in the same way by the speaker and hearer, but the manner in which it is interpreted by, or has meaning for, the speaker and the hearer can vary. Likewise, documents such as policies can be standardized by the form in which they are presented and distributed to a variety of settings. How these documents are activated and actually used in practice depend on where the document is being activated and who is using it. A document may hold words (such as *risk for deterioration*) that will be activated differently within the varied interindividual territory that the document circulates and the variety of practices it activates.

This generation of meaning occurs as the text is activated by the reader through its reading or use, resulting in certain socially influenced responses within the reader.

Individuals can also act on certain parts of the text and not others. Because texts result in activating the reader into forming some kind of response, the text coordinates people's practices in line with the power and control that the text intends. The reader of the text, in essence, is being coordinated by that text, and becomes its agent (Smith, 2005).

In exploring people's experiences of being ruled, one must consider how the intent behind the language used in texts can be visualized in social relations (Campbell, 2003). Language used in institutional discourse, for example, can mask the true meaning or intention of the terminology used in policies or rules. In order to understand text-mediated knowledge, one must be familiar with the ideological language of the institution and its ruling relations. If a person is not familiar with texts and their use, then they will not have this knowledge and understanding (Campbell & Gregor, 2002). This creates a division in the experiences of those who have the text-mediated knowledge and those who do not. It also creates a means of masking everyday experiences that can fall under ideological constructs or terminology that will subsume the details and variations of what is involved with a particular task or occurrence. These are processes that are of great interest to IE exploration.

Ethnomethodology. Harold Garfinkel's work in ethnomethodology also greatly influenced Dorothy Smith and her development of IE. According to Garfinkel (1967), ethnomethodology aims to uncover what is taken for granted. In IE, most of this focus involves exploring how work is organized. People act in certain ways, in certain situations, to make their actions fit the context. Garfinkel's work challenged the traditional views of sociology at the time he was forming and sharing his ideas. He viewed social organization as something that was based in everyday activities that were performed by individuals, and not as grand theoretical constructs (vom Lehn, 2014). In fact, Garfinkel argued “this social scientific striving for objectivity generates a corpus of knowledge that is fundamentally different from the practical knowledge that actors use in the contingent circumstances of everyday life” (p. 97).

Smith’s focus on activities anchored in the everyday is greatly influenced by ethnomethodology. Smith (2008) likens the approach of conducting IE research to “writing sociology at the ground level” (p. 417). She rejects a “top down” approach in conducting research that objectifies individuals and does not recognize their expert knowledge about how their everyday work that is related to matters being explored. Her approach provides a strategy to avoid “displacing the presence of people” where “agency has been transferred from people to sociological concepts” (p. 419).

Other considerations. Smith (2008) states that IE has “developed ways of discovering the translocal relations in people’s everyday lives and of tracking their organization” and that it “also explor[es] the relations and organizations’ of what might be otherwise called *power, governance*, and so on” (p. 421). In IE, investigation is directed towards understanding how institutional practices influence everyday work in order to secure the ruling interests. Ruling in this sense, sees the organizational interests and knowledge as being organized to outweigh other interests and knowledge (Campbell & Gregor, 2002). IE aims to make “power understandable in terms of relations between people and relations that rule” (p. 61). The French philosopher Foucault also viewed power and knowledge as being linked: whoever has the knowledge has the power. Power in this sense, is also contingent on the knowledge, and its sources, that are valued and esteemed in society (Foucault, 1980). However, while similar in some regards, Smith’s ideas pertaining to power were different than Foucault’s in so far as she remains stubbornly empirical. For Smith, knowledge is not something that circulates as abstract discourse, but rather, is manifest inside *discursive practices* that can be described and linked into everyday work.

Campbell (2001) describes Smith as being interested in exploring the intersection between power and knowledge and how its mediation through texts influences the manner in which knowledge and activities are coordinated. The influence of ruling relations can contravene what the individual believes is best to do in a given situation (Smith 1990). People may develop a localized body of knowledge regarding what they do in their daily activities that is in contradiction to or subordinated by the knowledge of the relations of ruling. This schism results in a “bifurcation of consciousness” within the individual (Smith, 1987, p. 6) and occurs when ideological knowledge is valued more so than what a person knows from doing their everyday actualities (Campbell, 2006).

Summary

Dorothy Smith did not see her knowledge and experiences as a mother being accurately represented by her sociological training and the theories she was teaching in the (then new) field of women’s studies. Knowledge about mothering and parenting was being organized by the sociological ideological structures in which she participated. It was from these observations about the contradictions embedded in what she came to call her “bifurcated consciousness” (Smith, 1987, p. 6) that she developed the “alternate sociology” (Smith, 2005, p. 2) she coined institutional ethnography.

Method

Institutional Ethnography Overview

Smith (2005) views IE as an *alternate sociology,* stressing that it differs from traditional approaches to sociological, and in particular, ethnographic research. Smith described IE as bringing the everyday/everynight world in which people live, with its ordinary behaviors, and language, into sociological discourse. Mykhalovskiy and McCoy (2002) identified this process as accessing a "practical knowledge" (p. 20) that assists in the understanding of people's everyday lives. IE research, therefore, begins with "identifying and describing the experiences of actual people" (Mykhalovskiy & Farrell, 2005, p. 164). These everyday life activities, according to Smith (2005) are "articulated and coordinated by extended social relations that are not visible from any particular social setting" (p. 36). Social relations organize life and IE seeks to explore what is perceived to be routine and "mundane" (Campbell, 2004, p. 28). By drawing the associations in these social relations, IE elucidates the connections between what have previously been formulated as concepts (e.g., power, authority, race, and gender) embedded in social context. This allows discovery of them as practices and activities that arise as troubling for people. (Campbell, 2004; DeVault, 2006).

Problematic and standpoint. IE researchers treat the terms problematic and standpoint as technical terms that are used to orient the study. A *problematic* is formulated within where people are positioned within the institutional order (Smith, 2005). This position is also known as their *standpoint*. Smith conceptualizes a problematic as a puzzle that is yet to be identified and explored. It is not a formal research question, nor is it a problem to be understood. It takes the experiences that are happening for the people whose standpoint is being explored and considers how:

> … these relations are a part of a complex of relations that reach beyond and

> coordinate what she or he is doing and what others are doing in relationship to her or him that doesn't begin and end with individual experience (p. 41-42).

In regards to both the problematic and the standpoint, the researcher is expected to use her knowledge of the setting to explore the broader social relations active within it. Thus, in some IE studies, where the researcher is familiar with the standpoint and the problems that arise there, that the researcher is a valuable source of data. Campbell (2004), states that the researcher must account for her own interests in the problematic and account for her knowledge concerning it. In this way, like other qualitative approaches, IE rejects the positivist stance of the detached researcher. The researcher can be an *embodied knower* who is familiar with the discourse surrounding the problematic (Campbell & Gregor, 2002). What the researcher knows about the topic under investigation is not considered bias. Instead, this familiarity with the context adds to how the researcher knowledgeably taking the standpoint from which the research will be conducted and supports the capacity to formulate a research problematic to be explicated.

Data collection. In formulating the research problematic, the researcher pays attention to aspects of the institutional process that are of issue, puzzling, troubling, or contradictory, listening carefully to how people speak of what is occurring in their lives. The process of using IE can involve talking to informants, observing behaviours, and reading texts (Campbell, 2004; Smith, 2005). It is different from other ethnographic approaches in that it treats descriptions of what is happening, not as the research topic, but as a way of gaining entry into the social relations of the setting (Campbell, 1998). For this present study, I interviewed informants and conducted textual analysis.

Interviews. Researchers ask questions concerning the everyday experience, or work, of individuals via unstructured interviews (Smith, 2005; Townsend, Langille & Ripley, 2003). Through such discussions, these informants act to provide the researcher with an understanding of their experiences. The interviews, in this sense, provides the researcher with an opportunity "to learn about a particular piece of the extended relational chain, to check the developing picture of coordinative processes, and to become aware of additional questions that need attention" (DeVault & McCoy, 2006, p. 23). The researcher is to act as a thoughtful and probing listener who is learning from the informant (Smith).

This exploration of everyday work is vital. IE has a "generous" (Smith, 2005, p. 151) conceptualization of work as a form of purposeful activity that includes "anything done by people that takes time and effort, that they mean to do, that is done under definite conditions, and with whatever means and tools, and that they may have to think about" (pp. 151-152). It also involves activities for which the person may or may not receive pay. Some of this work may not be easily recognized or readily visible, and therefore, it does not receive attention and recognition. As well, some of this work may be difficult to articulate or describe. DeVault (1991) identified this issue as it related to the challenges in articulating women's experiences, describing it as an *insufficiency of language*. Institutional or professional discourse in the forms of words, phrases, and terminology may mask what is actually involved in some work. In addition, although all informants are considered *expert knowers* of their work, they may not know enough to capture the bigger picture of what is happening in a situation. As Campbell and Gregor (2002) note, "people's knowledge and actions are already organized before they talk about them" (p. 78).

For example, in nursing, registered nurses are involved in collecting data from patients on admission to institutions. The guidelines for conducting this are available in textbooks and policy and procedure manuals. Generally, each facility or healthcare authority has approved forms to be completed that indicate what information is to be collected. What is collected as important in this process has been determined by others who have developed the form. It is based on what is considered to be appropriate from a health and legal perspective. The full intent of this work may be unknown to informants. Arguably, the institutional focus for accurate data collection could be more about reducing the risk for litigation than about clinical interests that nurses have about patients. Nonetheless, the nurses completing the form are organized within its pre-determined interests. Thus, “well intentioned work” by registered nurses might be “a part of oppressive relations of ruling” (Campbell, 2004, p. 39). Likewise, those creating the documents might not be fully aware of how the forms are actually completed in practice, the contexts under which they are used, and the challenges that exist in their completion.

Texts. Institutional discourse is examined to determine how it is linked with the other data sources. Because the ruling perspective is often represented through texts, the study of discourse in IE explores how institutions are constructed and coordinated through people’s engagement with documents. This is a critically important feature of social relations and is foundational to how IE can track *actions at a distance*. Language holds a privileged position within societies and indeed institutions (McCoy, 2006) and is a part of how people coordinate activity (Smith, 2005). Policies from a parent organization outline how to perform certain actions at its various different satellite locations. Texts stabilize language in-so-far that the printed form exists over time and place, and can be replicated, thus adding their ability to be standardized. In addition, texts such as policies can be distributed to these various satellite locations in print (hard copy format), or via email.

When examining texts, DeVault and McCoy (2006) advise consideration of the following:

- how the text comes to the informant and where it goes after the informant is done with it;
- what the informant needs to know in order to use the text (create it, respond to it, fill it out, and so on);
- what the informant does with, for, and on account of the text;
- how the text intersects with and depends on other texts and textual processes as sources of information, generators of conceptual frames, authorizing texts, and so on; and
- the conceptual framework that organizes the text and its competent reading (pp. 36-37).

Such documents do not work in isolation (Smith, 2005). For example, many organizations have mission and value statements that are influenced by societal factors, such as ideas and beliefs that can evolve over time.

It is important to follow how the text is activated from one point to another. Pence (2001) identified this as *processing interchanges* (p. 203-204) that influence how the informants' work is organized. Pence illustrated this process in her work with women who experienced domestic abuse. She described how women who reported abuse relayed their stories to police and others, who then documented this information according to institutionally mandated guidelines to be activated by others. Each interchange represents the point at which an individual takes up the text to act upon it according to his or her organizationally mandated work duties. Given the division of labor in an organization, a number of people could be involved with this process. Pence explored how texts involved with the reporting of such information mediated the process in which people experienced domestic violence found themselves, how they were treated, and how well their personal situations were understood. As such, the *person* as represented by their personal information, became a *case file* in which the individual, with her unique experiences, were lost.

By depicting the patient's story in organizational and professional language, the uniqueness of the individual is lost (Campbell & Gregor, 2002). It can also influence how others perceive the person. This is especially pertinent considering how, for example, a patient's documented *noncompliance* with treatment is perceived by nurses, often resulting in them being labeled as challenging or difficult. Nurses, in reading and acting as agents of the text (Smith, 2005), are participating in the textually mediated process of stripping away the individual's set of circumstances into what is considered proper to report according to what is identified on a form or in a policy and procedure statement. By examining texts and how individuals can activate them, we can see institutions as forms of power located in language or discourse that coordinate people's work. In this way, ruling relations exemplify "monologic objectified perspectives" (Smith, p. 123) that result in a loss of the local actualities of individual experiences in which the person becomes represented by the text.

Considerations with Institutional Ethnographic Research

Limitations of IE. Often, the direction that IE research takes unfolds as the study progresses. Information and understanding stimulate a need for the researcher to further explore some issues more so than others. This may prompt the researcher to seek out additional informants or explore some data sources more than others. While it can be difficult to precisely delineate the parameters of the research, some boundaries must be made (Smith, 2005). IE moves from the local individual social experience to the extra and translocal social experiences. There may be actors throughout the institution who are not directly related to the individuals involved in the study, yet they are a part of the complex web of social relations. To illustrate this, Smith encourages researchers to graphically map results, providing empirical links that move from the local actualities to the broader translocal practices and activities that exist. As Townsend et al. (2003) state "the notion of creating an analytic blueprint reflects the ontological belief that humans organize social institutions and … perpetuate the unconscious, routine, taken for granted ways of living and working in the everyday world" (p. 23). This diagrammatical representation of the findings aids in depicting covert social forces inherent within and influencing institutions.

The development of IE as a method is relatively new. There are concerns that IE research is too limited in being focused on one social setting. There are concerns that what is discovered cannot be generalized beyond the local arena of the study. However, in regards to generalizability, IE takes the single situation under scrutiny and links the description of what is happening and discovers the *generalizing relations* the texts produces in order to show how, what is happening in a single location is being similarly organized across time and geography (by laws, professional regulation and the like).

Smith (2005) noted that the “character of institutions in contemporary society [is such that] they are themselves forms of social organization that generalize and universalize across multiple local settings” (p. 42). In this way, concerns regarding universality and generalizability are formulated in a particular way within the IE approach (Townsend et al., 2003).

Access to texts and informants can be a challenge for the IE researcher. From a practical perspective, organizations may not want to share their information and obtaining participation can be challenging. Based on this, the success of IE is largely built on fostering good relationships between the researcher and the informants (Campbell, 2004), making the process of conducting IE research an evolving one. The strength of IE is its goal of presenting an accurate and truthful representation of the organization of the setting and discovering how ruling relations affect, and are affected by, people’s everyday activities (Smith, 2005).

Why Choose Institutional Ethnography for this Study?

In this study, IE was used to explore the disconnect between mental health legislation, practice, care standards and ethics, and actual everyday practice. There are instances in which mental health nurses are working without the full understanding of how these policies, legislation, and other texts influence their daily engagement with patients and others. As previously noted, Campbell (2004) described such activities as “well intentioned work” that might be a “part of oppressive relations of ruling” (p. 39). Mental health nurses often struggle with what they describe as clashing therapeutic and “enforcer” or monitoring roles while involved in mandated community care. Nurses’ intentions to provide care that meets personal and professional standards are laden with ideological concepts molded by legislation and policies governing them. As such, the "the power of an officially mandated organization overrules personal or professional intentions and exercises" (Campbell, 2004, p. 40). Therefore, in considering my question as to what is really happening with the use of CTOs in NL, the decision to use IE for this study was a logical one.

The Process of Conducting this Current Study

Problematic and aim of study. As previously noted, a problematic in IE is not the problem or a formal research question. The problematic explored in this study involved the conflicts or disjunctures regarding nurses' work with patients with mental illnesses who are considered for or mandated to a CTO. These "disjunctures" are "different versions of reality- knowing something from a ruling versus experiential perspective" (Campbell & Gregor, 2002, p. 48). There is conflicting experiences of the CTO depending upon where one is located in regards to its ruling relation, such as individuals with mental illness, families, nurses and other health professionals, managers, health administrators, policy makers, and judicial representatives. While the CTO, in theory, is intended to respect the rights of individuals while balancing the rights of society as a whole, disjunctures exist in how the CTO practices manifest in the everyday actualities of ethically caring for those who are affected by CTOs. Therefore, this study aimed to explore the web of ruling relations or greater social forces that concert nurses' work with individuals with mental illness who are on or considered for CTOs.

Setting. IE can encompass a wide setting in order to fully examine the larger influential social structures (Campbell, 2004). However, the focus of any IE study is the "circumstances located in the world of the subject" (Campbell & Gregor, 2002, p. 59).

This study into CTO practices was an exploration of *what is happening* in the actual or consideration of CTO use within the NL mental healthcare system. I sought to describe the everyday actualities of individuals affected by or involved with CTOs and endeavored to map how they are connected to the existing ruling relations influencing these activities. In particular, I was interested in how these processes impact the work of mental health nurses.

The CTO study explored work that took place in locations of relevance to the delivery of community mental health care. This included, but was not limited to, healthcare offices, staff offices, community agencies, private homes, and outpatient clinics. Permission was obtained from the administration of the regional health authority prior to data collection. This health authority is based in St. John's where the greatest concentration of NL's population lies. The region extends beyond the city boundaries to the Burin and Bonavista Peninsulas, thus encompassing a large geographical area. The population of this area tends to decrease in density the further one moves from the capital. Many of the area's communities are rural and remote in nature. This geographical information was relevant to the analysis and findings of this research.

Informants. In IE, participants are referred to as informants. These are the individuals who are considered to be the experts about their own practices as they relate to the social processes that the researcher wishes to examine (Campbell & Gregor, 2002). Recruitment for interviewees was accomplished through purposive sampling (Polit & Hungler, 1995). I was specifically interested in interviewing patients of mental health services, families of individuals with severe persistent mental illness, and judicial, bureaucratic, and mental health staff. Examples of contact letters for each of these groups are included in Appendix B. First contact was made with mental health care administrators seeking permission to contact staff and patients. Middle managers were sent letters informing them of the study and asking them to notify their staff of it. Staff were asked to discuss the study with patients and families, and to give them the study contact information if they were interested. Individuals within the judicial and bureaucratic systems who were knowledgeable about CTOs were also contacted. For the most part, agency administrators acted as contact intermediaries for middle managers, who were intermediaries for staff, who, in the health care setting, were intermediaries for patients and families. None of the information letters were distributed directly by me to potential informants but through the intermediary. Everyone was provided with my contact information if they were interested in participating or required further information.

Individuals interested in participating in the study were presented with the information and consent form provided in Appendix C. If the individual was willing to participate and met the criteria for inclusion, I contacted them and arranged a face-to-face or telephone meeting to discuss any questions or concerns. The consent form was signed at this time. The informants were not subjected to any pressure to participate in the study; they were reminded of their voluntary status in participating, informed that they could leave the study at any time without penalty, and were given ample opportunity to review and sign the form.

Criteria for inclusion in the research study included the following:

- Individuals who have involvement with the implementation or development of CTOs including:

  - Individuals with severe persistent mental illness
  - Family members of an individual with severe persistent mental illness
  - Healthcare providers involved in the care of individuals with severe persistent mental illness
  - Health care managers whose work was relevant to CTOs
  - Representatives from the judicial system (e.g. Mental Health Court)
- Mentally competent to provide consent
- Able to speak and read English
- Over the age of majority (age 19)
- Have expressed a willingness to participate.

In this instance, competency refers to one's capacity to "make specific decisions or areas of decision" (Ontario Enquiry on Mental Competency 1990 as cited in Robertson, 1994, p. 3).

In IE, the nature and number of informants needed emerges as more is known regarding the problematic. There is a need to have adequate representation from each group in order to obtain a detailed description of the everyday actualities that occur within the mental health system. Given the small nature of the potential informant pool in NL and the breadth of the informant groups needed in order to provide insight into the problematic, it was anticipated that approximately 20 informants would be recruited. In actuality, eleven (11) people were interviewed for this study.

Documents. The study involved the review of a variety of CTO related documents that were used as a means to gain understanding of the how CTOS function. These documents included: institutional policy and procedure manuals; mission and value statements of the health authority; legislation related to CTOs [in particular the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a)]; and historical documents. Permission was also sought to review any document that pertained to individual patients, including patient charts (See below under Data Collection).

Data collection. As discussed previously, IE is based in social ontology involving everyday life. Therefore, data collected must be reflective of this (Campbell, 2004). The study incorporated two different types of data sources necessary to conduct IE: interviews and document review.

Interviews. Interviews were conducted with key informants as previously identified. Some interviews were completed face to face while others were done over the telephone; all were audio-recorded for transcription. Samples of guiding questions for the semi-structured interviews are included in Appendix D. The interview process in IE has been descried as "talking with people" in that it is open-ended and may not take a standardized form (DeVault & McCoy, 2006, p. 22). It can also range from talking one-on-one with individuals to holding group discussions. The interviews I conducted were one-on-one. They were held in a location of mutual convenience to both the informants and I that was accessible, free of distractions, comfortable, and neutral in nature. If informants did not have access to transportation or required childcare services, reimbursement for cab fares and sitters was provided.

It was important for me to think organizationally when I conducted interviews for this study (DeVault & McCoy, 2006). In IE, the researcher's purpose is "not to generalize about the group of people interviewed, but to find and describe social processes that have generalizing effects" (p.18). The interviews were centered on the everyday work practices the informant practiced related to CTOs in order to learn what the informant actually did. Informants were asked to describe their experiences with CTOs in whatever context this fell (i.e. as a patient versus a staff member): "What happened?" "What happened next?" "What did you do?" "How do you normally complete this form?" These sorts of questions and prompts supported the informants to stay in the empirical ground of experience. The informant could also shed light on the activities of others through describing the work they perform.

When conducting these interviews, I noted the institutional or professional language being used (Campbell & Gregor, 2002). Work terminology can be laden with different meanings. I worked to avoid "institutional capture" (Smith, 2005). This occurs when the researcher and the informant are both familiar with the institutional discourse and communicate with each other with the presumption that concepts, terms and so forth, are understood equally and identically by both parties. This covers over descriptions of what people are actually doing (using words such as "revocation" or "hospital admission"). The institutional discourse that dominates the work of the informant is well known to them, such as medical terminology, policies, and procedures. However, language that is institutionally sanctioned can come to take precedence over the actual, everyday descriptions and nuances inherent in the human experience. The researcher must ensure that she has given the informant an opportunity to describe the experience as it happened for her or him and not to assume that she knows what the informant is describing. In doing so, I had to be aware of how my own experiences with institutionally sanctioned discourse could impact on my elicitation of informant descriptions (McCoy, 2006).

Smith (2005) reminds researchers to "constantly return to the particularities of what people are of have been doing, to their thinking and feelings, as well as to the circumstances, means, time, and other resources of that activity" (p. 157). Individuals will often conduct their socially mediated work in a manner that reflects some personal interpretation of how it should be accomplished; this must be explored. As well, professional language can obscure what people actually do. Informants may tend to give a cursory overview of the everyday actualities and provide accounts according to institutional language, or with policies and procedures in mind. Pence called this occurrence as giving "ideological accounts" (Pence, n.d. in Campbell & Gregor, 2002). The individual gives an account of what *should be* done and not *what is actually* done. However, the goal of IE is to learn what is actually happening. This is evident with nurses' work that tends to be lost within the language of an institution (Campbell, 2001; Diamond, 1986). As a mental health nurse, I considered the knowledge I have regarding the terminology used in describing different tasks, social processes, and work life. I needed to be astute in clarifying any information given to me and not presume that I understood the full intent or concept behind the term, solely based on my professional experiences.

The goal was to conduct interviews with a variety of informants who have experience with CTOs to see where the work overlapped (DeVault & McCoy, 2006). I needed to elicit different descriptions that people who are variously institutionally located in relation to the CTO. I took copies of the CTO documents when I met with informants to aid in discussion of the work processes involved with completing the form, and in creating, planning, and implementing the order. I was able to recruit eleven (11) informants to my study. One individual withdrew consent from the project and, in total thirteen (13) interviews were conducted with the remaining ten (10) informants. These individuals included family members, nurses, physicians, bureaucrats, administrators, social workers, and advocates. The length of the interviews varied, with second interviews being completed in three cases. During these follow-up interviews, I was able to clarify and expand upon information gathered from the informants during the initial interview.

One of the important goals of this study was to obtain patients' and families' descriptions of the work involved with being subjected to a CTO, to be considered for a CTO, or to be a family member of someone experiencing this. Despite repeated attempts through intermediaries, I did not have a patient come forward to participate. There could be any number of reasons for this. There are very few individuals who have actually been placed on CTOs to date in NL[10], although a number have been considered for a CTO. It is possible that individuals on CTOs were not interested in speaking with me about their experiences or that the intermediaries did not pass information on to potential informants. I was, however, fortunate to have been contacted by a family member of an individual who had been on a CTO. Any possible identifying points relating the work involved with living with someone on a CTO has been changed to preserve confidentiality.

Document review. There were a number of texts reviewed for this study. Of

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[10] The last official number of CTOs being activated in Newfoundland and Labrador was five (Newfoundland and Labrador Centre for Applied Information, 2012)

primary interest were: the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a); the *Mental Health Care and Treatment Act Policy and Procedure Manual (*Government of Newfoundland and Labrador, 2009); forms, pamphlets, and other documents related to the *Mental Health Care and Treatment Act*; the *Mental Health Act* (Government of Newfoundland and Labrador, 1971); the *Report of Inquiries into the Sudden Deaths of Norman Edward Reid and Darryl Brandon Power* (Luther, 2003); and the *Newfoundland and Labrador Mental Health Care and Treatment Act Evaluation Final Report* (Newfoundland and Labrador Centre for Health Information, 2012). Other documents reviewed included the *Hagan Inquiry Report* (Langdon, 1980), policies concerning CTO implementation, consent and capacity from the Regional Health Authority[11], *Charter of Rights and Freedoms* (Government of Canada, 1982), *United Nations' Declaration of Human Rights* (1948), *Code of Ethics* (Canadian Nurses Association, 2008), provincial and national nursing standards of practice, and other pertinent legislation such as that related to neglected adults.

Application was made to the regional health authority for approval to review patient charts. I was not interested in conducting a complete chart review. Instead, I wanted to view how forms pertinent to CTO consideration and use were completed in the documentation process. While this approval was obtained, I was unable to recruit a patient with CTO experience to this study and therefore, no chart was reviewed.

In the process of talking with informants, I asked them about the texts they commonly use in the consideration and implementation of CTOs, how these work, their purpose, and how they are connected to other texts and work processes. Smith (2006a) notes that texts can be explored in two ways: how they coordinate sequences of action

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[11] Please note that I do not intend to identify the Regional Health Authority by name.

and in terms of an intertextual hierarchy in that one text may guide the implementation of others. When analyzing the texts, I considered how the texts coordinated the work performed by the informants, bearing in mind how work is considered in IE. I also noted that there was an *intertextual hierarchy* (Smith) that existed in terms of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) guiding the activation of other documents and forms. I was attuned, as well, to examining the activation of texts for any *intertextual circles* that may exist (Smith). This is a circular feedback relationship that can exit between regulatory texts and subordinate texts that construct and coordinate particular representations about what is happening. The researcher is required to consider what the regulatory texts do and how the subordinate texts fit within the mandate of the regulatory text. This will be examined further in the findings and discussion chapters.

Journaling and field notes. Throughout this entire data collection process, I made field notes and kept a journal. This journal allowed me to record any notes and reflections on the information I obtained and aided in data analysis. There was a considerable amount of self-reflection involved in this process for me. I worked to be aware of my own ideological conceptualizations of caring for individuals who were involved with CTOs. I examined how I viewed concepts such as ethics, professionalism, and “good care”. I reflected on my opinions and thoughts regarding mandated care, something that elicits many conflicting feelings in me. This reflection aided in my emerging from what I termed my “ideological haze” (Snow, 2014). I grounded myself in considering what was *actually* happening, not what I thought *should* be happening. I needed to be able to clearly see the actualities of what was occurring in the everyday use of CTOs and how this was connected to translocal ruling relations impacting on such. Keeping descriptive notes aided in this process.

Data analysis. In IE, data analysis occurs concurrently with data collection in order to facilitate an accurate reflection of the events that are happening (Campbell, 2004). I first considered my own knowledge of the CTO process and how I had seen the process occur in my own clinical experiences. I schematically drew out this process on a white board to aid in my visualization of this. I obtained and reviewed the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) and the accompanying forms. I drafted a diagram on the process as outlined in the legislation and compared and integrated the two diagrams making notes at where the actualities of my experience deviated from the text (i.e. legislation). From this beginning, I began to conduct my informant interviews.

A credible typist, who signed an oath of confidentiality (see Appendix E), transcribed interview audiotapes. I had initially proposed data management through the use of a software package. I attempted to use this, but found it cumbersome and decided that a general word-processing program was more user friendly for my purposes. This program was helpful in storing data from the transcripts and organizing the data through adding comments and highlighting sections of importance and relevance to this study.

Interpretive coding does not occur in IE. DeVault and McCoy (2006) describe a personal communication with Dorothy Smith in which she refers to what others call the coding process in data analysis as *indexing*. This process of indexing aids in identifying the common threads embedded in the data that can be connected to texts and other trans-local happenings. This approach to indexing also reduces the likelihood that the realities of the everyday are not lost under the labels of codes.

The more the informants described the CTO process, the more I could add into the diagram depicting it. This diagram became increasingly complex and therefore I purchased and used a graphics software package that allowed me to create diagrams and flow charts from my handwritten work. This greatly aided mapping the connections between everyday practices, texts, and ruling relations. I later obtained the assistance of a graphic designer to further refine these diagrams and to produce the visual aids included in this document.

Smith (2005) likens the mapping of data to the creation of a puzzle. The data obtained through interviews and textual review all provided data and descriptors of the social processes that, once pieced together, help create a picture of what is happening in relation to how a particular problematic is being organized. Each individual piece might be a different set of work processes but it is apparent that the processes are directed towards a common purpose that can be described by creating the image of what is happening. The graphic software package, for example, aided considerably in identifying and mapping data as to where it is located in the creation of the puzzle. The web of interconnectedness in the creation and use of the CTO legislation was better illuminated as a result. In all, the graphic analysis, accompanied by the grouping and indexing, aided me to uncover and highlight the institutional processes being activated in people’s work (DeVault & McCoy, 2006).

The analysis moved from the individual to the larger social context as the analysis progressed (Smith, 2005). All level one or local data (Campbell & Gregor, 2002) (including interview transcriptions, information collected through the review of texts, and journal memos, that outline individual descriptions of activities) were examined for emerging accounts of the social relations and the disjunctures (contradictions) that exist within the implementation of a CTO. Texts and transcripts were read and reread looking for clues into the social processes that revealed the links into the broad social organization (Campbell, 2004). This emerging translocal or level two data (Campbell & Gregor, 2002) illustrated the interconnectedness of the broader ruling relations influencing the everyday. Descriptions of activities and happenings began to reveal how people's everyday lives are influenced by the ideological understandings that are inherent in the consideration or use of CTOs in mental health nursing.

I kept descriptive data concerning the nature of the informants, setting, and context. This information included the informants' position in the workplace and contextual information such as time of day for interviews and observations (Richards & Morse, 2007).

Rigor. In any qualitative study rigor is improved when there is methodological congruence within the overall research study. The research question, methodology, means of data collection, and analysis all must fit one another (Morse, Barrett, Mayan, Olson, & Spiers, 2002). In IE, it is the social ontology that is the core methodological tenet that must be maintained. IE is the description of a particular situation in which certain events of interest to the researcher and the study are occurring. Once activities or troubles are identified, they can be linked into the broader translocal social context (Smith, 2005). Information was constantly reviewed and reflected upon in order to maximize how it could be used to show how various local practices are linked into translocal social processes. In IE, the verification process maximized within the empirical evidence of the data and it is through this work that validity and reliability and rigor can be judged. In regards to sample size, in the case of IE, the goal is to recruit enough informants to the study so that an accurate description of their everyday actualities can be obtained in order to view the ruling relations at work.

Ethical considerations. The research proposal for this study was approved by the Research Ethics Office (REO) of the University of Alberta and the Health Research Ethics Authority (HREA) in NL. Once this approval was obtained, ethics approval was granted from the regional health authority. Approval was gained within careful consideration of the Tri-Council Policy Statement for Ethical Conduct for Research Involving Humans (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada, 2005). The following describes the steps that were taken to ensure the ethical conduct of the study.

Steps related to informant interviews. The information and consent form provided was thoroughly discussed with each potential informant (see Appendix C). Individuals were given the opportunity to ask questions (e.g., in-person meeting or telephone discussion) to ensure that the potential informant understands the purpose and nature of the study, its potential risks and benefits, and the specific procedures related to their participation. They were also encouraged to ask questions regarding the research process, and were informed of their ability to withdraw from the research process at any time without penalty. Strategies to maintain confidentiality were reviewed and its limitations explained by making each informant aware of my professional and legal obligation to report certain information (such as suspected child abuse or imminent risks for harm) if it was disclosed.

Informed consent was considered an ongoing process, beginning when individuals clearly expressed an interest in the research and met the inclusion criteria. Potential informants were given the opportunity to review the consent form at their leisure. Individuals were given a copy of their consent form, highlighting my contact information (see Appendix C). Contact information of the Research Ethics Office, University of Alberta, and the Health Research Ethics Authority, NL, were provided in case informants wanted to voice concerns regarding the study. In conducting research, it is generally recommended that the informants and the researcher should not be familiar with one another, as this might influence the individual's level of comfort in participating in the research process. Given my position as a mental health nurse and the nature of the small population of NL, it was possible that I could encounter individuals with whom I have had prior contact. When this did happen, I raised it as a consideration with them and reiterated the confidential and voluntary nature of the research process. The informants stated their comfort level with participating in this study and their willingness to continue.

Within the research interview, informants were clearly informed that they did not need to answer every question and that they could stop the interview at any time. If the latter occurred it was the informant's decision whether or not any of their interview contributions to that point were to be used as data. Informants, in recalling their experiences, could have become distressed during or following the interview. After the interview, I was available to them to debrief such concerns. I was mindful that I was acting in the role of researcher and not that of counselor. If there were any personal issues identified by the informants that I was unable to independently manage, there was an opportunity to refer the informant to someone who was better able to assist them. I had contact information for crisis counseling and other community supports that could be given to informants as necessary. I was prepared to engage with psychiatric emergency response services if the situation warranted, as per legal and professional obligations.

There is a need to consider the researcher's safety in the conduction of any naturalistic inquiry (Dickson-Swift, James, Kippen & Liamputtong, 2008). There were opportunities for me to visit individuals in either a semi-public place, such as an office, or other venue. I was in possession of a cell phone at all times and had a system in place of calling a contact individual once interviews were completed. I also considered how the information I was hearing would personally affect me. My experience in being a psychiatric and mental health nurse with skills in self-reflection and personal processing of sensitive information were of benefit to me in this study. In my capacity of a Doctor of Philosophy student, I was also mentored and supported by faculty experienced in the safe conduct of research (Dickson-Swift et al.).

Steps related to data storage and dissemination. All information from the study, including the data, demographics, copies of the consent forms, interview recordings, and any other information that may identify the informants, was and will continue to be kept in a locked cabinet, accessible only by me, in a locked office in my place of work. In addition, any material with names is secured and kept separate from the data. The computer upon which I did my work is encrypted and password protected. Informants were initially identified by numbers and, later, by androgynous pseudonyms. I have also referred to all individuals in this study with feminine pronouns in order to improve the flow of the information for the reader. Any publications or presentations arising from this study will not provide identifying informant information. The data will be kept as per University of Alberta's *Research Records Stewardship Guidance Procedure* (University of Alberta, 2015), which states the following:

> Research records must be retained for not less than:
>
> i. five (5) years after the end of a research project's records collection and recording period;
>
> ii. five (5) years from the submission of a final project report;
>
> iii. five (5) years from the date of publication of a report of the project research; or,
>
> iv. five (5) years from the date a degree related to a particular research project is awarded to a student whichever occurs last.

Summary

This study was designed to explore the use of CTOs in NL through interviews with key informants and textual analysis of documents of relevance to their implementation. In preparing to accomplish this, I examined the theoretical underpinnings that guided the creation of IE as a research method to gain a better understanding of the rationale for the approaches used. Various exemplars of IE studies were reviewed along with a thorough examination of the method itself. What I have presented here is how the generally accepted approaches to conducting such a study were employed in this instance whilst studying the use of CTOs in NL. This approach was successful in my gaining insight into how the legislation was being implemented and the everyday challenges for individuals, families, nurses and other health professionals associated with such.

In the following chapters, I will present the findings of this work. In chapter 4, I describe the various texts I examined for this study. The following three chapters comprise the analysis chapters. Chapter 5, the *Everyday Work Processes Associated with Involuntary Treatment*, describes the work of families, nurses, and others, in enacting the CTO in everyday life. Their work is complex and impacted by ruling relations that target mediating the risks involved in living with and caring for individuals with severe, persistent mental illness who are on CTOs. These descriptions and their interconnections are described in more detail in Chapter 6 (*Risk for Violence: A Ruling Relation in CTO Legislation*). In Chapter 7 (*Explicating the Social Organization of Activating the Mental Health Legislation*) I illustrate how other ruling relations are involved in how the CTO legislation is being activated within a confusing everyday practice environment. Finally, in the discussion and conclusion chapter (Chapter 8), I link my analysis with the existing literature while comparing and contrasting the findings and summarize the work completed.

CHAPTER 4

TEXTUAL BACKGROUND INFORMATION

There are a number of documents that will be explored through an institutional ethnographic (IE) lens in this dissertation. Given the complex nature of mental health legislation, policy documents, inquiry reports, and other documents of interest, each text will be described and its relevant sections for this research provided in this chapter. Those presented here are the ones that are of greatest relevance to the implementation and coordination of Newfoundland and Labrador's (NL) CTO legislation in everyday practice, rather than an exhaustive list of the texts I have examined for the purposes of this study.

Texts Influencing the Creation of Mental Health Legislation in NL

In order to consider the rationale for the structure of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) it is necessary to examine the influential documents that informed its creation. A synopsis of each of the documents that I found most influential and of importance to the examination of CTO use in NL follows.

Luther Inquiry and Report

Many aspects related to mental health care in NL changed after the release of the *Report of Inquiries into the Sudden Deaths of Norman Edward Reid and Darryl Brandon Power* (Luther, 2003). The *Luther Report* was the result of Judge Donald Luther's inquiry into the deaths of Norman Reid and Darryl Power. Both men had severe, persistent mental illness (SPMI). Within a span of 51 days in separate incidences, Mr. Reid and Mr. Power were shot and killed by police officers. Such a circumstance was unprecedented in

NL and the resulting *Luther Report* said much about the poor state of mental health services in NL. In the first line of the executive summary, Judge Luther states, “The health, social and justice systems failed Norman Reid and Darryl Power. That they allowed these men to arrive at the life and death situations of August 26, 2000, and October 16, 2000 respectively is a tragedy of enormous proportion” (p. i). At the time of the report’s release, NL had the oldest mental health legislation in Canada, something that was highly criticized. Judge Luther noted, “It was as if another killing had to take place before those responsible would exercise leadership and do what so desperately needed to be done” (p. ii). He claimed that there would never have been an investigation if Reid and Power had been only wounded. The stories of these men, the lives they lived, and the deaths they experienced comprise a substantial and moving component to the report. Their stories will be presented here to aid the reader’s understanding of the context that precipitated legislative changes in the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a).

The testimony provided at the Luther Inquiry gave healthcare providers, politicians, bureaucrats, other decision makers, and the public at large insight into the lives of these men. It revealed the realities in which they, as individuals with severe, persistent, poorly treated mental illness existed. Norman Reid lived in a small rural community on the north east coast of the island of Newfoundland that had little infrastructure, poor services and supports, and a high rate of unemployment. He developed mental illness in his teens and by his mid-twenties was considered so disabled by his mental illness that he was deemed unable to work or seek further education. He was incredibly resistant to taking his psychiatric medications. This resistance exacerbated his illness and resulted in frequent admissions to the provincial mental hospital. During times of mental instability, Mr. Reid became paranoid and delusional and was considered to be a danger to the community. As a result, Mr. Reid was feared and ostracized by his community (Luther, 2003).

While under a court order for three years that required him to take his medications, Mr. Reid's mental health improved and he experienced a lengthy period of stability. During the time of the court order, a probation officer and a community mental health nurse followed Mr. Reid's progress by making home visits and ensuring that he took his medications. Mr. Reid lived in very poor circumstances in substandard housing without electricity. At the time of his death, he was surviving on social assistance and cooking on a propane camp stove. Electrical services were never hooked up to his house due to an oversight by government social services, which allowed a $34.40 inspection fee to go unpaid. The day that Norman Reid was shot and killed, the Royal Canadian Mounted Police (RCMP) responsible for the area received complaints by people in the community that Mr. Reid was threatening to seriously harm community members. When the RCMP officers arrived, Mr. Reid exited his house with an axe, argued with them, and then came down off his steps with the axe threatening to kill one of the officers. The officer shot Mr. Reid "out of fear for public safety". On autopsy, Mr. Reid's blood drug screen was negative, indicating that his prescribed medications were not in his system and that he had clearly not taken them for some time (Luther, 2003).

The circumstances that led up to the death of Darryl Power are similar to those of Norman Reid's. Mr. Power, too, had a lengthy history of mental illness that was not well managed. He was shot and killed outside of this mother's apartment in Corner Brook, a small city on the west coast of the island of Newfoundland. Mr. Power had a history of anxiety, including panic attacks, sleeping issues, poor coping mechanisms, family relational issues, and depression. He had attempted suicide a number of times, particularly by overdosing, and had numerous admissions to the psychiatric unit in the local hospital. Mr. Power was described as having poor insight into his illness, often externalizing his issues onto others, and not managing his illness well. He was also living on social assistance with few supports (Luther, 2003).

On the night Mr. Power died, his mother notified the police that he was exhibiting "strange behavior". He had taken a number of different medications and had tried to eat broken glass. The police arrived at his mother's apartment to find Mr. Power acting in a threatening manner. It was apparent that he had knives and a hammer on his possession and was repeatedly telling the police to shoot him. Mr. Power was shot by one of the officers when he charged towards them. In one of the many suicide notes he had written, Mr. Power had stated that October would be his "last month on earth". As a result of the investigation into his death, it was determined that Mr. Power died of victim-precipitated homicide, also known as "suicide by cop" (Luther, 2003).

In his Report, Judge Luther noted, "It is the purpose of this inquiry to recommend changes to existing policies and practices with a view to significantly reducing, if not virtually eliminating the possibility of another medical history such as that of Norman Reid" (Luther, 2003, p. 10). There was considerable breadth to the evidence and to the scope of the concerns provided to the inquiry. The inquiry, however, was devised to make recommendations on issues related directly to the deaths of Mr. Reid and Mr. Power.

The criticism of the mental health system was strong. Judge Luther highlighted concerns regarding fragmented services and poor communication between government departments and services. His report set out a timeline to complete legislative reform to the mental health legislation. This included making recommendations to change the grounds under which individuals, thought to be at risk for harm while mentally unwell, could be apprehended. As well, it addressed the following: the criteria for physical deterioration; a professional liability clause; creation of a Mental Health Court; extra funding for case managers; creation of an Assertive Case Management team; continued support for an early Psychosis Program; increased numbers of nurse practitioners working in mental health; creation of a mobile crisis response unit and expanded crisis intervention; additional funding for consumer support programs; stigma education programs, particularly in schools; and greater education and appropriate non-lethal equipment such as TASERS or other conductive electrical weapons for police officers. In addition, Judge Luther recommended the inclusion of CTOs in mental health legislation. He suggested CTOs should be issued by a judge of the mental health division of the Provincial Court of NL after a hearing, and not by a psychiatrist as was occurring in Ontario and Saskatchewan at the time. It was also recommended that the Minister of Health and Community Services should automatically review legislative provisions for CTOs if the number of persons subject to these orders at any given time exceeded forty (Luther, 2003).

Extensive changes occurred in the NL health care system and in legislation after the release of Judge Luther's Report. Considerable media attention was given to the inquiry and subsequent report, spurring many stakeholder groups and the general public to become more vocal for mental health care reform. The NL Government responded and implemented many of the recommendations outlined in the *Luther Report*, including the implementation of CTOs.

Hagan Inquiry and Langdon Report

In examining the history of major incidents involving individuals with SPMI, the *Luther Report* (Luther, 2003) acknowledged that the Hagan Inquiry in1980 had identified similar concerns with mental health legislation 20 years prior to the deaths of Norman Reid and Daryl Power. The Hagan Inquiry was a Provincial Court inquiry led by Judge Langdon into the death of Thomas Hagan of Kingman's Cove, NL on August 12, 1979. A neighbor, a young man with schizophrenia, who lived near and was very close to the Hagan family, killed Mr. Hagan. In the report, filed in May 1980, Judge Langdon stated that at that time legislation provided "no legal procedure whereby a person who was released from an institution and refused to take medication could automatically be readmitted [to the institution] unless he met the criteria under the *Mental Health Act*[12]" (Langdon, 1980, p.8). Individuals in rural areas did not have easy access to health professionals who could assess severe exacerbations of their mental illness and determine if they needed treatment under the *Mental Health Act* (Government of Newfoundland and Labrador, 1971). Judge Langdon identified a "serious gap" (p. 9) between the discharge of patients from hospital and their follow-up care in the community. He noted this could have a deleterious effect on their adherence to their treatment and support for prevention of relapse. As a result, one of the recommendations in the Langdon Report was for some form of mandatory supervision to ensure medication compliance for the discharged individual under a conditional release from hospital.

This recommendation by Langdon in 1980 is of particular relevance to this study

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[12] Italics added.

and the examination of CTOs in NL as it provides evidence that mandatory outpatient treatment had been recommended as an option before the Luther Inquiry. As well, Langdon had expressed concerns with the limitations of the certification criteria under the *Mental Health Act* (Government of Newfoundland and Labrador, 1971). Recommendations identified in the Langdon Report included: automatically changing a voluntary but potentially dangerous patient's status to involuntary if they wanted leave hospital against medical advice; and conducting a review of Canadian legislation, particularly as it related to dangerousness. Recommended, too, was that only a conditional discharge from hospital be considered for individuals deemed "dangerous", "potentially dangerous" or "paranoid schizophrenic". It was Judge Langdon's assertion that people should not be discharged from a mental institution "until the mental condition no longer exists" (Langdon, 1980, p. 12).

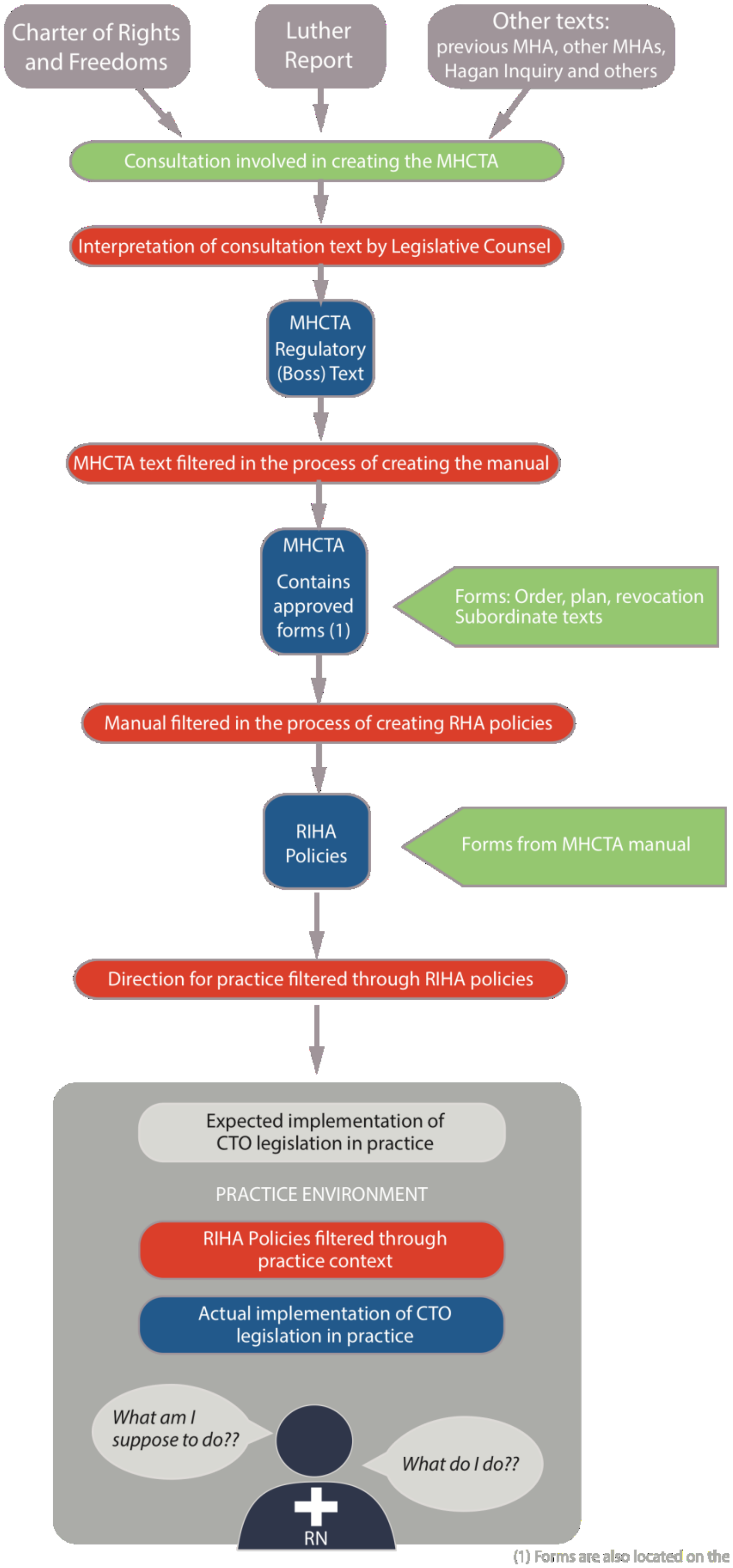
This last recommendation is a very interesting one as, in many cases, the "cure" of mental illness is impossible to attain. The nature of schizophrenia, denoted as a chronic illness, means that it will continue to exist, albeit in a manageable form, throughout a person's life. In the interest of "public safety", Langdon advocated that if an individual who was understood to be dangerous in the community, she should not be left to decide for herself if she should take medication. Rather, she should be placed in a "parole-like situation which is something between a full release and custody" (Langdon, 1980, p. 13). Judge Landon also advised that a complete review of the *Mental Health Act* (Government of Newfoundland and Labrador, 1971) and mental health care, in general, in NL, was necessary.

***Mental Health Care and Treatment Act* (Government of Newfoundland and**

Labrador, 2006a)

The *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) was passed in the NL House of Assembly in December 2006. This marked a significant milestone in mental health care in the province. Prior to this time, mental health care was regulated through the *Mental Health Act* of 1971 (Government of Newfoundland and Labrador, 1971). NL, prior to the adoption of the *Mental Health Care and Treatment Act*, had the dubious distinction of having the oldest, most outdated mental health legislation in Canada. In an effort to prevent such outdated legislation in the future, Section 6 of the *Mental Health Care and Treatment Act* states that "The minister shall, every 5 years, conduct a review of this Act and the regulations and the principles upon which this Act is based and consider the areas in which improvements may be made". In my discussions with informants, I was told mandating legislative review within a certain time frame is a rarity in government legislation.

In this IE analysis, the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) is considered to be the *boss* or regulatory text existing at the top of an intertextual hierarchy that regulates the actions of other texts (Smith, 2006a) (see Figure 1).



(1) Forms are also located on the NL Government website

Figure 1: Intertextual Hierarchy- Documents Related to CTO Legislation

Administering legislation generates "higher order" texts such as the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) that "regulate and standardize texts that enter directly into the organization of work in multiple local settings" (Smith, 2006a, p. 79). In this instance, the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) provides direction for a policy and procedure manual to aid in its implementation (Government of Newfoundland and Labrador, 2009). It provides numerous forms which must be completed at various points in the legislation's implementation in order for certain actions to be considered legal and enforceable[13]. In addition, the *Mental Health Care and Treatment Act* generates policies developed by each regional health authority. All of these lower level documents are nested in the legislation's regulatory power to coordinate and direct the healthcare and judicial practices that the texts organize.

The *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) is a lengthy piece of legislation. It outlines the law used to enforce many aspects of mental health care in the province. More specifically, Section 3(1) identifies that the purpose of the *Act* is to:

> (a) provide for the treatment, care and supervision of a person with a mental disorder that is likely to result in dangerous behaviour or in substantial mental or physical deterioration or serious physical impairment;
>
> (b) protect a person with a mental disorder from causing harm to himself or herself or another and to prevent a person with a mental disorder from suffering substantial mental or physical deterioration or serious physical

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[13] Each relevant form will be identified and analyzed in later sections of this dissertation and included in the list of appendices.

impairment;

(c) provide for the apprehension, detention, custody, restraint, observation, assessment, treatment and care and supervision of a person with a mental disorder by means that are the least restrictive and intrusive for the achievement of the purpose set out in paragraphs (a) and (b); and

(d) provide for the rights of persons apprehended, detained, restrained, admitted, assessed, treated and cared for and supervised under this Act.

The legislation defines what constitutes a mental illness in NL from a legal perspective. According to Section 2(1)(k) (Government of Newfoundland and Labrador, 2006a), a mental disorder is a disorder of "thought, mood, perception, orientation or memory that impairs (i) judgment or behaviour, (ii) the capacity to recognize reality, or (iii) the ability to meet the ordinary demands of life and in respect of which psychiatric treatment is advisable".

Background information regarding involuntary admission. The capacity to intervene directly in the community is new. Previously, individuals who were subjected to the mental health legislation were involuntarily admitted in hospitals. In the new legislation, criteria for Certificates of Involuntary Admission have been revised and the CTO section of the *Act* has been added. However, whether one is being subjected to a CTO or an involuntary admission, an individual must be judged at risk for deterioration, which is different from previous legislation. Changes related to deterioration and involuntary admissions emerge as an issue in my examination of CTOs. Therefore, for clarification, I am including a short description of this section of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a).

In being subject to a Certificate of Involuntary Admission (a process often identified as *being certified*), an individual becomes an involuntary (*certified*) patient. According to Section 17(1) of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a), a certificate of involuntary admission shall be in the approved form and contain the following information:

> (a) a statement by a person described in Subsection 17(2) that he or she has personally conducted a psychiatric assessment of the person who is named or described in the certificate within the immediately preceding 72 hours, making careful inquiry into all of the facts necessary for him or her to form an opinion as to the nature of the person's mental condition;
>
> (b) a statement by the person who has conducted the psychiatric assessment referred to in paragraph (a) that, as a result of the psychiatric assessment, he or she is of the opinion that the person who is named or described in the certificate
>
> (i) has a mental disorder, and
>
> (ii) as a result of the mental disorder
>
> (A) is likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration or serious physical impairment if he or she is not admitted to and detained in a psychiatric unit as an involuntary patient,
>
> (B) is unable to fully appreciate the nature and consequences of the mental disorder or to make an informed decision regarding his or her need for treatment or care and supervision, and

(C) is in need of treatment or care and supervision that can be provided only in a psychiatric unit and is not suitable for admission as a voluntary patient;

(c) a description of the facts upon which the person who has conducted the psychiatric assessment has formed the opinion described in subparagraphs (b)(i) and (ii), distinguishing between the facts observed by him or her and those that have been communicated by another person;

(d) the time and date on which the psychiatric assessment was conducted;

(e) the dated signature of the person completing the certificate of involuntary admission; and

(f) another matter required by the regulations.

The first certificate of involuntary admission can be completed and signed by a physician, nurse practitioner or other authorized individual. The second certificate must be completed by a psychiatrist, or, if one is not readily available, then another physician (§17.2.a-b). The role of the nurse practitioner as a signatory for the first certificate was included to address some issues in rural and remote areas that do not have regular access to general practitioners and very limited, often nonexistent, access to psychiatrists.

Old versus new: Major distinguishing features of the *Mental Health Care and Treatment Act* (2006). In many ways, the new *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) shared similar goals to that of its predecessor. Both pieces of legislation set out to provide guidance on the “treatment, care and supervision of a person with mental illness” to provide for the “apprehension, detention, custody, restraint, observation, assessment, treatment, and care and supervision” and to “provide for the rights of (these) persons” (§3.1) (Government of Newfoundland and Labrador, 2006a). However, there are distinct differences between the acts of 1971 and 2006.

Unlike the 1971 legislation, the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006) has an accompanying *Provincial Policy and Procedure Manual* (Government of Newfoundland and Labrador, 2009) that outlines the responsibilities of the regional health authorities in the implementation of the legislation. Another distinction is the inclusion of the risk for mental and physical deterioration as grounds under which the legislation can be implemented. Individuals no longer have to be actively suffering from an acute exacerbation of their illness to be subject to the law. If a person is assessed as deteriorating (but not yet acutely unwell), she can be subjected to the legislation. If, as a result of her illness, an individual is engaged in activities that are determined to be such that she and/or others are placed at risk for harm then this can be reported to peace officers who can detain the individual for assessment by a physician or nurse practitioner. In previous legislation, the peace officers would have to witness this activity first hand in order to intervene. Finally, the legislation introduced CTOs as an option to ensure treatment for individuals who are at risk of becoming unwell in the community.

Community Treatment Order Legislation

Community Treatment Orders

The *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) includes the proviso for the use of Community Treatment Orders

(CTOs) in Part IV of the legislation. In issuing a CTO, the psychiatrist must ensure that the following criteria (as noted in §40.2) have occurred:

(a) he or she has examined the person named in the order within the immediately preceding 72 hours and on the basis of the examination and other pertinent facts respecting the person or the person's condition that are known by or have been communicated to the psychiatrist, he or she is of the opinion that

(i) the person is suffering from a mental disorder for which he or she is in need of continuing treatment or care and supervision in the community,

(ii) if the person does not receive continuing treatment or care and supervision while residing in the community, he or she is likely to cause harm to himself or herself or another, or to suffer substantial mental or physical deterioration or serious physical impairment,

(iii) as a result of the mental disorder, the person is unable to fully appreciate the nature and consequences of the mental disorder and is therefore unlikely to voluntarily participate in a comprehensive community treatment plan,

(iv) the services that the person requires in order to reside in the community so that he or she will not be likely to cause harm to himself or herself or to others, or to suffer substantial mental or physical deterioration or serious physical impairment,

(A) exist in the community,

(B) are available to the person, and

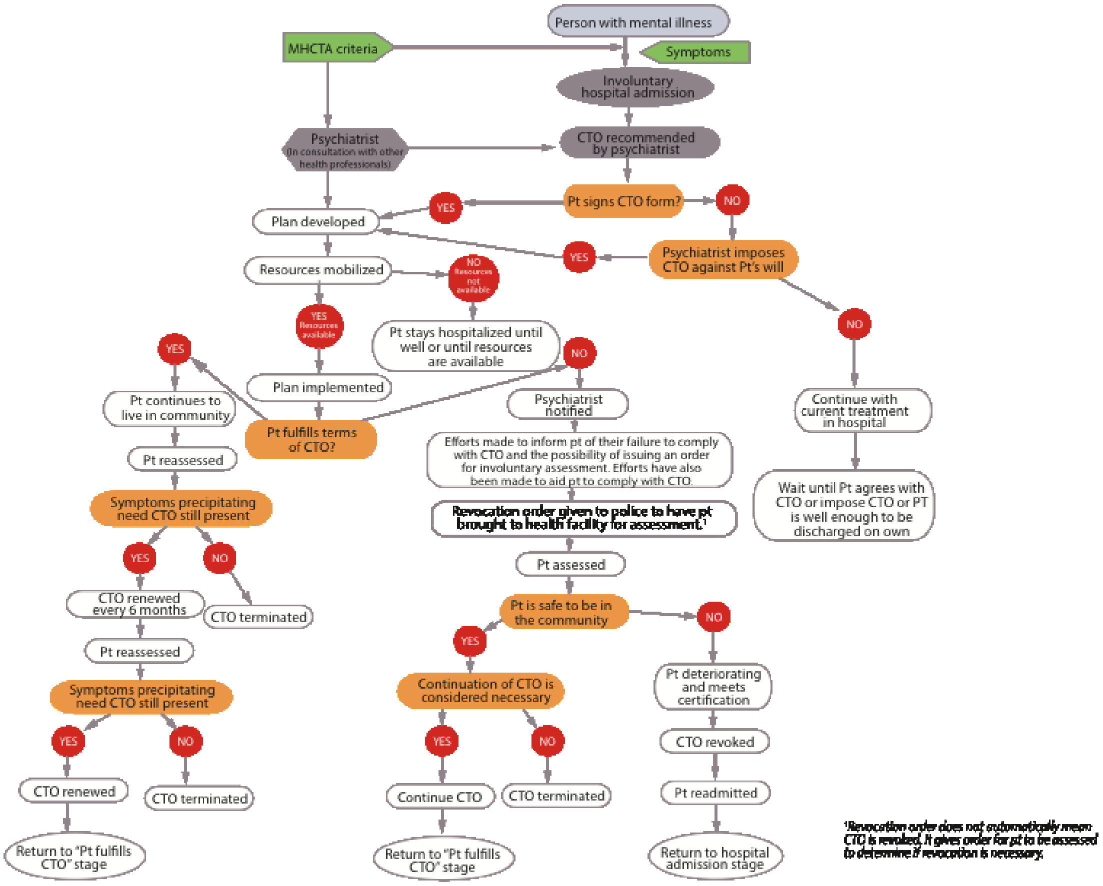
(C) will be provided to the person, and

(v) the person is capable of complying with the requirements for treatment or care and supervision set out in the community treatment order;

In order to be eligible, the individual must have had at least three involuntary admissions within a two-year period or have been subject to a previous CTO (§40.2.b).

The language in the CTO is very similar to the language used in Section 17 that outlines the Certificate of Involuntary Admission. Both legal processes identify the risk for harm to self and/or others as being a motivator to implement the certification or CTO. Both identify that the individual being subject to the law must be unable to fully appreciate the nature and consequences of the mental disorder. This is an important part of the certification *and* CTO criteria. The language differs between the CTO and the involuntary admission certificate. With involuntary certification, the legislation states that the person is *unable make an informed decision regarding the need for care, treatment, and supervision*, whereas in with the CTO, the individual is *unlikely to voluntarily participant in a comprehensive community treatment plan*. Another notable difference in the legislation is the fact that only a psychiatrist can issue a CTO (§17.2.a-b). The approved form to be completed for issuing the CTO is MHCTA-3 (see Appendix F) (Government of Newfoundland and Labrador, 2009). In issuing the order, the psychiatrist must have consulted other health team members and any others involved with the person's care in developing a community treatment plan (§40.2.c). Each individual who is to be involved with the plan must sign her agreement to the plan on the MHCTA-3 form (§40.2.d).

The *Mental Health Care and Treatment Act* Section 41 (Government of Newfoundland and Labrador, 2006a) outlines what a CTO must contain. According to Section 41, the order must include: the date of examination of the patient (§41.2.a); the facts used in forming the opinion that the CTO is needed (§41.2.b); the name of the psychiatrist who issued the order and is responsible for its management (§41.2.c); a description of the community treatment plan (§41.2.d); the names of the people who agree to accept responsibility for the general supervision and management of the plan and their obligations to report (§41.2.e); the names of the health professionals who will be involved in treatment and service provision (§41.2.f); the details of the undertaking of the patient who is to attend appointments with the issuing psychiatrist and other health professionals listed in the plan and comply with the plan (§41.2.g.i-ii); and, finally, the CTO must satisfy other requirements prescribed by the regulation (§41.2.h). The person who is placed on the CTO is to be given notice in writing that they have a right to retain counsel without delay, that they have a right to meet with a rights advisor and that they or their representative have a right to apply to the Board for a review of the issuance, renewal or revocation of the CTO (§41.3.a-c). A diagram illustrating the process of using a CTO is provided in Figure 2.



¹Revocation order does not automatically mean CTO is revoked. It gives order for pt to be assessed to determine if revocation is necessary.

Figure 2: General CTO Process

This process will be further analyzed in the subsequent chapters in this dissertation.

Community Treatment Plan

A companion document to the CTO is the community treatment plan. As with the CTO there are specific guidelines for what must be included in the treatment plan document. There must be a description of the medical or other supports the patient requires. This can also include income and housing that is needed by the person in order to live in the community (§42.a). The community treatment plan must also list the conditions relating to treatment, care and supervision of the person (§42.b), the patient's obligations under the order (§42.c), the name of the psychiatrist who issued the order and who is responsible for its supervision and management (§42.d), the name of the person who is responsible for the general supervision and management of the plan (§42.e), and the names of the healthcare professionals, persons and organizations who have agreed to be a part of the plan in providing treatment, care or supervision for the patient in the community and their obligations (§42.f) and any other requirements prescribed by the regulations (§42.g). The approved form for creating the CTO community treatment plan is MHCTA-4 (see Appendix G) (Government of Newfoundland and Labrador, 2009).

Administration of a CTO

Issuing a CTO. Section 44 of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a), stipulates that the psychiatrist who issues the CTO is the individual who is responsible for the general supervision and management of it (§44.1). Exceptions can occur if the psychiatrist is unable to carry out her duties. In this instance, another psychiatrist is named (who has consented) to act in the original psychiatrist's stead. The order must be amended to reflect this and a copy of this document is sent to the patient, her representative, the rights advisor, and each healthcare professional named in the order. This is done either by the psychiatrist or by the "administrator". The "administrator" is the person in charge of administrative functions within a psychiatric unit and includes her designate. In the *Act*, the designate is not identified.

The individuals and organizations who are named in the CTO documents may be required to submit reports regarding the status of the person with the mental illness to the psychiatrist who issues the order (§45.1). Treatments that can be enforced with a person on a CTO are described in Section 35 and 36 of the legislation (Government of Newfoundland and Labrador, 2006a). When a person has been certified *or* made involuntary, the attending physician or other individual may perform necessary diagnostic tests, prescribe and administer medication or other treatment, *without the consent* of the patient for the duration of the person's detention or mandatory community treatment order. This is done under the premise that it is "taking into account the best interests of the involuntary patient" (§35.1) which requires the physician to consider the following: (a) whether the mental condition of the involuntary patient will be or is likely to be improved by the specified treatment; (b) whether the mental condition of the patient will improve or is likely to improve without the specified treatment; (c) whether the anticipated benefit from the specified treatment and other related medical treatment outweighs the risk of harm to the patient; (d) whether the specified treatment is the least restrictive and least intrusive treatment that meets the requirements of paragraphs (a), (b) and (c); and (e) the wishes the involuntary patient expressed when she was competent (§35.2). Taking these factors into account is expected to ensure that the attending physician or other health professional will, where "appropriate", do the following: (a) consult with the involuntary patient and his or her representative; (b) explain to the involuntary patient and his or her representative the purpose, nature and effect of the diagnostic procedure or treatment; and (c) give consideration to the views of the involuntary patient and his or her representative with respect to the diagnostic procedure or treatment and alternatives and the manner in which diagnostic procedures or treatment may be provided (§35.3). According to Section 36, psychosurgery is prohibited for involuntary patients. When a CTO is issued or renewed, a copy of the order is given to the patient, the patient's representative, the rights advisor, each healthcare professional, person, and the designated person of any organizations named in the community treatment plan by either the administrator or the patient's psychiatrist (§43.a-b).

Renewing a CTO. A CTO expires six months after the day it is made unless it is renewed, terminated (§47.1) or revoked (§51). If the CTO is not renewed, then the psychiatrist or administrator is responsible for notifying the patient, the patient's representative, the rights advisor, and each healthcare personnel who is involved with the order (§47.2). There are no limitations on the number of times a CTO can be renewed (§48.2). In this sense, an individual could be kept on a CTO indefinitely. The psychiatrist or one of the health professionals or organizations named in the order can change the treatment plan (§49.1). To do this, written notice must be given to the patient, her representative, the rights advisor, and each professional and organization named in the order (§49.2) (Government of Newfoundland and Labrador, 2006a).

Terminating a CTO. A CTO can be *terminated* if after conducting an assessment of the patient, the psychiatrist finds that the person no longer requires a CTO in order to live in the community (§50.1). The patient can request this assessment. However, the psychiatrist can refuse to do this if the patient had been assessed within three months previous to the request (§50.2). If the psychiatrist finds that the criteria identified in Sections 40(2)(a)(i),(ii), and (iii) used to invoke the CTO no longer exist, then the psychiatrist must terminate the CTO, provide a copy of the terminations notice to the patient, administrator, representative, rights advisor, health professionals and organizations who were involved with the plan, and ensure the notice is in the approved form (§50.3.a-d) (Government of Newfoundland and Labrador, 2006a). The form for this documentation is MHCTA-7 (see Appendix H) (Government of Newfoundland and

Labrador, 2009). The CTO legislation has provisions to address what must happen if the person experiencing mental illness recovers sufficiently to warrant CTO termination. Individuals who have been subject to a CTO cannot be denied access to services that were provided under the CTO once they are no longer subject to it. As well, individuals can still voluntarily continue with participating in services in which they engaged while mandated under the CTO once it has ended.

Revoking a CTO. The CTO can be *revoked* (different from a termination) if the psychiatrist has reason to believe that the patient has *not been compliant* with a condition set forth in the CTO. In this case, the psychiatrist gives notice (a legal document) to a peace officer (§51.1) (see form MHCTA-8 in Appendix I). The psychiatrist has to have reasonable grounds that the conditions in Section 40(2)(a)(i), (ii), and (iii) continue to be met (§51.2.a) (i.e. the person is still suffering from a mental illness, is in need of care, and is unable to fully appreciate her illness or voluntarily participate in treatment). The revocation is ordered if the patient is refusing to have a psychiatric assessment completed (§51.2.b) and there have been reasonable efforts to inform the person of her failure to comply with the order (§51.2.c.i). The person who is subject to the CTO is informed that, if her noncompliance with the CTO persists, the psychiatrist will issue an order for an involuntary assessment. The person with mental illness is told about the possible consequences of the CTO being revoked (§51.2.c.ii). In revoking an order it must be documented that there has been reasonable efforts to provide assistance to the patient to meet with the terms of the order (§51.2.c.iii).

When there is a possibility that a CTO will be revoked, the *peace officer* has the authority to apprehend the person named in the order and to convey her to a facility for an involuntary psychiatric assessment (§51.3.a), observe and detain, and control the individual during the apprehension and conveyance to the facility (§51.3.b) and to take reasonable measures, including entering the premises and use of physical restraint, to apprehend the patient and take her into custody (§51.3.c). According to Section 2 (1)(o) of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a), a peace officer refers to a person who is a member of the Royal Canadian Mounted Police (RCMP), a member of the Royal Newfoundland Constabulary (RNC), or a sheriff, sub-sheriff, bailiff and deputy sheriff appointed under the *Sheriff's Act* (Government of Newfoundland and Labrador, 1991). The peace officer's authority to apprehend expires 30 days after it was issued. When an individual who is on a CTO is apprehended by a peace officer, the officer must tell the person the reasons for the apprehension or detention, that the individual is being taken to a facility for an involuntary psychiatric assessment, and that the individual has a right to retain and instruct counsel without delay (§10.a-c).

There is a confusing element in the issuance of a Revocation Order; it appears that the CTO does not automatically become null and void once the form is completed. When the person arrives at the facility, a psychiatric assessment has to be completed within 72 hours (§51.5). An individual could be assessed and found to be doing well, despite the risk for deterioration, and thus to be no longer in need of the CTO (§51.5.a). It is only after an assessment in which the individual is found to be in need of an *involuntary admission* to hospital that the CTO would be formally revoked (§51.5.a). A third option is that the individual could continue to live in the community with the CTO but with modifications made as to what she would be required to do as part of the Order (§51.5.b).

Despite the fact that the individual, in having her CTO revoked, meets, in essence, the criteria for involuntary certification according to the *Mental Health Care and Treatment Act*, the first certificate for involuntary certification must be completed (Government of Newfoundland and Labrador, 2006a). When the individual is ready for discharge, placing the person on a new CTO can be considered based on the fact that the individual has been on a CTO (§40.2.b.i) in the past two years. Implementing a CTO following a revocation and involuntary admission is *not* dependent on the criteria of three involuntary admissions in the prior two year period (see §40.2.b.ii).

Professional liability for a CTO. The creators of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) included clauses related to protection from liability for individuals who are implementing the CTO. These are found in Sections 7 and 52. Section 7 outlines protection from liability in a general sense for the entire *Act*:

> 7. (1) An action shall not be brought against, and an administrator, a physician, a psychiatrist, a rights advisor, a nurse practitioner, a health care professional, the board, a panel appointed by the chairperson of the board, a member of the board, or another person or organization shall not be liable for an act or failure to act, or for a proceeding initiated or carried out or purportedly initiated or carried out in good faith under this Act, or for carrying out duties or obligations under this Act or for an application, decision, order, certificate, notice or other authorization made or enforced or purported to be made or enforced in good faith under this Act.

> (2) An action shall not be brought against, and a facility, a psychiatric unit, a hospital authority, a peace officer or the Crown or an officer, employee, servant or agent of a facility, a psychiatric unit, a hospital authority, a peace officer or the Crown shall not be liable for a tort committed by a person who is subject to a certificate or order issued under this Act while that certificate or order is in effect.

With specific reference to CTOs, there is a protection of liability statement as well. It is stipulated that:

> 52. (1) Where the psychiatrist who is responsible for the management and supervision of a community treatment order believes on reasonable grounds and in good faith that a health care professional, other person or organization that is responsible for providing treatment or care and supervision under a community treatment plan is doing so in accordance with the plan, an action shall not be brought against the psychiatrist and he or she is not liable for a failure by that health care professional, other person or organization to provide treatment or care and supervision or for a default or neglect by that health care professional, person or organization in providing the treatment or care and supervision.
>
> (2) Where a health care professional, other person or organization that is responsible for providing an aspect of treatment or care and supervision under a community treatment plan believes on reasonable grounds and in good faith that the psychiatrist who is responsible for the management and supervision of the community treatment order, or a psychiatrist designated under Subsection 44(2) or another health care professional, person or organization named in the community treatment plan, is providing treatment or care and supervision in accordance with

> the plan, an action shall not be brought against, and the health care professional, person or organization person is not liable for, a failure by the psychiatrist or his or her designate or another health care professional, person or organization to provide treatment or care and supervision or for a default or neglect by that psychiatrist, designate, health care professional, person or organization in providing the treatment or care and supervision (Government of Newfoundland and Labrador, 2006a).

The inclusion of these sections in the legislation is relevant to this study's examination of its use in practice. This focus on professional liability emphasizes the significant legal issues that professionals are implicated in when they are named on a CTO. This emphasis on liability prompted me to question if CTOs were being avoided due to health professionals' concerns with liability. Liability concerns might arise when something goes wrong (e.g. if an individual on a CTO attempts suicide). Another concern, for example, includes the significant responsibility related to initiating this legislative authority to impede a person's civil liberties in the community. It is also a considerable responsibility for the other healthcare professionals, including nurses, who are involved with its implementation and monitoring. Much of the work of CTOs is based on an assessment of risk. Errors can be made in conducting this assessment. The legislation provides detailed assurances to professionals that they cannot be held responsible for one another's negligence. As long as steps have been taken to follow the "reasonably created" CTO plan "in good faith" (§ 52.2), then no action can be brought against the healthcare team if the person with the mental illness causes harm to herself or to others. Nonetheless, the consequences that the “no liability” clause portends emphasize the serious consequences that could ensue if a CTO goes wrong.

Rights Based Approaches to the CTO Legislation

According to the Government of NL’s Health and Community Services website, a rights approach “allows a balance between the individual’s right to health and safety and the need to offer interventions and supports where individuals are unable to make those decisions as a result of their mental illness” (Government of Newfoundland and Labrador, 2012, ¶2). This was a departure from the previous *Mental Health Act* (Government of Newfoundland and Labrador, 1971) which was not considered to be as attentive to the rights of individuals in terms of having input into their care. The following section provides details regarding the additions to the legislation intended to operationalize this approach.

Review Board

A Review Board is in place to hear and make decisions regarding applications filed by individuals who are affected by the legislation, namely patients with mental illness who have been certified or placed on a CTO (Government of Newfoundland and Labrador, 2006a). The board reports on its operations to the provincial government minister appointed to administer this *Act*[14] and performs other functions as required (§56.1-2). The board consists of a Chair who is a member of the Law Society of NL, four people who are in good standing with the Law Society, four physicians, and four people who are neither members of the Law Society nor physicians, but who have an interest in mental health issues. In this instance, preference is given to individuals who are or have been consumers of mental health services (§57.1.a-d). While a preference for individuals

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[14] Currently, this falls under the portfolio of the Minister of Health and Community Services.

with experience is noted, there are no guidelines as to what experience mix is considered desirable.

Persons who are on a CTO can apply to the Board for a review of their CTO criteria. A formal request in writing is made to the Review Board, which can be initiated when a CTO is issued or renewed. The Review Board has been granted all of the powers, duties, and immunities of a commissioner appointed under the *Public Inquiries Act*[15] (§68.1) (Government of Newfoundland and Labrador, 2006a). When a hearing is scheduled, the panel may require witnesses to attend and to have particular documents and records produced. Panel members can require that patients undergo psychiatric examinations by an independent psychiatrist. The Board can call upon health and other professionals to produce evidence (§68.2.b-c). Based on this evidence, the Board can make decisions as to whether an individual is to remain certified or on a CTO, or if the physicians' decisions should be nullified.

Human Rights Advisors

The *Mental Health Care and Treatment Act* legislation also includes provisos for the use of rights advisors. These individuals cannot be providing direct clinical care to the patient nor providing indirect care or supervision (§13.1) (Government of Newfoundland and Labrador, 2006a). The role of the rights advisor is to be a full patient advocate, providing advice and help patients (and their representatives; see below) who are involuntary admitted or detained on inpatient units or who are on CTOs. In the inpatient setting, the rights advisors are notified of individuals who are being involuntarily admitted or whose voluntary status is being changed to an involuntary status during a

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[15] For more information: http://www.assembly.nl.ca/legislation/sr/annualstatutes/2006/p38-1.c06.htm (Government of Newfoundland and Labrador, 2006b)

hospitalization. They are also notified if an individual is issued a CTO. The rights advisor is expected to meet with the person as soon as possible and within 24 hours of the person being detained or placed upon a CTO. During this meeting, the advisor is to discuss the meaning of the involuntary status or the CTO with the patient. In the case of an appeal of Review Board decisions, the advisor is to assist the person in accessing legal counsel (if requested). The advisor may attend these hearings with the patient. It is also expected that the advisor communicates with the patient and her representatives in a neutral nonjudgmental manner and that confidentiality is maintained (§14) (Government of Newfoundland and Labrador, 2006a). Section 15 of the legislation identifies the administrator or attending psychiatrist as responsible for ensuring that the rights advisor has been made aware when a CTO is issued, renewed, expired, terminated, or revoked and when there has been any application made to the Review Board.

Patient Representatives

The *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) also makes the provision for patient representatives. These are individuals, other than rights advisors, who have been designated for the role by the patient to act as next-of-kin. Patient representatives must have reached the age of 19 years, be mentally competent, and agreeable and available to act on behalf of a person with a mental illness (§2.1.t). The representative can apply on behalf of the patient to the Review Board for review of the CTO (§41.2.c), and must be given the following: copies of the CTO (§43); written notice of and changes in the psychiatrist managing the CTO (§44.3); written notice that the CTO has expired and is not being renewed (§47.2); written notice of any changes in the CTO plan (§49.2); written notice that the CTO is no longer in effect (§50.3.c); and notice that the person has been transferred to another facility, if applicable (§77).

Summary

In summary, the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) is a significant departure from previous NL mental health legislation. For the first time CTOs were included as an option for individuals who were frequently in and out of hospitals for mental health care. The inclusion of various rights-based roles such as rights advisors and patient representatives associated with implementation of the *Act* were initially well received. Given the complexity of the changes, however, it was recognized that clarification was needed regarding use of the *Act* and further documents were created.

Policy and Procedural Texts for Implementing the *Mental Health Care and Treatment Act* (2006)

There are a number of documents that provide background for and stem from the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a). The following is an overview of documents particularly relevant to this study. While there were others considered for this exploration, this overview is focused on what I consider most pertinent.

Mental Health Care and Treatment Act Provincial Policy and Procedure Manual (Government of Newfoundland and Labrador, 2009)

A *Mental Health Care and Treatment Act Provincial Policy and Procedure Manual* (Government of Newfoundland and Labrador, 2009) was created to assist in the implementation and interpretation of the *Mental Health Care and Treatment Act*

(Government of Newfoundland and Labrador, 2006a). The purpose of the manual is to "assist the Regional Health Authorities (RHAs) in implementing and interpreting the *Act*[16]" (p. 3) and, in doing so, it outlines the general policies and procedures that the RHAs should follow. The information contained within it is organized into a more readable format. Previous mental health legislation did not have an accompanying manual to aid in interpreting the law for implementation.

The Department of Health and Community Services (DHCS) states in the *Mental Health Care and Treatment Act Provincial Policy and Procedure Manual* (Government of Newfoundland and Labrador, 2009) that *policies and procedures* stemming from the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) will be reviewed once every three years. The manual outlines the process to be followed if the review results in a request for revision or addition to the *Act*. It is also noted in the policy and procedure manual that the DHCS, along with the RHAs and community agencies, will review the effectiveness of the *Act* on a yearly basis. This is to be in addition to its ministerial review that is to occur every five years.

***Newfoundland and Labrador Mental Health Care and Treatment Act Evaluation Final Report* (Newfoundland and Labrador Centre for Health Information, 2012)**

As legislated, the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) *legislation*[17] underwent an external review five years after implementation. The Centre for Health Information in NL conducted an analysis of the use of the legislation by reviewing statistical information and interviewing key stakeholders, including health professionals and patients. The focus of the resulting

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[16] Italics added.
[17] Italics added.

report (2012) is largely on the use of involuntary certification and admissions. However, there are some sections that address CTOs. The major issues identified included: compliance with requirements for treatment plan, previous involuntary admissions, lack of availability of community services, and education and involvement of peace officers. The report is based on the information collected via surveys, focus groups, and individual interviews. The data were analyzed using descriptive statistics and identification of themes.

Regional Health Authority Policies and Procedures

Policies and procedures have also been developed by regional health authorities and copies of these were obtained from the Regional Health Authority and reviewed for this IE research. These policies included those pertaining to *Consents* (2012), *Psychiatric Assessment* (including *Psychiatric Nursing Assessment and Suicide Assessment*) (2011a), *Responsibility to Patients Under Community Treatment Orders* (2011b), and *Return of Persons Who Fail to Comply With Community Treatment Orders* (2011c) (Regional Health Authority). These documents and their use are analyzed in subsequent chapters.

Other National and International Documents

The practices embedded in involuntary treatment for individuals with mental illness are textually linked to national and international interests in human rights and ethics. Given this, I reviewed some seminal documents pertaining to mental health, human rights and relevant documents developed for professional nurses. The following is a brief overview of the most relevant of these documents.

The Canadian Charter of Rights and Freedoms **(1982)**

This charter is a document of significant historical significance. It is a constitutional act that serves as a bill of rights for Canadian citizens. It guarantees rights and freedoms “to such reasonable limits prescribed by law” (¶ 2) and includes freedom of conscience and thought, belief and expression, mobility within the country, and the right to pursue a livelihood in any province. Individuals have the right to life, liberty, and security of the person, except when that would conflict with the principles of fundamental justice. Everyone under the *Charter* has the right to be secure against unreasonable search and seizure and the right not to be arbitrarily detained or imprisoned or subjected to any cruel and unusual treatment or punishment. As well, of note for this study, is Section 15 (1) which protects against discrimination based on mental disability.

The United Nations’ *Universal Declaration of Human Rights* (1948)

This declaration is another landmark document that outlines basic human rights that are considered universally fundamental. A number of the articles address issues that are of relevance to mental health and mental illness. These include Article 5 pertaining to freedom from torture or cruel treatment, Article 7 promoting equal protection for individuals under the law, and Article 25 addressing the right for standards in living and wellbeing, and access to treatment.

The Canadian Nurses’ Association (CNA) *Code of Ethics for Registered Nurses* (2008)

The CNA *Code of Ethics* (2008) provides ethical guidance for RNs in their provision of care to individuals, families, and communities in everyday practice. There are seven areas included for the RN to address: providing safe, compassionate, competent and ethical care; promoting health and well-being; promoting and respecting informed decision-making; preserving dignity; maintaining privacy and confidentiality; promoting justice; and being accountable (p. 3).

Summary

This research study started with a focus on ethnographic descriptions of people's everyday work with CTOs. The descriptions of people's work hold traces of the discursive origins of what is happening that can be traced into mental health inquiries, legislation, policy documents and professional regulation. The documents presented in this chapter are intended as a support for readers as they track the analysis developed in later chapters. In discussing these documents, a historical context was required as the basis for the mental health legislative reforms in 2006 that introduced CTOs.

This chapter has been crafted to afford readers knowledge of the "directions" that the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) and related texts provide for people whose daily work and lives are organized within its reach. In it, I begin to unravel the multiple legal and clinical processes vested in texts that coordinate the work of implementing or being subject to a CTO. I use the IE concept of "boss text" to examine the *Mental Health Care and Treatment Act*, that, although not *visibly used* (as an everyday document) in the local work settings, is nonetheless integral to the routine work processes that arise there. Both the *Mental Health Care and Treatment Act* boss text *and* the forms and computer fields of everyday work result in "texts in action" that organize the "institutional circuits" (Smith & Turner, 2014, p. 9) that CTO work organizes. These are the circuits I explicate as I build the analysis of this dissertation.

The documents detailed in this chapter provide the basis for a great many troubling and contradictory work processes that my analysis exposes. Even though the *Mental Health Care and Treatment Act* legislation of 2006 was an important attempt to prevent tragedies, such as those detailed in the Luther Report (2003), the analysis elucidated in this IE suggests that, despite the best intentions of stakeholders, professionals, and legislators, the social organization of CTOs in NL is coordinating troubling situations for people who experience SPMI *and* for their professional and lay caregivers. The CTO legislation pulls people into a legislative "pseudo-criminalization" of mental illness that, although purported to be therapeutic, jeopardizes real therapeutic work and places significant burdens on unpaid, poorly supported family and friends.

CHAPTER 5

THE EVERYDAY WORK PROCESSES ASSOCIATED WITH INVOLUNTARY COMMUNITY TREATMENT

In institutional ethnography, the "often taken-for-granted every day work" becomes the subject of inquiry and is examined for links with the ruling relations that influence it. In this chapter, I will introduce the reader to the everyday "ground level" work processes with which individuals affected by CTOs are involved (Smith, 2008). These work processes are considered the local level data. They produce an account of what is happening to individuals in their everyday lives. In this study, local work came in many forms, such as the paid work of healthcare professionals or the unpaid work of family members of patients with severe, persistent mental illness (SPMI) living with a CTO. Each informant was encouraged to tell her "story" regarding her work related to CTOs. It was my role at this stage, not only to attempt to see an "emerging picture" of what was happening in the everyday, but to also see the informants as experts in that they "know and can tell" (Campbell & Gregor, 2002, p. 85).

In this early analysis of data, I am not only collecting and describing what is happening but also attempting to explicate it and to identify the links into the broader organization. My goal has been to learn about how persons' CTO work is organised and coordinated (Campbell & Gregor, 2002). Details regarding the organization and coordination of the work will become more evident in subsequent analysis chapters in which I provide a more detailed textual analysis of the legislation and the ruling relations that coordinate its activation.

The Work of Individuals Living with Severe Mental Illness and their Families

The inclusion of CTOs in the *Mental Health Care and Treatment Act l*egislation (Government of Newfoundland and Labrador, 2006a) was strongly supported by families and groups representing their concerns. This reflects the interests that family and friends of people with SPMI have in the management of the illnesses. Many of the informants in my study described the way individuals with SPMI relied on family members, friends, and other informal supports to meet their needs in their daily lives. Families were described as being substitutes for healthcare professionals and as persons who were looked to for filling gaps in services, such as home care and transportation. This occurred regardless of the family's level of understanding of mental illness or its management. Such involvement poses considerable challenges to all involved.

The advanced care nurse informant, Lee, has heard stories of family members having to lock their doors and of being afraid to go to bed at night, while trying to maintain a relationship with a relative who was very mentally ill, violent, and unpredictable. She heard one mother state: "I'm out there trying to slip the pill into her breakfast because maybe I'll have a better day today because she's medicated and I don't have to be afraid". Family members were not only concerned that they or others were going to be hurt, but that the individual with the mental illness would be injured, placed in jail, or shot by peace officers. There was little external support for these families whom Lee described as being "without armour", "left out in the cold" and "on their own trying to cope". Pat, the psychiatrist informant described how healthcare professionals must consider who might be impacted by a person's mental illness. Pat questioned how much suffering a family caregiver experienced: "I have patients whose mothers and significant others have suffered a great deal ... patients have been violent to them". For the purposes of this research, it was very important for me to find a family informant who could provide descriptions of her[18] work in caring for a loved one with a mental illness and to learn what led up to that person being placed on a CTO and the work involved with its implementation.

One Family Member's Life with a Loved One with Severe Mental Illness

Family members living with individuals with poorly managed mental illnesses are subject to considerable stress, uncertainty, and hardship. Jamie, the family informant, said that it has been "pretty rough at times" living with her loved one, Kerry, who has a long history of SPMI that is not well controlled. Jamie described how Kerry has delusional thoughts. This means that Kerry has false, fixed beliefs which, despite any amount of rationalizing, are irrefutable to the person experiencing them, and signifies that the person is unable to accurately interpret the reality around her (Hamilton-Wilson, 2015). Kerry's illness manifests itself in symptoms of paranoia and suspiciousness about her medications and she does not want to take them. Without medication, these symptoms worsen, although her symptoms are present to a certain degree even when she is taking medication and is relatively well. Kerry has made serious suicide attempts that cause Jamie to worry about Kerry's safety. A consistent history of medication noncompliance and relapses has contributed to Kerry's admission to a mental health unit or facility over 30 times.

Kerry can become very violent and assaultive and has verbally threatened individuals in various social circumstances. Jamie, in particular, has come to fear for her personal safety. She described the need to have "eyes in the back of your head." For example, Jamie described being unable to sleep: "I was in fear to the point where, if I

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[18] I wish to provide a reminder to the reader that I have chosen to use feminine pronouns in this study.

went to bed, [Kerry] could end up probably getting a knife and stabbing me or smother[ing] me with a pillow or burn[ing] the house. I just had to keep a watchful eye." Jamie noted other situations in which she was threatened by Kerry and had to sleep in the car all night, as staying in the house with Kerry was unsafe. Jamie said, "That happened a good many times. Cold nights, warm nights." Jamie has reluctantly had to report Kerry's behaviour to the police, noting that it was either that or she would "kill me." Such incidents have led other family members to express concern for Jamie's safety while providing care for Kerry. They do not want to see Kerry as they feel unsafe around her. Jamie believes that if she does not provide the care and support Kerry needs, then no one else will.

Kerry had become isolated from others in the community and was "lonely." Jamie suggested to Kerry ways to become more sociable and involved, such as going to local card games, but Kerry did not want to do this. In addition, individuals in the community did not want Kerry attending their social activities. Jamie blamed this on their knowing about Kerry's illness and of the many incidents that required police involvement. According to Jamie, there are probably "two people out of a hundred" that treat Kerry as "a human being". Jamie feared that the community, as well as family members, viewed Kerry as a violent, "not to be trusted" person. Individuals in the community have called the police complaining about Kerry's activities when, according to Jamie, Kerry has not committed any of the acts which were reported. This rejection from others "hurts" Kerry and strengthens Jamie's resolve not to reject Kerry, despite all of the challenges she faces in caring for her.

There were few stipulations identified in Kerry's CTO. They involved medication compliance and keeping appointments with the listed healthcare providers. While the list was brief, Jamie said these two expectations were very important for Kerry's wellbeing. When Kerry took her medications, the intensity of paranoid, aggressive, and violent thoughts and the resulting behaviours were "not as bad" as what Kerry experienced when she was noncompliant[19]. Jamie stated that during periods of compliance, "You don't really have to look over your shoulder and be in fear." Jamie did not believe that the medications would "cure" Kerry but would provide some control over her symptoms. She stated that Kerry would "never be 100%" better and would be on a CTO for the rest of her life.

Being mandated to take medications is not a welcomed requirement for many individuals on a CTO. Jamie said Kerry was not happy being on her medications, with one in particular having "bad side effects". Kerry had received a variety of different medications and ECT (electroconvulsive therapy) since her initial diagnosis but without much success. Some medications would make Kerry so sedated that she would have enuresis (loss of bladder control) and excessive drooling, making her very upset and uncomfortable. Jamie described how she would sometimes hear Kerry crying over what was happening to her because of the medications. Antipsychotic medications can have a variety of side effects beyond sedation, such as causing involuntary muscle movements (such as lip smacking and tongue protruding); muscle dystonia (abnormal muscle contractions) such as torticollis (neck spasms) or potentially fatal laryngospasms (spasm in the larynx resulting in difficulty breathing); sexual dysfunction; and cardiac and liver

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[19] I wish to acknowledge that the term "noncompliance is laden with many different, and often negative, connotations in mental health literature. Other terms that could be used include non-adherence.

dysfunctions (Hamilton-Wilson, 2015). The decision to take medications with these types of side effects is a difficult one. Taking the medications results in the possibility of having these serious, life-altering, and sometimes permanent, side effects. Not taking the medications results in living in a state of disconnect from reality where one could be a danger to self or others.

Given the reluctance that Kerry, and many others, have toward taking psychiatric medication, the mere act of *mandating* an individual to take medications does not mean that the person will *actually* take them. Jamie stated Kerry is "determined" not to take medications; she does not care about the CTO, and believes that the CTO is, in fact, "killing" her. Jamie said Kerry had periods of wellness without having a CTO. During these times, Jamie provided Kerry with support in the form of helping to maintain a home, with cooking, cleaning, monitoring medications, and ensuring that Kerry kept her appointments. Problems arose when Kerry would be noncompliant and then threats to Jamie's and others' personal safety became a significant risk. It was during such a time when Kerry was noncompliant with medications that she became seriously mentally ill and was assessed as at risk for harming others and placed on the CTO.

Ironically, the CTO does not foster treatment compliance for all patients. As previously noted, the person on a CTO cannot be automatically readmitted to hospital without being assessed as a risk for deterioration leading to harm to self or others (Government of Newfoundland and Labrador, 2006a). This legislation is based on negative reinforcement whereby the threat of re-hospitalization is used as a deterrent. For some individuals, this threat might be an ideal deterrent for noncompliance. For Kerry, however, it does not provide an impetus to stay medication compliant. Jamie described how Kerry feels “cornered” while on the CTO and stops taking her prescribed medication sooner than what she might when not on a CTO. This occurs despite the possible repercussions of being readmitted to hospital. The threat of returning to hospital is less of an imposition than having to take psychiatric medications and, if this is the case for one individual, it might be so for others. In this instance, it seems counterintuitive to use rehospitalization as a deterrent if Kerry does not perceive it to be a less desirable option to taking medications.

The CTO is seen as a “last resort” for patients with severe, persistent, poorly managed mental illness. The ongoing, cyclical nature of the criteria for being placed on a CTO is meant to be used as an indicator that other less coercive means to help the individual to stay well have failed. If the main deterrent in the CTO legislation is not effective for some individuals, then what could be used to foster compliance? While this question is beyond the scope of this dissertation, it is nonetheless important to consider. What happens if the individual lacks insight or understanding into one’s illness?; does not have an intrinsic drive to participate in activities that will (or are believed to) maintain wellness?; participates in what is believed (or sanctioned) as necessary for wellness but does not feel “well” as a result and wants to stop (or does)?; and what kind of “clout” does the legislation actually have in practice if “re-hospitalization as a threat" fails?

The burden of mediating Kerry’s disdain for taking medications with the threat of re-hospitalization falls to Jamie, whose vulnerability inside the CTO system is very apparent. With or without the textually mediated monitoring of individuals on CTOs, families are the ones who will often act as the substitute for formal monitoring and support in lieu of healthcare professionals such as nurses. Jamie was the everyday face of

CTO enforcement for Kerry. She assumed additional roles within the CTO process and became a part of the monitoring and reporting structure, which often put her into precarious situations. While Jamie's role in the CTO is seen as informal caregiver, the descriptions of the work Jamie performs and how it is coordinated tells a different tale.

Jamie was *formally* pulled into the legislative responsibilities of the CTO when she was identified on the CTO document as a family contact person for Kerry[20]. As such, Jamie was the formally identified contact who received information from the hospital regarding Kerry's progress when she was an inpatient and from the community mental health nurses when an outpatient. Jamie's daily, ongoing CTO work processes included notification of the nurse as to Kerry's progress. Jamie also consulted with the family physician and the psychiatrist, but this was infrequent. At times, Jamie had to push those in positions of authority to believe her concerns and take them seriously. One of the formal texts that pulled Jamie into the ruling relations of the CTO was when she received information or documentation concerning Kerry's CTO via registered mail. In this sense, Jamie became textually implicated with the responsibility for the progress of the CTO. Jamie's work has been schematically represented in Figure 3. In it, there is a clear representation of the numerous points in the CTO process where Jamie's work as a family member intersects with the textually mediated CTO process.

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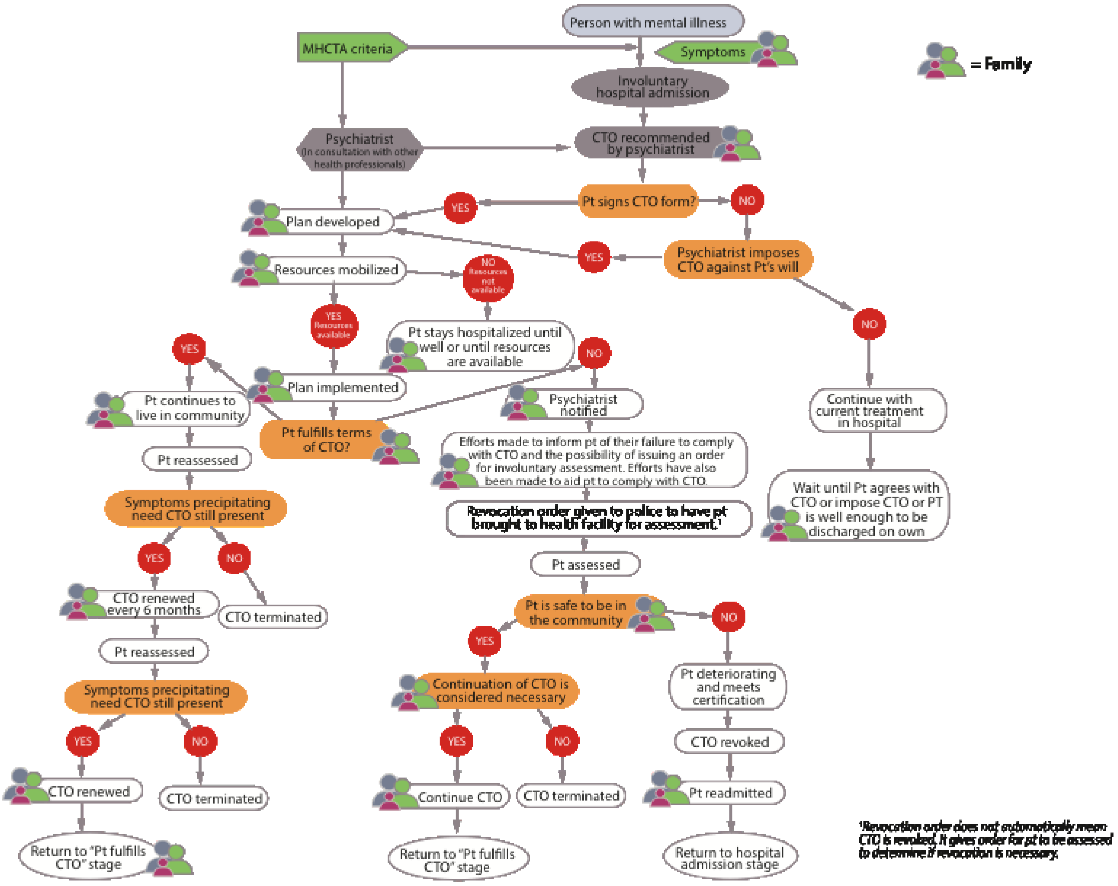
[20] According to the legislation, Jamie was acting as Kerry's patient representative although she did not refer to herself in these legal terms. I was unable to review the actual CTO document to which Kerry was subject.



¹Revocation order does not automatically mean CTO is revoked. It gives order for pt to be assessed to determine if revocation is necessary.

Figure 3: Family Involvement in the CTO Process

Jamie became the "expert" who was relied upon to manage Kerry's illness. Jamie said that it was important for mental health staff to be helpful, understanding, and easy to talk to but, she implied, at times professional intervention did not support her work with Kerry. She recognised that the textually mediated assessments of Kerry could not accommodate her own expert knowledge of the nature and progression of Kerry's illness. For example, Jamie described situations in which healthcare professionals had assessed Kerry to be doing "well" from a psychiatric perspective, but Jamie remained concerned. Jamie knew how Kerry could manage to be on "her best behaviour" in order to get out of hospital or avoid readmission. Thus, the intermittent professional assessments expected to monitor the effectiveness of the CTO did not “work” to keep Kerry and Jamie well supported.

While the healthcare professionals named on the CTO document have certain professional accountabilities that will be described later, Jamie’s informal/formal involvement with the CTO was critically important. It was based on her personal knowledge of Kerry, how Kerry lived her day-to-day life, and how her mental illness would fluctuate. Jamie contacted the nurse, physician, and police at times when she felt it was warranted. Healthcare professionals also consulted Jamie about Kerry’s progress if any concerns, such as medication noncompliance, arose. Jamie was the individual responsible for ensuring Kerry took her medications, attended appointments, ate, slept, and did not disturb the peace. She was Kerry’s escort in attending appointments in larger centers and had to seek out financial assistance for their travel (including having the cost of their meals reimbursed, as the travel time was lengthy). All of this work was not formally identified on the CTO form, but was a vital part of Kerry’s ongoing health maintenance and CTO adherence. Jamie did this while managing Kerry’s sometimes bizarre behaviour, such as “grabbing the steering wheel of the car and trying to go off the road” while Jamie was driving Kerry to her appointments. Jamie understood Kerry’s undertaking with the CTO and what was expected of Kerry. Jamie, however, became the everyday enforcer and monitor of the CTO. In a sense, it became Jamie’s CTO undertaking as well as Kerry’s. Jamie’s work aided healthcare professionals to conduct their work in monitoring. Without Jamie (or an alternate live-in support), there would have been no one at the everyday level to provide the intensity of monitoring that Jamie provided.

There is possibility for considerable discussion of Jamie's work from the perspective of the body of knowledge surrounding informal care giving. However, my analysis reveals the socially organized exploitation of the loyalty that one family member provides to another in acting as a caregiver. In particular, my descriptions show how the care provided extends into the realm of what might be considered a healthcare professional's scope of practice and responsibility. In listing Jamie as the family support person and having her officially and textually involved in the CTO process, Jamie is being formally organized to take on these CTO responsibilities that are actually within the purview of government and its designates (i.e. the healthcare professionals, including nurses).

There is a lack of evidence that suggests that Kerry or Jamie had much input into the creation and implementation of the CTO under which they were living. Kerry did not want to be a part of the CTO that was being offered to her; she did not want to take medications that were prescribed for her; and she did not want to have any healthcare professionals involved in monitoring her daily activities. Jamie said that Kerry was informed of all CTO stipulations and given written documentation regarding it, but there is no indication that Kerry (or Jamie) had any input into its creation.

Despite often being quite verbally and physically abusive towards Jamie, Kerry could interact well with others, such as healthcare professionals. There were times, however, when this too was quite strained. There were both tenuous and strong relationships with the community mental health nurses involved with Kerry's monitoring. Jamie stated there had been a number of nurses involved with Kerry over the years. She recounted having to inform and teach each nurse about what Kerry could be like when mentally unwell and how Kerry could behave (i.e. noncompliant with medications, violent, and verbally abusive). She described her observation that some of these nurses were young and inexperienced regarding support needed by individuals with mental illness, like Kerry, who were living in the community. The current community mental health nurse involved with Kerry's care has been with her for some time. Jamie said that the nurse makes home visits and telephone calls to evaluate how Kerry is doing. From Jamie's experience, this contact is not enough, but she felt that the nurse was doing as "much as she can". For Jamie, who has been involved in community mental health for so long, this current nurse is appreciated because she demonstrates concern, not only for Kerry, but for Jamie as the family caregiver. Jamie said the nurse occasionally calls her to see how she is managing and coping.

While having good family support is largely viewed as aiding a person's recovery, the mere presence of family involvement may not be positive in nature. Family members expected to provide support and care for a relative with SPMI often have their own health concerns, both physical and mental. They may have pre-existing coping difficulties, addiction problems, and physical challenges. These health situations, in addition to what conventional psychiatry would identify as "pre-existing maladaptive coping and interpersonal relating in family contexts", could lead to family involvement being more of a stressor to the individual with SPMI than a support.

As well, some family members who provide support in challenging situations may develop mental health concerns themselves as a result of the stress of living with an individual with poorly managed SPMI. For instance, Jamie has had to seek out mental healthcare for herself over the years living with and caring for Kerry. The current community health nurse, being aware of this, shows concern for Jamie's wellbeing, even though it is not a part of her set of direct responsibilities as part of Kerry's CTO.

The Everyday Work of Community Mental Health Nurses

It is apparent that Jamie's work is closely linked to that of mental healthcare professionals. The healthcare informants interviewed in this study also described this involvement. All indicated there was a considerable amount of work involved with caring for individuals who were being considered for, or who were on, a CTO. This work occurs in various stages and includes determining if an individual qualifies for a CTO, preparing the individual for discharge from hospital on a CTO, determining what community resources are available and accessible, and creating, implementing, and monitoring a CTO plan. The healthcare professionals who are involved in this work of providing some form of care or service to individuals on CTOs include, but are not limited to, nurses, physicians, and social workers. Together, they comprise the CTO team and are identified by name on the CTO form. The basic everyday work of these individuals in relation to the CTO is described below, with the main focus being on the work of nurses. A more detailed analysis of healthcare professionals' activation of the CTO legislation is provided in Chapter 7.

The context in which mental health nursing is practiced in Newfoundland and Labrador (NL) has changed since the release of the *Luther Report* (2003) (see Chapter 4). The overwhelmingly negative depiction of mental health care in the province added fervor to the work of many individuals and community groups advocating for improvements. In response to this document, the NL government stated that it would place more emphasis on community mental health care. Services such as the Assertive

Community Treatment team, a mobile crisis response unit, and more community based mental health nursing positions (in urban and rural areas) were created.

According to informant Kris, a community mental health nurse, the objective of placing more emphasis on community mental health services was “to accommodate the individuals out in the community who were probably missing mental health services” and who were “suffering alone”. Kris said these individuals were those who had few supports from families or the community and who did not seek help due to stigma regarding mental illness and mental health services. Using institutional ethnography, Kris’s explanation would be examined as a somewhat ideological and institutional view of why the services were put into place whereby she uses the discourse of “suffering” to justify the rationale for providing better mental health resources. Her explanation about what motivated the changes in services leaves out two major considerations: how they emerged within a politically delicate climate for government in the aftermath of Judge Luther’s scathing description of mental health services in NL (Luther, 2003), and public concerns related to people who died in the process of being “missed” by mental health services.

The government’s increase in community mental health nursing positions, particularly in rural NL, added to the number of nurses who provided mental health “case management” work in the province. In mental health nursing, case management is defined as the full range of responsibilities a healthcare professional undertakes when assigned the care of an individual with SPMI. These responsibilities include providing continuity in assessing, planning, implementing, and evaluating care (Pollard, 2015). For example, in my experience, case managers assist individuals in obtaining a community service based on an identified need. This entails making referrals to counseling services or advocating for increased income support.

This case management role of community mental health nursing originated in the time following deinstitutionalization, a movement that saw many individuals with SPMI discharged from psychiatric institutions where they had previously resided. Kris described her understanding of the objective of case management, which she understood included the responsibility to find cases; to “go out there and actually seek these people out in the community and find out who they are and provide support for them.” Kris believed that the actual role of the community mental health nurse fit well with what was intended for the role when it was created. According to Kris, the improved services were working. Kris’s impressions are congruent with ideological constructions that community mental health services are better and more humane than the prior system of institutional services, which was not as effective in screening, identifying, providing care for, and monitoring individuals with SPMI:

> To compare services for these hard-to-reach individuals now, compared to say ten years ago, I think there is a major improvement because of these case management positions. Well, at least now there are people specifically assigned to getting out there in the community to find these people, [who] are reaching out to them, offering them a helping hand and offering them support. Knocking down some of those barriers that were traditionally there in helping these people get in for treatment and getting the services that they need. I honestly have to say I think there is an improvement for sure in identifying these individuals that are out there

> suffering from chronic, persistent mental illness (Kris, community mental health nurse informant).

However, while there is an improvement to the institutional *description* of the community mental health nurse case manager contribution in the community, the reality of the work role proves to be quite different. Despite Kris' belief in the new models of care, she experienced the many challenges facing nurses working in community mental health. Kris understood that some of the issues she encountered in her work could be addressed on a "system level", in that there is a need to be able to "provide more service and better service to these people". She saw a lot of challenges existing for her patients and, while some of these challenges have been overcome or "we're gradually overcoming" them, there are "still a lot of challenges that exist for these people".

Case managers have heavy caseloads. The process of assigning a patient to a case manager is usually initiated by a physician who determines that close monitoring would benefit the patient. At this juncture, an individual might be waitlisted in a very lengthy process that could involve months. Contrary to Kris's impression that she could seek people out who required her support, in most situations, people with mental illness and their families cannot independently approach a nurse case manager and request services and, even though nurses may become aware of individuals in the community who are suffering from mental health concerns, these individuals may not become a part of the nurses' caseloads. Community case managers are knowledgeable about the "challenges that exist for these people" but the systems in place that organize the case manager's practice impact how they can work on behalf of people with mental illness, even those individuals with the more severe, persistent types.

The knowledge about who does and who does not need to be prioritized within the heavy caseload is informed by the case manager's intimate knowledge of the people they visit. Kris described being "fortunate" with her caseload as "I've been in this position for [a number of] years. I'm comfortable with my clientele. I can tell when they're not well or when they're doing well". However, this knowledgeable familiarity and expertise is a double-edged sword. Kris describes that, because of her insight and experience, she has taken on more patients in her caseload, increasing from the normal range of 15 or16 people to a range of 20 or 21. According to Kris, "about half" of her caseload are "fairly stable" as "they have supports in place now and they're doing fairly well so I find it fairly manageable personally".

Despite Kris's evident professional competence and the skill with which she manages her caseload, what is missing here is analytic insight into how a "caseload" works and how Kris's competent expansion of her duties may actually create a series of contradictory practices, especially as they relate to the systems by which caseloads are funded and resourced. Nursing positions are created and designed with a certain allotment of work in mind. A usual caseload equates to the work allotment of one position; in the situation of mental health case managers and mental health nurses, this equals "following" 15 to 16 people. According to the numbers indicated by Kris, there is an apparent need for more community mental health nurses in the community, given that her current workload is approximately 30% over what is normally expected. Kris' expertise notwithstanding, the resource of time impacts the way she able to perform her duties and meet the far-reaching complexity of the social, health, and geographical demands involved.

Moreover, the subtle reference to “supports in place” covers over the actual people upon whom Kris is relying to ensure that the people in her caseload remain stable. In Kris’s description of “fairly stable” with “supports” that allow her to find her caseload “fairly manageable,” the work of individuals like Jamie (who sleeps in her car in order to avoid physical altercations with family member, Kerry who is on a CTO) are not apparent. They are subsumed into a professional language of “fairly stable” or “doing well”. Each individual who represents a “case” is an individual proceeding with his or her own mental health resources, activating variously demanding treatment options, and relying on varied capacity of family involvement. Without the work of family members or other support persons, the individuals with SPMI might not be as stable, resulting in a greater strain on formal mental health resources. Community mental health nurses, like Kris, would not be able to take on extra individuals into their case load, if the “acuity levels” of all changed due to the absence of a family member to ensure they take their medications, bring them to appointments and so forth. Without this, many individuals with SPMI would not even be able to live in the community. These work processes of variously involved support people get lost in referring to a person with SPMI as a “case”, a “caseload” and “fairly stable”.

Kris said she relies on her considerable knowledge of each individual patient in order to provide follow-up and to feel comfortable with caseload increases. Some of this information comes from the support person. Kris’s knowledge about her caseload is a professional knowledge that she relies upon to ensure her caseload remains manageable. For Kris, the knowledge is established over time: “I follow my [patients] very closely and over the years I know what to look for when they are starting to become unwell again or whatever and I recognize when they need some treatment”. However, what is apparent in Kris’s description of her work is how her increasing caseload likely limits her capacity to follow people closely and how (most likely) there are all sorts of informal caregivers who support Kris to know “when they are starting to become unwell again”. Such is the case with Jamie, who contacts the police officers and community mental health nurses in her area when Kerry’s psychotic symptoms begin to increase. Kris, when she encounters this type of situation in her practice, would normally contact the individual’s psychiatrist by phone, inform the psychiatrist about the person’s symptoms, and see if the psychiatrist “could get the person in for an assessment”. While this professional knowledge is built from her own education and experience, we can see from Kris’s competent description of her professional work that her understanding of her work and the processes to which she is held cannot accommodate or fully recognize the informal community support systems upon which “getting in for an assessment” invisibly relies.

During our conversations, Kris shed light on the challenges she encounters in being a community mental health nurse involved with caring for individuals on CTOs. This shift in the conversation was contradictory to her initial characterisation of her work. She described the process of working with individuals with SPMI as “very challenging” at times. She understood challenges were often related to clients’ symptoms of delusional thoughts, hallucinations, and the fear of seeking or receiving help from others. These symptoms, while having some underlying similarities, varied from individual to individual. Kris described the skillful and “tricky” work involved in working to convince people to seek out help and in actually getting them access to professional resources and services. Kris undertook this work very seriously but described the times when she resorted to being what she termed as “manipulative” in “trying to convince [the patient] to go to get a psychiatric assessment and get appropriate treatment from that.” Having to talk an individual into doing something she did not want to do such as taking medications, attending appointments, encouraging CTO adherence and so forth, was described as very difficult work that came with risks and frustrations. Despite Kris’s initial report that she finds her caseload “manageable”, her work is not always a positive experience for Kris or the patient.

For example, it is a part of Kris’s responsibility to assess how regularly individuals are taking their psychiatric medications. This can be challenging if the individual is taking oral medications. If a depot medication is prescribed[21], it is much easier to be notified if the individual has missed an appointment with the healthcare professional administering the injection. Kris had a person in her caseload who was on a CTO and taking the injected medication; if the patient missed a dose, it was Kris who was to notify the lead psychiatrist who “had the authority to contact the police in the area to apprehend this individual and bring them back in for psychiatric assessment”. The “ruling relation” of the CTO text is activated for patients who do not always adhere to the plan. Kris described one individual who found the CTO “very restrictive” and was “not usually very happy about it”. In addressing this situation Kris called up her knowledge and training about the CTO, explaining to me that these restrictions were necessary for the patient’s “own benefit and for the benefit of the community”. In this way Kris reinforces the dominant knowledge related to “benefit to the community” and overlooks much of the

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[21] A depot medication is one that is administered by an intramuscular injection. The medication is prepared such that active ingredients are absorbed slowly over time. It is usually administered into a large muscle mass such as the dorsal or ventral gluteal muscles. Depending on the medication and dosing schedule, the individual could receive the injection from once a week to once a month (Royal College of Psychiatrists, 2015).

more complicated and nuanced ways of understanding “stability” and “instability” and the price that families pay to ensure “benefit to the community”.

It is apparent that the professional caregivers bear a great deal of the burden of ensuring persons on CTOs receive treatment and support from the team. While this is a significant burden to bear, it is accompanied by resources and strategies that families lack. The professional is charged with clinical decisions related to how risk to the public is assessed when a person with SPMI becomes acutely unwell. This, however, seems to produce a narrow definition of “public” when contrasted to how family members and informal caregivers associated with a person with SPMI living in the community must negotiate the risk. From the descriptions of individuals whom I interviewed, it is not necessarily the greater public who is most at risk of harm from someone who is mentally unstable: it is those who are closest to them such as families, care providers, and so forth. However, the amount of support they receive from formal caregivers, such as nurses, to deal with such risk varies.

Kris, an experienced and competent case manager, provided further insight into the burdens placed on community professionals whose job is to support a patient’s mental stability and who are well aware of the serious consequences if they fail to meet this responsibility. Just as the monitoring work of family can be overlooked by mental health nurses, so too can the nurses’ knowledge be overlooked. Other health team members may not give it the consideration that it warrants. For example, Kris said, “The doctor might be reluctant to [act on the advice or assessments of the nurse] unless the person is actively suicidal or threatening other people or something like that, so it is a challenge”. Kris reiterated her need to engage in good communication with the other professionals on the team, particularly when changes in the mental status of the patient were observed. This communication process has basis in the CTO legislation and is analyzed in more detail in Chapter 6.

In some situations, such as the predominately rural setting in which Kris works, the nurse is the healthcare professional with the most stable contact with the patient. Kris recognized how pivotal this position is for people with SPMI who are living "independently". Community mental health nurses, like Kris with her extraordinarily heavy caseload, are involved with the formal reporting and monitoring structure and receive information from families and patients regarding their day to day living. However, Jamie and other informal caregivers provide intense care and monitoring that nurses such as Kris cannot provide given the community context.

Despite these challenges, Kris describes her work with a CTO's implementation as "continuously monitoring". This includes a number of different activities for Kris. She is involved with monitoring how the patient is adhering to the plan by tracking attendance at appointments with physicians; contacting family members to obtain their perspective as to how the patient is progressing; and calling or visiting the patient at home to conduct an assessment. She also keeps in contact with the lead psychiatrist and the family physician to gain information, from the medical perspective, about how the patient is progressing. In addition, Kris assesses the patient's response to medications and monitors for any problematic side effects and, when necessary, reports this to psychiatrist in case there was a need for medication adjustments. As previously described, Kris follows patients dispersed within a large geographical area. The size of the area creates difficulties in reaching patients at times. Phone calls to patients were common - when the individual has a phone. When she performs home visits, it is sometimes difficult to reach more than two patients in a day. Kris describes her caseload as including patients with “persistent, chronic, mental illness, [who] usually do not respond well to typical treatment…, suffering from usually psychotic disorders, whether that be schizophrenia, schizoaffective disorder, or bipolar disorder with psychotic features and even sometimes drug induced psychotic disorders”. Kris said this is in addition to “basically continuing the usual case management type service, providing advocacy and support in all other aspects of the client’s life as well”. This includes referring the patient to community services for any social or other needs that might arise. Kris’ work in the CTO process is indicated in the CTO Process diagram, along with the beginnings of disjunctures that are coming to light. These will be further discussed in subsequent chapters (See Figure 4).

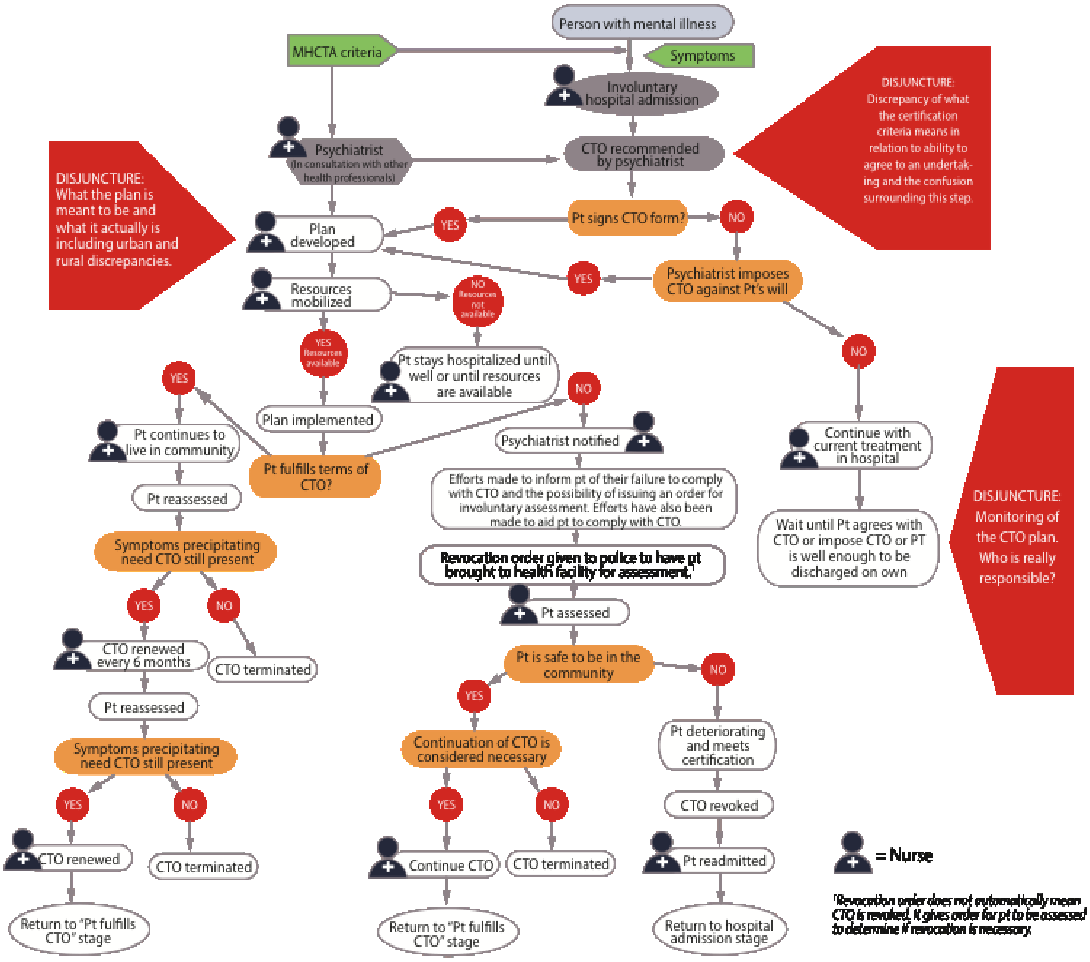

Figure 4: Community Mental Health Nurse Involvement in the CTO Process

Both families and nurses share common points of intersection with the CTO process. This is key within the authorized intentions of the CTO. Both Kris's work and Jamie's work is absolutely critical to the success, or failure, of a CTO. Kris is relied upon for her concentrated contact, professional knowledge and experiences, and her ability to provide patients and families with connections to other resources. Jamie is relied upon to provide the community mental health nurse with information regarding how Kerry is functioning, if she is taking her medications, and so forth. I suggest that workers such as Kris *and* the family members who work informally within the ruling relations of the CTO emerge as the "canaries in the coalmine", expected to warn when risk is mounting. This role activates the ruling relations of the CTO into the lives and work practices of those most closely connected to the people who are the object of the order. It becomes apparent that many more people than the patient on a CTO are subject to its ruling relation.

Summary

The everyday work of individuals most closely affected by the implementation of CTO legislation is lost in the discourse surrounding it. The actual work is caught between the desire to provide support and therapeutic interventions and the legislative need to exert control over the individual subject to the CTO. The nature of what is supportive is questionable and, as the evidence in this study indicates, support is hinged on the presence of an individual such as a family member who is not a formalized caregiver and whose own concerns and needs are subordinated in this discourse. This experience is mirrored, to a certain degree, in nurses' work with individuals and families involved with CTOs. Their actual, everyday work is lost in what is institutionally organized through workload measurement and expectations. Community mental health nurses often experience higher than normal caseloads, a situation they would be, for the most part, unable to manage, if not for the work of families also providing monitoring of mental health status and concerns. In the following chapters, the ethnography is broadened from these experiences into the institutional policies and the threads of activities that link into and coordinate everyday work.

CHAPTER 6

RISK FOR VIOLENCE: A RULING RELATION IN CTO IMPLEMENTATION

What was shown in the prior chapter is a case of what actually happened when a person was placed on a CTO. My evidence of the first-hand, everyday work of invoking and living with a CTO contrasts significantly with the idealized, expressed purpose of a CTO: to support mental wellness and to balance risks due to mental illness with public safety. I use the data I gathered as evidence to support an assertion that the wellbeing of people with mental illness and genuine interest in their mental wellness are interests that are subordinated to the mandate for public safety. As well, I show that the CTOs' link with the criminal justice system, through the formalized activation of a legal regime, overrules other espoused interests of CTOs (i.e., the medical regime of therapeutic intent). These are serious issues that are embedded in the legislation and the processes, policies and resources that organize how an "ideal CTO candidate" is constructed and whether and how that person can be helped by a CTO.

The purpose of this chapter is to describe the various conditions and social relations that organize whether or not a person becomes subject to a CTO. The relations are complex and, although they appear to offer clear direction, due to the particulars of each unique case they are necessarily applied in numerous and sometimes, inconsistent ways. The result is that individuals who would seem to be "ideal candidates" can slip through the bureaucratic CTO web. Most often, the CTO implementation seems to be organized within understandings of public risk (wherein family caregivers appear to be excluded from the category of being in "the public"). The care of individuals who fall within the category of being “at risk to deteriorate” is coordinated by the ruling language associated with “risk” and within ambiguous ideas about what constitutes “deterioration”.

The Process of Becoming an “Ideal Candidate” for a CTO

Much of the information I have about living on a CTO is from a family member, healthcare professionals, and others who have experience in caring for, and working with, the people who had been placed on a CTO order. In the section that follows, I use what my informants told me to provide a brief overview of four individuals for whom a CTO was considered, enacted, or *not* enacted. I use these cases as exemplars to describe the work processes that organize the consideration of placing someone on a CTO. In Chapter 7, I move to a more detailed explication of the textual processes that underpin what happens.

Taylor, a nurse with acute mental healthcare experience provided a detailed account of the case of Kelly, who was assessed as a person with severe persistent mental illness (SPMI) and as an “ideal CTO candidate”. The formal terms of a CTO seem to fit well with Kelly’s mental health history. In addition, its application to Kelly’s case is congruent with the implementation of the legislation as it is ideologically designed. In fact, it seems an ideal example. Kelly had a long history of mental illness that was not well controlled due to “medication noncompliance”. She did not regularly take medications as prescribed and became a danger to herself or others when mentally unwell (often through violent acts). Over the past 20 years, Kelly had frequent admissions to acute care (upwards of 20 to 25) and was “well known to the police”. Given this significant history, there was a great interest in placing Kelly on a CTO. Considerable concern existed that if Kelly lived in the community without taking prescribed medication and without being monitored by healthcare professionals, she would become violent again and pose a risk to others. There were very few community resources available to Kelly when she was discharged from hospital. The main ones involved appointments with a community mental health nurse, a family physician, and a psychiatrist. While Kelly was also at risk for self-harm associated with physical and mental deterioration, this form of risk was not the main impetus for placing her on a CTO. The drive to enforce medication compliance with the ultimate goal of public safety was paramount.

It would be erroneous to depict all individuals with mental illness as violent, but in Kelly's case it was a reality. Hers was an uncommon situation wherein her illness could lead to psychosis that created violent impulses[22]. In my experience as a mental health nurse, there is a tendency of healthcare professionals to become wary of individuals with a history of violence. Such individuals with mental illness, depending on the frequency and severity of the past violence, develop a "reputation" within the mental health care system. As identified in mental health literature, a person's history of violence is considered to be a major predictor of his or her potential for future violence. Thus, in a general mental health assessment, nurses and other healthcare professionals attempt to ascertain if the person has had a history of violence or aggression (Savard, 2015). This history stays with the individual and the person becomes deemed (or labeled) as "violent" or "high risk". Once this category of mental illness is in place, it is perpetuated by a set of work processes enacted through the manner in which nurses and others respond to the individual in texts and other professional practices. It is these practices that provide a

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[22] Individuals with mental illness tend to be at greater risk for experiencing violent acts towards themselves, rather than towards others (Elbogen & Johnson, 2009).

foundation for the work of assessing individuals like Kelly with her strong history of violence and multiple hospital admissions. It is individuals with this type of history for whom the CTO is most likely to be enacted.

Not all people whose case records show evidence of SPMI and who are considered ideal candidates for CTOs get placed on one. They may fit the criteria but in the location of where they live, there may be a dearth of community resources available to have the CTO put in place. This “lack of resources”, as previously noted, is not always the preeminent concern. My data indicates there is a drive to have CTOs in place for *some* patients and, in particular, those with outwardly violent histories. Some individuals vehemently reject placement on a CTO (by refusing the undertaking) and thus the CTO is not enacted. The evidence amassed here indicates that, while the legislation and the terms of CTOs appear to be organized only around particular symptoms, history, and treatment needs, the considerations regarding placement of a person on a CTO actually include many other factors. These factors are not explicit in the regulatory framework of the CTO but are critical considerations for the healthcare professionals involved.

Kris, the community nurse informant, described what happened in a second exemplar I use, the case of Mel, a person with SPMI who had a history of medication non-compliance and repeated readmissions to a psychiatric facility. These admissions lasted for weeks or months until Mel became stabilized on medications, the mental illness symptoms were reduced, and Mel was assessed as being “safe” for discharge. There were times when Mel would go home, take medication, and continue to be mentally stable and “safe” (in Mel’s instance, this meant she would not be psychotic) for two or three months. However, once Mel began to feel better at home, she would self-determine that she did not need medications anymore, stop taking them, become psychotic, mentally deteriorate within “a number of days or weeks”, and require hospitalization. This was a cyclical pattern for Mel and it was “strongly recommended” by her healthcare providers that she would benefit from being placed on a CTO. In Mel’s case, risk for violence directed towards others was not identified as a major concern and was not one of the determinants of seeking the use of a CTO. Rather, according to Kris, the proposed CTO well aligned with a “therapeutic” intent: for her to continue to take medications and stay mentally well. Mel was open and receptive to the idea of being on a CTO. However, many concerns were raised about the remote area where Mel lived. There were not enough formalized “services” to support the CTO. As well, there was no effort to support Mel to move to an area that had more community services necessary to maintain a CTO. Therefore, the CTO was not enacted for Mel. This is despite the fact that there was a similar paucity of services available for Kelly, a person with a violent history.

Without the travel restrictions that a CTO mandates, Mel eventually relocated to an area of the province that had a different regional health authority and Kris lost contact with her. Kris believed that Mel’s pattern of wellness and deterioration would continue in her new place of residence and was concerned as to what would happen to her mental well-being. Kris did not know if Mel was eventually placed on a CTO in the other health authority or if renewed efforts were made to offer Mel a CTO once supports were available. In summary, the work that was done in attempting to place Mel on a CTO that was directed by a therapeutic intention (as opposed to risks to public safety) was futile. For Mel, this meant that she left the nurses and other healthcare professionals with whom she had built relationships and possibly lost many support opportunities for her mental well-being.

Shannon, the social work informant, provided the data for a third individual, whom I will discuss in this chapter (Drew) who was also considered for a CTO. Although Drew did not have a history of violence, Shannon said that the healthcare team had some “preliminary discussions” about placing Drew on a CTO. However, Drew did not want to be on a CTO, did not want to be followed in the community by any service, and wanted to be left alone. Because she lived close to an urban area, the healthcare team instead referred Drew to the Assertive Community Treatment (ACT) team[23] who, without a CTO, were unable to maintain contact with her. In this case, because the healthcare team interpreted the CTO legislation as involving a consensual “undertaking”, they did not force the CTO on Drew. Therefore, another seemingly “ideal candidate” for a CTO was not placed on one, despite her history of repeated hospitalization, many involuntary admissions, and medication noncompliance.

Analysis of the CTO legislation and its administration reveals how Drew and Mel, both with similar histories and meeting the same CTO criteria, did not come under the CTO conditions. Mel and Drew both experienced noncompliance with medications and had periods of mental stability when they were medication compliant. Drew did not want to be on the CTO, did not want to have supports set up, and did not want to be followed by the ACT team. Therefore, Drew did not meet the legislative requirements as they were *being interpreted* at the time (that is, consenting to being on a CTO undertaking) and did not fit the narrow view of “risk to self and others”. Mel, who lived

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[23] The ACT team provides intensive follow-up and monitoring for individuals with SPMI in the community who are at high risk for deterioration.

outside of a major centre and lacked many of the needed community supports in place to have a CTO established, was willing to entertain the idea of being subjected to a CTO. However, she too did not meet the legislative requirements as interpreted and implemented by those involved with her care at the time (i.e. not having the community supports in place as per §40.2.iv.B). Kelly, on the other hand, a similarly unwell person *with a history of violence* was placed on a CTO, *despite having a dearth of community resources*.

This leads to the question: How is an *ideal candidate* socially organized within the CTO? Given the description of Kerry and Jamie's case in Chapter 5, and that of Kelly here, the potential to pose a risk to public safety was the preeminent consideration. Therefore, is a history of violence and public safety the ruling relation of the CTO administration? In the case of Mel and Drew, the desire to provide therapy to these individuals was the paramount concern. However, how did it happen that these and other *ideal candidates* cannot be supported by the terms of a CTO?

These cases inform the findings of this doctoral research and support my assertions that, despite the fact that CTOs are discussed within a discourse of *therapy*, the CTO is organized by its formulation as *legislation*. It is within the *legal interests* that the CTO is organized to work. The situations of Mel and Drew vary considerably from that of Kelly, Kerry, and Jamie who are living their lives in a physically and emotionally precarious manner that is sanctioned by the CTO legislation. How does it happen that the tragic plight of, and the considerable risk to, Kelly, Kerry, and Jamie can be overlooked within the medical and legislative regimes that espouses wellness and safety?

Lee, the advanced practice nurse (APN), believed that CTOs are not reaching many of those who need more focused, structured community care. According to Lee, it is the complexity of life situations that surround individuals who are considered for CTOs that cannot be accommodated within the legal terms and conditions. While in principle, the CTO legislation was a result of stakeholder consultation with individuals and groups familiar with these complexities, as a legal and binding *text in action*, it cannot accommodate the *actual complexities* that arise in the possibilities for community support for individuals with mental illness and their caregivers. APN Lee personally knows of individuals who "should be on CTOs but are still not on CTOs." Other informants I interviewed also described knowing individuals who they considered candidates for CTOs, who could potentially benefit from consistent treatment, but who are not placed on one.

The "Three in Two" Criterion

As previously identified, the criteria for issuing a CTO (as noted in §40) are similar to those outlined in Section 17 of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) for involuntary admission. According to the legislation, individuals are admitted to hospital involuntarily if they have a mental disorder and as a result of that disorder, they are at risk for harm to self or others, to suffer substantial mental or physical deterioration or serious physical impairment, are unable to fully appreciate the nature and consequences of their disorder and need for treatment, and are in need of treatment which a psychiatric unit can only provide (§17.b.ii). This criterion for involuntary admission is linked into the CTO insofar as, in order to be eligible for a CTO, the patient must have had at least three involuntary admissions within a two-year period or have been subject to a previous CTO (§40.2.b). The intent of this stipulation is that CTOs are for patients with SPMI who experience difficulty maintaining wellness in the community, challenges engaging in treatment, and repeated episodes of mental deterioration to the point where they are at a severe risk for harm to themselves or others. However, applying these stipulations into the everyday use of the document are not as clear-cut as the legislation sets out.

The context in which individuals can be involuntarily certified to hospital is invariably complicated. The CTO criteria set the number of involuntary admissions within a time period (three admissions within two years). Theoretically, this is understood to be a good indicator of severity of the mental illness and risk for relapse. However, the numbers of involuntary admissions that a person experiences yearly may not reliably reflect an individual's level of impairment, the severity of the illness, or its chronicity. In practice, what occurs is individuals are involuntarily admitted (certified) to hospital only if they do not agree to admission and can subsequently be forced to remain in hospital as long as the certification conditions exist. This activation of the involuntary clause (and its implications for the CTO criteria) holds a contradictory twist: A large number of seriously ill individuals do not resist hospitalization and thus the activation of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) does not occur. Therefore, while the invoking of the legislation is meant to mandate treatment for an individual suffering from a severe exacerbation of a mental illness, the number of times it is used is not always a true indicator of severe deterioration. Sometimes, individuals with mental illness who could benefit from more intensive monitoring in the community might have been infrequently certified or admitted to hospital. The person who cannot be placed on a CTO could still have the same level of mental illness and debilitation due to treatment non-compliance as someone who meets all of the legislative requirements.

As a result, there are people who could benefit from a CTO, who have been severely ill in the past two years, are chronically and seriously mentally ill, are not well maintained on some form of treatment regime, and are deteriorating in the community, but they do not meet the CTO criterion of the requisite history of involuntarily admissions. For example, Ashley, the administrative informant, said that it is possible that there are individuals who could be eligible for a CTO from a clinical perspective, but are not because they are not currently certified, they did not have a history of involuntary admissions, or they do not have the requisite number of certifications in the specified time frame. Therefore, the legislation is not necessarily based on depth of illness, but on meeting a prescriptive set of criteria.

In practice, Pat, the psychiatrist, felt that meeting three involuntary admissions in two years was an “onerous” and “untenable requirement” for many patients. It was Pat’s belief that many of her patients with SPMI in the community “needed” a CTO, but she could not initiate one because of “those [three in two] requirements”. While the vast majority of patients do not require this level of intense care and service, Pat informed me she “immediately” knew of “three or four people” who “should be subject of the Treatment Order” and if she could use her professional discretion to place the individuals on a CTO, she would “just like that, I’ll do it tomorrow”. Therefore, this “three in two” criterion seems to unfold in practice differently than how was intended. Based on her clinical experience, Pat described what she believed was a more individualized approach to determining if a patient should be placed on a CTO:

> The requirements should be: Does this person have a current mental illness? Does this person require ongoing treatment? Has this person failed to avail [of] and to accept ongoing treatment? And as a result, has the person deteriorated repeatedly?
>
> We are all about stopping the deterioration and that should be the requirement.

Here, Pat is communicating the discourse of *therapy*, which is her primary interest. It is what she expects to be gained from the use of CTOs. The challenge with taking an approach, however, is that the medical-legal world is not oriented to therapy, nor using a vague representation of deterioration or mental illness severity. In the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a), the severity of a person's mental illness and their risk to become unwell are foremost measured by the number of involuntary admissions one has within a certain time frame. It does not seek to ascertain where an individual falls on a gradient of severity, nor does it gauge an individual's personal experience of deterioration or the desperation and challenges family and other supports people experience in providing care. Illness severity and deterioration, in this legal instance, are represented by a prescriptive set of numbers that dictate whether or not an individual will not be placed on a CTO.

Risk for Deterioration: Patient Wellness versus Public Safety

From a community mental health nursing and other healthcare professional, therapeutic standpoint, one of the main purposes of the CTO legislation was an expected reduction in the likelihood of individuals with SPMI to deteriorate in the community. It is initially identified in Section 3(1) of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a), which is:

> (a) to provide for the treatment, care and supervision of a person with a mental disorder that is likely to result in dangerous behaviour or in substantial mental or physical *deterioration* or serious physical impairment;
>
> (b) to protect a person with a mental disorder *from causing harm to himself or herself or another*[24] and to prevent a person with a mental disorder from suffering substantial mental or physical deterioration or serious physical impairment.

Deterioration is not in the list of defined terms that are included in the legislation, nor is it defined within the legislation itself. While the risk for deterioration has been added to the *Mental Health Care and Treatment Act*, it is an entirely theoretical term because future "risk" is abstract and impossible to foretell with certainty.

Risk for deterioration is also identified in the criteria for issuing a CTO, whereby the nested use of risk and deterioration, within the documentary processes of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a), reappear in the language of the CTO with reference to "harm to himself or herself or another", with the *physical* risks (violence) taking precedence over mental deterioration. According to Section 40(2), the psychiatrist must do the following:

> (a) he or she has examined the person named in the order within the immediately preceding 72 hours and on the basis of the examination and other pertinent facts respecting the person or the person's condition that are known by or have been communicated to the psychiatrist, he or she is of the opinion that
>
> > (i) the person is suffering from a mental disorder for which he or she is in

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[24] Italics added.

> need of continuing treatment or care and supervision in the community,
>
> (ii) if the person does not receive continuing treatment or care and supervision while residing in the community, he or she is likely to cause harm to himself or herself or another, or to suffer substantial mental or physical *deterioration*[25] or serious physical impairment,
>
> (iii) as a result of the mental disorder, the person is unable to fully appreciate the nature and consequences of the mental disorder and is therefore unlikely to voluntarily participate in a comprehensive community treatment plan,
>
> (iv) the services that the person requires in order to reside in the community so that he or she will not *be likely to cause harm to himself or herself or to others*[26]*,* or to suffer substantial mental or physical *deterioration* or serious physical impairment,
>
> (A) exist in the community,
>
> (B) are available to the person, and
>
> (C) will be provided to the person, and
>
> (v) the person is capable of complying with the requirements for treatment or care and supervision set out in the community treatment order.

A surface reading and understanding of the legislation would seem to indicate that patients can be involuntarily placed and maintained on a CTO as long as they have the potential to deteriorate mentally or physically as a result of their mental illness. Moreover, because the language of "risk" is linked to the language of "causing harm to

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[25] Italics added.

[26] Italics added.

himself or herself or another", the "risk" of deterioration (and how the CTO is activated) appears to be harnessed to public safety and *not* to the overall risk of reduced quality of life for the person experiencing the illness.

Deterioration in mental status and wellness is often indicated by impairments in the person's ability to engage in self-care, to attend to activities of daily living, to focus and engage in purposeful activity, and to interact with others socially. As previously noted, some individuals with SPMI experience cognitive and social impairment to the point where they become harmful to themselves or others; it can be challenging to determine the likelihood of the individual to deteriorate to this level. If a person has a long-standing issue with repeated mental deterioration and is viewed as being very likely to continue this pattern in the community, she could indefinitely be considered "at risk to deteriorate" and could theoretically be on a CTO indefinitely for the rest of her life. My informants discussed how the risk for harm to others was the paramount consideration in making the decision to implement the CTO. Again, this subordinates the need to protect the individual from the effects of their mental illness to protecting the public from the individual.

Kris, the community mental health nurse informant, described how the terms of the deterioration criteria in the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) coordinated what happened for Sidney, a patient who *was* placed on a CTO. For Kris, this case was a success story for the CTO legislation. Sidney has a history of deterioration, mostly due to medication noncompliance. When unwell, Sidney also has a tendency to become violent. With the chronic nature of her mental illness, Sidney is a person who, according to Kris, "could inevitably be on a Community Treatment Order for the rest of her life". During Sidney's "entire adulthood", she "deteriorated every single time when she stopped medication". In demonstrating this pattern, Sidney exemplified a "revolving door client". This is a term often given to individuals who demonstrate a cyclical process of being re-hospitalized, started on medication, being sent home, stopping medication, deteriorating rapidly and needing re-hospitalization. Many of the informants described how individuals exhibiting such patterns would be considered for CTOs, but very few of these patients were actually *placed* on one. In Sidney's case though, because Kris and the rest of the health care team know Sidney so well, including her "cycle" and "pattern", they know with a high degree of certainty that Sidney "is going to deteriorate without treatment".

Given such longstanding behaviours, Sidney's situation appears to be a rare success story in that she stayed out of hospital while taking medications as mandated. Without actually interviewing Sidney and her caregivers, some skepticism about the true "success" of this case needs to be maintained. However, what is clear is that being on the CTO reduced Sidney's recurrent mental deterioration to the point of requiring repeated acute care admissions. However, given the number of individuals in the mental health system who exhibit such behaviours, I question why the CTO legislation is not used more often.

One of the ideological explanations posited by Lee, the APN informant, pointed to the revisions made to the old mental health legislation. According to Lee, there was a desire to move away from the concept of *demonstrated* dangerousness to *potential to deteriorate* and be dangerous, if not treated. Lee explained it this way: under the prior *Mental Health Act* (Government of Newfoundland and Labrador, 1971), nurses, other healthcare professionals and peace officers were required to observe, “first hand”, an individual being a threat to self or others. This created practical challenges in its implementation.

According to Lee, there is some hesitancy for peace officers to act in the face of “risk for deterioration” versus “demonstrated dangerousness”, the former now being their mandate under the new legislation. Under the *Mental Health Act* (Government of Newfoundland and Labrador, 1971), peace officers were required to have more “first-hand” exposure to the evidence indicating that an individual posed a threat to self or others. Under the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a), this potential threat does not have to be witnessed by the peace officer but reported to them by the psychiatrist directly involved with the CTO. This was supported by Kris, the community mental health nurse informant, whose experience suggests peace officers and healthcare professionals are “very reluctant” to force an individual to come into a facility for an assessment or for treatment “just because they might be experiencing some delusional thoughts” even though this could indicate a deterioration in mental status. In Kris’ experience, peace officers were more likely to bring the person into hospital for assessment if, “like the old criteria… the patient was suicidal or homicidal”, therefore demonstrating a greater acute risk for dangerousness. Conversely, I was informed that other peace officers welcome the changes in that they like the new freedom they are afforded in the new legislation.

The general standard to which peace officers are held is outlined in the *Canadian Charter of Rights and Freedoms* (Government of Canada, 1982) that discusses the “reasonable suspicion” that a person is about to commit “an indictable offense”. While individuals with SPMI can have repeated, recognizable indicators of deterioration, there appears to be a hesitation in some peace officers to evoke the full weight of the legislation until there is a undisputable infraction that would warrant the individual to be reprimanded for assessment. These are the key clauses in the CTO legislation (very different from other processes of detainment and custody) that land, in troubling ways, inside the work of peace officers and healthcare professionals, including nurses, in direct practice. In summary, while there is considerable difference in the reformed *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) and the old *Mental Health Act* (Government of Newfoundland and Labrador, 1971), it becomes apparent that changing the legislation does not necessarily support changed resources or practices.

In the case of a CTO infraction the work of determining how to proceed is built on medical and legal criteria that are different from the ordinary way the medical *or* the legal systems would routinely proceed. A great deal of emphasis is placed on "assessment" but this too is complicated. The ruling relation for assessment rests predominately with the psychiatrist, who is most often relying on the reports of other people. Sometimes there are differences between the assessment of a community mental health nurse and that of the attending psychiatrist. Sometimes, as we saw in the case of Kerry and Jamie (when Jamie noticed Kerry was deteriorating), the view of the family member is different from the view of the community health nurse. As well, the judgment of a peace officer (in the absence of an expert medical opinion) may also rest on different forms of knowledge than either the family or the medical professionals.

Ascertaining risk to deteriorate, as described in the legislation, requires a good understanding of the individual who has the mental illness, in addition to their social and behavioural history. Kris described how she *knows* Sidney, based on the long history of working with her and how this differed from the psychiatrist's knowledge of Sidney. This is where different modes of knowledge become authorized and others subordinated. In Kris's experience, what became apparent is that *knowing* Sidney in this first hand way was not always enough to convince the psychiatrist that something was wrong. Without the psychiatrist's order to revoke the CTO, peace officers, in the absence of immediate physical risk, are similarly constrained by the legislation. However, this too can be overturned by experiential everyday knowledge, as Kris described how she worked closely with the peace officers in the area in which Sidney lives, and feels comfortable to ask them to "check on" Sidney from time to time.

Regardless of the apparent expanded wording in the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) that does not require a peace officer to witness and evaluate an act of aggression, ultimately it is the psychiatrist who is authorized to *act* to invoke the legislative powers of the police. Moreover, within this primary responsibility for invoking the authority of the CTO (to apprehend and hospitalize), the issues of ongoing therapeutic relationships are sidelined. The immediate focus in these actions is on containing the risk to others and the patient and not primarily on a maintaining a "therapeutic" relationship. The ideological concepts of autonomy, coercion, and therapeutics become blurred when there is an immediate goal of risk reduction. This is a powerful ruling relation that seems to consistently overrule interests in the therapeutic wellbeing and genuine rights of the person (and her family) who grapple with mental illness and its impact on everyday life.

To elaborate, as the gatekeepers for using the legislation, psychiatrists are expected to follow the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) by closely adhering to the CTO criteria, including the use of the deterioration criteria. For psychiatrists, a component of their decision-making is based on making clinical judgments using their own assessments and what is reported to them by other healthcare professionals, including nurses. As this research account has been showing, these features of mental deterioration can be subtle and highly individual. The nuances of seeing deterioration might have not even been observed by the psychiatrist, but by the family and other community caregivers who are with the individual more frequently. The reliance on such subtleties can lead to ambiguity and worries about the legal implications of the CTO. In comparison, the "refusal of treatment" is more "clear-cut". A situation in which an individual refuses to take medication or refuses admission to hospital when they have met certification criteria holds up under scrutiny as a more defensible reason for the psychiatrist to act.

From Kris' descriptions, the community mental health nurses' *observations of deterioration* were not responded to by the psychiatrists in the same way, or as quickly as, the patient's *refusal of treatment*. This refusal is built into the legislative responsibilities of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) and the CTO mandate which authorizes psychiatrists to respond. There was no clear indication that the community mental health nurse's input into the monitoring could *not* be taken up by the psychiatrist; the information provided by a community mental health nurse or other healthcare professional such as a social worker could also be taken into consideration. However, it is the psychiatrist who has the ultimate authority and responsibility related to CTOs and who is thus closely bound to the "letter of the law" (legislation) for action. These conditions, the structure for communicating this information, and the medical-legal accountability systems begin to explicate how it happens that there are times in which the nurse's first-hand knowledge of the individual and her mental illness can be reported but not acted upon as quickly as one would hope.

The CTO legislation is legally binding and gives the decision-making power to the psychiatrist to make clinical decisions regarding deterioration. While those who live most closely with a person with mental illness experience knowledge of deterioration most directly, their reports are mediated into the purview of the community mental health nurses' work processes. The nurses' knowledge is mediated even farther away within the work processes of the psychiatrist who is often geographically distant and relying on written or verbal reports. Thus the text-mediated actions of the psychiatrist, largely based on the observations of others, must be carefully balanced with her legislative authority to act.

The "Chafing" in the Ideological and Practical Understandings of Deterioration

Blair, a bureaucrat informant who previously worked in a government ministry provided insight into the bureaucratic understanding of "deterioration". Her perspective, which developed within her administrative responsibilities related to CTOs, contributes further insight into the difficulties experienced by community mental health nurses and other frontline workers whose daily work is tied up in activating the CTO with the embedded contradiction of therapy versus surveillance and interdiction. Blair explained that when the "new" *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) was being drafted, the concept of deterioration "was well understood by the medical field" but it "wasn't understood well by the legal people".

Blair described how the two disciplines came together to craft the legislation. She relayed how the lawyers, whose field requires precision, criteria, and categories that can be responded to in legal terms, had challenges conceptualizing the "ebbs and flows" of mental illness and related ambiguities such as suicide risk and impaired judgment. The medical professionals had a different approach to knowing about the risk for deterioration and carried a different set of interests other than those organized by legal knowledge. The physicians' knowledge about deterioration, based on clinical experiences with patients discharged into the community that included refusal to take medications, relapse into acute and severe symptoms of mental illness, and the need for readmission was seldom clear cut and definitive. Despite these different discursive positions (that of therapy and of legality), because the CTO is at its heart ***legislation,*** medical knowledge was subordinated to the legal imperatives of an enforceable law. What became evident in my study is that while physicians have a good knowledge of, and are comfortable with, the assessment and identification of the risk for deterioration from a medical perspective, they are being organized into the legal view and discourse of risk and risk management.

My informants who described what happens when a patient "hits rock bottom" emphasized this essential contradiction between the medical and legal systems. They describe incidents of people becoming violent, going to jail, and losing family and friends, along with the supports associated with them. From a legal perspective, these same events are seen only through the language of the mental health legislation, which legally links severe deterioration and the necessity to use physical restraint to control risk to self and others. The legislation further activates the legal authority to admit the person into the secured resources of acute mental health services. “Deterioration”, conceptualized and organized as “physical risk,” organizes the downward progression into a seriously mentally unwell state that can include, but extends beyond, the immediate risk for suicide or violence towards others. The everyday progressive nature of that decline, before a person hits “rock bottom”, might involve the following: the person stops bathing for weeks or even months; she might not eat or drink and become malnourished and dehydrated; she does not launder or change her clothes for weeks or months; she does not use her toilet for urination or defecation as she has delusional thoughts about doing so; she does not pay bills and risks losing utility services or shelter; she does not interact with family or friends; she engages in high risk behaviour such as unprotected sex, bartering sex for drugs, or uses dirty needles; and so forth. These are very real, actual situations of which my informants and myself are aware. Thus, from a clinical and therapeutic perspective, the deterioration criterion should be based on the person’s patterns of behaviour and on informed predictions. A person should not have to “hit rock bottom” of being *violent* before help can be provided. This is exactly what the CTO was designed to address as physical deterioration (in the context of a person’s symptoms and history) can involve prolonged refusal to eat, bathe, and so forth. However, in fact, it is precisely at this juncture, in practicality, where it appears to break down with risk for violence being the preeminent concern.

The social organization of the term “deterioration”, linked as it is to physical risk to self and or others as it is organized within the CTO, contributes to troubling issues in current practice. Elaborating on her knowledge as a psychiatrist involved in policymaking, Pat believes “people may be interpreting *Act* narrowly”. The current *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) is “much broader than the last one” in that “the conditions that the person has to meet in order to become an involuntary patient are much broader”, essentially meaning that it is potentially easier for a psychiatrist to involuntarily admit a person than with the older legislation. Pat recounted an experience from many years ago in which she was involved in gathering national opinion as to whether or not “emotional deterioration” should be a part of certification criteria.

Pat said that the response from many participants was “Oh my God are you kidding? That’s too broad. There will be a deluge of people becoming involuntary patients” and “How would you define emotional deterioration?” To this, Pat responded, “that’s the business of people who are in mental health. It’s their expertise to define what emotional health is and what emotional deterioration is”. Therefore, according to Pat, psychiatrists have the knowledge and expertise to implement the legislation using these broader criteria. However, due to a different form of “exactness” introduced by the legal requirement to more rigidly categorize and define the concept of deterioration, psychiatric knowledge becomes more difficult to activate and, as Pat describes, it results in professional hesitance to act. This is due to the authoritative relation and accountability practices that are embedded differently (and more explicitly) into legal practices than they are into medical ones. The legal protections that are provided to people with mental illness, and the legal rigor with which a psychiatrist must act, ultimately seem to, work against the wellbeing of people with SPMI.

Evidence of the competing interests of legal and medical knowledge becomes even clearer when Blair, the bureaucrat informant, describes the committee work leading to the parliamentary vote on the legislation. She said there was considerable concern from lawyers that, with the new criteria, physicians were given too much breadth to take away patient rights. However, psychiatrists who had prior experience working in the judicial system supported the argument for including, what they believed, were broad deterioration criteria. According to Blair, these psychiatrists observed patients deteriorating “pretty quickly” at times and the psychiatrists noted the need to intervene quickly. However, Blair identified that the major concern of the mental healthcare professionals was that the use of the deterioration criteria would result in people being assessed as needing to be on a CTO “for the rest of your life”. The legal and social implications of subjecting citizens to this level of state intervention were troubling to both the lawyers *and* the psychiatrists. According to Blair, this imposition of the CTO “for life” has not happened in other jurisdictions using CTOs, but she notes that the concern for these sorts of practices warrants monitoring.

As previously noted, medical knowledge about deterioration and its physiological implications are different from the legal implications of deterioration. There is the presumption that the two are the same but this is not the case. Both professional groups (the medical and the legal people) work to plan and predict outcomes based on worries about people being subject to various medical and legal conceptions of “rights”. Pat, the psychiatrist informant, was very frank in describing the ambiguities and issues with

CTOs and rights. To her, CTO use is “a violation of rights” but, tellingly, she recognized that “it’s also a violation of rights if we don’t do it”. Here, Pat’s awareness of the “public good” (and the safety of citizens who may be at risk when a person with mental illness becomes violent) is being measured against the well-being of the person with SPMI and their right to receive treatment and be as mentally well as possible. However, this dual concern gets buried in her ideological views about the *intended* purposes of the CTO.

We have seen how these intended, therapeutic purposes are subordinate to the physical “risks” of violence that the data shows *is actually how* the administration of CTO legislation is most often triggered. According to Pat, people who have an illness have a “right” to receive treatment[27] and “that’s why the law is there. The law is saying ‘listen, there are people who do not appreciate that they have a mental disorder and as a result they will deteriorate emotionally, physically, etcetera’ and we are giving you a legal tool to stop that”. According to Pat, “if we don’t use it, I think we are violating the patients’ rights to treatment and health”.

In contrast to Pat’s observations regarding the confusing ambiguities about “whose rights” take precedence in the face of deterioration, Ashley, the administrative informant, did not have the same misgivings. From the standpoint of a health administrator, the inclusion of deterioration in the CTO legislation is working well. The information that Ashley receives is organized within the ideological intentions and conceptual feedback related to CTOs. Very far removed from the daily lives of people like Jamie and Kerry and the healthcare professionals in direct practice, Ashley is under the impression that the deterioration criterion is working well and that people with SPMI

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[27] Note the *United Nations’ Declaration of Human Rights* (1948) Article 25 identifying a person’s right to an adequate standard of living, including access to medical care.

are not being left in the community to become seriously ill. According to Ashley, their decline is being identified and acted on sooner than it would have been in the past.

Ashley recounted a situation in which she had been involved when a person on a CTO with SPMI was assessed to be deteriorating in the community. Ashley indicated that the healthcare providers reported the deterioration to the psychiatrist, the psychiatrist used the assessment of deterioration to have CTO revoked, and the person was admitted involuntarily for inpatient treatment. However, in Ashley's account of this case that apparently unfolded in exactly the way that the CTO is ideologically designed to work, there were problems that Ashley minimally addresses.

According to Ashley, the only reason she was involved in the case was because there was confusion about the bureaucratic administration of the CTO in that the legal issues of the involuntary admission were unclear. In this case, no one knew whether or not the patient required a *new* certificate of involuntary admission, or if the original form from the patient's previous involuntary admission and CTO issuance was still valid, given the CTO revocation. Ashley was consulted because of the legal implications for the hospital. These were serious legal concerns that threatened to overshadow the therapeutic plan.

Summary

The data collected in this study demonstrates that, contrary to the belief of most healthcare professionals, the decision to place an individual on a CTO is not primarily contingent upon an assessed therapeutic need, but upon an assessed risk the individual has for violence. Violence can be demonstrated (e.g. through actual violent acts) or assessed as a risk through the individual's "potential to deteriorate". While preventing risk for harm to oneself is considered to be a desired therapeutic outcome by nurses and others, it is the risk for violence towards others, namely the greater public safety that trumps the CTO decision-making process. It is not even contingent, in any great measure, on the risk for harm to those who are considered caregivers, such as family members. These individuals live in the precarious shadow of the effects of untreated or poorly managed SPMI. In this sense, the desire to provide therapeutic intervention for individuals being considered for CTOs is subordinated by the legal discourse and public protection. This disjunture in medical and legal discourse is influencing the overall interpretation and implementation of the CTO legislation in the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a). This will be further described in the following chapter.

CHAPTER 7

EXPLICATING THE SOCIAL ORGANIZATION OF ACTIVATING MENTAL HEALTH LEGISLATION

Informants described to me myriad instances in which they experienced some confusion in how to interpret the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) and its respective policies. These challenges existed from the very start of the process of initiating the plan. In many instances, the medical and legal discourses do not integrate well, leaving those implementing and affected by CTO legislation confused. As noted in the previous chapters, discussions with my informants demonstrated a strong emphasis on reducing the risk for violence for the community at large and less so with the intention for a legal action to be therapeutic. This chapter will focus on how ruling relations concert the activation of the mental health legislation into a highly confusing practice.

Education for Implementing the CTO Legislation

The *Mental Health Care and Treatment Act* was given royal assent in the Newfoundland and Labrador (NL) legislature in 2006 and came into effect in October 2007 (Government of Newfoundland and Labrador, 2006a). An in-service education program to prepare for the implementation of the *Act* was provided for mental health staff, such as community and acute care mental health nurses and physicians and various stakeholder groups, such as police organizations and mental health consumer activist groups. The education varied with the timing of the implementation of the *Act*'s components. There were initially intensive sessions to orient health care professionals and others to the *Act* through a general overview prior to its implementation in 2007.

There was less emphasis on providing orientation to the CTO legislation that came into effect on January 1, 2008. The ongoing education was designed to make staff aware of the roles and responsibilities of the rights advisors, the role of the patient representative, the roles of the health care professionals and others listed in a community treatment plan, and the certification process. The *Mental Health Care and Treatment Act Provincial Policy and Procedure Manual* (Government of Newfoundland and Labrador, 2009) indicates that CTOs are the responsibility of the Regional Health Authority who must ensure that staff are educated about the rights of patients under the *Mental Health Care and Treatment Act*.

According to Blair, the bureaucrat informant, the *Mental Health Care and Treatment Act Provincial Policy and Procedure Manual* (Government of Newfoundland and Labrador, 2009) was created to provide some consistency in the interpretation and application of the *Act* (Government of Newfoundland and Labrador, 2006a). She acknowledged, however, that there was little emphasis placed on CTO education. She surmised this was because the CTO portion of the legislation did not come into effect until one year after the *Act*'s general implementation. Individuals delivering the orientation sessions focused more on the "actual involuntary hospitalization". The rest of the legislation, including that related to CTOs, was not included in the first educational sessions. Blair likened this type of CTO education to a "crash course".

My data revealed that orientation to the CTO was sporadic. Taylor, the acute care mental health nurse informant, said that there was "a big learning curve" in the implementation of CTOs. She said, "We had a lot of questions and we were getting a lot of different answers and being pushed off to a lot of different people to get those answers.

That’s what it felt like to me”. When Taylor encountered patients who might benefit from a CTO, she experienced considerable frustration and fatigue as she tried to find information about the CTOs. She recalled working in circumstances with many unknowns.

Shannon, the social work informant, also recalled having a lack of orientation to the legislation. She could not remember if the team referred to the *Mental Health Care and Treatment Act Provincial Policy and Procedure Manual* (Government of Newfoundland and Labrador, 2009) when they were activating a CTO. She noted that the team of mental health care professionals with whom she was partnered did prepare themselves for the CTO by reviewing the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a), and by using the Government of Newfoundland and Labrador website whenever a potential CTO candidate was identified. She described the team as “muddling through” the information and the process without any clear direction. In addition, Shannon reported that there was little involvement from administration, management or education in this process and that the team “struggl[ed] with it”.

This lack of attention paints an impression that the education to inform professionals about CTOs (as an integral and much anticipated part of the new legislation) was an afterthought. The research informants linked much of the initial confusion regarding CTOs to the overall lack of education regarding its design and application. The *Mental Health Care and Treatment Act Provincial Policy and Procedure Manual* (Government of Newfoundland and Labrador, 2009), which was apparently intended to clarify the legislation for practical use, does not contain much direction regarding CTOs, quite possibly the least understood aspect of the legislation. The intent and design of the policy manual was to present the legislation in a form that could be readily applied to practice situations. According to my informants, however, the policy manual was not helpful. In addition, the CTO education sessions were relegated into the work of the staff educators, individuals with already full workloads and responsibilities situated in departments generally understaffed. While at the initial unveiling of the legislation some support was provided from externally acquired nurse consultants, the informants noted that these consultants were not involved with the CTO orientation. While the informants' concern with their orientation to CTOs is quite relevant, the issues surrounding the use of CTOs extend far beyond a possible dearth of in-servicing. There were, and continues to exist, many other complexities which require explication.

The Process of Implementing the CTO

The Confusion Between Consent and Undertaking

The legal language of "undertaking", which is embedded in the CTO, introduces conceptual and abstract language that does not make sense in the actualities of front-line professionals and that of the individuals who experience severe, persistent mental illness (SPMI). Informants described considerable confusion in how the process of having the patient sign the CTO form was implemented in practice. Some informants understood that the actual process of the patient signing the CTO form, to merely acknowledge that she was being placed on a CTO, was the undertaking (and not necessarily an informed, voluntary act). Others understood it more within the ethical framework as a requirement for fully informed autonomous voluntary consent. Given the fact that a CTO is a means of enforcing involuntary treatment, this latter interpretation is erroneous. Regardless, the "undertaking" language in the CTO legislation is a problem.

My own review of the documents supports an analysis that shows how serious contradictions are built into the ruling relations of the CTO. The part of the CTO form in question (§ 2) (Government of Newfoundland and Labrador, 2006a), and as detailed in the *Provincial Policy Manual* (MHCTA-03 Policy # 1.30.30 Appendix F) (Government of Newfoundland and Labrador, 2009), states that:

> I, the undersigned, shall attend appointments with the psychiatrist who issued the community treatment order, or with another health care professional, person, or organization, referred to in the community treatment plan at the time and places scheduled, and comply with the community treatment plan described in the community treatment order. I understand my rights under this order which include: the right to retain and instruct counsel without delay in person or by other means; the right to meet with a rights advisor; the right to apply to the board (myself or my person/patient representative) for a review of the issuance, renewal, or revocation of the community treatment order; and the right to be advised of the functions and address of the board.

The person with the mental illness being placed on the CTO is expected to read, comprehend, and sign this form.

The term "undertaking" in the legal context is "a promise given in the course of legal proceedings by a party or his counsel, generally as a condition to obtaining some concession from the court or the opposite party" (The Law Dictionary, 2015). Robin, the informant with a legal background and experience with the *Mental Health Care and*

Treatment Act Review Board[28], compared Section 40(2)(a)(iii) with Sections 41(2)(g)(i) and (ii) of the *Act* (Government of Newfoundland and Labrador, 2006a), which state "a CTO shall [meaning it is mandatory and it will] contain an undertaking by the person who is the subject of the order to attend appointments with the psychiatrists and to comply with the community treatment plan". According to Robin, this is the section that is interpreted by some people to mean that a CTO requires *consent* from the patient. Even some psychiatrists understand it this way.

Robin explained that there is "a bit of a difference" between undertaking and consent: "An undertaking is a legal pledge or it's a pledge or a promise which may be enforced. Consent is not necessarily enforceable". In this sense, according to Robin, an undertaking is a legal commitment. It "carries with it weight of if there is a breach, the person does not attend to the psychiatrist or does not comply with the community treatment plan, they will be in breach of the CTO, in which case then the person should be then conveyed back to the psychiatric facility for further assessment". Put simply, consent cannot be legally enforced; an undertaking can. Thus, I argue here, it is only within this need for *enforcement* that the legal language of "undertaking" can make sense. However, as my data uncovers, it is a language that seems fundamentally at odds with how nurses and other healthcare professionals have been organized to understand their work with patients and the foundational principles of "informed consent".

Even more confusing to the medico-legal understanding of the language of "undertaking" in CTOs is the difference between a CTO undertaking and other forms of legal undertakings. Robin explained that legally, in the justice system, a probationary

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[28] The *Mental Health Care and Treatment Act* Review Board is a "13 member board appointed by the Lieutenant-Governor in Council to hear and decide applications under the Mental Health Care and Treatment Act" (Government of Newfoundland and Labrador, 2009, § 5.0).

term or a parole internment is not much different than the use of undertaking in the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) legislation: “if you are in breach of a term of your probation, then you are brought back to court and you are charged with a breach of probation, and there are subsequent legal ramifications for that”. According to Robin, “Strictly speaking, an undertaking in this [the CTO] context is similar [to probation] in the sense that if the person does not attend the appointments; if the person does not comply with the community treatment plan; if they are in breach of the CTO”, then “there are consequences from there.” Robin explained that this is the reason why, in Section 41 Subsection 3, there is a clause that identifies that a person subject to a CTO has a right to “retain counsel, to meet with a rights advisor, things of that nature” as the CTO is a “significant document that, if it is not complied with, [then] there are significant consequences”. As Robin identified, the consequences of being involuntarily returned to a health facility, however, are different than “going back to court”. Thus, although the undertaking might appear to allow for the same rights and responsibilities, given the nature of deterioration in mental illness, the actuality of how the CTO is administered is very different from probation. This produces friction with how previously established legal conventions are applied to this new area of medico-legal practice.

Health care professionals’ understandings of an “undertaking” are buttressed by a powerful healthcare policy framework that directs its employees. The Regional Health Authority has a policy on consent that is prefaced with a statement that autonomy is valued within the organization and that every competent person has the right to make decisions for herself. Within the policy, there is a detailed discussion of the definitions of competency and capacity. According to this policy, competency involves stipulations that:

> … the person making a health care decision must be legally competent. The competency of a person is his or her legal status regarding his or her ability to make decisions. In the context of health care, the test for competency is to determine if the patient/resident/client is able to understand and appreciate the nature and consequences of the proposed treatment or health care decision so as to be capable of rendering an informed judgment. Competency may vary according to the question before the patient/resident/client. Incompetency is established by legal means and relies on clinical assessment of capacity (Regional Health Authority, 2012, p. 5).

The healthcare policy about consent is also linked to the medico-legal discourse. Consent is not a category of institutional practice that is unique to the legal system but spans research and healthcare systems. As well, in determining competency, one must have the capacity or inherent ability, aptitude, or characteristics to be competent. Capacity is a term that has also been medicalized and, according to this Regional Health Authority policy, capacity involves possessing:

> … the mental capacity to authorize the intervention. Capacity is a clinical concept that describes the assessment of an individual's ability to make treatment of health care decisions. It refers to the patient/resident/client's understanding of the nature, risks, and benefits of not undergoing the treatment. It determines that the person's ability to make specific decisions is not impaired by such things as mental health, emotional, medical, or chemical conditions (Regional Health Authority, 2012,

p.5).

To summarize, within the health care professions' discourse, competency is a legal concept, whereas capacity is intended to translate legal ideas into "clinical concepts". In order to be seen as competent to provide informed consent, the individual must fall into a category of being a patient who has been deemed able to understand the information that is relevant in making the health care decision, and to appreciate the consequence of the decision. One must have the capacity (or inherent ability) to be competent in order to make health care decisions.

Further complicating this, the assessment of competency for consent does not apply to all patients in the same way. For example, in the Regional Health Authority policy, there is a section regarding the "Refusal of Intervention for Incompetent Persons" that applies to children and "neglected adults", but not those individuals with a mental illness. Children and adults who have some form of cognitive impairment are identified as those who have a diminished capacity (or inherent inability) to make competent decisions regarding their care. Approaches to caring for people with a mental illness whose competency or capacity is questioned fall under the purview of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) and the policies that flow from it. Here, patients need to be categorized as competent/incompetent (and therefore voluntary/involuntary) before the criteria of the *Act* can be applied.

The language of competency, in tandem with the "capacity to comply", is a contradictory component of the medico-legal language that is built into the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a). As previously noted, the CTO legislation states that the individual must: be suffering from a mental disorder; be in need of ongoing community treatment, without which, their mental or physical state would deteriorate; not fully understand the nature and consequences of their disorder; and be unlikely to voluntarily adhere to a community treatment regime (§40.2.a.i-iii). From this perspective, the individual on a CTO is akin to an involuntary patient, but rather than being institutionalized, is residing in the community outside of the traditional confines of an institution where all involuntary mental health patients would previously have been treated.

My data demonstrates that mental illness and its effects on competency and capacity are not easy to categorize from both a medical and legal perspective. This ambiguity compounds the varied ways that the policies are implemented. Complicated legal language and its interpretation by health care professionals increase the risk for confusion in policy implementation in practice settings. Evidence from my interviews indicates that those working with CTOs are struggling to understand the medico-legal discourse in the context of the ideologically expressed therapeutic intentions of what the CTO is “supposed” to be. However, a CTO is a *legal* decision- not a health care decision. Charged with activating policies into the lives of people with mental illness, healthcare professionals are challenged by definitions in the legislation and policy when applied to real people. It is difficult to make distinctions in the discourse within varied contexts and resources.

My analysis uncovers another significant contradiction in the act and the practices it organizes. In Section 40(2)(a)(v) of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a), it is stated that the person who is placed on a CTO must be "*capable of complying*[29] with the requirements for treatment or care and supervision set out in the community treatment order." It appears that Section (v) is contradicting Section 40(2)(a)(iii) in that, as a result of a mental disorder, the person is unable to fully appreciate the nature and consequences of the mental disorder and is therefore *unlikely to voluntarily participate* in a comprehensive community treatment plan. This stipulation has little to do with consent, as *capability* of complying and *actually* complying are not contingent on consent if the treatment is being forced under the threat of a unwanted negative outcome, that being hospital readmission. Therefore, complying (or compliance) is a misnomer for participating in the CTO plan under compulsion.

Adding to this complexity is the confusion as to what happens once a person signs the undertaking. The CTO plan is supposedly created for the patient but, according to Robin, the legislation says, "it should simply contain an undertaking by the person; it doesn't necessarily say that the person should have executed it or should have agreed with it". This is how the process generally works: a patient could be discharged into the community with a CTO, with the undertaking in place, and would be expected to uphold the stipulations of the CTO. Medication compliance is the most frequent stipulation identified for a CTO. It can be monitored in the community, but unlike an acute care setting, there is no one to physically force an individual to take the pills (save for the support person who might place oral medications in food for the individual to unknowingly take). Nurses and other health care professionals might be skeptical of a patient's ability or willingness to be compliant with taking medications, but it might not be enough to keep the person admitted to hospital. Therefore, the individual can be

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[29] Italics added for emphasis.

discharged from hospital with the understanding that while they are *supposed* and *expected to* take their medications regularly, they may not *want to* and *will not*.

Pat, the psychiatrist informant, described the initial confusion in how consent was linked to signing the CTO document. When she sought clarification regarding this, Pat was told from different sources that a patient had to sign the form and, conversely, that a patient did not have to sign the form. She was given a strong impression, however, that the CTO could not be implemented if the involuntary patient did not sign the form. Pat said she believed this understanding of the process did not “make intellectual”, “logical” or “ethical sense”. She did not believe that any patient signature was necessary because to expect an involuntary, certified patient to sign a form consenting to be an involuntary patient under a CTO was “philosophically wrong”. She described this as the “main impediment” to using CTOs. In Pat’s opinion, the nature and severity of the mental illness, along with the fact that a patient is involuntary and certified at the time of CTO consideration or implementation, negates the patient’s ability to *competently* sign a legal form which stipulates agreement and understanding that a CTO is being enacted. Pat believed that this practice of the patient signing the CTO form was included in the CTO legislation as a well-intended means to protect the rights of the patient and to ensure that the person was aware of, and agreeable to, the process. However, she also believed “You’re not protecting the patient’s rights by asking the patient to sign”. Herein lays additional confusion for many nurses and other healthcare practitioners as to what is the true rationale for the signature: is it to indicate that the individual has seen the document but does not necessarily agree with it, or is it that the individual agrees with and consents to being on the CTO?

Teaching the Ideological Practices of the CTO

There is a considerable amount of printed material in the form of pamphlets that discuss CTOs and outline basic information. These pamphlets are often used for patients and families (sample provided[30] in Appendix J). The educational materials are peppered with words such as "***eligibility***", "***interventions and services***", "***supervise***s", ***"must***" which are italicized and in bolded font. The phrase ***"if the required and necessary services are unavailable, the CTO cannot be implemented"*** is also in bold italics. This is puzzling because there is a dearth of community mental health services and yet there are individuals on, or considered for, CTOs (such as Kerry) who are cared for by family members (such as Jamie). As well, Kris—the case manager whose caseload far exceeded the established numbers— revealed that even the designated case-managers are likely inaccessible on a regular basis.

Who is undertaking the order? All of this complex and abstract language aside, what has been evident in my data is that a person's capability to comply with a CTO hinges on the presence of others who, by default, are implicated in the CTO stipulations. In other words, it is the work of other people who make the person with a mental illness "able" to comply. Other people are present to ensure that medications are being taken, appointments being met, transportation provided for appointments, and so forth. A person is aided in being able to comply because, as a rule, they lack the physical, mental, and economic means to do so themselves. In the CTO legislation, this is apparent in the form of identifying support people and resources, specifically, *nurses and other health care professionals* who will aid the individual in adhering to the CTO plan (See Appendix G).

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[30] Other pamphlets related to the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006) can be found at http://www.health.gov.nl.ca/health/mentalhealth/mentalhealthact_resources.html.

Each nurse and health care professional who is to be involved with CTO implementation must agree to participate and the agreement must be documented (§42.1.d). Thus, according to the *Act*, a person cannot be placed on a CTO without implicating a great number of people (Government of Newfoundland and Labrador, 2006a). When a CTO is issued or renewed, a copy of the CTO is given to the patient, the patient's representative (the person who is identified to act in the interest of the patient, usually the next of kin), the rights advisor (the individual appointed by Government who is informing the individual of their rights under the *Act*) and each health care professional, person, and organization named in the community treatment plan by either the administrator[31] or the patient's psychiatrist (§43.a.b). The nurses and other healthcare professional informants with whom I spoke stated that they received information about the CTO, including a copy of the CTO form itself.

In actuality, it is the work of the informal caregivers, such as family members, who are providing the most support that results in compliance with treatment. It is they who are the ones most often providing transportation, ensuring medications are taken, aiding in the activities of daily living (such as hygiene maintenance and food preparation), and monitoring mental and physical functioning. Family members, if listed, appear within the CTO documents as *support persons.* It is unclear as to what their obligations are from a legal standpoint. In being listed in the CTO documents, family members are to receive information regarding any changes to the CTO process. In practice, Jamie, the family member (patient representative) with whom I spoke said she received formal documentation about her involvement in the CTO via registered mail.

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[31] According to Section 2 (1) (a) of the *Act* the "administrator" of the CTO is the person in charge of administrative functions within a psychiatric unit and includes his or her designate (Government of Newfoundland and Labrador, 2006a).

Jamie received a copy of Kerry's CTO and also any changes that might have been made to it as the CTO progressed. It is not clear, however, what will happen if Jamie or any other family member listed in the CTO is no longer in the patient's life.

There is a section in the CTO form (Appendix F) for a Crisis Plan to aid in identifying what community crisis supports are "available". These supports may be very few, depending on the location of the person and existing resources. Currently, in many areas of NL, formalized interventions would mostly involve contacting the police, a healthcare professional, or a crisis line. There are many communities where there is no psychiatric emergency, or any emergency, department, let alone a mobile crisis response team. As well, most areas of the province were not covered under a provincial 911 emergency response program until March 1, 2015 ("Province, St. John's Reach Last Minute Deal on 911Service", 2015). Thus, for many people on a CTO, the "community crisis supports" outlined in the CTO actually rely entirely on the informal support of families, and in some cases, peace officers. Here is where the textual organization of the CTO subtly organizes the shifted responsibility for crisis intervention from formal community mental health supports to informal supports and the criminal justice system.

It is these features of the CTO processes that organized the experiences of Jamie and Kerry whereby the "crisis" intervention saw Jamie sleeping all night in a locked car when Kerry's illness overcame her. Thus, the inclusion of crisis supports in the CTO document appears to be a means of providing legal or documentary "proof" that the issue of crisis management has been identified and addressed, but it does not ensure whether or not the crisis management plan is meaningful or potentially effectual.

In summary, a person is on a CTO because he or she has a history of noncompliance and is unlikely to comply with treatment, yet she must be capable of complying. Further, this “capability” often relies on the informal support of others and not something inherent within the patient. This foundational “compliance work” is overlooked in any of the medico-legal constructions of the CTO, in the policy framework, and in the many resources expected to support its success. Thus, even though the argument I am building here is related to the contradictions embedded in the day to day lives of people with mental illness and their caregivers, it is apparent that these tensions and contradictions are generated within serious confusion and misunderstandings about how the CTO works, either as a therapeutic plan ***or*** (as I have argued earlier) the ruling relation of a legal process focused on public safety.

Official roles and responsibilities of those people named in the undertaking. In Section 4(10) of the *Mental Health Care and Treatment Act Provincial Policy and Procedure Manual* (Government of Newfoundland and Labrador, 2009), information regarding the responsibilities of all the individuals involved with the plan is outlined. This information is also provided, in a broader manner, in the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a). For example, under Section 44 of the *Mental Health Care and Treatment Act*, the psychiatrist who issues the CTO is the individual who is responsible for its “general supervision and management” (§ 44.1). While the psychiatrist is identified as the “leader” of the CTO, the actual CTO form (see Appendix F) also requires that an individual be named who is “responsible for” the general supervision and management of this plan, but does not stipulate as to whom this could be. Therefore, there is some confusion as to what leadership practices would look like vis à vis monitoring and the everyday management work of the CTO. This has repercussions for people who are actually providing the care, including informal caregivers whose responsibilities are not well delineated anywhere in the legislation or policies, yet who often provide the bulk of the direct care, monitoring, and adherence to the CTO stipulations.

As previously described in Chapter 5, the way the various roles and responsibilities of those involved with CTOs are enacted can lead to breakdowns in communication. This is especially true for the gap between whoever is considered the "leader" of the CTO and those involved with its day-to-day implementation. For example, in one CTO plan, Kris, the community mental health nurse, explained that the family physician did not always inform Kris when Sidney, the patient, missed her appointments to receive mandated medication injections. This concerned Kris, as "according to the black and white rules of the legislation around CTOs" the health care professionals who are involved with the CTO are expected to be provided with information relevant to the plan. It was Kris' understanding that the person who *should* be notified of CTO breeches, such as a patient missing mandatory appointments, was the psychiatrist. Kris was unsure if the psychiatrist was properly being made aware of changes or issues, given that Kris herself was only sometimes informed of missed appointments or other concerns. Although Kris was not named on the CTO, she became the *defacto* monitor and coordinator of Sidney's illness.

Individuals on CTOs are expected to maintain "regular contact" with their healthcare providers, but how "regular contact" is to be operationalized is not explicit. Clear expectations for the care workers are not outlined, and the resources necessary for such “regular contact” are not specified in the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) or its *Provincial Policy and Procedure Manual* (Government of Newfoundland and Labrador, 2009). Shannon, the social work informant, described how she was involved in creating a CTO plan. She said: “there wasn’t a lot of clarity” regarding how to make contact with the patient. It was determined that “regular contact” depended on the person, the team involved, and the circumstances surrounding the CTO. What is also not explained is how the process of maintaining “regular contact” is factored into the workloads of community workers, the families, and the patients themselves.

“Protecting” those involved with CTOs. Some of the informants described situations in which health care professionals were concerned with the official responsibilities that accompanied the use of CTOs. Pat, the psychiatrist informant, said that in using CTOs “technically you’re taking on a huge responsibility to make sure that the treatment is delivered out in the community.” There was considerable discussion regarding the discomfort with invoking the CTO legislation and the perception that this step took away a person’s rights. In reviewing my interviews, I noted that many informants, not just the direct health care providers, expressed concern with the level of responsibility that accompanied the use of a CTO and the liability for any adverse events (patient or public) that might occur. The CTO legislation includes a protection of liability statement:

> 52. (1) Where the psychiatrist who is responsible for the management and supervision of a community treatment order believes on reasonable grounds and in good faith that a health care professional, other person or organization that is

> responsible for providing treatment or care and supervision under a community treatment plan is doing so in accordance with the plan, an action shall not be brought against the psychiatrist and he or she is not liable for a failure by that health care professional, other person or organization to provide treatment or care and supervision or for a default or neglect by that health care professional, person or organization in providing the treatment or care and supervision.
>
> (2) Where a health care professional, other person or organization that is responsible for providing an aspect of treatment or care and supervision under a community treatment plan believes on reasonable grounds and in good faith that the psychiatrist who is responsible for the management and supervision of the community treatment order, or a psychiatrist designated under Subsection 44(2) or another health care professional, person or organization named in the community treatment plan, is providing treatment or care and supervision in accordance with the plan, an action shall not be brought against, and the health care professional, person or organization person is not liable for, a failure by the psychiatrist or his or her designate or another health care professional, person or organization to provide treatment or care and supervision or for a default or neglect by that psychiatrist, designate, health care professional, person or organization in providing the treatment or care and supervision (§52.1 and 2, Government of Newfoundland and Labrador, 2006a).

The inclusion of this liability statement appears to act as a disclaimer for any wrongdoing that might happen as the CTO unfolds for an individual with mental illness. It is unclear, however, as to how the presence of such assurances for liability protection is actually perceived by the health care provider. It is also unclear as to how liability statements in the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) really do protect health care professionals from errors resulting from decisions made in “good faith”. The crafting of the *Act* has been dominated by legal discourse because it is legislation. The legislation, however, is so tied with clinical practice that the medico-legal knowledge and practices become blurred. Concerns related to liability might contribute to the reluctance of health care professionals to use CTOs. This section of the legislation, however, states that as long as people acted “in good faith” no one is liable. This caveat of “good faith” is not explicated in any way that would give individuals guidance as to what it constitutes nor does it indicate how to determine if any individual is, in fact, acting with or without it. As a regulated professional reading this, I find that it is confusing that someone who might have demonstrated “neglect”, as outlined above, could be held not liable, as long as they could be somehow construed as acting in “good faith”.

Taking a “rights based” approach. The *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) was seen as a step in taking more of a rights-based approach to mandating mental health care. The legislation introduced the role of the rights advisors as a resource to individuals who are certified or placed on CTOs to ensure that they are aware of their rights while under it. Because rights advisors cannot be individuals who are involved in the care and supervision of individuals under CTOs (§13.1), their stance is seen to be neutral in nature.

Once a person has been placed on a CTO, the rights advisor should meet with her as soon as possible and within 24 hours of the person having been issued a CTO. The purpose of this meeting is to discuss her rights and the meaning of being on the Order (§ 14). Informants have stated that it is sometimes difficult to meet with patients who are issued CTOs within this time frame. According to the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a), the administrator or attending psychiatrist is responsible for ensuring that the rights advisor has been made aware of the fact that a CTO was renewed, expired, terminated, or revoked and if there has been any application made to the Review Board (§15). In reality, the CTO may be finalized shortly before discharge and by the time the rights advisor is able to meet with the patient, she may have already left the hospital. Thus, in the actual activation of the CTO, the expected checks and balances are often not followed. Further, because the rights advisor is focused only on the rights of the patient, the rights of and protections for the family members implicated in the undertaking are completely absent from the institutionalized legal protections.

Plan Compliance and the Concerns with Services and Resources

The actual process of activating the CTO "treatment plan" is similarly complicated. Once the decision is made to place a patient on a CTO, there is the need to develop a plan for community treatment and related activities, as well as a plan for the involvement of others. As directed by the CTO legislation, policies, and its interpretation into practice, some of this planning has been considered before the decision is even made to invoke the CTO. The health care team must decide, not only what each CTO will involve, but whether or not it is even possible to order a CTO given the context of where the patient lives and the services available. However, as discussed in previous chapters, the lack of an ideal level of services and supports does not necessarily deter CTO implementation. In issuing the order, the psychiatrist is expected to have consulted with other health team members and other people (often family) involved with the person's care to develop a treatment plan (§42.1.c).

Section 42 of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) outlines what is to be included in the community treatment plan. According to the legislation, the necessary medical and other supports that the patient needs, such as income and housing, must be described. The plan must also detail the conditions related to the treatment(s) to which the person who is subject to the CTO must adhere (§42. a-c). The result is a potentially complicated plan structure. As noted in the *Act*, according to Section 40(2)(iv)(A)(B) and (C), the "services" must exist, be available, and be "provided". Meeting this requirement is delegated to the health authorities to detail. In the Regional Health Authority for example, there is a policy entitled *Responsibility to Patients under Community Treatment Orders* that outlines what is to be provided for individuals on a CTO (Regional Health Authority, 2011b). What has actually happened in practice is the formation of seemingly simplistic plans that are focused on medication compliance and appointment attendance. The amount of actual work that goes into these activities, as described in Chapter 6, indicates what is planned is complex and cannot be, in honesty, presented as simple.

CTO "compliance" does not solely stem from a mentally ill person's competency or capacity to provide consent. The work of compliance can vary depending upon how challenging it is to find services. Even if services are available, they may not be readily accessible. Section (40)(2)(a)(v) in the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) states the person must be capable of complying with the treatment and following the rules for supervision set out for her. This statement conjures images of a person having the mental capacity or competency to comply. However, if a person cannot get to appointments, or access other services, compliance is jeopardized. The individual may be mentally willing, able, and intend to stay well, but due to a lack of transportation, is not physically able to comply with the stipulations of the CTO. In Section 40(2)(iv)(C), the legislation states that the services a person needs for a CTO to be implemented “will be provided to the person”. Section 42 (a) also states that the CTO must include a plan of treatment for the individual, including medical and other supports, and that income and housing are included. However, there is no indication in the legislation whether income assistance provides the means by which a person can access certain services, such as transportation, nor is guidance given as to how income and housing are mandated. Some individuals on CTOs, such as Kerry, are receiving income assistance from the provincial government and have funding for some of their healthcare-related expenses. However, it cannot be assumed that all persons on a CTO are in this situation, nor that the government will fund all expenses. In support of compliance with care and treatment, health care professionals are expected to educate the patient about the benefits of continuing with treatment once the CTO is over and to advise the patient about the risks if treatment is discontinued (Government of Newfoundland and Labrador, 2009).

CTO Revocation, Termination, and Renewal

Under the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a), there are three possible bureaucratic outcomes of the CTO. These are CTO revocation, termination, and renewal. The following provides a description of these sections of the legislation and how they have coordinated the everyday CTO practice surrounding these measures.

Revocation. As previously identified, individuals who are placed on a CTO are informed that they must comply with the stipulations in the CTO or risk having the CTO revoked. According to the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a), the person who does not comply is to be apprehended by a peace officer who will bring the individual to a facility to be assessed. To do this, the administrator or psychiatrist is to take the following step: prior to the CTO being revoked, the psychiatrist must give notice to a peace officer. The peace officer has the authority to apprehend the person named in the order and to convey them to a facility for an involuntary psychiatric assessment (§51.3.a), to observe, detain, and control the individual during the apprehension and conveyance to the facility (§51.3.b), and to take reasonable measures, including entering the premises and use of physical restraint, to apprehend the patient and take them into custody (§51.3.c). The approved form directing the peace officer to do this is the *Order for Apprehension, Conveyance and Examination of a Person who Failed to Comply to Community Treatment Order (CTO)* (MHCTA-8-see Appendix I) (Government of Newfoundland and Labrador, 2009). Once the patient is apprehended, the officer is directed by the legislation to tell her the reasons for the apprehension or detention; that the patient is being taken to a facility for an involuntary psychiatric assessment, and that the patient has a right to retain and instruct counsel without delay (§10.a.b.c).

Jamie, the family informant, described how Kerry once breeched the CTO and was apprehended by police. Kerry resisted being apprehended and was physically removed by force from her home. She said the process of viewing Kerry being forcibly "dragged out" to the police cruiser was a "terrible experience". In actuality, the revocation of the CTO does not occur until the person is assessed and it is determined that the person requires treatment in a mental health facility.

Termination. The CTO must be terminated if, after conducting an assessment of the patient, the psychiatrist finds that the person no longer needs the presence of the CTO in order to live in the community (§50.1). While the patient can request this assessment, the psychiatrist can refuse to do it if the patient had been assessed within three months previous to the request (§50.2). There is no rationale provided as to why this is the case. If the psychiatrist finds that the criteria identified in Sections 40(2)(a)(i), (ii), and (iii) that had been used to invoke the CTO are no longer met (i.e. the person is no longer "certifiable") then the psychiatrist must terminate the CTO. It is required that the psychiatrist must then provide written notice to the patient, administrator, representative, rights advisor, health care professionals and organizations who were involved with the plan, and that the notice is in the approved form (MHCTA-7) (§50.3.a-d). This form is identified as *Notification Advising a Patient that the Community Treatment Order is No Longer in Effect* (Government of Newfoundland and Labrador, 2009) (see Appendix H). To date, the termination of a CTO due to a person's "recovery" from their mental illness has not occurred and this part of the legislation has not been tested in practice. To date, individuals have either breeched the CTO and are remanded for treatment, or have had their CTOs extended by the renewal process.

Renewal. A CTO expires six months after the day it is made unless it is renewed (§43), terminated (§47.1) or revoked (§51) (Government of Newfoundland and Labrador, 2006a). It is not identified in the legislation as to why this time frame has been used. However, as noted by some informants and based on my own knowledge of mental illness, for individuals who have had an acute exacerbation of their illness (particularly if their illness is schizophrenia), time is required for medications and other treatments to work to resolve the illness processes at work in the brain. There is a greater likelihood that mental functioning will improve if the time mandated for medication compliance is at least six months. Given the chronic nature of many SPMIs, the psychiatrist might determine that a CTO longer than six months duration is necessary. There are guidelines in the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) legislation regarding how the CTO can be renewed. Kris described her understanding of how the CTO renewal process occurred as:

> Usually the client will meet with the psychiatrist again, as per regular meetings with their psychiatrist…. Typically, just before the six-month period they probably have an appointment with their psychiatrist in which the psychiatrist … goes over the plan again, and the order again, and just informs the client that we're going to renew this again for another six months.

There was no description as to if, or how, the nurse or the patient has input into this decision.

According to Section 1(80) of the *Mental Health Care and Treatment Act Provincial Policy and Procedure Manual* (Government of Newfoundland and Labrador, 2009), if "renewals of certification or CTOs not completed within established time frames" (p. 11), this constitutes an "occurrence". Serious implications can occur for patients and professionals if there is an unintended lapse in the CTO. From a legal perspective, the patient, at that point, is no longer is under the mandate of the CTO and thus free to do what she wishes. If this includes discontinuing medications or stopping any other forms of treatment, then she can no longer be legally enforced to do this. For patients who have serious potential to become a danger to self or others, discontinuing treatment is a significant concern. For nurses and other health care professionals, this lapse in the order creates the need to go through the bureaucratic process of filing an occurrence report and dealing with the bureaucratic sequelae from this, in addition to the concerns they might have regarding the wellbeing of the patient and others.

Pat, the psychiatrist informant, believed that there should be a “process in place that keeps tabs on all the renewals” and that this process had not been “clearly established”. While Pat commented that she was not “in a position” to “accurately” identify a person who was responsible for monitoring the CTOs, Pat stated she was not aware of anyone who tracked CTO expiry dates. She recounted one case in which a CTO expired by mistake, but did not describe this as constituting an “occurrence.” This omission left me unable to determine if this occurrence was addressed as such.

In addition, there is confusion in how well the previously identified form MHCTA-7, which notifies the patient and others when the CTO is no longer in effect, is being completed (Appendix H). Ashley, the administrative informant, said that she was uncertain if it was being used. At the time of our interview, Ashley had not seen a completed copy. Given the fact that I am unaware of any individual being “taken off” a CTO because they have recovered, it is possible that this form has never been completed. According to Ashley, when it is completed, “it's supposed to go to the person (the patient), to their representative, to the rights advisor, and each health care professional person who was named on the community treatment order plan [and] a copy should be provided to the administrator."

Overall, there seems to be a discrepancy with the idea of who is doing what with the patient, as per the CTO legislation and policies. The nurse informants expressed challenges in performing their monitoring duties, while engaging in activities that are not in direct accordance with the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a). There was also concern regarding the group cohesiveness and communication of the CTO team, as a number of the informants state that this is not happening to the extent it should. Given there is no accountability if issues arise out of actions done or not done in "good faith", there is confusion as to with whom the responsibility lies for ensuring the day to day monitoring of the individual on the CTO is completed and reported. Therefore, the patient who needs to receive this mandated intensive follow-up might not actually be getting it.

***Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) Review Board**

Under the *Mental Health Care and Treatment Act* (2006a), individuals who are certified or placed on a CTO have a right to appeal the CTO decision and have their situation examined by a Review Board (see the form MHCTA-13 *Application/Withdrawal of Application for Review by the Mental Health Care and Treatment Review Board* form in Appendix K). The Board reports to the Minister of Health and Community Services on its operations and performs other functions (which are not clearly stipulated in the legislation) as required (§56.1.2). Members are appointed to the Board and consist of a Chair who is a member of the Law Society of

Newfoundland and Labrador, four people who are in good standing with the Society, four physicians, and four people who are neither members of the Law Society, or physicians, who have an interest in mental health issues. Preference is given to those individuals who are or have been consumers of mental health services (§57.1.a-d). A person can apply to the Review Board each time a CTO is issued or renewed. If a CTO has been renewed, then a review can take place with every second renewal. In certain situations, the administrator or psychiatrist can make the application on the person's behalf.

The Review Board has been granted all of the powers, duties and immunities of a commissioner appointed under the *Public Inquiries Act* (Government of Newfoundland and Labrador, 2006b) (§68.1), meaning the Board has the authority for measures such as calling for witnesses and requiring the provision of evidence such as documentation. When a hearing is scheduled, the panel may require witnesses to attend and have documents and records produced. It can arrange for patients to have psychiatric examinations by a psychiatrist. It can also call upon other health and other professionals to produce evidence for the panel (§68.2.b.c).

Robin, the legal informant, described the role of the Review Board:

> The Review Board is constituted under the *Mental Health Care Treatment Act*, under Section 56, and then from there the Board selects panels to hear applications that are made by either the person who is subject to the CTO or the Administrator or psychiatrist who wishes to have that reviewed and there is certain aspects of the legislation that requires automatic review in which case the health authorities must make those applications and in other cases the person who is subject to the CTO must make the application.

The Board has limited experience with respect to CTOs and according to Robin, “Our mandate is strictly to review applications that come before it asking for review of the CTO or its removal… and our mandate is to review that pursuant to Section 40 Subsection 2 of the Act.” She provided this account of what typically happens when the Review Board becomes involved with making a CTO appeal:

> So what typically happens is that if a person who is subject to a CTO wishes to review their being placed under a CTO or if there is a renewal of the order and the hospital authority must make an application then to repeat the appropriateness of the order ... then those applications are placed before the Board for review. Simply, the Board sits and hears the evidence from the Health Authority and the person who is subject to the CTO and the Board then determines whether or not the criteria pursuant to Section 40 are met and that is all that we do.

Robin said that since 2007 the Board has had three applications to review CTOs, but they do not keep statistics on how many CTOs are implemented, as they are not mandated to do this.

Robin described the process of hearing CTO review applications as going “fairly smoothly. There doesn’t seem to be much in the way of controversy over those particular decisions that were rendered”. A tribunal is put into place to consider the appeal. This consists of a lawyer, a physician, and a member of the public. The patient making the appeal is represented by a lawyer, as is the hospital authority. The psychiatrist who put the CTO in place and other health care professionals can also be present to provide information. Robin described the process as being a hearing:

There is evidence that is called it's usually sworn or it's affirmed, and we will start with the health authority first because they have the burden to show that the CTO should stay in place. So the hospital authority will start to give its evidence and its evidence should be and usually is in conjunction with Section 40, Subsection 2 of the Act. The hospital authority has to show that the person subject to the CTO still ... meets the criteria of Section 40 Subsection 2. So they give the evidence first to show that this person has a mental disorder, this person would cause harm to himself or others, or would suffer deterioration in his mental or physical health if he were not receiving treatment in the community. So they basically show that and support each of the criteria with giving evidence. Once they have finished giving evidence, then the person who is subject to the CTO or his lawyer will cross-examine the physician, the psychiatrist usually, and then once that evidence has been heard then the person who is subject to the CTO will give his or her evidence. Then what will happen, the panel members may have questions for any of the parties, and once that has been done and each of the parties have given their submissions in terms of ... the hospital authority will usually say, "well based upon all the evidence that I've heard I think the CTO should remain in place" and then the person who is subject to the CTO will typically say. "well the criteria have not been met or there is no evidence about this, or there's no evidence about that, and the CTO should be removed". So then what happens then, the hearing is adjourned. The panel will then convene and discuss the issue, discuss the evidence, and then it must render it's decision within three clear days, and that decision is then is sent to the person who is subject to

> the CTO, their lawyer and to the hospital authority. It's all tape-recorded in the event that either the hospital authority or the person who is subject to the CTO does not agree with our decision. Then either of them can appeal that decision and they can appeal within 30 days to the Supreme Court of Newfoundland.

Robin said there has only been one appeal of a Review Board's decision to the Supreme Court and that involved an involuntary admission certificate. The majority of appeals heard by the Review Board involve involuntary admissions, as there are very few CTOs. Robin said that the Board does not "normally see" how patients react to their decisions. The Board has three clear days to render its decision, which would then be emailed or faxed to the person. Robin described the difficulty in being unaware of the numbers of CTOs that are being implemented very year. Knowing the statistics "should give you some idea as to whether or not people are ambivalent to it or content" as it is currently difficult to determine if the process of using CTOs is working well.

Robin said that there are times that, from the Board's perspective, an individual who is appealing an involuntary certification may meet all of the criteria of the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a), and the Board may feel that "a CTO would be ideal in some situations and to keep the person from being in hospital." This person is repeatedly admitted involuntarily, repeatedly appeals the decision, and there is a consistent finding that the person is in need of continued treatment. Robin also noted that there are times Board members feel the individual could be treated in the community if there was an ACT team in place in the person's home area. For Robin, the issue of the undertaking, in addition to "issues or resources and things of that nature," is prohibiting CTOs from being put into place. From the Board's perspective "we're seeing that there may be the potential for more CTOs to be out there, but there may be this issue with the interpretation of the legislation that may be preventing (this)".

Summary

The manner in which the legislation is written, interpreted, and implemented in light of the disjunctures in the medico-legal discourse results in considerable confusion for those whose lives are affected by CTOs. For example, key components of the CTO process, such as understanding and engaging in an undertaking, are clouded by varied interpretations of how competency and compliance can be applied. What is strongly evident in my data is that the decision to implement a CTO is a legal and not a therapeutic decision. The ideological conceptions of what compromises "good care" for individuals with SPMI living in the community on a CTO collide with what is legally expected in protecting the public from the perceived threat that untreated mental illness holds. Individuals on CTOs are threatened with the prospect of returning to a mental health facility if noncompliant with the treatment plan. It is difficult to determine how effective these threats are for individuals who truly do not want to be subjected to the restrictions of the CTO legislation. In addition, the process of an appeal being placed on the CTO follows a legal process, one in which the burden of proof is on the health authority to provide evidence that the individual must remain on the CTO. While the patient is afforded legal representation, this process, again, does not have a therapeutic purpose. It is to ensure that the legal process of implementing the CTO is sound with the goal of upholding the legal responsibilities to protect the public.

The act of implementing CTO legislation to force an individual into mental health treatment is a significant decision that has serious repercussions from an individual liberty, family support, human resource, and health care service perspective. In this and the preceding two chapters, I discussed the threads of social and ruling relations that are evident in CTO use in NL. The disjunctures in the everyday implementation of the CTO legislation and the confusion that results dispute the rhetoric that surrounds it. In the next chapter, I will discuss how my analysis compares to and builds upon the current body of knowledge in this area.

CHAPTER 8

DISCUSSION AND CONCLUSION

In this study, institutional ethnography (IE) was used to explore the process of implementing CTO legislation in NL to yield a detailed analysis of the disjunctures that exist. In this concluding chapter, I will highlight the friction that was evident when the path of the CTO was traced from its implantation from its legislative beginnings to its use in the everyday mental health care context. What is also important in this discussion is the manner in which CTOs have been previously explored in research and other literature. CTOs are promoted as a means of maintaining the wellness of persons living with persistent and severe mental illness (SPMI), but also critiqued for a lack of clear efficacy in accomplishing this (Kisley & Campbell, 2014). There is little agreement in the literature that CTOs yield effective results in medication compliance, hospital readmission rates, or reduced length of stay in hospital (Kisley & Campbell). There are discrepancies in the variables that CTOs are expected to effect in that there are numerous questions as to what qualifies as evidence that the legislation is working. There are also differences of opinion among the self-reported experiences of CTOs by families, nurses, physicians, and others, who are involved with CTO implementation. This lack of consensus is reflective of confusion in the process of enacting the legislation and the expectation that legislation can ensure consistency across the various situations where a CTO may be implemented.

The predominant disjuncture that emerged in the data was the clash between the medical/therapeutic intent of the legislation and the legally mediated goal of using the CTO to reduce the risk for harm to the general public from individuals with SPMI. While the protection of the public is a noble intent, I have uncovered how this approach is at odds with the “rights based approach” that is promoted in the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a). CTO legislation is not focused on therapeutic outcomes. It is not an intervention. It is a means of policing the enforcement of mandated care with the goal of reducing the risk for members of the public being harmed by individuals experiencing exacerbations of their SPMI. This is in contrast with the goals of nurses in providing care that yields therapeutic results.

Disjunctures Between the Legislation and the Actualities of its Use

Individuals and Families

While collecting data for this study, I was informed of various challenging and complex situations in which individuals living with SPMI were living. In some cases, living with a SPMI on a CTO was better understood with the assistance of family members who were instrumental in supporting the individual. My research explicated the social organization of family and supports within the medico-legal regime that have been described in other research paradigms. In the CTO literature, there is a strong focus on how the actions of families support mandated treatment. Family members hold an important place in mental health care as “families, rather than institutions, have become the major providers of the long-term care necessary for those with serious and persistent mental illnesses” (Doornbos, 2002, p. 39). Despite this, healthcare providers have reported instances in which they do not see family members of their patients and do not give them information regarding their loved one’s diagnosis, medications, or prognosis (Marshall & Solomon, 2004), even though such collaboration is an expected aspect of mental health care (CFMHN, 2014). Because family members, such as Jamie, are discursively drawn into role of care provider through being identified in CTO documentation, they have a strong role to play in keeping the patient as safe as possible. Without family support, patients have a tendency to struggle (Gault, 2009).

Jamie was a supporter of the CTO being used to force Kerry to take her medications, particularly so given Kerry's determination not to take them. Jamie ensured Kerry attended appointments to receive her medications via injection and maintained her follow-up with the psychiatrist. Jamie observed that Kerry tends to stay out of hospital longer when she is on a CTO. This has been identified by other research as a possible benefit of using CTOs (Hunt et al., 2007). It does not, however, eradicate the possibility of Kerry being noncompliant with the CTO, even with the threat of having to be apprehended by police and forcibly taken to a mental health facility[32]. It was challenging for Jamie to be the face of the CTO through her attempts to facilitate Kerry's compliance. As described in the Chapter 5, this sometimes placed Jamie in dangerous situations in which her personal and emotional safety was at risk. Therefore, the idea of the CTO as a "safety net" (Ridley & Hunter, 2013; Stroud et al., 2015) is erroneously projected, as CTOs do not reduce risk *carte blanche*. While the CTO legislation activates monitoring processes that are seen as reducing safety concerns for the public at large, it is the work of the family member, including her monitoring, that is not being discursively recognized as providing the net. Nor is the risk to the family member in doing so acknowledged.

While there is evidence to suggest that some individuals who are placed on CTOs develop a reluctant acceptance of its reach into their lives (Dawson & Mullen, 2008; Ridley & Hunter, 2013; Stroud et al., 2015), this was not clearly described to me in this

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[32] See Chapter 5 for the description of Kerry being taken from her home, put into a police care without proper attire, and brought to a mental health facility.

study. Jamie's descriptions of Kerry's loathing for being on the CTO did not give an impression of acceptance. Some of my informants also described the actions of patients who refused to adhere to the CTO, telling nursing and other staff, outright, that they were not going to follow it. This could be described as a lack of respect for the "legal authority" of the CTO (Stroud et al., p. 90). Many individuals on CTOs are not depicted as expressing this "respect"; they refuse to participate in the mandated treatment and are brought back to hospital, contributing to the evidence that the CTO does not prevent readmissions (Segal & Burgess, 2008). This "lack of respect" extends beyond an anarchist approach to being on a CTO. It is questionable as to how patients can demonstrate respect for something that is considered by them to contravene their rights and in which they adamantly do not want to participate.

Previous research indicates that individuals who are fearful of mental health treatment and are embarrassed to engage in therapy are more likely not to seek assistance (Zartaloudi & Madianos, 2010). My IE research suggests there is a complex set of circumstances that appear to be contributing to this aversion to seeking help. For example, for Kerry to seek help, she has to open the metaphorical door to allow other unwanted issues into her life. Jamie said that Kerry was fearful of taking her medications due to their adverse side effects. In Kerry's case, she was prescribed injectable, older generation, antipsychotic medications that have many adverse side effects, such as movement disorders. Some newer generation injectable medications[33] on the market have different side effects, such as increased risk for diabetes and cardiovascular disease

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[33] These medications are expensive and unattainable for some individuals. Newer generation injectable antipsychotics are not currently listed on the Newfoundland and Labrador Provincial Drug Plan Coverage Status Table (June 2015) formulary that indicates which medications are accepted under the Provincial Drug Plan and which require special authorization in order to be prescribed (Government of Newfoundland and Labrador, 2015).

(Hamilton-Wilson, 2015). Whether Kerry accepted taking the older generation or newer medications, she would be at risk for problematic life long side effects. For individuals receiving medications from provincial social assistance programs, there is often little choice as availability is dependant on what the government is willing to provide. This lack of control and choice in medications can be threatening to the individual receiving them (Watts & Priebe, 2002). Kerry's disagreement with the physician's risk-benefit analysis determining the need for psychiatric medications is not unfounded. In addition, government bureaucracy in the implementation of the mandated treatment does not provide many options from which prescribers can choose, given the individual needs and concerns of their patients.

There is evidence that individuals with SPMI who live without meeting most of their daily needs also experience poorer quality of life (Wiersma, 2006). When Jamie described some of the gaps in Kerry's ability to meet her basic needs, I was left to question the quality of life Kerry experienced. Like many other individuals with SPMI, Jamie said Kerry felt lonely and isolated (Buckland, Schepp & Crusoe, 2013), lacked a clear sense of self-identity (Gault, 2009; Watts & Priebe, 2002), and was generally unhappy (McKenna, Simpson, & Coverdale, 2006). Jamie attributed some of this to the restrictions the CTO placed on Kerry's life. People have a need to complete "normal" everyday activities and this need takes on a different meaning when the person is unwell (Sitvast, Abma & Widdershoven, 2011). Kerry's everyday living was greatly impacted by her SPMI, its treatment, and the lack of community support, making the "cure" seemingly as bad as the illness.

The Discursively Mediated Work of Nurses

There are relations of ruling that influence the practice of mental health nursing in general. Firstly, there is an "overriding ideology of nursing" as a "caring profession" (Clarke, 1991, p. 39). As a caring profession, many of our practice standards are in relation to the desired virtues and ethics that support this image. One of the core foundations upon which this is based is the primacy of the therapeutic relationship. Various descriptions of the process of developing this relationship can be found in the literature. For example, the process of developing a therapeutic relationship can be initiated with "therapeutic friendliness" (Gardiner, 2010, p. 142) involving basic, friendly communication aimed at aiding the patient to feel comfortable with the nurse. Therapeutic engagement (Gardiner, 2010, p. 144) is expected to follow, during which trust is established. This can be at a superficial or deep level and leads to the therapeutic relationship. The definitions of "therapeutic relationship" vary and all do not capture its finer aspects. The nuances of developing trust and deepening a relationship are sometimes challenging to articulate, with some definitions making the process sound mechanical and linear. Despite being an ideological concept that is considered integral to nursing practice (Forchuk & Reynolds, 2001), the presence of the therapeutic relationship within institutional discourse and practice often fades out of focus.

The nurse informants interviewed identified the importance of the therapeutic relationship and incorporated similar language to that of the "relationship" discourse in their descriptions. This was paradoxically bounded by the nurses' acts of forcing medication administration or contacting police; acts that were described as undesirable coercive and oppressive actions for the patient. The deleterious effects of coercive care on the therapeutic relationship have been previously explored (Sheehan & Burns, 2011;

Stroud et al., 2015). However, the nurse and other healthcare informants rationalized such actions as being necessary for the good of the patient.

Nurses in my study described various means by which they “softened” the coercion they wielded in enforcing the CTO. Kris, the community mental health nurse, described using somewhat “manipulative measures” to ensure patients remained active in treatment, maintained appointments, and took their medications; all goals of the CTO. Her methods are similar to what Gardiner (2010) described as “therapeutic leverage” in which the nurse “uses the relationship in subtle ways to influence the direction of the client” (p. 146). It is not intended to be malicious or coercive, but to be used as a means to “assist the client to make the best decisions regarding their illness and health” (p. 146). Kris’ employment of such measures stemmed from her familiarity with patients over months and years in knowing how to communicate with them, the nuances of their illness and its presentation, and what could be used as leverage to facilitate compliance. This work is not easily represented in the institutional monitoring of CTO activity.

Nurse and other informants were troubled by CTO use, but attempted to rationalize it with references to beneficence (wanting to do good) and utilitarianism (the desire to do what is good for the greatest number of people) (Beauchamp & Childress, 2009). The desire to be “therapeutic” is impacted by bureaucratic ideology that is focused, in part, on healthcare spending. The economic context dominates healthcare delivery with its attention on rationality, efficiency, and impersonality (Austin, 2007; Crowe & Carlyle, 2003). Nurses’ work is being reformed by groups and organizations that represent these ideological perspectives on change in healthcare delivery (Rankin & Campbell, 2006) and often results in clashes with nurses’ ethical (or ideological) viewpoints (Leung, 2002). The ideological practices of the CTO legislation, and by proxy, nurses' work, are being used to decrease the number of hospital admissions, lengths of stay, and healthcare costs (Gray et al., 2008). With the ruling relations that are evident in the actions of the institution subordinating that of the nurses there is a devaluing of the work that nurses perform.

"Engagement" is another ideological professional concept that organizes how professionals think about and work with patients. To engage means, "to occupy the attention or efforts of another". It can also mean "to bind, as by pledge, promise, contact, or oath; make liable" (Dictionary.com, 2015). From the descriptions of the nursing informants, engagement is a process of "connecting" with the patient (and others) that aids the person to feel comfortable with the nurse and encourages treatment compliance. The use of the terms "engage" and "engagement" in the CTO context is confusing. Nurse informants described how, ideally, the feeling of a connection between the nurse and patient would be present before a patient would comply with treatment. However, what seems to actually happen is that the patient must be compliant with the CTO regardless of engagement occurring. In forcing patients to "engage" in treatment, patients are actually forced to "comply". Such activities can actually foster defiance in patients and reduce the likelihood they will participate in treatment activities (Van Dorn et al., 2006; Zartaloudi & Madianos, 2010). Being compelled to meet with family physicians, psychiatrists, or the community mental health nurses does not necessarily ensure that patients will engage or develop a therapeutic relationship with the health professional. This contradiction lines up with Campbell's (2004) concern that nurses' "well intentioned work" is part of the oppressive relations of ruling" (p. 39).

A requirement of a nurse's being engaged is having the opportunity to invest in activities that promote relationships. It takes time to get to know people and their needs (Addis & Gamble, 2004) in community mental health contexts. In Chapter 5, Kris (the community mental health nurse) described challenges with managing heavy caseloads in the community, particularly given the dispersed nature of the province's population. Kris's increased workload, an expectation of being an experienced community mental health nurse, sometimes made it challenging for her to have time to "engage". For some patients, time is considered a valued "commodity" that nurses have to give to patients, believing that commitment of time reflects an "act of genuine caring" (Addis & Gamble, p. 454). For some patients such as Kerry, the interpretation of these intended "acts of caring" by the nurse can be clouded by the patients' altered thought processes (along with previous negative experiences with the mental health care system), thus prompting them to doubt and be suspicions of the nurse's motives. It can take considerable time to develop trust in the presence of such symptoms. There is an acknowledgement by nurses of these challenges that exist in their daily practice. Muir-Cochrane (2001) reported that nurses described their challenges with increasing caseloads as "doing the best we can" (p. 214).

CTOs as Ensuring Service Provision or Service Compliance?

There were two important considerations regarding the manner in which services are provided for CTOs in NL. First, according to my informants, the enacted CTOs stipulated a seemingly "simplistic" plan for services that focused mainly on medication compliance and attending appointments. Other skills, such as counseling, that nurses and other healthcare professionals can provide were not ordered. Second, of the low number of CTOs enacted, most were used for patients living in rural versus urban areas. These are important in the context of the lack mental health services in NL. When services do exist, they are often not able to meet the demand while waitlists often remain lengthy for patients who are suffering.

Informants frequently referred to the Assertive Community Treatment (ACT) teams that are available in NL. The focus of this study was not on the use of this approach to treatment provision. While in the NL context the ACT team does not compel treatment, it is possible the team could follow a person on a CTO. What is of interest here is the informants' descriptions of the ACT team plans being more comprehensive than the CTO plans. They included the provision of more intensive care and follow-up for patients, such as life skills (for example, helping the patient learn how to shop for groceries), in addition to traditional services such as medication supervision. This is in stark contrast to the sparse services that are mandated by CTOs in NL. This reaffirms the focus on service provision, accessibility, and support, and not exclusively the mandating of treatment, as being integral to the wellness of those with SPMI.

The Challenges with Getting the CTO Started

Informants described considerable confusion surrounding the three involuntary admissions in two years criterion in the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) (§40.2.b), particularly in the beginning of CTO use in NL. They recognized the need to set a certain standard by which the legislation could be applied. However, as discussed in Chapter 6, there were discrepancies in how this standard was applied depending on where the patient lived and her history of violence. What my research has demonstrated is that if a patient's history and future potential does not include risk to others, then the history is not viewed as problematic *from a legislative perspective,* despite the *therapeutic concerns* that untreated SPMI can be very disabling for those experiencing it.

The majority of informants knew of patients who did not “fit” easily in the CTO criteria in terms of having the requisite number of involuntary admissions in a certain time frame, but who still had serious exacerbations of their illness. My data also uncovered cases where informants knew of individuals who have had multiple involuntary admissions, such as having three involuntary admissions in six months, who were not considered for a CTO. The criteria identified in all mental health legislation I reviewed did not provide any flexibility for application of the rules that are intended to be enacted as stipulated, clearly and without ambiguity. It is arguable that the criteria as set forth in mental health legislation lack complete relevance and applicability within myriad mental health practice environments. The legislative stipulations and criteria are not (and I assert, cannot possibly be) truly reflective of *all* individuals who have SPMI who need mandated community treatment within their highly individualized and complex contexts.

From the discussions I had with the informants, and from review of the documents involved, the act of signing the CTO form is intended to be a “legal undertaking”. However, the informants described how a number of healthcare professionals initially interpreted the process of signing the CTO form as constituting consent. There is continued confusion as to what the signing process actually signifies. The blending of legal-medico concepts created confusion between the process of giving consent and being made aware of a legal “undertaking”. Pat, the psychiatrist informant, described the CTO as a legal order that the patient was not required to sign. She likened it to the process of certifying an individual for involuntary admission. Such actions are based on the patient being assessed as having a deficit in her ability to make decisions (Milne et al., 2009). This constellation of competing features of the CTO makes the signature page meaningless in terms of representing patient consent or agreement. However, it does provide a means to confirm the patient was (apparently) told of the terms of the CTO.

From a legal perspective, the CTO should be considered an order, to which the patient does not need to sign or otherwise express agreement (as she is being *ordered* to follow it). However, this legal understanding does not match the directions on the CTO and plan forms (see Appendix F and G) *requiring* the patient to sign it before leaving the hospital. This demand for a signature is also a part of an erroneous accountability system that makes it *appear* as though patients have been "informed". Here again, the medico-legal discourses compete inside the work of front-line practitioners and patients.

Legislating Compliance and Recovery

CTOs are legal mechanisms that are discursively activated as a response to mental healthcare treatment noncompliance in individuals with SPMI who are considered a risk to public (and to a lesser extent, personal) safety when unwell. They act to coordinate the process of creating and implementing a plan of care. They further outline and provide the conduit to activate the repercussions of failure to comply. They are not, in that sense, providing care, but are instead a means of highlighting the "legal recognition of the need for care" (Stroud et al., 2015, p. 89). From my discussions with the informants, there was some variation in the objective demonstration of noncompliance. Informants stated, in support to the textual descriptions of such[34], that if patients do not adhere to the terms as set out in the CTO plan, then they would be considered noncompliant with the plan and risk CTO revocation.

There is a disjuncture in what informants described as textually "supposed to happen" in suspected situations of noncompliance with the adaptive practices that professionals employed. Informants described occasional situations in which there was flexibility in applying CTO stipulations, thus avoiding designating the patient as noncompliant. For example, Kris, the community mental health nurse informant, described situations in which her patient explicitly did not comply with the plan and was reminded of the need to do so by healthcare professionals. In one instance, Kris described sending the police to a patient's home to aid in making this "reminder". Therefore, the CTO legislation is not being followed to the strictest "letter of the law" in this situation.

Nurses, like Kris, in these situations, use their professional judgment to aid in making decisions. However, these decisions are clinically based judgments that are being made within a legal context that might not be as receptive to such judgments if a person's mental illness goes awry. The *Mental Health Care and Treatment Act's* liability statement (§ 52) is included to protect the decisions of those healthcare professionals that are "made in good faith" with respect to the CTO (Government of Newfoundland and Labrador, 2006a), which could possibly provide some protection to the healthcare professional. However, there is other legislation and documents that guide nurses in making clinical judgments based on the situation that presents before them. Nurses' professional actions in NL are governed by the *Registered Nurses' Act* (Government of

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[34] See the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a) § 51.

Newfoundland and Labrador, 2008b) that gives the Association of Registered Nurses' of Newfoundland and Labrador (ARNNL) the authority to enforce the *Registered Nurses' Act* through their *Scope of Nursing Practice* (ARNNL, 2006) and *Standards for Practice for Registered Nurses* (ARNNL, 2013) documents. For example, in the *Scope of Nursing Practice* document, some of the principles for decision-making are described as the following:

> The determination of the most appropriate practitioner to provide a specific health service or to perform an intervention will depend *upon client needs*, competency of available professionals, and *the context of practice*. Agency decisions regarding specialty and shared competencies for nurses must reflect safe and competent care, the *best interest of the client*, and be *supported by all applicable legislation*[35], standards, guidelines, and policies (p. 7).

Therefore, the *Mental Health Care and Treatment Act* legislation (Government of Newfoundland and Labrador, 2006a) and subsequent creation and implementation of the CTO plan, cannot be strictly followed; the nursing practice context varies requiring flexibility in it its implementation. However, nurses who use clinical judgments in making decisions in this regard are arguably in violation of documents governing their practice. This is despite the fact that nurses must consider "client needs" in formulating decisions that reflects the "context of practice" and are in the client's "best interest" (ARNNL, 2006, p. 7).

The word "noncompliance" is sometimes substituted with "non-adherence". Vuckovich (2010) described how the word "noncompliance" is falling out of favour in mental health nursing. Coercion, however, is meant to achieve compliance. If an

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[35] Italics added.

individual is coerced to take medications, then the term "adherence" is not appropriate as it denotes more of a willingness to "adhere" to treatment. CTO legislation is not meant to ensure adherence, but compliance; this is the word included in the *Mental Health Care and Treatment Act* document (Government of Newfoundland and Labrador, 2006a).

The rhetoric surrounding the NL CTO legislation (Government of Newfoundland and Labrador, 2006a) being "rights based" is reflective of the ideological valuing of autonomous choices that patients can make in relation to their care. When deemed necessary, the desire to do good for a patient takes a paternalistic shift in having an outsider make decisions regarding the need for care. In practice, the legislation is being activated from a utilitarian perspective. There is the desire to protect the public from the potential harm of an individual with SMPI living untreated in the community. The needs of the many outweigh the needs of the few.

While there are debates as to the effectiveness of mental health treatments, it is generally accepted that compliance with medications and other treatments, (but mainly medications) predominates other interventions or steps. Medication noncompliance is associated with a poor quality of life (O'Reilly et al., 2006) and informants described medication compliance as being foundational for many patients in their recovery. However, it can be a considerable length of time for many psychotropic medications to take effect (Hamilton-Wilson, 2015). For some patients, such as Kerry, negative personal experiences with mental health care may have tarnished their impressions of the mental health system and professionals, thus lowering their willingness to be a part of it and to wait for medications to take effect.

The use of CTO legislation in NL involves forcing patients to take medications.

The link between using CTOs and achieving medication compliance by patients has been explored by researchers for some time (see Coffey & Jenkins, 2002) and continues to be a major piece of the argument to support CTOs. For example, Ridley and Hunter (2013) interviewed individuals who experienced compulsory treatment and reported that many of those who had been on CTOs described them as “medication orders” (p. 515). Other research has found that CTOs tend to focus on forcing the uptake of medical aspects of services provision (such as medications) (Stroud et al., 2015) and not on other needs such as housing and financial support. These socioeconomic supports (i.e. housing and financial support) are identified in the *Mental Health Care and Treatment Act* legislation (Government of Newfoundland and Labrador, 2006a) (see §42.a) but have not actually been implemented in practice.

Some informants used an ideological account of “recovery” as being the goal of CTO use. The concept of recovery and use of a recovery model is being increasingly incorporated into nursing practice. It is likened to a journey undertaken by an individual with mental illness. The person, with help from peers, maintaining hope, and using their own personal strength, takes responsibility for their illness. According to the “recovery” model, the path on this journey can involve setbacks during which the individual may experience illness exacerbations (Canadian Mental Health Association, Ontario Division, 2003). As well, within the anticipated journey towards recovery the patient and their family are described as being expected to take the lead and to be “partners” in care provision and decision-making. The focus is to be on coping and resilience with a plan of care that is tailored to the needs of the patient. The goal is to aid the individual to have a good quality of life and not just control the symptoms of their psychiatric illness

(Caldwell, Sclafani, Swarbrick & Piren, 2010), even when there are setbacks in this process. It starts with “the fundamental belief that not only is recovery possible, it should be expected regardless of diagnosis or situation” (MHCC, 2015a, ¶ 2).

There is evidence that the professionals I interviewed are being influenced by the recovery discourse in so far that they expressed their belief that CTOs could aid in keeping an individual on their recovery journey and cited examples of how individuals’ lives had improved because of medication compliance. There was evidence of well-intentioned hope that everyone on a CTO would be recovering, but for some patients like Kerry, the anguish she associated with being on a CTO or involved with any care provision was an impetus to resist what was mandated. This recovery rhetoric is flawed when applied to situations involving mandated care and, in particular, to the textually mediated work of individuals activating the CTO legislation in NL. Patients, like Kerry who fervently resist treatment, are not active partners in their care. The desire to reduce risk and operationalize the legislative means to do so becomes a powerful ruling relation that surpasses any therapeutic intent. Jamie, the family member interviewed, is also not fully treated as a partner in recovery in that she is living precariously while providing the “on the ground” monitoring and support for CTO implementation.

It is possible that, once the symptoms warranting CTO implementation lessen, the patient’s ability to take part in recovery widens. Based on the data from this study, I argue it is not the CTO that accomplishes this; it is the treatment that has been mandated. This stance clashes with the legal concept of therapeutic jurisprudence that investigates “the extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or anti-therapeutic consequences” (Wexler & Winick, 1991).

While a law can set into motion the necessary provision of services and the means to compel their use, ultimately, it is *the actual participation in the services* that contributes to, but does not necessarily ensure, recovery (or at least, control and stability of a chronic mental illness).

Operationalizing the Textually Defined Deterioration Criteria

The risk for deterioration is of one of the main threads woven through the use of CTOs in NL. There was a general acceptance from the informants that, in keeping with the deterioration clause (§40.2.a.ii) in the *Mental Health Care and Treatment Act* (Government of Newfoundland and Labrador, 2006a), patients have a risk for deterioration in their mental status based on prior episodes of noncompliance and illness patterns. This is not an exact prediction of noncompliance, but an estimation of the likelihood that deterioration could happen. There is concern that the deterioration clause could be used in a broad sweeping manner and that many individuals would be forced on a CTO due to an over exaggerated perceived risk for harm. However, my research has described that CTO legislation is *not* being overused. In fact, based on my findings related to CTO decisions, it is not being used to anticipated levels.

Informants described how individuals with a low risk for harm to others as generally being excluded from CTOs. This adds to the evidence of the influence of the ideological conceptualization of violence and of it being a strong trigger for activating the CTO legislation. While a history of violence has been identified as a possible predictor for CTO use (Xiao et al., 2004), violence risk is often overestimated. There are subtleties that must be considered in the assessment of risk. For example, in a study by Appelbaum, Robbins, and Monahan (2000), the levelled risk of violence was identified as dependant on the type of delusions that are present, with individuals having violent delusions being more at risk for acting in a violent manner. Other individuals with delusions did not have this associated risk.

The justice and the healthcare systems are overlapping in the delivery of many mental health services, including CTOs. Police officers are often the first responders to situations involving individuals with mental illness in the community (Fisher, 2007). The involvement of the police is activated when they are notified of the need to apprehend an individual who is deemed noncompliant with her CTO. The process of involving the police is seemingly contradictory to what is "supposed" to be valued in health care. It is also in conflict with the role police are "supposed" to be performing. Fisher investigated concerns in New South Wales, Australia, when, in a submission to an inquiry regarding mental health services, the Police Services and the Police Association stated they were becoming a "*de facto* after-hours mental health service" (p. 230). Fisher responded to this concern by examining how mental health nurses, in turn, were becoming "*de facto* police" (p. 230) in dealing with attempting to manage violent behaviour on inpatient units. Families can also be brought into this discussion given the descriptions Jamie provided regarding her daily life of monitoring Kerry and reporting to authorities as necessary.

The experiences of patients who have been detained by police vary considerably. Patients, such as Kerry, have had negative experiences in which she was forced out of her home, placed in a police car, and brought to a mental health facility. However, there are studies that describe positive patient encounters with police. In one study, individuals with mental illness reported that their general positive interactions with police that researchers identified as “procedurally just” (Livingston, Desmarais, Greaves, Parent, Verdun-Jones & Brink, 2014, p. 285). The concept of procedural justice values mental health professionals, and others, including patients in a fair decision making process (McKenna et al., 2000). Patients must perceive fairness in their encounters, feel they are able and motivated to participate, and that they and their contributions are validated and respected (Lind & Tyler, 1988). It is beyond the scope of this study to determine if the treatment Norman Reid and Darryl Power received by police officers was procedurally just. However, in the time since the Luther Inquiry, there has been an increased interest and activity in providing more education and training for police offices in NL, such as through the *Changing Minds*[36] program offered by the Canadian Mental Health Association (2015), partially with the goal of increasing procedural justice.

Methodological Considerations

There are challenges to conducting research regarding mental health issues. Despite the significant need for more research, this is an area that tends, in general, be underexplored. One concern is gaining approval for such research. There can be delays in obtaining ethics approval, garnering support from different agencies and so forth. This may stem from individuals being unaware of the nature of mental health and illness, the confusion concerning competency and capacity, the apprehension in having “mental health patients” signing consent forms, and questions about the value and need for such inquiry. There were a number of delays in beginning data collection for this study for these reasons. There were some well-intentioned concerns expressed in conducting research with individuals who have SPMI. I thoroughly reviewed the Tri-Council Policy Statement (Canadian Institutes of Health Research, Natural Sciences and Engineering

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[36] See http://cmhanl.ca/services/training/changing-minds/

Research Council of Canada and Social Sciences and Humanities Research Council of Canada, 2010) on ethical research and ensured that what I proposed to do (and, ultimately what I actually did) was in keeping with it. Some members of the ethics review committee, however, were difficult to convince. In addition, the third party recruitment technique required to ethically recruit participants was challenging to implement. Individuals could only be contacted only through intermediaries. As I have experience working within the mental health system, I am aware of many individuals whom it may have been beneficial to interview. However, in using my own network I had to be very mindful of the ethical guidelines I set forth in conducting this study. I was very aware that stigma can impact people's level of comfort with speaking with researchers about experiences with mental illness, including patients, family members, and healthcare professionals. That being stated, health professionals were interested in the research topic and it was much easier recruiting professionals than it was patients and families.

It was challenging at times being an "informed knower". George W. Smith described the importance of knowing how the world is "reflexively, rather than objectively organized" and therefore the researcher must "inhabit the world that she is investigating" (1990, p. 613). In IE, the knowledge and experiences of the researcher as an informed knower is considered data and can be integral to analysis. As a reflexive practitioner, educator, and researcher, I had to consider what I have personally seen in practice, how my work is impacted by the legislation, and how I have approached the issues that were identified in the analysis.

In terms of methodological challenges, I had to carefully sift through the data and reflexively assess whether or not what informants told me was empirically useful.

Sometimes it was apparent that people were in the ideological or institutionally captured space; they understood the topic abstractly and some were not close enough to the ground level to see what was happening. There is a significant amount of rhetoric surrounding theoretical conceptions of support, follow up, and the therapeutic relationship. My research has shown the considerable challenges in operationalizing these ideological concepts into the everyday work processes of those involved with CTOs. This challenge is a prominent feature of the way in which CTOs are discursively and socially organized to occur through legislation and policies. There is a need to emerge from this ideological thinking as it can keep us from seeing what is really going on in mental health nursing practice.

Unfortunately, I was unable to speak with a patient informant and learn of her work related to being on or considered for a CTO. It would have been extremely beneficial to have such descriptions. However, the interviews with people who are “close” to the enactment of a CTO provided robust data about work processes. In particular, the family informant’s experience emerged as key data. The discussion I had with Jamie was detailed and lengthy. However, a challenge arose here too. In order to maintain Jamie’s anonymity there were some work processes in which she had engaged that I was unable to present here for analysis. The specifics of her situation would have jeopardized her anonymity. For this same reason of anonymity, I attempted to exclude or alter any non-essential information and descriptors provided by all of the informants. During data collection I received an expression of concern from a manager within the Government of Newfoundland and Labrador civil service that aspects of my research could be in conflict with the *Personal Health Information Act*[37] (PHIA) (Government of Newfoundland and Labrador, 2008a) that protects the confidentiality of individuals' personal health information. I am familiar with this legislation and consulted the Chair of the Health Research Ethics Board in NL regarding these concerns. I was supported in my understanding that, given my research was approved by two ethics boards (one in Alberta and one in NL), and was approved by the Regional Health Authority, that this was enough assurance that the research was ethically sound from a methodological perspective. Despite this, certain individuals within a particular branch of government who had knowledge of and workings with the CTO legislation were instructed by management not to participate in my study. This response conveyed a misunderstanding of the PHIA legislation that could seriously impact other healthcare related research in NL. It was a decision that, despite consultations with the provincial ethics committee granting approval for my research, I could not overcome.

Future Considerations

There are varying views of what should happen to the findings from IE studies. Such research is meant to elucidate the webs of influence and disjunctures involved with work processes, thus providing a useful analysis for the broad networks of people who are implicated in the work processes under study. Activist IE researchers such as George W. Smith (1990) suggest taking the analysis and moving it forward, lobbying, and taking a more political approach to making change. As discussed previously, Marxism has an interest in revealing truths for social change through one's active participation in society (Carroll, 2006). While the institutional ethnographer's main purpose is to describe and explicate the social relations that exist within an institution, the potential for such

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[37] See http://www.health.gov.nl.ca/health/PHIA/

elucidation is far reaching. Doran (1993) noted that Smith's work has "given voices to those who have been excluded from the relations of ruling" (p. 58). The knowledge garnered by using IE to describe what is happening on a local and translocal level, through the influence of ruling relations, unleashes great potential for activism (Campbell & Gregor, 2002).

However, a researcher's own position as a professional or scholar can limit the influence that an IE study can make. Most of the true "activist researchers" engaging in institutional ethnographic research are located outside of the professional networks they critique (see Bisaillon, 2013; Frampton, Kinsman, Thompson & Tilleczek, 2006; G. Smith, 1990). Like all IE researchers their first interest is in mapping the social relations involved in their struggles. They identify contraindications or disjunctures that exist and strategize the targets that can be challenged. Through the examination of the complexity of the social forces involved, they can also find allies and other sources of support for their endeavors (Kinsman, 2006). Despite its activist roots, there are serious challenges faced by all IE researchers in regards to actually "making change". Smith (2007) describes this as stemming, in part, from a "circularity" that is occurring in the new "public management" (p. 19). According to Smith, everyday actualities become lost in a process of measuring outcomes by a set of textually mediated standards developed by the institution that, in turn, supports the ruling relations that continue to suppress the acknowledgement and visibility of what is happening on the ground level. More simply put, the agents of ruling relations are measuring their own actions based on their own set of benchmarks. As such, "The circularity of the modes in which government and public institutions become accountable are also modes that ensure that accountability will be essentially divorced from the actualities of the everyday lives of those who participate" (p. 26). This process creates a vortex from which change is difficult to generate.

Given the challenges that have been explicated in relation to adhering to the somewhat contradictory and theoretically driven practices that are stipulated in the CTO legislation regarding monitoring, there is room to consider how such gaps could be reduced. The legislation states who is to be contacted when and regarding what. These rules have a broad reach extending from the legislation into the work practices of individuals within the healthcare system. This presents considerable challenge for nurses and other healthcare professionals in delivering care in under resourced constituencies where lack of mental health infrastructures make the uptake of these rules difficult, if not impossible to follow. If CTOs are to continue, then there is a need to consider the distribution of better supports[38]. To emphasize, there is a strong message in this study echoing the lack of community mental health services in NL, and in particular, rural and remote areas. Furthermore, the people who provide support and services also need to be supported. The terms and conditions of the CTO need to be made clearer and, wherever possible, patients, families and professionals need to be disabused of the rhetoric of the apparently "therapeutic" focus that is expected to lead to "recovery"[39].

When the CTO legislation was initiated, there was a demonstrated lack of understanding as to how it was to be implemented in practice. While this might have improved with time, there is a responsibility to ensure that those whose work will be impacted by CTOs are well informed of what is involved. This education must be

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[38] Whether or not CTOs continue, there is a need to examine and improve the distribution of mental health services in NL.

[39] It is outside of the scope of this study to examine the process of recovery as it is ideologically conceptualized versus how it is operationalized in practice. The disconnect between the two is a worrisome disjuncture in mental health care that needs to be explored further.

provided within the understanding that healthcare professionals are generally not legal professionals, despite the fact their work is discursively managed by *both* legal and medical professional ideologies. The work of families must be recognized for the challenges it involves. Ways to improve the lives of informal caregivers need to be a priority.

Dissemination

The process of disseminating and transferring the knowledge garnered from this research will take place in a number of forms. The results from this study have been developed as a doctoral dissertation to be submitted in partial fulfillment of the Doctor of Philosophy (Nursing) Degree at the University of Alberta. The completed dissertation will be defended, also as part of meeting doctoral requirements.

I will develop an executive summary of the findings to be presented to the key stakeholders for their review. In doing so, I will offer to meet with these groups (e.g. managers, staff, patient advocacy groups such as CHANNAL, family advocacy groups such as SSNL, CMHA, government departments) to discuss the findings. There will be opportunity for both peer-reviewed and non-peer-reviewed presentations at venues such as conferences, local meetings of key stakeholders, and other community groups. I will develop the findings into at least one manuscript to be submitted for publication[40]. I will also contact local cable network broadcasting programs and other media outlets to determine if they are interested in discussing the study and results. My dissemination goal is to increase the awareness of the challenges with the CTO legislation, to show people how it is working, and to suggest it is not the panacea for all of the issues facing

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[40] Peer reviewed academic journals considered include *International Journal of Law and Psychiatry*, *Archives of Psychiatric Nursing*, and *Journal of Psychiatric and Mental Health Nursing*.

individuals with SPMI. While it is a tool that could be used in forcing treatment, it is not the answer for facilitating wellness in individuals who live their lives under the watchful eye of the legislation.

Conclusion

Taking a standpoint is the first step in conducting IE research (Smith, 2005). In choosing the standpoint of mental health nurses, I explored how nurses' work is interwoven with the experiences and work of individuals who are subjected to CTOs, who care for individuals either informally or formally, and who are involved with the administrative aspects of creating and enacting the legislation. In doing so, I aimed at providing "accurate and faithful representations of how things work" (Smith, p. 42) in relation to CTO use in NL. The incongruousness in the ideological clouding (Snow, 2014) of what is supposed to occur in CTO implementation and what was described to me by the informants speaks to the power that medico-legal institutions have in coordinating people's work (Smith). What is traceable in the data I have collected and analyzed for this study is the *ideological* goal of reducing risk, particularly that of harm to others. The dominant discourse in risk reduction that came into light was the desire to keep the public safe from the deleterious outcomes of uncontrolled SPMI for some individuals.

The *Luther Report* (2003) was a common discussion point in many informant interviews. It was described by one of the informants as bringing a change in perspective of what good mental health care involved. Others identified the impetus for the Luther Inquiry and Report, the shooting deaths of Norman Reid and Daryl Power, as being the main motivators for mental health reform in the province. The dire circumstances under which Norman Reid and Daryl Power lived were beyond the realm of understanding for many people in NL. It is also disturbing that these extreme situations were not isolated to Norman Reid and Darryl Power then, or to many individuals and families now in our current context. Informants who were involved in the stakeholder consultation process relayed that CTO legislation was intended to address some of these concerns; to treat and stabilize the illness, connect the person to supports, and consequently address some of the socioeconomic stressors that people endure. The creation of CTO legislation has not adequately addressed these concerns. These challenges continue to exist as they do in other jurisdictions that have had CTOs for some time.

According to the *Luther Report* (2003), the idea of creating CTO legislation was a controversial topic in the Reid-Power inquiry. Judge Luther was of the opinion that "quite clearly this tragic situation would not have occurred when and how it did, if Community Treatment Orders were in effect" (p. 60). This was, and continues to be, a strong statement. Those opposed to CTOs are often of the opinion that it is best to work to engage with people, not to coerce them, and that CTOs should be suggested as a last resort.

For nurses caught in the melee of this situation, there is a certain amount of dissonance in perceiving one's role as the harbinger of force and coercion into the homes of individuals with SPMI and their families. While alternatives such as assertive case management are possible, it remains likely that there will continue to be an identified need for CTOs. The legislation should not be confused with care, as the intent of the legislation is to provide the power of the law to enforce treatment compliance. The debate regarding the ethical and therapeutic nature of such a coercive approach will continue as long as such legislation exists.

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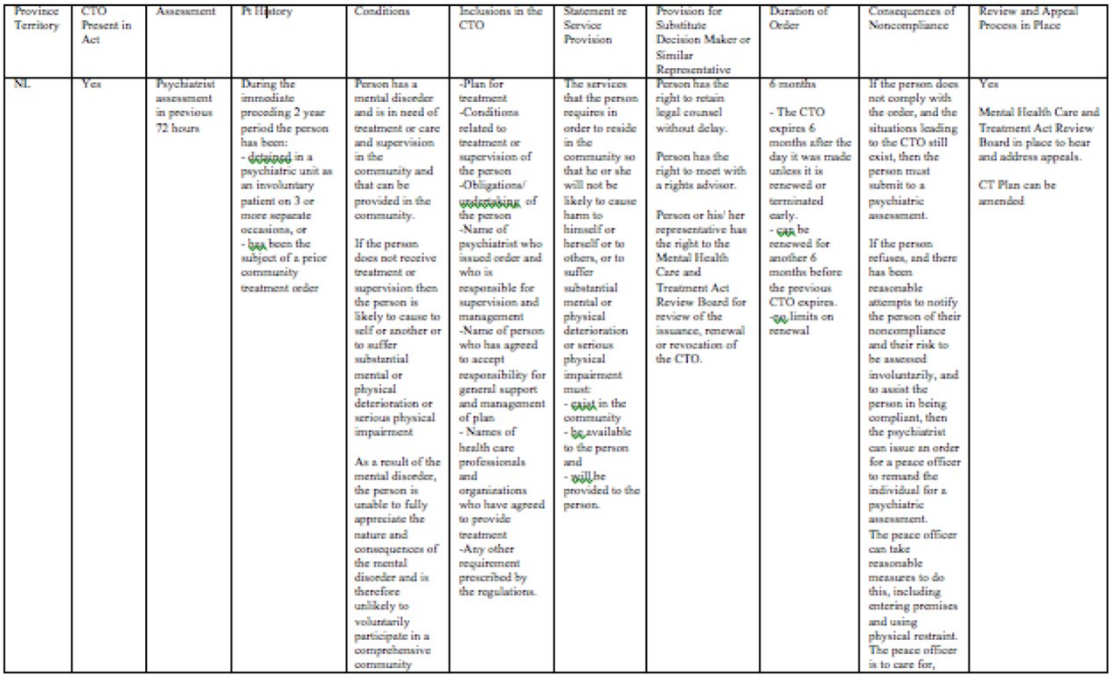
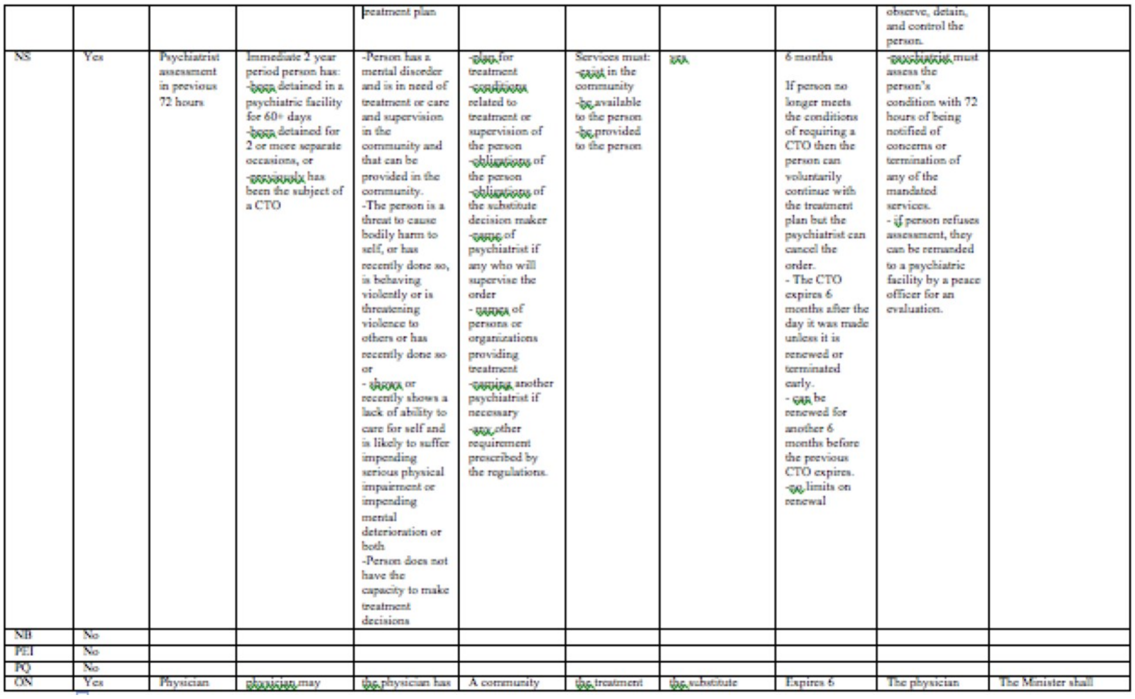
Appendix A

Summary of Community Treatment Orders in Canadian Mental Health Acts



Province Territory	CTO Present in Act	Assessment	Pt History	Conditions	Inclusions in the CTO	Statement re Service Provision	Provision for Substitute Decision Maker or Similar Representative	Duration of Order	Consequences of Noncompliance	Review and Appeal Process in Place
NL.	Yes	Psychiatrist assessment in previous 72 hours	During the immediate preceding 2 year period the person has been: - detained in a psychiatric unit as an involuntary patient on 3 or more separate occasions, or - has been the subject of a prior community treatment order	Person has a mental disorder and is in need of treatment or care and supervision in the community and that can be provided in the community. If the person does not receive treatment or supervision then the person is likely to cause to self or another or to suffer substantial mental or physical deterioration or serious physical impairment As a result of the mental disorder, the person is unable to fully appreciate the nature and consequences of the mental disorder and is therefore unlikely to voluntarily participate in a comprehensive community	-Plan for treatment -Conditions related to treatment or supervision of the person -Obligations/ undertaking of the person -Name of psychiatrist who issued order and who is responsible for supervision and management -Name of person who has agreed to accept responsibility for general support and management of plan - Names of health care professionals and organizations who have agreed to provide treatment -Any other requirement prescribed by the regulations.	The services that the person requires in order to reside in the community so that he or she will not be likely to cause harm to himself or herself or to others, or to suffer substantial mental or physical deterioration or serious physical impairment must: - exist in the community - be available to the person and - will be provided to the person.	Person has the right to retain legal counsel without delay. Person has the right to meet with a rights advisor. Person or his/ her representative has the right to the Mental Health Care and Treatment Act Review Board for review of the issuance, renewal or revocation of the CTO.	6 months - The CTO expires 6 months after the day it was made unless it is renewed or terminated early. - can be renewed for another 6 months before the previous CTO expires. -no limits on renewal	If the person does not comply with the order, and the situations leading to the CTO still exist, then the person must submit to a psychiatric assessment. If the person refuses, and there has been reasonable attempts to notify the person of their noncompliance and their risk to be assessed involuntarily, and to assist the person in being compliant, then the psychiatrist can issue an order for a peace officer to remand the individual for a psychiatric assessment. The peace officer can take reasonable measures to do this, including entering premises and using physical restraint. The peace officer is to care for,	Yes Mental Health Care and Treatment Act Review Board in place to hear and address appeals. CT Plan can be amended



				treatment plan					observe, detain, and control the person.	
NS	Yes	Psychiatrist assessment in previous 72 hours	Immediate 2 year period person has: -been detained in a psychiatric facility for 60+ days -been detained for 2 or more separate occasions, or -previously has been the subject of a CTO	-Person has a mental disorder and is in need of treatment or care and supervision in the community and that can be provided in the community. -The person is a threat to cause bodily harm to self, or has recently done so, is behaving violently or is threatening violence to others or has recently done so or - shows or recently shows a lack of ability to care for self and is likely to suffer impending serious physical impairment or impending mental deterioration or both -Person does not have the capacity to make treatment decisions	-plan for treatment -conditions related to treatment or supervision of the person -obligations of the person -obligations of the substitute decision maker -name of psychiatrist if any who will supervise the order - names of persons or organizations providing treatment -naming another psychiatrist if necessary -any other requirement prescribed by the regulations.	Services must: -exist in the community -be available to the person -be provided to the person	xxx	6 months If person no longer meets the conditions of requiring a CTO then the person can voluntarily continue with the treatment plan but the psychiatrist can cancel the order. - The CTO expires 6 months after the day it was made unless it is renewed or terminated early. - can be renewed for another 6 months before the previous CTO expires. -no limits on renewal	-psychiatrist must assess the person's condition with 72 hours of being notified of concerns or termination of any of the mandated services. - if person refuses assessment, they can be remanded to a psychiatric facility by a peace officer for an evaluation.	
NB	No									
PEI	No									
PQ	No									
ON	Yes	Physician	physician may	the physician has	A community	the treatment	the substitute	Expires 6	The physician	The Minister shall

		assessment within the 72-hour period before entering into the community treatment plan,	issue or renew a community treatment order under this section if during the previous 3year period, the person, (i) 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, or (ii) has been the subject of a previous community treatment order under this section;	examined the person and is of the opinion, based on the examination and any other relevant facts communicated to the physician, that, (i) the person is suffering from mental disorder such that he or she needs continuing treatment or care and continuing supervision while living in the community, (ii) the person meets the criteria for the completion of an application for psychiatric assessment under subsection 15 (1) or (1.1) where the person is not currently a patient in a psychiatric facility, (iii) if the person does not receive continuing treatment or care and continuing supervision while living in the community, he or she is	treatment order shall indicate, (a) the date of the examination referred to in clause (4) (c); (b) the facts on which the physician formed the opinion referred to in clause (4) (c); (c) a description of the community treatment plan referred to in clause (4) (b); and (d) an undertaking by the person to comply with his or her obligations as set out in subsection (9) or an undertaking by the person's substitute decision-maker to use his or her best efforts to ensure that the person complies with those obligations. • ON legislation specifies the use of Community Treatment Plans as follows: **Community**	or care and supervision required under the terms of the community treatment order are available in the community;	decision-maker, can be involved in developing a community treatment plan for the person; person or substitute decision maker has the right to retain legal counsel.	months after the day it was made. A community treatment order may be renewed for a period of six months at any time before its expiry and within one month after its expiry.	shall not issue an order for examination under subsection (1) unless (a) he or she has reasonable cause to believe that the criteria set out in subclauses 33.1 (4) (c) (i), (ii) and (iii) continue to be met; and(b) reasonable efforts have been made to, (i) locate the person, (ii) inform the person of the failure to comply or, if the person is incapable within the meaning of the *Health Care Consent Act, 1996*, inform the person's substitute decision-maker of the failure, (iii) inform the person or the substitute decision-maker of the possibility that the physician may issue an order for examination and of the possible consequences, and (iv) provide assistance to the person to comply with the terms of the order	establish a process to review the following matters: 1. The reasons that community treatment orders were or were not used during the review period. 2. The effectiveness of community treatment orders during the review period. 3. Methods used to evaluate the outcome of any treatment used under community treatment orders. **First review** The first review must be undertaken during the third year after the date on which subsection 33.1 (1) comes into force. **Subsequent reviews** A review must be completed every five years after the first review is completed. **Report** The Minister shall make available to the public for inspection the written report of the person conducting each review.

				likely, because of mental disorder, to cause serious bodily harm to himself or herself or to another person or to suffer substantial mental or physical deterioration of the person or serious physical impairment of the person, (iv) the person is able to comply with the community treatment plan contained in the community treatment order, (v) the treatment or care and supervision required under the terms of the community treatment order are available in the community;	**treatment plans** A community treatment plan shall contain at least the following: 1. A plan of treatment for the person subject to the community treatment order. 2. Any conditions relating to the treatment or care and supervision of the person. 3. The obligations of the person subject to the community treatment order. 4. The obligations of the substitute decision-maker, if any 5. The name of the physician, if any, who has agreed to accept responsibility for the general supervision and management of the community treatment order under subsection 33.5 (2). 6. The names of				**Return to physician** An order for examination issued under subsection (1) is sufficient authority, for 30 days after it is issued, for a police officer to take the person named in it into custody and then promptly to the physician who issued the order. **Assessment on return** The physician shall promptly examine the person to determine whether, (a) the physician should make an application for a psychiatric assessment of the person under section 15, (b) the physician should issue another community treatment order where the person, or his or her substitute decision-maker, consents to the community treatment plan; or (c) the person should be	

					all persons or organizations who have agreed to provide treatment or care and supervision under the community treatment plan and their obligations under the plan. 2000, c. 9, s. 15.				released without being subject to a community treatment order.	
MB	No									
SK	Yes	Psychiatrist's assessment in previous 72 hours	Immediate 2 year period person must have been: -detained in inpatient facility for 60 days or longer -detained in an inpatient facility at least 3 times or -the subject of a previous CTO	If person does not receive treatment person is likely to cause harm to self or others or suffer substantial mental of physical deterioration as a result	-state the facts on which psychiatrist makes decision -describe the services that will be provided -state the person is to submit to medical treatment and attend appointments as scheduled -identify who is authorized to ensure that the person will receive services -show the date when the examination was made -be signed by the psychiatrist and witnessed -be in the prescribed form.	Services must: -exist in the community -be available to the person -be provided to the person	xxx	Valid for 3 months. If examiner is not a psychiatrist, valid for 21 days. If a second psychiatrist is required, then 3 months from the second.	Person could be readmitted to a facility	xxx
AB	Yes	In the previous 72	Immediate 3 year period person must	In the opinion of the 2	Duration of the order	Treatment must exist and	The use of a patient advocate is	6 months Can be renewed	The psychiatrist can issue and	Yes

		hours, the person was assessed by 2 physicians, one of whom must be a psychiatrist, and who share the conclusion that the person has a mental disorder.	have been: -detained in inpatient facility for 30 days or longer -detained in an inpatient facility at least 2 times or -the subject of a previous CTO	psychiatrists, the person is likely to cause harm to self or others, suffer mental or physical deterioration, or serious physical impairment.		be available in the community. It is the opinion that the person is able to comply with treatment. Either: -consent is obtained from the person or if the person is not competent, then in accordance with section 28(1) -consent to the issuing of the CTO has not been obtained but in the opinion of the physicians the person has a history of not complying with treatment and that it is necessary to prevent harm., and that the CTO is reasonable (least restrictive alternative)	described in the act.	before expiration date. There are no limits to number of renewals.	order to a peace office to apprehend the person and bring them to a facility for assessment. The Act also states that the peace officer can take reasonable measures to do this, including entering premises and using physical restraint. The peace officer is to care for, observe, detain, and control the person.	CTO can be amended Can be cancelled if reasons for invoking order change
BC	No										
YK	No										
NWT	No										
NT	No										

Appendix B
Contact Letters

Mental Health Managers
Eastern Integrated Health Authority
Waterford Bridge Road
St. John’s, NL

Date

100 Forest Road
St. John’s, NL
A1A 1E5
709-777-8180

Dear Managers,

My name is Nicole Snow and I am a registered nurse enrolled in the PhD Program (Nursing) at the University of Alberta. My area of clinical expertise and research is mental health. I am interested in learning more about the use of Community Treatment Orders (CTOs) in the mental health system in Newfoundland and Labrador. I am particularly interested in what happens during the consideration and implementation of CTOs and how nurses are involved. This study is meant to explore how processes used to consider the use of or implement CTOs are possibly reflective of larger social influences, to highlight these processes, and to learn from them to improve patient care. This will involve interviewing staff, families and patients and reviewing documentation such as policy manuals.

The proposal for this study has been submitted to the University of Alberta Ethics Review Board and to the Health Research Ethics Authority (HREA). Individuals who are interested in participating in this study will be required to sign a consent form as per standard ethical procedure.

I am interested in meeting with you to discuss the nature of the study in detail. Please feel free to contact me via the information provided.

Sincerely,

Nicole Snow MN, RN, CPMHN(C)
nsnow@cns.nf.ca

Mental Health Court
St. John's, NL

Date

100 Forest Road
St. John's, NL
A1A 1E5
709-777-8180

Dear XXXX,

My name is Nicole Snow and I am a registered nurse enrolled in the PhD Program (Nursing) at the University of Alberta. My area of clinical expertise and research is mental health. I am interested in learning more about the use of Community Treatment Orders (CTOs) in the mental health system in Newfoundland and Labrador. I am particularly interested in what happens during the consideration and implementation of CTOs and how nurses are involved. This study is meant to explore how processes used to consider the use of or implement CTOs are possibly reflective of larger social influences, to highlight these processes, and to learn from them to improve patient care. This will involve interviewing staff, families and patients and reviewing documentation such as policy manuals.

The proposal for this study has been submitted to the University of Alberta Ethics Review Board and to the Health Research Ethics Authority (HREA). Individuals who are interested in participating in this study will be required to sign a consent form as per standard ethical procedure.

I am interested in meeting with you to discuss the nature of the study in detail. Please feel free to contact me via the information provided.

Sincerely,

Nicole Snow MN, RN, CPMHN(C)
nsnow@cns.nf.ca

Mental Health Staff
Eastern Health
St. John's, NL

Date

100 Forest Road
St. John's, NL
A1A 1E5
709-777-8180

Dear Staff,

My name is Nicole Snow and I am a registered nurse enrolled in the PhD Program (Nursing) at the University of Alberta. My area of clinical expertise and research is mental health. I am interested in learning more about the use of Community Treatment Orders (CTOs) in the mental health system in Newfoundland and Labrador. I am particularly interested in what happens during the consideration and implementation of CTOs and how nurses are involved. This study is meant to explore how processes used to consider the use of or implement CTOs are possibly reflective of larger social influences, to highlight these processes, and to learn from them to improve patient care. This will involve interviewing staff, families and patients and reviewing documentation such as policy manuals.

The proposal for this study has been submitted to the University of Alberta Ethics Review Board and to the Health Research Ethics Authority (HREA). Individuals who are interested in participating in this study will be required to sign a consent form as per standard ethical procedure.

I am interested in meeting with you to discuss the nature of the study in detail. Please feel free to contact me via the information provided.

Sincerely,

Nicole Snow MN, RN, CPMHN(C)
nsnow@cns.nf.ca

Information Letter for Patients and Families

Date

100 Forest Road
St. John’s, NL
A1A 1E5
709-777-8180

Hello,

My name is Nicole Snow and I am a registered nurse. I am also a PhD (Nursing) student at the University of Alberta. My background is in mental health. I am interested in learning more about the use of Community Treatment Orders (CTOs) in Newfoundland and Labrador. I would like to know what happens in how people are considered for or are chosen for CTOs. To do this, I would like to speak with people with mental illness and who have been on or considered for a CTO. I would also like to speak to their family members. I hope that this information will benefit people living with mental illness in the future.

This study has been approved by the University of Alberta Ethics Review Board and the Health Research Ethics Authority (HREA). People who are interested in this study will be asked to sign a consent form saying they agree to take part.

I am able to meet with you to talk more about the study. You can contact me at the phone number, address, or email given.

Thank you for your time.

Sincerely,

Nicole Snow MN, RN, CPMHN(C)
nsnow@cns.nf.ca

Appendix C

Information and Consent Forms

INFORMATION SHEET

Study Title: Using Institutional Ethnography to Explore Community Treatment Orders

Principal Investigators: Nicole Snow MN, RN, CPMHN(C)
Wendy Austin, RN, PhD, Faculty of Nursing,
University of Alberta

An invitation.
You are being invited to participate in a research study examining the consideration and implementation of Community Treatment Orders (CTOs) in Newfoundland and Labrador.

What is the purpose of the study?
The purpose of this study is to learn more about the use of Community Treatment Orders (CTOs) in the mental health system in Newfoundland and Labrador. We are interested in what happens during the consideration and implementation of CTOs and how nurses are involved. This study is meant to explore how processes used to consider the use of or implement CTOs are possibly reflective of larger social influences, to highlight these processes, and to learn from them to improve patient care. This will involve interviewing staff, families and patients, and reviewing documentation such as policy manuals.

What will happen if you take part in the study?
If you agree to take part, you will be asked to sign a consent form. You will be asked to talk about your experiences with the researcher. This conversation will be of about 1 to 1.5 hours in length and will be tape-recorded. You will be asked to discuss your experiences with the consideration or implementation of CTOs. You can ask questions about the research at any time. You are not required to answer all questions if you do not wish. You can end the conversation at any time, or stop and continue it at a later date. You are free to quit participation in this study at any time. A follow-up discussion may be necessary to clarify points discussed in the first conversation. You may refuse this if you wish.

If you are a patient, the researcher will ask to review your chart. You can refuse this if you wish.

What are the possible benefits to you?
The possible benefits to you for participating in this study are that you may learn more about the mental health system and CTOs. It will also give you an opportunity to discuss your experiences in a confidential manner. This study will hopefully give the researchers more information about the consideration and use of CTOs in Newfoundland and Labrador.

What are the risks to you?
You may feel uncomfortable talking about your experiences with the mental health system with the researcher. You may also feel uncomfortable having the researcher read charts. If you are uncomfortable, please let the researcher know. If other help seems

necessary, we will help you find it. We do not know of any other risks or benefits if you take part in this study.

How we will maintain your privacy?
Your identity will be protected. Any research data collected about you during this study will not identify you by name, but by a coded number. Your name will not be disclosed outside of the research study. Personal health records relating to this study will be kept confidential. Any report published presentations given as a result of this study will not identify you by name. The information you give will be kept in a locked filing cabinet. Any electronic files will be password protected on a secure server. Data will be stored for at least five years after the study is done. Only members of the research team will have access to information.

There are some situations when professional codes of ethics or the law requires reporting. If you tell us about immediate harm to self or others, or abuse of minors, then we must report it.

Results of the research
The intent is to publish and present widely the results of this research. It is hoped that this information will be shared with health care workers, managers, administrators, and government officials.

Use of data in future research
At this time, no secondary analysis of date as a whole is planned. However, if any further analysis is conducted with the study, ethics approval will be sought first.

Reimbursement of Expenses
You will be reimbursed up to $40 for cab fares to the interview site. If you required childcare, this will also be reimbursed. You will also be given a gift card in thanks of your participation.

If you have any concerns about any aspect of the study, then please contact the Health Research Ethics Board of the University of Alberta at (780) 492-0302. This office is not connected with the study or the researchers.

Please contact any of the individuals listed below if you have any questions or concerns.

Nicole Snow, PhD (Nursing) Candidate, Faculty of Nursing, University of Alberta, and Faculty, Centre for Nursing Studies, St. John's, NL. nsnow@cns.nf.ca. (709) 777-8180.

Dr. Wendy Austin, Professor and Canada Research Chair, Dossetor Health Ethics Centre, and Faculty of Nursing, University of Alberta, Edmonton, AB. waustin@ualberta.ca. (780) 492-5250

Study Title: ***Using Institutional Ethnography to Explore Community Treatment Orders***

Principal Investigators:
Nicole Snow MN, RN, CPMHN(C), nsnow@cns.nf.ca, (709) 777-8180
Wendy Austin, RN, PhD, Faculty of Nursing, University of Alberta, waustin@ualberta.ca, (780) 492-5250

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits involved in taking part in this research study?	Yes	No
Do you understand the risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time?	Yes	No
Do you understand that if you participate in this study your position will not be affected one way or the other?	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you understand who will have access to the research data?	Yes	No

This study was explained to me by:

____

I agree to take part in this study.

______________________________ ______________________________

Research Participant (Printed Name) Signature Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

______________________________ ______________________________

Witness (Printed Name) Signature Date

Appendix D

Sample Questions for Interviews

Sample Questions for Interviews

Professional Groups:

Please describe your typical day in working as a mental health nurse (manager, administrator, mental health court representative, government representatives).

Please describe your daily activities in working with people who have a CTO (or are being considered for a CTO).

Have you experienced moments in which you did not feel comfortable or frustrated with the consideration or implementation of a CTO? If so, please describe what happened during these times. What made these situations troubling for you?

What texts (documents, forms) do you use in the consideration or implementation of CTOs? How do they work? How are they connected to other texts (documents, forms)? How do they affect your everyday work activities?

Patients:

Please describe your daily experiences in being an individual with a mental illness.

What is your typical day like?

Please describe your daily experiences in living with a CTO (or being considered for a CTO)

Please describe your typical experiences in dealing with mental health nurses (managers, mental health court representatives, government representatives).

Please tell me about the troubles and frustrations you have experienced as a patient of mental health services – in particular how they relate to any knowledge or experience you have with CTO.

Family Members:

Please describe your everyday experiences in being a family member of an individual with a mental illness.

Please describe your experiences with your family member being considered for a CTO.

What is your typical day like in caring or being responsible for someone with a mental illness?

Please describe your typical experiences in dealing with mental health nurses (managers, mental health court representatives, government representatives).

Please tell me about the troubles and frustrations you have experienced as a patient of mental health services – in particular how they relate to any knowledge or experience you have with CTO.

Appendix E

Oath of Confidentiality

OATH OF CONFIDENTIALITY

Using Institutional Ethnography to Explore Community Treatment Orders

I, ___________________________, hereby promise, to the best of my ability, to respect the privacy of the participants in the study above and to keep all information related to the study confidential, barring legal and professional obligations.

____
(Signature)

____
(Date)

Appendix F

Community Treatment Order (MHCTA-03)

MENTAL HEALTH
Care & Treatment Act

Newfoundland
Labrador

Department of Health & Community Services
Mental Health Care and Treatment Act, 2006
Section 41(1)

Community Treatment Order

First Community Treatment Order (CTO) ______________ Renewal Date ______________
Issue Date of previous CTO ______________ Expiry Date of previous CTO ______________

Section 1. To be completed by psychiatrist

I,____ , certify that on the _______ day of
(please print name in full)

________________, 20____, at ____,
(place of examination)

I examined ____
(name of person who is the subject of this order)

of ______________________________________ at ____________________________.
(residence) *(time)*

On the basis of the examination and other pertinent facts respecting the person or the person's condition that are known by or have been communicated to me I am of the opinion that:

(a) The person:

- (i) is suffering from a mental disorder for which he or she is in need of continuing treatment or care and supervision in the community,
- (ii) is likely to cause harm to himself or herself or another, or to suffer substantial mental or physical deterioration or serious physical impairment if he or she does not receive continuing treatment or care and supervision while residing in the community,
- (iii) as a result of the mental disorder, is unable to fully appreciate the nature and consequences of the mental disorder and is therefore unlikely to voluntarily participate in a comprehensive community treatment plan,

and that

(iv) the services that the person requires in order to reside in the community so that he or she will not likely to cause harm to himself or herself or to others, or to suffer substantial mental or physical deterioration or serious physical impairment,
  - (A) exist in the community,
  - (B) are available to the person, and
  - (C) will be provided to the person, and

(v) the person is capable of complying with the requirements for treatment or care and supervision set out in the community treatment order;

I ______________________________ have issued this order and am responsible for
(psychiatrist)
its general supervision and management. A community treatment plan under the general

supervision and management of ______________________________ has
(please print person responsible for plan)

been developed for the treatment or care and supervision in the community.

______________________________ will report to ______________________________
(name of person responsible for plan)

on the progress made by ______________________________ on the plan.
(person subject to CTO)

The health professionals, persons and organizations who have agreed to provide treatment and support services under the plan and who will report to ______________________ are:
(person in charge of CTO)

____

____

____

____

____

____

____
Date

____
Signature of examining physician

____
Signature of witness

Section 2. To be completed by person who is the subject of the order

I, ______________________________ the undersigned, shall attend appointments with the
(person subject of CTO)

psychiatrist who issued the community treatment order, or with another health care professional, person or organization referred to in the community treatment plan at the time and places scheduled, and comply with the community treatment plan described in the community treatment order.

I understand my rights under this order which include:

- The right to retain and instruct counsel without delay in person or by other means;
- The right to meet with a rights advisor;
- The right to apply to the board (myself or my person/patient representative) for a review of the issuance, renewal or revocation of the community treatment order;
- The right to be advised of the functions and address of the board.

____
Date

____
Signature of person subject of CTO

____
Witness

Section 3. Notice of transfer of supervision and management responsibilities of order

I, ______________________________ have transferred the general supervision and
(psychiatrist who issued the order)

management responsibilities of the community treatment order to:

____
(please print name of psychiatrist who is assuming responsibility)

____
Date

____
(Signature of psychiatrist issuing the order)

____
Date

____
(Signature of psychiatrist assuming responsibility)

The following amendments have been made to the order:

____
____
____
____
____
____
____
____
____
____

NOTE:

- a copy of this note should be provided to the person who is the subject of the order, the person/patient's representative, the rights advisor and each health care professional, person and organization named in the community treatment plan.

Appendix G

Community Treatment Plan (MHCTA-04)

MENTAL HEALTH
Care & Treatment Act

Newfoundland Labrador

Department of Health & Community Services
Mental Health Care and Treatment Act, 2006

Community Treatment Plan

Person subject of the Community Treatment Order: ______________________
(please print name of individual)

D.O.B.: ______________ MCP #: ______________________

Psychiatrist Issuing Order: ______________________
(please print name of psychiatrist)

Contact #: ______________ E-Mail: ______________________

Person responsible for the general supervision and management of this plan (Section 42e):
Name(please print): ______________________
Contact #: ______________ E-Mail: ______________________

Medical Supports:

Psychiatrist's Name (please print): ______________________
Contact #: ______________ E-Mail: ______________________

Obligations:

Treatment/Medications:

Plan for Prescription Drug Coverage: ______________________

Psychiatrist's Name (please print): ______________________

Contact #: ______________________
E-Mail: ______________________

Obligations: ______________________

Treatment/Medications: ______________________

Income:

Indicate this individual's source(s) of income: ______________________

If in receipt of income support, please provide the name of his/her Income Support Worker (please print): ______________________
Contact #: ______________ E-Mail: ______________

Housing:

Indicate the housing arrangement that is in place for this individual: ______________________

Community Supports:

Indicate the community health care professionals, persons and agencies who will be contributing to community-based care, support and supervision under this plan, (e.g. ACT Team, community agency, family member, priest/minister):

Primary Community Mental Health Service:

Name: ____________________

Position: ____________________

Agency: ____________________

Contact # ____________________

E-Mail: ____________________

Obligations re: Care/Support/Supervision:

Secondary Services and Supports:

Name: ____________________ Position: ____________________

Agency: ____________________

Contact # ____________________ E-Mail: ____________________

Obligations re: Care/Support/Supervision: ____________________

Name: ____________________ Position: ____________________

Agency: ____________________

Contact # ____________________ E-Mail: ____________________

Obligations re: Care/Support/Supervision: ____________________

Name: ____________________ Position: ____________________

Agency: ____________________

Contact # ____________________ E-Mail: ____________________

Obligations re: Care/Support/Supervision: ____________________

Name: ____________________ Position: ____________________

Agency: ____________________

Contact # ____________________ E-Mail: ____________________

Obligations re: Care/Support/Supervision:

Crisis Plan:

Obligation of person subject to the Community Treatment Order

The person who is the subject of this plan shall comply with the above conditions including:

- Attending appointments with physicians, other health professionals and organizations;
- Taking medications and accepting other prescribed treatment/support.

Failure to Comply: (*as per Section 51*)

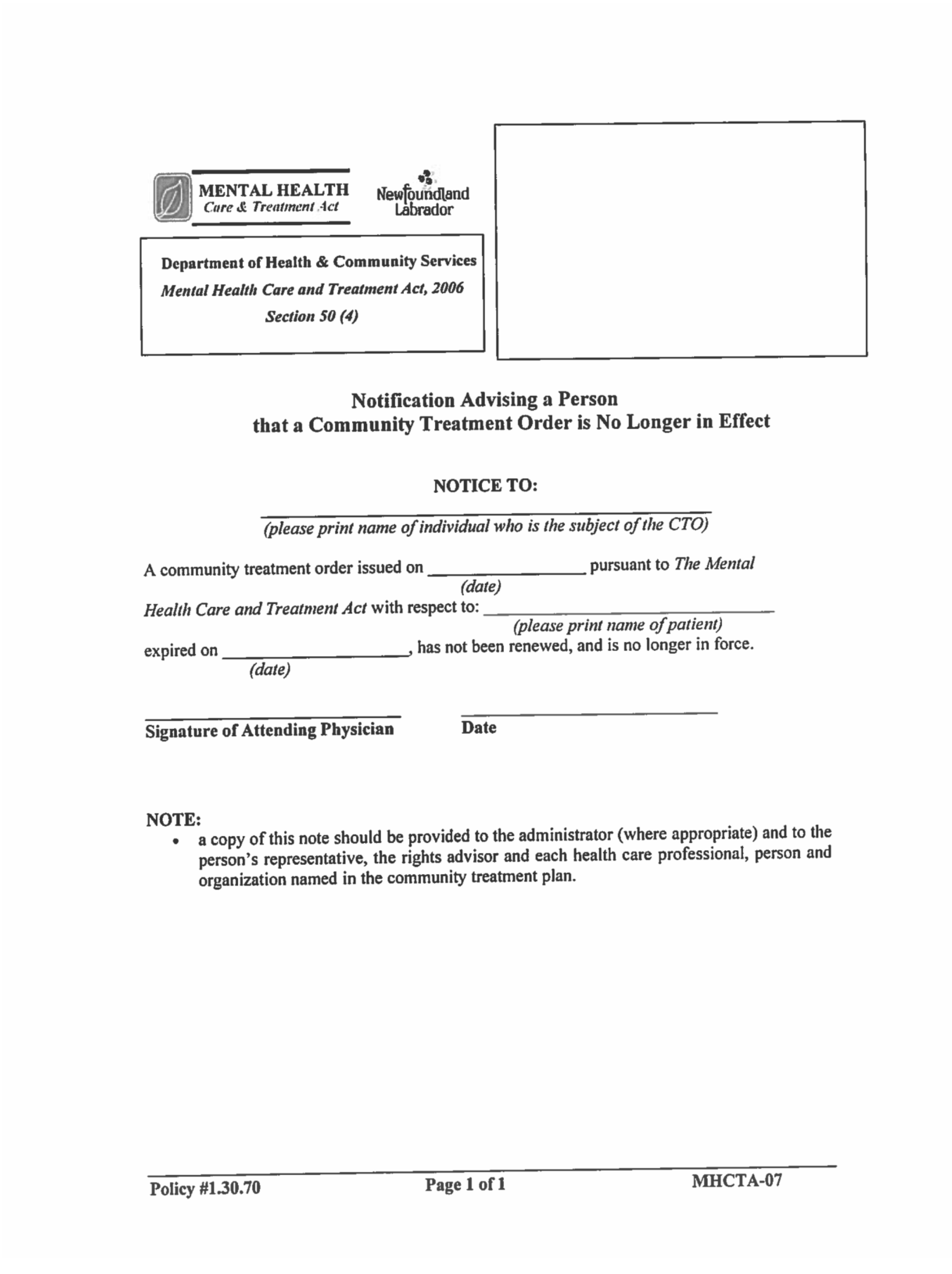
(Person subject to the CTO)

(Attending Psychiatrist)

Signed on: ____________________________
(date)

Appendix H

Notification Advising a Person that a Community Treatment Order if No Longer in Effect (MHCTA-07)



MENTAL HEALTH
Care & Treatment Act

Newfoundland Labrador

Department of Health & Community Services
Mental Health Care and Treatment Act, 2006
Section 50 (4)

Notification Advising a Person that a Community Treatment Order is No Longer in Effect

NOTICE TO:

____
(please print name of individual who is the subject of the CTO)

A community treatment order issued on ________________ *(date)* pursuant to *The Mental Health Care and Treatment Act* with respect to: ______________________________ *(please print name of patient)* expired on ____________________ *(date)*, has not been renewed, and is no longer in force.

____
Signature of Attending Physician

____
Date

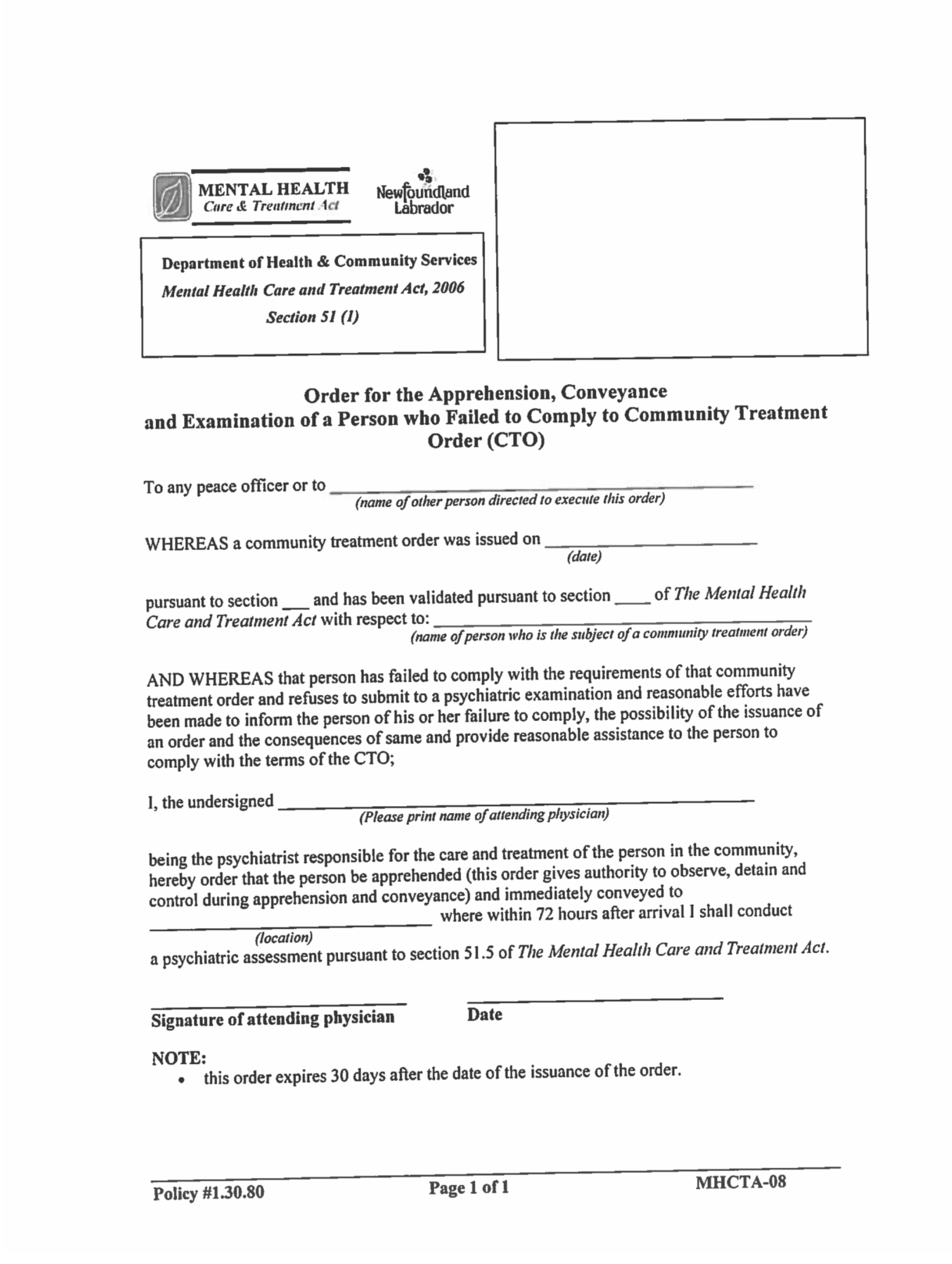
NOTE:

- a copy of this note should be provided to the administrator (where appropriate) and to the person's representative, the rights advisor and each health care professional, person and organization named in the community treatment plan.

Policy #1.30.70 **Page 1 of 1** **MHCTA-07**

Appendix I

Order for Apprehension, Conveyance and Examination of a Person who Failed to Comply to Community Treatment Order (CTO) (MHCTA-08)



MENTAL HEALTH
Care & Treatment Act

Newfoundland
Labrador

Department of Health & Community Services
Mental Health Care and Treatment Act, 2006
Section 51 (1)

Order for the Apprehension, Conveyance and Examination of a Person who Failed to Comply to Community Treatment Order (CTO)

To any peace officer or to ______________________________
(name of other person directed to execute this order)

WHEREAS a community treatment order was issued on ______________________
(date)

pursuant to section ___ and has been validated pursuant to section ____ of *The Mental Health Care and Treatment Act* with respect to: ______________________________
(name of person who is the subject of a community treatment order)

AND WHEREAS that person has failed to comply with the requirements of that community treatment order and refuses to submit to a psychiatric examination and reasonable efforts have been made to inform the person of his or her failure to comply, the possibility of the issuance of an order and the consequences of same and provide reasonable assistance to the person to comply with the terms of the CTO;

I, the undersigned ______________________________
(Please print name of attending physician)

being the psychiatrist responsible for the care and treatment of the person in the community, hereby order that the person be apprehended (this order gives authority to observe, detain and control during apprehension and conveyance) and immediately conveyed to ______________________ where within 72 hours after arrival I shall conduct
(location)
a psychiatric assessment pursuant to section 51.5 of *The Mental Health Care and Treatment Act*.

______________________ ______________________
Signature of attending physician **Date**

NOTE:

- this order expires 30 days after the date of the issuance of the order.

Appendix J

Sample Pamphlet

- the conditions that relate to care, treatment and supervision of the person named in the CTO
- the names and responsibilities of the health care professionals, persons and organizations who have agreed to provide treatment, care and supervision.

Other terms and conditions

A CTO has a term of six months, and the psychiatrist may renew the order as required for additional six-month periods. During that time, if an individual fails to meet the conditions of the CTO, the supervising psychiatrist may require that the individual be returned to the psychiatric facility for assessment.

Patient rights

Patients will receive a copy of the CTO as part of the legislative commitment to ensuring patient rights. The CTO also outlines the rights of the patient. This includes the patient's right to apply for a review of the CTO by the Mental Health Care and Treatment Act Review Board.

The Act provides patients whose care is managed through a CTO with access to a Rights Advisor. In addition to explaining the rights to which the patient is entitled, the Rights Advisor may also provide the patient with more information about how they may request a review of the CTO by the Review Board.

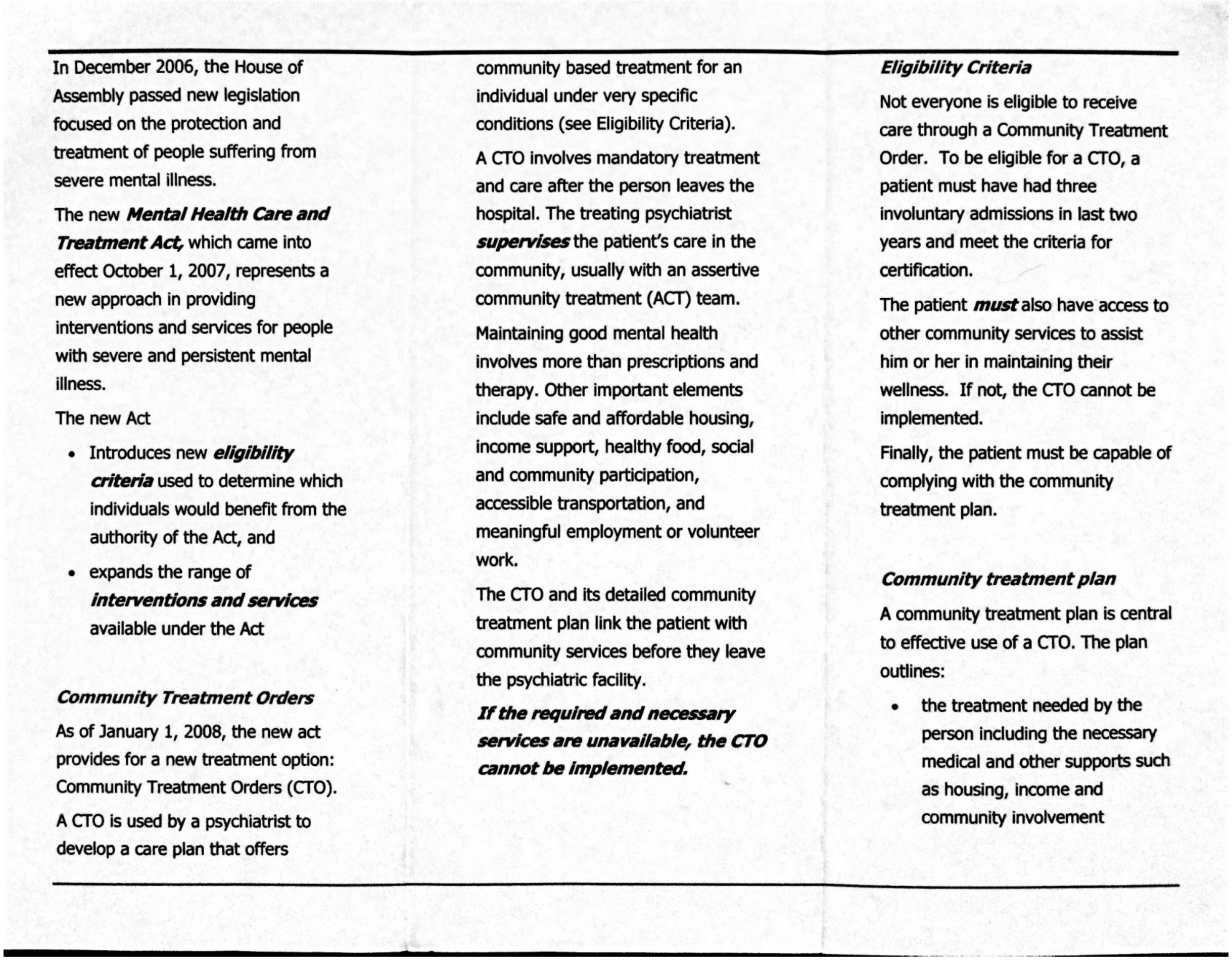
For more information contact:

www.gov.nl.ca/health/mhcta

Newfoundland
Labrador
Department of Health & Community Services

MENTAL HEALTH
Care & Treatment Act

Community Treatment Orders (CTOs)



In December 2006, the House of Assembly passed new legislation focused on the protection and treatment of people suffering from severe mental illness.

The new ***Mental Health Care and Treatment Act,*** which came into effect October 1, 2007, represents a new approach in providing interventions and services for people with severe and persistent mental illness.

The new Act

- Introduces new ***eligibility criteria*** used to determine which individuals would benefit from the authority of the Act, and
- expands the range of ***interventions and services*** available under the Act

Community Treatment Orders

As of January 1, 2008, the new act provides for a new treatment option: Community Treatment Orders (CTO).

A CTO is used by a psychiatrist to develop a care plan that offers community based treatment for an individual under very specific conditions (see Eligibility Criteria).

A CTO involves mandatory treatment and care after the person leaves the hospital. The treating psychiatrist ***supervises*** the patient's care in the community, usually with an assertive community treatment (ACT) team.

Maintaining good mental health involves more than prescriptions and therapy. Other important elements include safe and affordable housing, income support, healthy food, social and community participation, accessible transportation, and meaningful employment or volunteer work.

The CTO and its detailed community treatment plan link the patient with community services before they leave the psychiatric facility.

If the required and necessary services are unavailable, the CTO cannot be implemented.

Eligibility Criteria

Not everyone is eligible to receive care through a Community Treatment Order. To be eligible for a CTO, a patient must have had three involuntary admissions in last two years and meet the criteria for certification.

The patient ***must*** also have access to other community services to assist him or her in maintaining their wellness. If not, the CTO cannot be implemented.

Finally, the patient must be capable of complying with the community treatment plan.

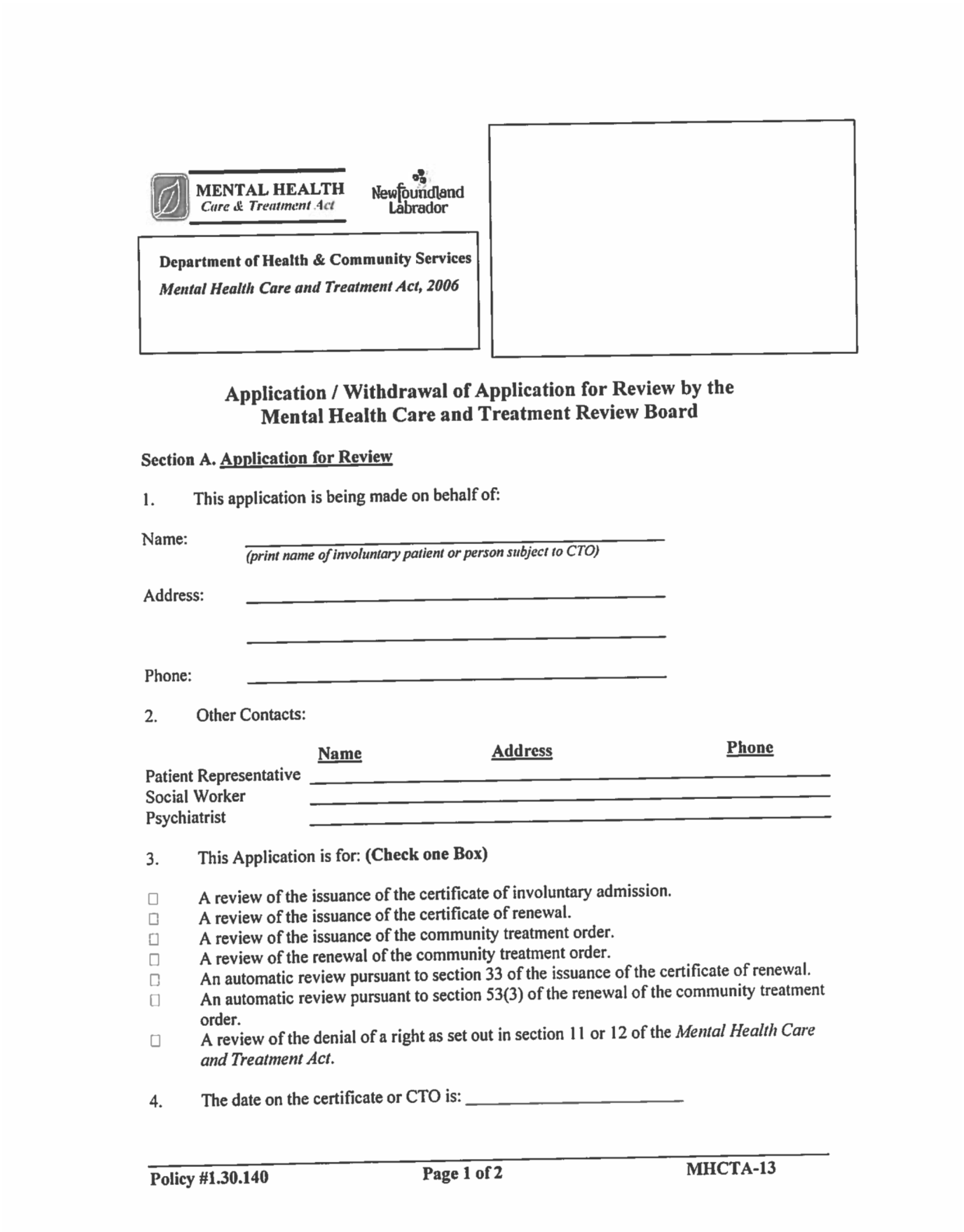
Community treatment plan

A community treatment plan is central to effective use of a CTO. The plan outlines:

- the treatment needed by the person including the necessary medical and other supports such as housing, income and community involvement

Appendix K

Application/Withdrawal of Application for Review by the Mental Health Care and Treatment Review Board (MHCTA-13)



MENTAL HEALTH
Care & Treatment Act

Newfoundland
Labrador

Department of Health & Community Services
Mental Health Care and Treatment Act, 2006

Application / Withdrawal of Application for Review by the Mental Health Care and Treatment Review Board

Section A. **Application for Review**

1. This application is being made on behalf of:

Name: ____________________
(print name of involuntary patient or person subject to CTO)

Address: ____________________

____

Phone: ____________________

2. Other Contacts:

	Name	**Address**	**Phone**
Patient Representative			
Social Worker			
Psychiatrist			

3. This Application is for: **(Check one Box)**

☐ A review of the issuance of the certificate of involuntary admission.
☐ A review of the issuance of the certificate of renewal.
☐ A review of the issuance of the community treatment order.
☐ A review of the renewal of the community treatment order.
☐ An automatic review pursuant to section 33 of the issuance of the certificate of renewal.
☐ An automatic review pursuant to section 53(3) of the renewal of the community treatment order.
☐ A review of the denial of a right as set out in section 11 or 12 of the *Mental Health Care and Treatment Act.*

4. The date on the certificate or CTO is: ____________________

5. Please describe what you want the Review Board to do and why:

Signature of Person Making Application

Date

Section B. **Withdrawal of Application for Review**

Signature of Person Withdrawing Application

Date