Perspective

Residence Conditions on Community Treatment Orders

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Objective: To identify the clinical reasons and legal authority for including a residential placement condition in a community treatment order (CTO).

Method: We describe the clinical reasons for imposing a residence condition and discuss how this is authorized by the laws of the Canadian provinces (using Ontario as the main example).

Results: A residence condition can facilitate numerous benefits, including: regular access to a person by a clinical team; continuing therapeutic relations; supervision of medication; provision of general medical care; and reduction in substance use, risks of victimization, and other unintended harm. A resident condition can be lawfully imposed when it clearly fits the purposes of the CTO legislation and stops short of authorizing detention in a community facility.

Conclusions: In certain circumstances, a residence condition is clinically justified and a lawful aspect of a CTO.

Les conditions de résidence des ordonnances de traitement en milieu communautaire

Objectif : Identifier les raisons cliniques et l'autorisation légale d'inclure une condition de placement en résidence dans une ordonnance de traitement en milieu communautaire (OTMC).

Méthode : Nous décrivons les raisons cliniques d'imposer une condition de résidence et nous discutons de la façon dont les lois des provinces canadiennes l'autorisent (en utilisant l'Ontario comme exemple principal).

Résultats : Une condition de résidence peut favoriser de nombreux avantages, notamment : l'accès régulier à un membre d'une équipe clinique; des relations thérapeutiques continues; une supervision de la médication; la prestation de soins médicaux généraux; et la réduction de l'utilisation de substances, des risques de victimisation et d'autres dommages involontaires. Une condition de résidence peut être légalement imposée lorsqu'elle concorde clairement avec les fins de la législation des OTMC et qu'elle ne va pas jusqu'à ordonner la détention dans un établissement communautaire.

Conclusions : Dans certaines circonstances, une condition de résidence est justifiée cliniquement et comporte un aspect légitime d'une OTMC.

A CTO under mental health legislation obliges a person with an SMI to adhere to specified elements of a community treatment plan (the CTO plan). Similar requirements may be imposed as conditions of leave from inpatient committal. The power of recall to hospital is the main enforcement mechanism.

The evidence remains equivocal concerning the treatment efficacy of CTOs. Conflicting results have been reached by randomized controlled trials, large longitudinal studies, and before-and-after studies using patients as their own control subjects.[1,2]

Some CTO plans include a residential placement condition. In Ontario, the office of the Public Guardian and Trustee, acting as an SDM, sometimes consents to the requirement that a person on a CTO "reside in a group home or residential setting which, by program design, supports the development of life skills and promotes treatment adherence" (words observed in CTOs in the course of the second author's psychiatric practice).

Residence conditions can take several forms, imposing different limits on liberty. The person may be required to live in a certain kind of residence (a long-term care home), or one providing certain support (24-hour supervision), or at a specified address. Alternatively, the services a housing agency will provide may be listed, such as assessing the person's mental health, monitoring compliance with oral medication, or administering an injection. Imposing very stringent conditions, such as never leaving without supervision of staff, could be viewed as causing a person to be detained in the community facility.

In addition, house rules that the person must follow will usually apply at the residence. Those rules might include, for example, a ban on smoking inside the home. Where the person is required to live in the residence by the CTO, they are, in effect, required to follow those house rules to avoid being asked to leave.

In our article, we consider when residence conditions are clinically indicated, when they are lawful, and the options for their enforcement.

Clinical Reasons for Imposing a Residence Condition

Deinstitutionalization has progressively decreased the availability of hospital beds. Some hospitals have formally decided they will not provide custodial care, thus patients are discharged when active care ends. This means clinical teams increasingly need to manage people with little insight and problematic behaviour, in community settings.

Adequate housing is essential for people with persistent and SMI.[3] There is a well-established association between housing quality and improved clinical outcome.[4,5] But what sort of housing is required? It must be affordable for people on a disability benefit and tailored to each person's needs. A small group of patients require arrangements that can compensate for their cognitive disabilities and can help control conduct that precludes successful community tenure. Residential placement in a group home, staffed 24 hours by clinically trained staff, can provide sufficient supervision to meet these aims. Elements of therapy and supervision that may be essential include the following:

1) Daily monitoring of a person's mental state. This may help identify agitation and facilitate earlier intervention.
2) Daily supervision of oral psychotropics by group home staff. Alternatives, such as eyes-on supervision of medicine ingestion by clinical outreach teams, are very labour intensive, thus they cannot be provided for most patients.
3) Daily monitoring of physical health. Patients with SMI have increased mortality rates,[6] for several reasons, including a tendency to ignore physical symptoms and perhaps limited contact with family physicians.[7] Research from 2 Australian states indicates patients on CTOs have lower rates of mortality, possibly owing to increased observation by clinicians.[8,9] Residential staff often notice signs and symptoms and can facilitate treatment.
4) Daily supervision of oral medication for physical conditions. Medical comorbidity is common in patients with SMI, and many are nonadherent to prescribed medication, both for medical and for psychiatric illness.
5) The provision of a daily structure and supervision by staff. Both can reduce opportunities for substance use.
6) Nocturnal supervision. This also significantly reduces opportunities for substance use, and can limit the risk of victimization and other unintentional dangers, such as wandering outside in harsh weather.

Abbreviations

CTO	community treatment order
SDM	substitute decision maker
SMI	severe mental illness

Clinical Implications

- Supported residence requirements can make CTOs viable and can support patients' discharge from hospital.
- A clinician who prescribes such a requirement should monitor the quality of services the residence provides.
- The main mechanism for enforcing the requirement is recall to hospital for noncompliance, not detention at the residence.

Limitations

- The scope of the authority conferred by law on clinicians to impose a residence requirement varies between the Canadian provinces.
- Some detailed aspects of the law on this subject require judicial interpretation.
- We are not aware of any research on the treatment efficacy of such requirements.

7) Finally, group homes usually provide 3 meals a day and encourage basic hygiene that can promote overall health.

In its position paper[10] on CTOs, the Canadian Psychiatric Association recommends that a placement clause requiring a person to reside in a high-support group home may be appropriate in some cases. However, when a psychiatrist imposes such a condition, under a treatment order, there is a professional duty to ensure the services provided reach a minimum standard. This will usually require the responsible psychiatrist (or members of the treatment team, or others on whom they can rely) to personally inspect the premises, to monitor the residence's quality, and ensure it is hygienic, provides an acceptable level of care, and has staff with the professional skills necessary to supervise the patient. Ongoing vigilance is needed to detect deteriorating standards, as conditions may alter, for example, when ownership or management of the residence undergoes change. If problems in quality cannot be resolved, and no alternative accommodation is immediately available, it may be necessary in the interim to recall the person to inpatient care.

The staff or managers of a residence may be reluctant to accept a client who is required to live there as a condition of a CTO, fearing they will incurr extra responsibility if they sign on to provide accommodation on those terms. They may believe they would be obliged to retain the person as a resident, to comply with the CTO, even if the person's behaviour was highly disruptive. In reality, the CTO is not strictly binding on accommodation providers. It does not force retention of a resident who violates house rules, nor set aside general tenancy law, and those qualifications could be noted in any agreement to provide services to a client on a CTO.

Legal Authority for a Residence Requirement

The main legal issues concern the power to impose a residence requirement, the impact on rights, and the mechanisms of enforcement. A residence requirement can clearly limit rights protected by law, including the Canadian Charter of Rights and Freedoms—the right to personal privacy, for instance, freedom of movement and association, and generally the right to choose where one lives. To be lawful, therefore, a residence requirement must be clearly authorized and constitute a justified limitation on rights. At a minimum, this requires use of the least restrictive intervention needed to maintain the person's community tenure.

The law may authorize imposition of a residence requirement in numerous ways. First, the CTO legislation may expressly say a residence condition can be imposed. For instance, Saskatchewan's law has recently been amended to declare that a CTO must "if considered necessary, state that the person is required to stay at a residence specified by the psychiatrist."[11]

Second, even if there is no express authority in the legislation to impose a residence requirement, it may still fall within the stated scope (or purposes) of the conditions or obligations that the legislation says can be included in a CTO plan. The precise words used in the law to describe the scope of the conditions that may be imposed can be critical here. Generally, the CTO legislation of the provinces authorizes conditions to be imposed concerning a person's treatment or care and supervision (as in Ontario, Nova Scotia, and Newfoundand and Labrador).[12–14] Those words seem broad enough to cover a residence requirement imposed for the clinical reasons discussed above, which focus on care and supervision.

Alberta's legislation permits CTO conditions about treatment or care[15]—a phrase that may be broad enough to cover the residential conditions of community care. Whether a residence requirement is covered by the bare term treatment is more doubtful, in light of the impact on rights. A province's law may define treatment for these purposes, clarifying the matter. For instance, Ontario's Health Care Consent Act defines treatment very broadly as "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan."[16] If no such definition is provided, the courts might not consider the bare term treatment broad enough to cover a residence condition.

The official forms issued by a province, for recording the details of the CTO plan, may also be relevant—if, for instance, they were highly prescriptive and contained no space to include a residence requirement in the plan, as seems the case in Alberta.

Third, in some provinces, when the person under the CTO lacks the capacity to consent, imposing a residence requirement would need to be authorized by their SDM. For instance, in Ontario the approval of the SDM is required, and the Health Care Consent Act (as mentioned above) says one form of treatment that an SDM can approve is a community treatment plan under the Mental Health Act. These rules were applied by Consent and Capacity Board of Ontario in the case of *MBG*,[17, p 4] where the CTO required a woman to reside in "housing where meals and support will be available" and required her to consult clinicians "if she wants to move" so "assistance could be given to find appropriate housing." The Board decided that an SDM could consent to those conditions of the CTO. The Board found that this did not involve consent to the woman's detention in a psychiatric facility; the conditions imposed were consistent with the purposes of the CTO regime—to

keep people engaged with psychiatric services and out of hospital; and residence conditions could operate consistently with The Charter, as a less restrictive alternative to repeated hospitalization, though that would ultimately depend on the precise restrictions imposed in the particular circumstances.

Finally, orders for community treatment that include residence requirements are issued by the Superior Court in Quebec under the general incapacity provisions of the Civil Code.[18] These are akin to residential placement orders that might be made in other jurisdictions under adult guardianship law.

Enforcement of a Residence Requirement

The principal means of enforcement is recall of the person to hospital for reassessment, at the discretion of the responsible physician, for failure to comply with the plan. For instance, Ontario's law requires a person on a CTO to "comply with the community treatment plan" and authorizes recall for assessment of a person on a CTO who "has failed to comply with his or her obligations" under it.[19] Once assessed, a person can only be admitted as an involuntary patient if they meet the jurisdiction's inpatient committal criteria. In contrast, if, at recall, the person is considered able to live safely in the community, outside the designated residential placement, the prior placement clause would no longer apply and a new plan would then possibly need to be drafted.

There is then the question of whether the requirement can be directly enforced by parties other than the responsible physician, such as by staff of the residence concerned. Could they lawfully prevent the person leaving the residence contrary to the CTO plan? No authority to enforce the plan by direct interference with the physical freedom of a person leaving a community residence is conferred by CTO legislation in Canada on the staff, the police, neighbours, or members of the public. Nor does CTO legislation confer direct authority on such parties to apprehend and return a person to such a residence. The usual remedy to a person leaving contrary to the plan is to contact the responsible physician, who may activate recall.

Other legal rules may justify immediate intervention in an emergency. For instance, the police may intervene if their general power, under mental health legislation, to detain a person in urgent circumstances applies. Moreover, any person would be justified in intervening in an emergency, under the common law of necessity, when the relevant legal standards were met—these being based on the concepts of mental disorder or incapacity plus an imminent threat of harm.[20] Ontario's law notes the continuation of this justification for intervention, when it says, "This Act does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others."[21]

Detention in a Community Residence

Very stringent residence requirements on a CTO, such as allowing the person to leave the residence for only a few hours a day, or constant electronic monitoring, might be considered unlawful if so strict as to produce de facto detention in a community facility. They may infringe the right of every person not to be subject to arbitrary detention protected by the The Charter (Section 9) and by the common law. Mental health legislation expressly authorizes the detention of compulsory patients in hospital but not detention of people on a CTO, and detention in these circumstances would usually fall outside the scope of an SDM's power to approve.

Nevertheless, it may be hard to draw a line between unlawful detention and lesser restrictions on liberty that are acceptable. Detention occurs, in law, when a person is confined in a restricted space, without their consent, by walls, coercion or assertion of authority, for a significant period of time.[20] It may therefore occur when a person is told they must not leave the confines of a certain residence or else they will be returned to hospital. No sharp line can be drawn between restrictions on and deprivation of liberty.[22] It depends on the intensity, duration, and consequences of the restrictions imposed and the degree of surveillance and control exercised. Locked doors are not definitive and a person may be deemed detained although permitted brief outings.[23]

Attaching very stringent conditions to a residence requirement would be vulnerable to challenge in court. For instance, allowing a person to leave the residence only for brief periods when accompanied by staff may cross an impermissible line.

Conclusions

In sum, a residence condition restricts a person's usual right to live where they choose and should never be imposed as a routine requirement of a CTO. Nevertheless, there can be important clinical reasons for imposing it, particularly when the person may only achieve successful community tenure when they receive a certain level of care. It should not be considered a disproportionate limit on rights when there is a reasonable prospect that it will promote successful residence outside hospital and no less restrictive alternative exists.

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References

1. Rugkåsa J, Dawson J, Burns T. CTOs: what is the state of the evidence? Soc Psychiatry Psychiatr Epidemiol. 2014;49(12):1861–1871.
2. Kisely S, Hall K. An updated meta-analysis of randomized controlled evidence for the effectiveness of community treatment orders. Can J Psychiatry. 2014;59(10):561–564.
3. Goering P, Veldhuizen S, Watson A, et al. National final report: cross-site At Home/Chez soi project. Calgary (AB): Mental Health Commission of Canada; 2014. Available from: http://www.mentalhealthcommission.ca.
4. Baker F, Douglas C. Housing environments and community adjustment of severely mentally ill persons. Community Ment Health J. 1990;26(6):492–505.
5. Newman SJ. Housing attributes and serious mental illness: implications for research and practice. Psychiatr Serv. 2001;52(10):1309–1317.
6. Saha S, Chant D, McGrath J. A systematic review of mortality in schizophrenia: is the differential mortality gap worsening over time? Arch Gen Psychiatry. 2007;64(10):1123–1131.
7. Kisely S, Cox M, Smith M, et al. Inequitable access for mentally ill patients to some medically necessary procedures. CMAJ. 2007;176(6):779–784.
8. Segal SP, Burgess PM. Effect of conditional release from hospital on mortality risk. Psychiatr Serv. 2006;57(11):1607–1613.
9. Kisely S, Preston N, Xiao J, et al. Reducing all-cause mortality among patients with psychiatric disorders: a population-based study. CMAJ. 2013;185(1):E50–E56.
10. O'Reilly RL, Brooks SA, Chaimowitz GA, et al. Mandatory outpatient treatment [CPA position paper]. Can J Psychiatry. 2010;55(6 Insert 1):1–7. Available from: http://publications.cpa-apc.org/media.php?mid=912.
11. Mental Health Services Act, S.S., c. M-13, section 24(3)(1)(d.1), as amended by Bill 27, An Act to Amend the Mental Health Services Act, 2014.
12. Mental Health Act, R.S.O. 1990, c. M.7, section 33.7.
13. Involuntary Psychiatric Treatment Act, 2005, S.N.S. 2005, c. 42, section 48(b).
14. Mental Health Care and Treatment Act, S.N.L. 2006, c. M-9.1, section 40(2).
15. Mental Health Act, R.S.A. 2000, c. M-13, section 9.1(2).
16. Health Care Consent Act, 1996, R.S.O. 1996, c. 2, section 2.
17. *In the matter of MGB.* Canadian Legal Information Institute (CanLII) (2003) n.14360 (ON, CCB).
18. Nakhost A, Perry JC, Frank D. Assessing the outcome of compulsory treatment orders on management of psychiatric patients at 2 McGill University-associated hospitals. Can J Psychiatry. 2012;57(6):359–365.
19. Mental Health Act, R.S.O. 1990, c. M.7, section 33.1(9) and 33.3(1).
20. Dawson J. The law of emergency psychiatric detention. N Z Law Rev. 1999;2:275–303.
21. Health Care Consent Act 1996, R.S.O. 1996, c. 2, section 7.
22. *Guzzardi v Italy* (Application no. 7367/76) (1980) ECHR 5.
23. *Pleso v Hungary* (Application no. 41242/08) (2012) ECHR 1767.

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Books Received

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My Autistic Awakening: Unlocking the Potential for a Life Well Lived. Rachael Lee Harris. Lanham (MD): Rowman & Littlefield; 2015. 224 p. US$34.00.

The Theft of Memory: Losing My Father, One Day at a Time. Jonathan Kozol. Toronto (ON): Doubleday Canada; 2015. 304 p. Can$27.95.

Geriatric Depression: A Clinical Guide. Gary J Kennedy. New York (NY): Guilford Publications; 2015. 234 p. US$35.00.

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Overdiagnosis in Psychiatry. Joel Paris. London (GB): Oxford University Press; 2015. 208 p. £22.99.

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The Triune Psyche: The Four Brains, the Eight Minds, and the Three Moving Spirits. Ali Sharafi. Penticton (BC): Ali Sharafi; 2015. 480 p. Can$21.00.