Evaluation of Legislated Assisted Community Treatment in the Northwest Territories

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Abstract

Background: The Northwest Territories (NT) tabled the new Mental Health Act ('the Act') in 2018. Founded on the principles of person-centered and recovery focused care, the Act includes the use of Assisted Community Treatment (ACT). ACT is a treatment option for select individuals who have had an involuntary psychiatric hospitalization to continue mandated treatment in the community. However, there has been no uptake of ACTs in the NT to date. This evaluation project was designed to gain a greater understanding of the barriers to ACT implementation, and to identify strategies for enhancing their use.

Methods: An integrative literature review was conducted to explore the evidence related to Community Treatment Orders (the more common term for ACT nationally). Consultations were organized to gain insight from representatives of the Government of the Northwest Territories (GNWT) on priority issues for evaluation. An evaluation plan was developed, and data were collected from health care provider groups to identify the issues related to the lack of ACT implementation.

R**esults:** Five themes were generated from the data: education and training barriers; concerns with ACT issuance; cultural considerations; ACT continuance concerns, and community resources and connections. Five main recommendations were then created to increase initial uptake of ACTs in the NT.

Conclusions: Research on the effectiveness of CTOs is mixed but there are notable benefits for clients if they are enacted using a recovery-oriented framework. The GNWT's efforts to support the implementation of ACTs will be optimized by using a collaborative and person-oriented approach with community and health system partners.

Key Words: Community Treatment Orders, Clinical Effectiveness, Process Evaluation

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Evaluation of Legislated Assisted Community Treatment in the Northwest Territories

In 2018 the Government of the Northwest Territories (GNWT) tabled the new Mental Health Act ('the Act') to improve mental health services for individuals in the Northwest Territories (NT) (2018). The Act was created with the aim to guide health care practitioners in their delivery of ethical care that respects the rights of individuals and their families as they navigate the mental health system (GNWT, 2018). The Act was created through the principles of person-centred treatment and recovery oriented practice and included significant updates from the prior mental health act which was outdated.

The Act includes the provision for health care practitioners to enact Assisted Community Treatment (ACT) certificates. The aim of ACTs is to provide community care for individuals who remain on involuntary treatment status through an agreed upon community treatment plan (GNWT, 2018). In most jurisdictions these are known as Community Treatment Orders (CTOs). Although the Act was tabled in 2018, no individual has yet been discharged from a psychiatric hospitalization in the NT with an ACT in place. This is somewhat surprising given that in 2018, 61% of all inpatient admissions were involuntary, and 18% of all admissions were readmitted within twelve months. The need to improve the readmission rate is a key governmental goal.

The aim of this practicum project was to gain a fulsome understanding of the perceived challenges and barriers that are currently preventing the implementation of ACTs in the NT. By gaining insight, effective solutions, and recommendations could be created to reduce the current barriers to implementation. This project was endorsed by the Department of Health and Social Services (DHSS) who provide the oversight of service quality, standards of care, and legislative direction for the GNWT's health authorities. Through the creation of recommendations, the

DHSS will better be able to work with the health authorities to implement solutions which will increase the uptake of this service for individuals and their families in the NT.

Practicum Goal

The overall goal of the practicum was to develop and implement an evaluation for part four of the NT's Mental Health Act: Leave and Treatment in the Community which would result in recommendations for the DHSS.

Practicum Objectives

There were a total of four objectives for this practicum. They included:

1. Evaluate the uptake and utilization of Assisted Community Treatment (ACTs) at an inpatient and community level in the NT;
2. Identify ongoing challenges and barriers, as experienced by staff, since implementation of ACTs;
3. Outline key findings and develop recommendations or deliverables which would improve uptake of ACTs in the NT; and
4. Demonstrate advanced nursing practice competencies.

Methods

A methodology was developed which would guide the evaluator in the creation and implementation of an evaluation which would result in the achievement of the practicum goal and objectives.

Literature Review

An integrative literature review was completed as a first step in the evaluation process to provide the groundwork for a formal evaluation. The literature review focused on the use of

CTOs, particularly as related to clinical effectiveness, best practice, and the factors associated with successful implementation in other national and international jurisdictions.

Overview and Findings

The integrative literature review process yielded 75 articles for review following initial screening and cross-referencing of data bases for duplicate studies. Screening of articles for relevance plus the removal of secondary research resulted in 33 articles for critical appraisal:15 editorials or reviews, 11 quantitive studies, nine qualitative studies and seven reviews of literature. Critical appraisals were conducted using the Public Health Agency of Canada (PHAC) Critical Appraisal Toolkit (2014) and the Qualitative Review Form developed by Letts et al., (2007). Articles that failed to contribute to the overall aim of the project, or were of weak design were discarded, leaving 23 studies for the integrative review.

Results. The themes derived from critical appraisal included: i) the clinical effectiveness of CTOs, ii) the impact of CTO implementation on the health system, and iii) factors that support successful implementation. Each main theme had a number of sub themes which were explored. A brief overview of these themes, and their subthemes is provided below.

Clinical Effectiveness of CTOs. The clinical effectiveness of CTOs has mixed evidence resulting from a lack of strong, replicated studies, which build a body of evidence. One subtheme addressed the system outcomes that were achievable from the use of CTOs: i) a reduced length of inpatient admission stay, and ii) increased length of time from discharge to readmission (Awara, 2013; Harris et al., 2019; Kallapiran et al., 2010; Kisely et al., 2013). While there is not enough research to substantiate a direct correlation between placing individuals on CTOs and a reduction of inpatient admission time, it is worthy of ongoing examination. The second subtheme, improved medication adherence and symptomology, used retrospective data to

examine if medication adherence was improved for individuals on CTOs and thus reduced symptomology. Positive findings were reported by Canvin et al. (2014) and Riley et al. (2018). The third subtheme, increased use of community or outpatient services has received less attention than the prior subthemes. However, Kisely et al. (2013) found improved uptake in community service attendance. This could be presumed to be occurring as the greater number of people who are placed on CTOs should be receiving less acute care and more community based care on an ongoing basis.

The Impact of CTOs Implementation on the Heatlh System. The second theme builds upon the last subtheme, increased uptake of community services, and includes the subthemes of streamlining health care services and staff workload. Streamlining health care services is a result of the expectation of a reduced burden on the acute mental health system from the use of CTOs (O'Donoghue et al., 2016). The need for acute and emergency psychiatric services should be lessened as community-based programming is used to support individuals on CTOs. Longitudinal research will be required to confirm these initial research findings.

The second subtheme, staff workload was based on the phenomenological insights obtained from staff who worked with individuals impacted by CTOs. When focused on recovery, and committed to the collaborative process of CTO administration, Light et al., (2015) found that more education and support were needed for health providers to help them better understand their role and increase their capacity to effectively support patients and their families on CTOs.

Factors that Support Successful Implementation. The final theme illustrated issues that promoted the success of CTOs. It provided guidance on strategies to facilitate patient and system outcomes. Two subthemes were identified: threats to autonomy**,** and education and understanding of rights. Threats to autonomy are perhaps the most controversial aspect of CTOs

due to patients and their families reporting experiences of coercion, feeling lack of control, and ambivalence towards their treatment (Banks, 2016; Canvin et al., 2014; Edan et al., 2018; Jannson & Fridlund, 2016; Light et al., 2017; Stroud et al., 2015). The final subtheme, education and understanding of rights was important as it demonstrated that ongoing education to improve insight was essential during the ongoing delivery of a CTO (Stuen et al., 2018). Further, Banks (2016) found that this education was required for health care providers and their families so that all parties involved in a CTO were privy to the same knowledge and ongoing delivery of information.

Consultations

A consultation plan was created and executed by the evaluator to determine the expectations of the evaluation from the DHSS and health authorities, which include the Northwest Territories Health and Social Services Authority (NTHSSA), Hay River Health and Social Services Authority (HRHSSA), and Tlicho Community Services Agency (TCSA). The consultation process was guided by four goals which included:

1. To examine the vision, and historical and policy context for the introduction of ACTs in the NT in 2018;
2. To determine the expected goals and outcomes for the evaluation;
3. To assist in identification of priority evaluation issues and topics that will need to be addressed in the ACT evaluation; and
4. To determine the strengths and limitations of different data collection methods to identify the most productive approach.

Consultation Overview and Findings

Consultations with key participants from the DHSS, NTHSSA, HRHSSA, and TCSA resulted in four main themes which were used to guide the development of the evaluation plan. These themes included: the vision; the development and implementation of the mental health act; specific considerations for the evaluation; and future collaboration. These themes are briefly summarized below.

The Vision. The updates to the Mental Health Act were politically driven due to a need for more holistic, person centered and recovery focused care in the NT. By utilizing a stepped care approach in which individuals could enter the mental health system wherever it made sense for them, it was hoped that service delivery would be improved. The utilization of ACTs in the NT was intended to allow the client to engage in the least restrictive care possible. This vision, as described by the DHSS is not congruent with the vision of health authorities who were picturing a more traditional CTO model which enabled health care practitioners to order individuals to engage in CTOs and take medications against their will in order to live in the community. This misalignment was important to note so that it could be further examined.

The Development and Implementation of the Mental Health Act. The DHSS's Policy, Legislation, and Communication (PLC) team completed a jurisdictional scan to determine similarities that the ACTs would encompass of the CTOs. Engagement took place throughout the NT in the form of a standing committee which interviewed key stakeholders to determine the seven guiding principles of the Act. The principles included: reduced delays in decision making; respect for the person; consideration of safety; least intrusion treatment approach; consideration of family involvement; respect of the person's wishes; and, respect for privacy (Mental Health Act, 2018). Engagement also took place with health care providers, and the Royal Canadian

Mounted Police (RCMP) in the NT. Communications following the Act coming in to effect included a webpage, handouts, brochures, and a clinical guide. Health authorities received training around the entirety of the new Act, and were responsible for the operationalization of processes.

Specific Considerations for the Evaluation. All consultees wanted to better understand why there had been no implementation of ACTs in the NT. They questioned the source of the problem, particularly if there was a lack of awareness, or underlying issues with the legislation. It was also identified that the type and intensity of education needs be explored to facilitate future implementation.

Future Collaboration. The goals of the evaluation were determined to be best collected using differing methodologies. The need for a variety of data gathering tools was identified as it would provide a more comprehensive evaluation. Open communication, and flexible availability would be noted to be essential for the evaluator – particularly in navigation of invitations throughout formal channels.

The results of the consultation process, which were collected via interviews with pre-determined key stakeholders were used to guide the development of an evaluation plan.

Evaluation Planning

The evaluation plan was created and implemented by the evaluator to gain further insight on the lack of uptake of ACTs as determined through the consultation process. A mixed method design was utilized which allowed for the collection of both qualitative and quantitative data from participants. Participants were selected based on their role in the uptake of ACTs and included: physicians, nurse practitioners, psychiatrists, community mental health nurses, and the inpatient psychiatric team. Quantitative data in the form of a simple survey was disseminated to

physicians and nurse practitioners to gain their perspectives and knowledge of the ACT process. A survey was disseminated to the inpatient psychiatric team of nurses and senior management to gain their sense of ACTs and the barriers as related to implementation. One on one interviews were completed with psychiatrists, community mental health nurses and senior management at the inpatient unit to gather qualitative data as related to their concerns for the ACT process.

Overview of the Evaluation Initiative

The evalution process was successful and yielded valuable data in the identification of the barriers that are currently in place to implementing ACTs in the NT. A total of five interviews were completed with psychiatrists (42% response rate), and five interviews with community mental health nurses (100% response rate). Surveys were distributed to physicians and nurse practitioners which yielded a low response rate of seven health care practitioners (5% response rate), and four inpatient psychiatric staff (40% response rate).

Review of both the quantitative and qualitative data was completed on an ongoing basis to determine any major themes or barriers which were consistent amongst participants. Although the scope of the project was to gain insight as to why ACTs had not yet been utilized, findings also indicated trepidation about the ability for the ACTs to be maintained once utilized and thus recommendations were created that would address both implementation and sustainability concerns.

Main themes derived from the data included: education and training barriers, legislative concerns regarding ACT issuance, cultural considerations, potential ACT continuance concerns, and community resources and connections. These will be briefly summarized.

Education and Training Barriers

Feedback from all participants indicated that the training provided had not been specific to ACTs, and they were unaware or felt unable to reach out for follow up when clinical scenarios presented themselves afterwards. All providers expressed wishes for annual or tailored training that would be based on clinical scenarios and allow for access to a representative for problem solving.

Legislative Concerns Regarding ACT Issuance

There were significant concerns from psychiatry and community mental health nurses that there were potential legal problems in the legislation at this time. There were three sub-themes that outlined the nature of these legal concerns. The first subtheme, involuntary status, outlined health care providers feeling that the need for a patient to be of involuntary status, and the criteria for ACT certificates were contradictory to one another. The second subtheme, requirement for consent, was contested by most health care practitioners as they felt that it defeated the purpose of requirement for an ACT – that the individual is lacking the insight and judgement to voluntarily engage in community treatment – thus they would not sign the community treatment certificate. The last subtheme, the criteria for ACT certifcation was felt by psychiatry to be too vague and thus open to possible legal repurcussions dependent on the interpretation.

Cultural Considerations

The need for recovery oriented and person focused care is driven by the cultural considerations that need to be taken in to account when residing in the NT. Specific questions were answered related to cultural considerations from three self-identifying indigenous community mental health nurses. All participants felt that further consultation and involvement

of culture needed to take place as to not infringe on the movement forward towards reconciliation.

Potential ACT Continuance Concerns

All participants felt that there were several issues which were preventing implementation, due to the concerns for an inability to maintain the treatment once it began. One of these maintenance concerns was the requirement for in-person reassessment. Due to the requirement for individuals to present, in person, every six months, there was concern that this would not be feasible for the health care system given the geographical landscape and reliance on locum physicians. The current understanding by those interviewed and surveyed has also revealed that there is a perception that inpatient beds must be physically blocked in the event that an ACT patient returns to hospital for treatment. This requires clarification and further investigation. Lastly, health care providers were concerned that ACT patients were provided the ability to bypass the admissions process, and thus the opportunity to assess and rule out any medical concerns which may be a factor in their presentation are missed.

Community Resources and Connections

The final theme focused on the lack of communication and collaboration between practitioners and departments that would be involved in the issuance and maintenance of ACTs in the NT. It was identified that a disconnect between the health authorities and Department of Justice was a potential concern due to the siloing of services despite a significant overlap in clients who would be served by ACTs. The second subtheme, ACT teams was brought forward as a desire for implementation so that case management could be thoroughly followed and not provided to or by only one practitioner or discipline – thereby increasing the recovery focused and person oriented lens of care.

Recommendations

The process and evaluation resulted in recommendations for the DHSS. The recommendations were intended as accomplishable goals which could advance the issuance of ACTs in the NT using a collaborative approach between the DHSS and health authorities– thus reducing further delays in implementation. The recommendations are:

1. Develop and implement ongoing educating, consultation and training opportunities for existing, new and locum health care providers to ensure they have the knowledge and skills to effectively manage their role in ACT implementation;
2. Assign a DHSS employee or representative with the responsibility to provide support and oversight in the implementation of the Assisted Community Treatment Program;
    a. Explore the development of a territorial Assisted Community Treatment team to deliver virtual and in person case management for individuals living in the community under an ACT order;
3. Consult legal services regarding select provisions of the ACT and how they are currently interpreted within the health system to: i) clarify the policy intent of the select legislative provisions and ii) determine the need for amendments to the legislation;
    a. The maintenance of the individual's involuntary hospital status while living in the community under mandated community treatment and care;
    b. The requirement for the individual to sign the ACT form prior to their release from hospital;
    c. The effectiveness of the criteria used to determine the suitability of an individual to receive mandated assisted community treatment;

   d. The requirement for an in-person reassessment or readmission at the end of the six-month treatment order to determine their level of health and wellbeing and future treatment plan;
   e. The requirement for the designated facility to keep an inpatient bed vacant while an individual on an ACT is living in the community;
   f. Review of the decision for individuals to bypass the admissions process upon readmission;
4. Establish a territorial ACT implementation working group comprised of key stakeholders to provide support and expertise in actioning the evaluation recommendations and facilitating the use of ACTs;
   a. When operational, engage the Mental Wellness and Addictions Recovery Advisory Group in a collaboration to build cultural safety and humility into the ACT process;
   b. In collaboration with relevant health care providers develop a policy manual and user guide to support health professionals in the implementation of ACTs; and
5. Initiate a collaboration between the DHSS and the Department of Justice to identify ways to better support and treat individuals with serious mental illness who are involved with the legal system.

Advanced Nursing Practice – Competencies

Optimizing health systems is an advanced nursing practice competency. It is defined by the Canadian Nurses Association (2019) that the advanced practicing nurse has the capacity to "contribute to the effective functioning of health systems through advocacy, promoting innovative client care, and facilitating equitable, client centered health care". While completing

this evaluation, I was able to demonstrate achievement of this competency through the process itself, and subsequent recommendations. This evaluation will serve as the next steps in system-level change, aid in strategic planning at a system level, and has identified gaps in legislative socio-political issues that are influencing health policy and standards of practice.

The advanced practicing nurse competency of research has also been exemplified through this project. This competency is defined by the Canadian Nurses Association (2019) as the advanced practicing nurses capability in, “generating, synthesizing, critiquing and applying research evidence”. Through the evaluation of the ACTs I completed a thorough review of literature around CTOs to determine the effectiveness and known barriers in other jurisdictions. This foundation allowed me to work, as an evaluator to create recommendations for the similar process of ACTs, which has provided insights on the current practice at a system level.

The advanced practice nurse exemplifies leadership. This competency is defined by the Canadian Nurses Association (2019) as the advanced practicing nurses’ capacity to be, “leaders in the organizations and communities where they work. They are agents of change, consistently seeking effective new ways to practice, improve care, and promote APN”. This has been demonstrated through the final report in which key findings, barriers and recommendations have been identified. By acting as a leader and spearheading this important service, I am exemplifying this quality to lead true change at an organizational level which will improve care for individuals, families, and communities in the NT.

Conclusion

This project has outlined that the intention of ACTs in the NT, while similar to the intended use of CTOs is more firmly grounded in the principles of the Act, particularly recovery oriented care and person focused services. Significant disconnect has occurred between the

DHSS and health authorities, particularly with issuing practitioners who have concerns around training and the legal repurcussions of the necessary legislation in place to enact ACTs. Ongoing work needs to be enacted that ensures training is provided consistently, cultural considerations are routinely considered, and opportunities are provided for clinical situations to be answered by departmental representatives. With the appropriate supports in place it is likely that ACTs can be provided to clients in the NT. A legal opinion will be necessary to provide reassurance to issuing health care providers as they move forward with issuing ACTs.

This project allowed for the evaluator to outline her capabilities as an advanced practice nurse, particularly as related to the optimization of health care systems, research, and leadership. This project, and subsequent implementation of ACTs in the territory will have far reaching effects that go beyond the individual, to creating change that is grounded in person-centered, recovery oriented practices and serves communities, practitioners, and all other stakeholders with care that is rooted in the guiding principles as intended by the Act.

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Appendix A - Integrative Literature Review

Implementation of Community Treatment Orders in Response to Serious Mental Illness: An Integrative Literature Review

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Abstract

Background: The Northwest Territories (NT) implemented the new Mental Health Act which allows for issue of community treatment orders (CTOs) by the attending medical practitioner; however, there has yet to be uptake of CTOs to date. This review sought to gain an in-depth understanding of the effectiveness of CTOs, how they can be implemented to support success for patients and the health care system, and to lay the groundwork for an evaluation of the reason for non-use of CTOs in the NT.

Methods: An integrative literature review was conducted which allowed for the inclusion of all empirical and theoretical literature to date. Searches were conducted across two databases, thematic analysis was completed, and themes and sub-themes are presented for consideration.

Results: Twenty-three papers were included in the review. Of those included, six were reviews of literature, eight were quantitative research and nine were qualitative research. Quantitative research was primarily retrospective in nature and of medium quality. Qualitative research was also of moderate design and medium quality.

Conclusions: Major themes found included: the clinical effectiveness of CTOs; the impact of CTOs implementation on the health system; and, factors that support successful implementation. While none of the research found in this literature review spoke directly to the barriers as perceived by staff, the factors that support successful implementation, and the impact on the health system provide key insight to what may be lacking in the NT to issue successful CTOs.

Key Words: Community Treatment Orders, Clinical Effectiveness, Integrative Review

Implementation of Community Treatment Orders in Response to Serious Mental Illness: An Integrative Literature Review

The Government of the Northwest Territories (GNWT) released the new *Mental Health Act* (the Act) on September 1, 2018 (2018b). The Act was released to guide the GNWT in the provision of safe, ethical care for vulnerable citizens living with serious mental illnesses while focusing on their rights, safety, and the use of person-centred treatment to promote recovery (GNWT, 2018b). Community treatment orders (CTOs) are a statute within the Act which provides physicians with the capability to issue an order, as agreed upon with the individual, to engage in a mandated set of terms often involving community treatment and medication administration (Corring et al., 2018). By entering in to a CTO with the individual, health care providers are better able to provide care in the community in the least restrictive manner possible, which supports the goals of the Act to provide safe, ethical care to those living with serious mental illnesses.

CTOs were implemented in the United States more than 30 years ago, and have since been implemented in more than 70 countries worldwide (Maughan et al., 2014). Kisely (2016) reported that in Canada, the first CTO was introduced in Saskatchewan in the 1990s and has since been followed by all provinces, except New Brunswick. Since the time of Kisely's systematic literature review (2016), the province of New Brunswick has assented to the implementation of CTOs (Government of New Brunswick, 2017). Most recently, implementation has occurred in the Northwest Territories (NT) in 2018 (GNWT, 2018), leaving only two jurisdictions void of CTOs, Nunavut and Yukon Territory.

When first introduced, CTOs were intended to de-institutionalize patients with severe and persistent mental illness from the psychiatric hospital system (Kisely et al., 2019). Individuals

with severe mental illnesses often become subject to a cyclical pattern of involuntary, or certified hospital admissions which result in restrictive inpatient treatment and subsequent relapses in the community due to the nature of their illness (Rugkasa, 2016). The use of legislation to support individuals to re-enter society and receive mandatory community treatment, has since been widely studied due to concerns around the patient's rights, mixed evidence of treatment effectiveness, and the ethical concern of coercion.

Since the implementation of CTOs in the NT, there has been no orders issued for the community treatment of hospitalized individuals who are certified under the Act. As the Department of Health and Social Services (DHSS) has the mandate to evaluate the Act, it is essential to understand what is preventing the use of CTOs in the NT. As a first step in laying the groundwork for a formal evaluation of the non-use of CTOs, this integrative literature review is designed to examine and clarify the evidence related to effective implementation, impact and use of CTOs. Best practices for CTO implementation and factors which enhance implementation will be highlighted. This evidence / information will be used in the design and data collection phases of the CTO evaluation.

Background

The Act permits physicians to issue a CTO, in collaboration with the care team, and patient, if they meet a set of criteria and are held within hospital involuntarily (Mental Health Act, S.N.W.T, 2018) It must be in the opinion of the physician that the patient is suffering from a severe mental illness, requires supervision in the community, has capacity to engage in a community treatment plan, and has access to appropriate community services to prevent future decompensation (Mental Health Act, S.N.W.T, 2018). The terms of the community treatment plan are decided in consultation with the patient's treatment team, are agreed too by the patient

and/or their substitute decision maker and can include a wide array of requirements (Gowda et al., 2019). Terms that physicians may impose include, but are not limited to: compulsory recall to hospital if terms are violated, requirement to attend clinician appointments, medication adherence, and abstinence from harmful behaviours such as substance abuse (Nagra et al., 2016).

CTOs were implemented with positive intentions to reduce the occurrence of re-admissions for those with severe mental illness by continuing their treatment in the community, with the least possible restrictions (Mfoafo-M'Carthy & Shera, 2013). Since implementation there have been growing concerns about the level of coercion patient's undergo, particularly with the threat of rehospitalisation if they do not comply with legal orders, and reducing their autonomy and right to make informed decisions (Mfoafo-M'Carthy & Williams, 2010). This is only the beginning of the concerns that have been brought forth with CTO implementation. Snow and Austin (2009) presented an excellent overview of the ethical and practical implications of CTOs, such as the conflicting relational ethics that may occur between patients and their health care providers in the administration of treatments or procedures which a patient may not fully understand, feel ambivalent towards, or are nearing the line of coercion.

Unfortunately, the NT does not release data concerning the number of individuals admitted to hospital involuntarily, nor the community of origin. This is most likely due to privacy concerns – with very small community sizes it is quite likely that an individual can be determined from their identifiers if demographic information is released to the public. However, there is still valuable information available from the GNWT (2019b) which provides an indication of mental health hospitalizations by disorder type, as compared to national averages. For patients admitted primarily with schizophrenia or another psychotic disorder, the total length of stay is calculated to be 26.7 days per 1000, compared to the national average of 24.2 days per

1000 (GNWT, 2019b). In addition, schizophrenia and other psychotic disorders have remained in the top five reasons for admission since 2013 (GNWT, 2019b). This is an important consideration as schizophrenia and psychotic disorders are amongst the most common diagnoses for patients placed on a CTO (Silva et al., 2019).

A significant gap exists in our data collection throughout Canada; although we collect statistics related to hospital admissions, discharges, and diagnoses, there is little information regarding the number of CTOs which have been implemented nationally. Orr et al. (2012) completed a review following implementation of CTOs in Alberta, Canada which provides helpful data for the NT due to the close geographic proximity and similarities between Mental Health Acts. Within 18 months of implementation, Alberta saw 238 CTOs issued, demographics were collected on 193 of these (Orr et al., 2012). Of the 193 individuals on CTOs in Alberta, 65% were male, with an average age of 37, 89% were unemployed, 49% had a diagnosis of schizophrenia, and 98% received medication management as part of their CTO.

Given the concerns noted above, it is important to consider if there are any alternatives that could provide service to patients without the ethical confliction of coercion, impacted right to autonomy and self-determination, and potential infringement on patient rights. Assertive outreach teams, which have been implemented in Alberta, consist of clinicians who work to assist individuals in the community to remain independent through the use of recovery focused and psychosocial rehabilitation principles (Alberta Health Services, 2020). Another avenue of consideration is by reducing the economic burden of mental health costs through promotion, prevention, and early intervention strategies to reduce societal costs of care using an upstream approach (Centre for Addiction and Mental Health, 2020). While these approaches would

mitigate some of the psychosocial challenges for patients with severe mental illness, they do not address the intensive case management needed for some of this population.

A commonality that should be considered between CTOs and alternative treatments are the multi-disciplinary nature of health care teams. In the Act it is stated that the attending medical practitioner is responsible for issuing the community treatment certificate to an involuntary patient (Mental Health Act, S.N.W.T, 2018). As discussed by Nagra et al. (2016), when a patient is issued a CTO it can provide access to improved supports through a multi-disciplinary team of health care providers, and a dedicated psychiatrist to oversee treatment. However, in order for community treatment to be effective, it is essential that the health care system have capacity, and have a clear understanding of staff roles as related to CTO issuance, responsibilities, and scope of practice when working in the community (Vine, 2019). At the time of this review there is no ‘gold standard’ or pathway of care for individuals issued a CTO, or CTO programs.

As society continues to more forward, despite mixed evidence, it is essential that we know the most up to date evidence so that CTO implementation can be of the most benefit to both patients and the system, while easing barriers, improving rights, and creating transparency in the health care system.

Methods

An integrative literature review has the capacity to inform nursing practice as it encompasses past empirical and theoretical literature on the chosen subject, yielding valuable conclusions which can guide practice, policy, and research (Whittemore & Knafl, 2005). To guide the review, determination of the problem was required in the form of a research question:

Are CTOs effective, and if so, how? Additionally, what evidence is there regarding the best practices that result in effective implementation, impact and use of CTOs?

Initial search methods included the search terms, “Community treatment order*” AND “evaluation*” OR “implementation*” however this did not provide significant literature for review. After consultation with the librarian from Memorial University’s Health Sciences Library, search terminology was broadened to, “Community treatment order*” in (Ti)tle. Additional parameters included restriction to English language, published within the last 10 years to ensure up to date evidence, and journal articles. The same terms and conditions were used in databases: the Cumulative Index of Nursing and Allied Health Literature (CINAHL), and PsychINFO. CINAHL yielded 149 results, and PsychINFO yielded 172. I completed screening based on applicability through titles and abstracts, as well as cross referencing the databases to ensure no duplications of articles; concluding with a total of 75 articles for further review.

Gray literature was also screened through a Google search using the following term: [“community treatment orders” clinical effectiveness filetype:pdf site:.ca] which yielded valuable literature around the successes of implementation as gathered by other ministerial evaluations.

I next screened each article for relevance to this literature review which yielded a total of 42 articles. Next articles were categorized to indicate if they were primary research or resources. This resulted in the following: seven reviews of literature, 15 editorials or reviews, 11 quantitative studies and nine qualitative studies.

Critical appraisal of literature reviews and quantitative studies was conducted using the Public Health Agency of Canada (PHAC) Critical Appraisal Toolkit (2014) and qualitative studies were appraised using the Qualitative Review Form developed by Letts et al., (2007) from

McMaster University. Following critical appraisal, studies were discarded if they were considered to be weak overall or lack contribution to the aim of this review. Final results included six literature reviews, eight quantitative studies, and nine qualitative studies. These will be thoroughly examined within this paper, and literature summary tables may be found in Appendix A, B, and C. Overall evidence can be considered to be of medium quality and moderate design strength.

Gray literature pertaining to this review will be considered and integrated with the appropriate themes. It is important to note that while there were only two retrieved reports (McLeod, 2012; Orr et al., 2012), they provide valuable inter-jurisdictional insight to the process of CTO implementation and uptake but may be more useful in the creation of an evaluation plan. A visual representation of this methodology can be found in Appendix D.

In deciding of these main themes, and sub-themes, thematic analysis was applied to the entirety of the data collected and reviewed. Consideration of the aims of this literature review were important for categorization due to the large number of studies which focused only on clinical effectiveness.

Results

Three main themes were derived from the evidence that was reviewed to address the review question. These themes were: i) the clinical effectiveness of using CTOs, ii) the impact of CTO implementation on the health system, and iii) factors that support successful implementation. Each main theme has a number of sub themes which will be discussed in relation to the strength of the evidence that supports the theme.

The Clinical Effectiveness of Using CTOs

Clinical effectiveness is determined through the evaluation of a program or an interventions

outcomes, if these outcomes are desirable and are congruent with the hypothesized result it can be considered to be clinically effective in that situation (Nasrallah, 2005). In order to determine ongoing clinical effectiveness, research must be conducted and studies replicated, consistently finding and reporting the same outcomes, resulting in evidence of the effect. Clinical effectiveness of CTOs presents with mixed evidence; sub themes include: reduced length of stay; improved medication adherence and symptomology; and increased community/outpatient services.

Reduced Length of Stay and Admission Rates

Four quantitative investigations reported an increased length of time from discharge until readmission when an individual was discharged on a community order (Awara, 2013; Harris et al., 2019; Kallapiran et al., 2010; Kisely et al., 2013). These findings were supported by two systematic literature reviews (Kisely, 2016; Maughan, 2014) and a meta-analysis of randomized controlled trials (Kisely & Hall, 2014) which acknowledged the trend of reduced admission rates and shorter lengths of stay during readmissions. It is important to note that the quantitative studies, of medium quality and results are all conducted using retrospective designs where patients served as their own controls. For instance, statistical analysis by Awara (2013) looked at an individual's index admission (the admission in which they were discharged on a CTO), the length of this admission, and the date of any subsequent admissions. Review of this data, retrospectively allows trends such as greater length of time within the community and shorter duration of stay during subsequent admissions to be tracked. Significant findings were provided by the mean days admitted to hospital and were calculated pre-CTO (76 days), during CTO (37 days, $p = 0.01$), and post CTO (24 days, $p = 0.01$).

An interesting note is that while both Awara (2013) and Harris et al. (2019) found that

admission rates and lengths of stay were reduced with implementation of CTOs, both used calculations from the time of index admission. Kalliparan (2010) chose to remove the variable of index admission and instead view the patients over the entirety of their admission history. Upon removing the index admission variable, there were found to be no significant differences in the rates of admission or length of stay for patients when placed on a CTO; however, the small sample size and lack of clarity for this decision reduce the strength of this observation. It could be possible that the decision to remove index admission was due to the fact that a patient would, most likely, be at their greatest level of being unwell during that time resulting in a longer index admission, and thus skewing results in favour of any subsequent admissions. As the mean measurement is more likely to be sensitive to outliers (such as an extremely long admission), there is the possibility that this approach could result in unbelievable results and skewed data (Kellar & Kelvin, 2013).

It is impossible to say with surety that placing individuals on a CTO reduces their admission rates and length of stay; however, there does seem to be enough correlation and evidence that it is worthy of future research, and consideration upon implementation of CTOs in the NT. Of particular interest, Kisely & Hall (2014) noted that the risk ratio (CI:95%) of patient's admission days while on CTOs, to those in a control group of outpatient community mental health patients, not on CTOs was found to be 380:369 respectively ($p = 0.81$) indicating no statistical difference between the groups – this conflicts with our previous evidence. In review of Kisely & Hall's (2014) meta-analysis it is unclear what the history of the included outpatient community mental health patients consist of, and how comparable the two populations truly are. Two literature reviews also positively support findings that CTOs impact re-admission and length of stay; Kisely (2016) and Maughan (2014) found that there was increased time spent in

the community until re-admission (n = 13 studies) and reduced admission length of stay overall (n = 7 studies).

Improved Medication Adherence and Symptomology.

Four original, quantitative research studies examined symptom reduction through either regular outpatient contact and treatment, or adherence to medications (Canvin et al., 2014; Ingram et al., 2009; Riley et al., 2018). In 2009, Ingram et al. examined retrospective data in a mirror image study to determine if there were any reductions in variables of interest between individuals treated with oral antipsychotic medication to those treated with depot antipsychotic medication. Ingram et al. (2009) found that medication adherence resulted in reduced violence and homelessness for both groups of individuals on CTOs regardless of medication type. The age of Ingram et al. (2009) study, as well as doubts around the validity of their instrument – which was not tested, are concerning. Although not research, Isobel and Clenaghan (2016) completed a cross-sectional audit of a comparable population and variables, with an assumedly validated instrument, which confirms the reduced history of aggression for those placed on CTOs.

Qualitative findings also provided support that CTOs may reduce symptomology and improve medication adherence. Both Canvin et al. (2014) and Riley et al. (2018) reported that, when an individual was placed on a community order, medication adherence was emphasized and the client was often successful in improving adherence. CTO concerns were also highlighted; it was noted that some individuals were ambivalent about having to attend clinical appointments (Canvin et al., 2014). The lack of a recovery-oriented model of care in the community was also identified as limiting the positive impact of CTOs and medication adherance (Edan et al., 2018; Riley et al., 2018).

For care teams to move forward with successfully issuing CTOs in the NT, they will require careful consideration of balancing recovery oriented practice and least restrictive treatment, to gain the potential benefits of CTOs for the health system and patients while building trusting relationships without coercion or threatening patients with readmission to psychiatric facilities (Corring et al., 2018).

Increased/improved Outpatient Services

Although it has received less original research than medication adherence and symptomology, increased outpatient services is worthy of discussion due to the importance and initial intention of CTOs. Kisely et al. (2013) found through their controlled-before after study that the standard multiple regression analysis found statistical significance in the year prior to CTO implementation for individuals with their outpatient provider (B = -4.74, $p = <0.001$) and the year following CTO implementation (B = 3.34, $p = <0.001$) revealing the significant uptake in outpatient service and/or attendance to appointments. O'Donoghue et al. (2016) examined the incidence of CTOs issued in a mental health system that implemented a reform to a more recovery based service however; their findings actually indicate that despite adopting this lens of care they had increased rates of CTOs in the subsequent year. These results should be interpreted with caution due to a weak study design, and a system which had only been reconfigured within the last year, it is also important to consider that an increase in CTOs issued may not reflect reduced quality in service, if the CTOs were implemented in consultation with the patient and with the long term vision of improved quality of care and stabilization an increase in CTOs may be a positive sign of change.

For CTOs to be issued in the NT, it will be essential that the focus is on therapeutic usage of outpatient services. Evaluation of the mental health services available in the NT will yield

valuable information as to how, and if, patients on CTOs can be adequately supported to achieve their goals.

A summary of the clinical effectiveness of CTOs. While we cannot say with confidence that placing patients on CTOs has direct effect of reduced admissions and lengths of stay, medication adherence, or improved outpatient service delivery; we can say that the primarily retrospective cohort studies presented are believable due to the accuracy of information presented, and are worthy of more consideration. To strengthen surety and research it would be helpful to conduct studies of greater design strength and quality as the research here is primarily of medium quality. It is well known that RCT would improve research in this area, but the ethical balance of withholding patient treatment create an impossible scenario to study.

The Impact of CTOs Implementation on the Health System

CTO implementation shifts the service delivery model in health care from an acute care, hospital based treatment program to more intensive community treatment program. In order to evaluate the non-use of CTOs in the NT is is necessary to have an understanding of how CTOs can be best supported both in hospital and in community to ensure resources are sufficient for implementation. When CTOs work effectively, they are shown to reduce the rate and duration of admissions to hospital (Awara et al., 2013), which should, in time, reduce acute care service burden and improve or facilitate the establishment of community based supports. Reduced system burden upon implementation of CTO is broken down in to the following sub-themes: streamlining of health care services; and staff workload.

Streamlining of Health Care Services

The success of CTOs will be largely dependent on the capacity of the health care system to support their uptake. It needs to be considered that initially there may be more burden placed

on the health system (O'Donoghue et al., 2016) however, if implemented effectively, in time there should be reduced need for acute and emergency care services, and thus reduced expenditures (Kisely et al., 2013). Both O'Donoghue et al. (2016) and Kisely et al. (2013) utilized retrospective data to examine descriptive statistics and utilization of health services. O'Donoghue et al. (2016) examined CTO usage pre and post the redevelopment of a community mental health program that adopted a recovery focused model of care. When the rate of CTO usage was examined pre and post-program redevelopment, a significance difference was found. The pre-development rate was 100.8 CTOs per 100,000 population while the post-development rate was 111.1 CTOs per 100,000 ($p=0.04$). This suggests a positive trend away from acute care services.

Kisely et al. (2013) provided a strong analysis of their results, adjustment for the possible differences between groups, and significant attention was given to matching of the controls, increasing accuracy of results. Standard multiple regression models were used to examine a multitude of factors which may have changed the results; however, they consistently found insignificant changes to their outcomes, of increased service use in the community and reduced admission length for their group of CTO cases (n = 2958) – this shows that further longitudinal studies are required to determine the believability of this theme (Kisely et al., 2013).

Further research is required to determine timelines of system burden. The possibility of initial uptake creating more administrative burden for physicians and care teams will need to be measured and evaluated following uptake of CTOs in the NT.

Staff Workload

Three qualitative studies examined the perceptions and experiences of health care workers who provide care for individuals placed on a CTO; (Edan et al., 2019; Jannson &

Fridlund, 2016; Light et al., 2015) providing valuable phenomenological insight to practitioner experiences. Edan et al. (2019) utilized appropriate purposive sampling to discuss recovery oriented practice and CTO usage. Jannson and Fridlund (2016) utilized an exploratory design to identify psychiatric staffs' perceptions of the creation of therapeutic alliances with patients who would be discharged from certification to a CTO. Both Edan et al. (2019), and Jannson and Fridlund (2016) found overlapping themes in their interviews, particularly pertaining to the commitment and investment by staff that was required for ongoing care.

CTOs, when implemented with success, should focus on recovery (Edan et al., 2019). There is also the benefit of having a multidisciplinary team that could result in greater distribution of workload and thus, reduced workload for care providers (Wood et al., 2015). Edan et al. (2019) noted that staff wished to work from a recovery-oriented practice framework but the lack of organizational support was a barrier. This was further supported by Jannson & Fridlund (2016) who interviewed psychiatric nurses, finding that while in support of CTOs, staff struggled to find the line between coercion and motivation when working with clients at the inpatient level.

A committed, recovery focused team who work in collaboration with the patient through admission, discharge, and community treatment is necessary for success. In some jurisdictions general practitioners (GPs) can be the primary caregiver, but in many places this role primarily belongs to the psychiatrist (Light et al., 2015). In order to create a multidisciplinary team, which occurs along the spectrum of care, and utilizes a recovery oriented lens it would be necessary to look at the many roles different health care providers can play such as the study completed of GP roles by Light et al. (2015). Light et al.'s (2015) study provided valuable insight in to the necessity for more research through their qualitative findings, which indicate that there is

significant confusion around health care providers' roles in CTOs. Further study is required to fully understand how CTO uptake and multidisciplinary teams could enhance system efficiency and improve workload of staff. Reduced administrative burdens (Corring et al., 2018), reducing case loads, and a lack of community resources (Dawson, 2016) also contribute to current problems with workload. This is important to consider for the NT due to the heavy reliance on locums, high turnover rates of staff, and significant vacancies in health care positions; in fact, the GNWT has committed in the 19th legislative assembly to increasing the health care labor force by 20% by the spring of 2021 (GNWT, 2019a). Improving work loads for health care providers should correlate with improved retention and reduced vacancies – CTOs being issued could impact this significantly.

A summary of the impact of CTOs implementation on the health care system.

Applicable research leaves doubts to the potential for streamlining of services and reducing the workload of staff. While this is desirable it needs to be further studied with, at minimum, moderately designed studies that can provide measurable outcomes of CTO issuance as related to system reorganization and/or health care teams.

Factors that Support Successful Implementation

The most ethical and controversial aspect of CTOs and Mental Health Legislation has to do with the rights of individuals. Weller et al. (2019) discuss the many ethical issues surrounding the administration of CTOs, from patients feeling coerced to enter a CTO, to a lack of understanding of their rights and treatment, to losing their voice and ability to self-advocate during treatment. Understanding the experiences of patients on a CTO brings awareness to potential educational needs and concerns that may be related to the non-use in the NT at this

time. Sub-themes found in the data include: threats to autonomy; and education and understanding of rights.

Threats to Autonomy

Six phenomenological, qualitative studies explored the experiences of individuals and families when an individual family member was placed on an CTO (Banks, 2016; Canvin et al., 2014; Edan et al., 2018; Jannson & Fridlund, 2016; Light et al., 2017; Stroud et al., 2015). Common findings revealed that coercion, lack of control, and ambivalence are experienced by patients or their families. The rationale for grouping these together was due to the removal of rights for the patient during the time of their treatment.

Banks (2016), Canvin et al. (2014), and Edan et al. (2018) found that patients felt they were lacking control over their lives, and that their wishes were not considered, to the extent where they felt that they experienced the same level of rights as when held involuntary. Many patients expressed ambivalence and voiced a reluctant acceptance that CTOs are a better alternative than involuntary hospitalization (Stroud et al., 2015).

Coercion concerns both patients and staff; for instance, patients felt that the conditions placed on them by the CTO were a requirement to avoid re-admission (Canvin et al., 2014), leading to feeling a lack of control and distrust in the health care system (Light et al., 2017). Clinicians also expressed concerns around coercion, particularly clinicians who worked to maintain rapport and build trusting, recovery oriented treatment with their patients. The genuineness of the relationship was often threatened when a patient is placed on a CTO (Canvin et al., 2014; Edan et al., 2018; Jansson & Fridlund, 2016). These findings identify common experiences among family, patients, and health care providers that provide insight and

understanding about some of the difficulties that result when CTOs are used. It may prove to be an important consideration in the lack of uptake of CTOs in the NT.

Education and Understanding of Rights

Typically, we consider informed consent to be indicative of full understanding and voluntary acceptance of treatment by the patient (Lally, 2013). When an individual is placed on a CTO, they are effectively bound by law to engage in treatment, which brings up the ethical debate of education and understanding of rights. Insight is not a black or white concept, rather it exists on a spectrum of understanding; however, a lack of insight is a characteristic of many severe mental health disorders and is shown to improve as an individual recovers (Lally, 2013).

For this reason, the importance of medication and treatment education cannot be downplayed or considered a onetime event; rather, ongoing education is required during the CTO if we hope to see improved insight and a successful patient-client relationship (Stuen et al., 2018). According to Banks (2016) the lack of education goes beyond just what is provided to the patient and their family, but also extends to health care professionals. Bank's (2016) phenomenological study found a thematic indicator of a lack of understanding of how CTOs should be utilized, which also reduced clinician's understanding of patient rights. Banks (2016) and Stroud et al. (2015) both used qualitative, exploratory designs to interview subjects and gain a greater understanding of the education provided to patients, and the perception of their rights when issued a CTO. As with the previous sub-theme, gathering experiences from a wide range of participants improves the believability of these sub-themes, that they have the potential to be a significant barrier for uptake, and need future study and consideration.

Summary of the factors that support successful implementation. Qualitative research, overall of moderate design and medium strength, provides believable evidence that there remains

significant confusion around CTO terms and rights for both patients and their health care providers. The information collected, thematically, from qualitative research is convincing, particularly related to patients ambivalence, and staffs' concerns around coercion.

Discussion

Research, quantitatively and qualitatively, provides mixed results about CTO implementation, and clinical effectiveness for both patients and health care systems. It is evident from the above that more research is needed, with larger sample sizes, and measurable variables – such as randomized control trials – in order to begin to make real conclusions of CTOs use. What we can say, is that qualitative research shows us that there is potential for growth with CTO implementation as long as the patient's needs and a recovery oriented lens are applied to care. We can also see, from quantitative data, that the socio-demographic and clinical characteristics of patients is comparable internationally; Silva et al. (2019), provided an excellent overview of incidence and prevalence in Switzerland, and their results of demographic characteristics are very similar to what other studies reveal. The majority of CTO patients are male, in their mid-40s, single, diagnosed with a psychotic disorder, and are considered to be a danger to themselves or society (Silva et al., 2019).

The main themes found in this literature review, which are supported by other reviews of literature, are indicative that there is a significant amount of trial and error in CTO implementation. Unfortunately, this means that implementation comes with risks to patients and professionals, determining how to mitigate these risks while maximizing the benefits for all parties will be an essential component as an evaluation plan for the NT is created.

It is also clear from the research that CTO implementation is not only issued by psychiatrists, rather it is a multidisciplinary, team based treatment. Consultation with key

stakeholders will need to include all potential disciplines which could be involved in the care of a patient when they are placed on a CTO if we are to truly understand why uptake hasn't yet occurred in the NT. Light et al. (2015) focused their study on findings related to the GP role for patients on CTOs, future research focused on other disciplines such as nursing, occupational therapy, and social work could provide us with valuable data about the many perspectives a team based approach could provide to our patients.

Conclusion

At this time the NT is faced with a unique opportunity. By understanding the evidence, even if it is mixed, we are able to complete an evaluation and make recommendations so that we can set the groundwork for CTOs that maximize the positive findings as outlined in this review. By maximizing these findings we should be able to set a foundation for CTO implementation which is evidence informed, and creates the most benefit for both patients and the health system.

Vine and Judd (2019) report that CTO usage is decreasing in Australia, despite greater legislation allowing for implementation, the concern being that uptake is not occurring due to a lack of services that are required for CTOs to be successful (Vine & Judd, 2019). The NT is faced with many challenges, geographical, transient populations, and reduced service access to name a few. Knowing this in advance will allow for brainstorming and further research to be conducted on how CTO implementation can be supported as a territory while moving forward in a recovery oriented, person centred model.

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Appendix A - Literature Summary Table – Quantitative Studies

Study/Design	Methods	Key Results	Comments
Authors: Awara, 2013 Design: Retrospective cohort	N: 34 participants, all of which were on a CTO Country/setting: England, United Kingdom Participants: served as their own control. The below reflect the majority of characteristics • Male gender (68%) • Age: 45 (SD: 11.9) • Single: (68%) • Unemployed (100%) • Schizophrenia (71%) Data collection: determine the mean length of stay (LOS) and admission rates (Adm) for participants **pre-CTO**, **during CTO,** and **post-CTO** over a period of 12 months. Analyzed with SPSS14 using chi-square, *t*-test, and regression analysis. Outcomes: Identification of length of stay and admission rates during and post-CTO.	**Pre-CTO** Group 1: Mean LOS: 76 Mean Adm: 1.3 **During CTO** Group 1: Mean LOS: 37, *p=0.01* Mean Adm: 0.47, *p=0.001* **Post-CTO** Group 1: Mean LOS: 24, *p=0.01* Mean Adm: 0.30, *p=0.001*	Strength of Design: **Moderate** Quality: **Medium** Issues: • No information provided for ethical conduct. • Small sample size.

Study/Design	Methods	Key Results	Comments
Authors: Harris et al., 2019 Design: Matched Case-control	N: 5548 participants between 2004 and 2009. Country/setting: New South Wales (NSW), Australia Group 1: participant data was extracted from the Mental Health Review Tribunal (MHRT) of NSW. Group 2: "Control" group was based on variables believed to be confounders. Data collection: Odds ratio completed of CTO vs. non-CTO to determine treatment effect. Outcomes: Reduced admissions and length of stay, increased time in community, increased treatment in community	**Hospital Readmission (CI:95%)** Group 1 = 30% Group 2 = 32.1% OR: 0.90 *P=<0.005* **Days to readmission** Group 1 = (mean) 164.8 Group 2 = (mean) 109.4 OR: 1.47 *P = <0.0005* **Number of admissions** Group 1 = (mean) 0.5 Group 2 = (mean) 0.7 OR: 0.90 *P = <0.005* **Community Treatment Days** Group 1 = (mean) 3.9 Group 2 = (mean) 2.5 OR: 0.98 *P = <0.0005*	Strength of Design: **Moderate - Strong** Quality: **Medium - High** Issues: • Increased risk of bias due to matched case-control design = variables *believed* to be a confounder by the authors.

Study/Design	Methods	Key Results	Comments
Authors: Ingram et al., 2009 Design: Naturalistic retrospective mirror image study (cohort study)	N: 94 participants met inclusion criteria (on CTO and diagnosis of schizophrenia) Country/setting: Melbourne, Australia Group 1: Participant treated with oral antipsychotic medication (n=31) Group 2: Patient treated with depot antipsychotic medication (n=63) Data Collection: retrospective medical record review. Classification based on variables of interest and included: • Aggression, suicidality, and homelessness pre and during CTO • Family contact pre and during CTO • Employment status pre and during CTO Outcomes: indicated reduced violence and homelessness. No statistically significant indication of reduced suicidality, or	**Aggression, Suicidality, and Homelessness** Group 1: Mean aggressive events: • Pre-CTO = 1.23 • During-CTO = 0.65 • *P = 0.031* Mean SI: • Pre-CTO = 0.19 • During CTO = 0.006 • *P = 0.157* Homelessness: • Pre-CTO = 0.13 • During CTO = 0.003 • *P = 0.083* Group 2: Mean aggressive events: • Pre-CTO = 0.86 • During-CTO = 0.43 • *P = 0.007* Mean SI: • Pre-CTO = 0.29 • During CTO = 0.21 • *P = 0.687* Homelessness: • Pre-CTO = 0.14 • During CTO = 0.008 • *P = 0.157*	Strength of Design: **Moderate** Quality: **High - Medium** Issues: • A data collection instrument was created for the study – no mention of testing for validity. • No information provided on ethical approval although may not be required due to surveillance data primarily used

Study/Design	Methods	Key Results	Comments

	improved family contact.	**Family Contact (living with)**
		Group 1:
		• Living with family
		  o Pre-CTO = 16
		  o During CTO = 16
		• *P = 0.313*
		Group 2:
		• Living with family
		  o Pre-CTO = 34
		  o During CTO = 35
		• *P = 0.281*
		
		Employment Status (full time)
		Group 1:
		• Full time
		  o Pre-CTO = 3
		  o During CTO = 2
		• *P=0.594*
		Group 2:
		• Full time
		  o Pre-CTO = 7
		  o During CTO = 3
		• *P=0.073*	

Authors: Kallapiran et al., 2010 Design: retrospective cohort	N: 28 participants included, 26 analyzed. Country/setting: NSW, Australia Participants: 26 participants under CTO at the time. A: including	**Number of Admissions Per year (pre CTO: During CTO)** Group 1A: 2.54:1.14, *p = 0.01* Group 1B: 1.54:1.14, *p = 0.123* **Length of Stay** Group 1A: 41.58:20.23, *p = 0.01*	Strength of Design: **Moderate** Quality: **Medium** Issues:

Study/Design	Methods	Key Results	Comments
	index year of admission. B: removing index year of admission Data collection: Standard descriptive analysis of demographic and inpatient data. rANOVA Outcomes: When considering the LOS and number of admissions with the index admission, there were statically significant differences in the post-CTO data. Removing the index admission created non-statistically significant outcomes.	Group 1B: 20.00:20.23, *p = 0.98*	• Small sample size reduces the generalizability • Decision to remove index admission date is not thoroughly explained. Yes it causes drastic changes, but clinically the difference from index is more significant than without – drawing doubts to the validity of the study
Authors: Kisely et al., 2013 Design: CBA	N: 2958 controls, 2958 CTO cases Country/setting: Western Australia, Australia Group 1: 2958 Control – not on CTO, matched based on age, discharge date, diagnosis and sex.	**Length of Stay (regression coefficient)** • B = -5.23, *P = <0.001* **Contact in year prior to CTO** • B = -4.74, *p = <0.001* **Contact in year post CTO** • B= 3.34, *p = <0.001*	Strength of Design: **Moderate** Quality: **Medium - High** Issues: • Although a CBA, medium overall design given due to

Study/Design	Methods	Key Results	Comments
	Group 2: 2958 participants on CTOs. Data collection: Descriptive Stats = odds ratio and t-test Characteristics and service use = standard multiple regression models. Outcomes: LOS = less for those on CTOs Increase in Contact with Outpatient Services	Patients increased their contact with outpatient services in the year post CTO and admission lengths were shortened.	non-randomization of control group (manual selection of comparisons) • No mention of ethics (not required as an evaluation) • No mention of data collection methods, training, or control of potential biases • High rating due to excellent data collection and analysis with controlled group
Authors: O'Donoghue et al., 2016 Design: Ecological Study	N: data examined as 'groups', see below. Country/setting: Australia Group 1: Rate of CTOs prior to system reconfiguration Group 2: Rate of CTOs post reconfiguration of system (recovery oriented model) Data collection: Looked at rates per 100,000 within 4 health service areas to determine change	**Rate Ratio of CTOs** Total: 1.10 *P = <0.04* **Rate Ratio of CTO Variations** Total: 0.83 *P = 0.07*	Strength of Design: **Weak** Quality: **Medium** Issues: • Cannot correlate change in service delivery to increased CTO implementation due to short time since implementation (<1 year). • Increase in rates is surprising = requires further follow up and study.

Study/Design	Methods	Key Results	Comments
	in rates. Rate Ratio used appropriately to determine measure of association. Outcomes: findings indicated an increase usage of CTO implementation and variation of orders. See totals under key results.		• Group data = potential for ecological bias
Authors: Silva et al., 2019 Design: Retrospective epidemiological study	N: 241 participants who were placed on a CTO between 2013 (implementation) and 2017 Country/setting: Vaud, Switzerland Group 1: 241 participants placed on CTOs between 2013 and 2017. (Retrospective study). Data collection: Incidence and Prevalence: cases per 100,000 Socio-demographic, clinical characteristics and CTO characteristics: descriptive analyses	**Incidence and Prevalence** • 4.8-9.6 per 100,000 **Sociodemographic & Clinical Characteristics** • Mean age: 48.8 • Sex, % = Male, 54.8 • Single = 47.9% • Independent Housing = 72% • Involuntary admission = 67.9% • Main dx = schizophrenia = 41.8% • Danger to selves = 45.2% **CTO Characteristics** • CTO requested by forensic psychiatrist = 31.5%	Strength of Design: **Weak** Quality: **High** Issues: • Weak study design but information was accurate and data analysis statistically sound

Study/Design	Methods	Key Results	Comments
	Time to discharge: Cox's proportional hazard regression models <u>Outcomes:</u> See instructions under "Data collection" above.	• CTO ordered by guardianship = 93.4% • Legal criteria = 59.3% • Medication = 51.7% • Appointments = 86.3% • Home visits = 52.9% • Person in charge = psychiatrist = 83% • Discharge reason = success = 43% **Time to Discharge** Significant factors • Living in hospital (B = 3.544, *p = <0.001* • Non-medical professional in charge of CTO (B = 3.506, *p = <0.001).*	

Appendix B – Literature Summary Table – Literature Reviews

Study/Design	Methods	Key Results	Comments
Authors: Corring et al., 2018 Design: Systematic Review	N: 14 articles, >700 clinicians Country/setting: International Inclusion Criteria: qualitative methodology which examined clinician perspectives. Databases: gray literature, PsychINFO, MEDLINE, EMBASE, and CINAHL. Outcomes: See instructions under "Data collection" above.	Main Themes **There are benefits of CTOs** • Clinicians found they could provide recovery oriented practice while maintaining required treatment **Medication Compliance** • Medication non-compliance is noted to be a major factor in hospital readmission, and thus is necessary for CTO implementation. **Improvements** • CTOs could be improved by reducing cumbersome administrative work for physicians. • Improved community and multi-disciplinary support to address social needs.	Strength of Design: **Moderate** Quality: **Medium**
Authors: Dawson, 2016 Design: Integrative	N: 48 papers Country/setting: International Inclusion Criteria: publication year	**Case Findings** • Reason for CTO usage • Suitability of client **Assessments** • Care planning (lacking)	Strength of Design: **Moderate** Quality: **Medium**

Study/Design	Methods	Key Results	Comments
Literature Review	>2000, topic was related to CTO mental health practice or legislation Databases: CINAHL, pubmed, medline, Scopus, PsychINFO, and ProQuest, Outcomes: Mixed results. Main issues were classified by themes: case findings, assessment and care planning, care-coordination, and case closure. See key results for themes and sub-themes. Case management specifically is noted to require improvements for workers.	• CTO goals (medication compliance) **Care coordination (team approach)** • Coercion (lack of comfort by workers) • Negative relationships • Mixed relationships • Support frequency **Case Closure/Discharge** • Discharge criteria is unclear • Discharge difficult to achieve Case management: multiple challenges including large case loads, lack of resources, lack of linkages to alternative professionals	Issues: • Majority of papers were qualitative in nature. • Quantitative research included but in depth analysis not provided to reader. • Detail lacking for data synthesis. Only 1 author. • Themes were poorly organized and difficult to follow, although detail rich.
Authors: Kisely & Hall, 2014 Design: Meta-analysis of RCTs	N: 749 subjects (3 studies) Country/setting: International. Inclusion Criteria: Must be RCT. Databases: Cochrane Schizophrenia Group Register, Science Citation Index, PubMed, MEDLINE, and Embase Outcomes: No differences found for use of CTO vs. voluntary	**Change in Bed Days (Readmissions)** • Total treatment days o CTO = 380 o Control = 369 o RR = 0.98 *P = 0.81* **Psychiatric Symptoms** • N = 331 • SMD = -0.03 • CI = 95% (-0.25 – 0.19)	Strength of Design: **Strong** Quality: **Medium** Issues: • Quality of the RCTs was not optimal. Less than 4 studies included. • Small number of studies is a limitation for generalizability • Reported potential bias (unequal inclusion criteria in

Study/Design	Methods	Key Results	Comments
	admissions/outpatient treatment. See key results for more information. Risk ratios completed (see key results). Totals provided in key results (CI: 95%).	**GAF** • N = 335 • MD = -1.36 • CI = 95% (-4.07 – 1.35) No significant differences for either.	RCTs) • Unclear if one or both authors assessed articles for inclusion.
Authors: Kisely, 2016 Design: Systematic Literature Review	N: 9 studies included for review. Country/setting: Canada Inclusion criteria: Quantitative and qualitative studies conducted in Canada which provided data on CTO effectiveness. Databases: PUBMED & MEDLINE Outcomes: outcomes were mixed, see key results.	**Reduced Admission or Readmission Time** N = 4 studies **Increased Services (Community)** N = 3 studies **Patients Ambivalent** N = 2 studies **Health Care Providers/ Family Positive or Satisifed** N = 3	Strength of Design: **Moderate** Quality: **Medium** Issues: • No mention of gray literature. • Only searched two databases.
Authors: Maughan, 2014 Design: Systematic Review	N: 18 articles included for review. Participants on CTO total = 14,757. Country/setting: International Inclusion criteria: Quantitative, experimental, or epidemiological studies published between 2006 and 2013,	**Increased Admission Rate** N = 3 **Reduced Admission Rate** N=9 **Increased Admission Length** N=3 **Reduced Admission Length** N=7 **Increased Community Services**	Strength of Design: **Moderate** Quality: **Medium** Issues: • Only one author assessed studies that met the inclusion criteria. • No articles excluded even in weak

Study/Design	Methods	Key Results	Comments
	Databases: PsychINFO, Medline, EMBASE. Outcomes: outcomes were mixed, see key results for grouped themes.	**Use** N=3 **Reduced Community Services Use** N=2 **Improved Medication Adherence (MPR)** N=3 **Reduced Medication Adherence** N=1	design or quality. • Report that results continue to be conflicting; however do not account for the significantly reduced admission rate and length found in studies.

Appendix C – Literature Summary Tables – Qualitative Studies

Study/Design	Methods	Key Results	Comments
Authors: Banks, 2016 Design: Qualitative	N: study 1: 72 (response rate = 18.4%), study 2: 30 (response rate = 22.7%). Country/setting: United Kingdom Data collection and Sampling: Semi structured interview guides with service users, clinicians, mental health practitioners, and relatives. Purposive sampling. Data Analysis: Digitally recorded interviews, transcribed, thematic analysis (inductive approach). Outcomes: Categorized by main themes. (see key results)	**Involvement, Control, Choice** • Feeling lack of control • CTO Preferred to hospitalization • System/service utilization pressures (bed demands) • Increased community support **Information and Rights** • Lack of understanding about service user rights • Differences in clinician understandings of CTO utilization • Need for greater support	Strength of Design: **Moderate** Quality: **Medium - High** Issues: • low response rates • detail was lacking on thematic analysis and how coding occurred.
Authors: Canvin et al., 2014 Design: Phenomenological	N: patients (26), psychiatrists (25), family carers (24) (total = 75) Country/setting: United Kingdom Data collection and Sampling:	**CTO Conditions** • Psychiatrists = need measurable conditions. • Patients = 'requirements' for what they had to do, no differentiation between mandatory or discretionary conditions.	Strength of Design: **Moderate** Quality: **Medium - High** Issues: • Given the multidisciplinary

Study/Design	Methods	Key Results	Comments
	Purposive sampling, in depth interviews. (conducted by 3 authors). Digitally recorded, transcribed, and checked for accuracy. Data Analysis: Constant comparative methods. Inductive-Deductive style. Outcomes: 4 main themes. See key results.	• Family = legal authority that they could lean on, mixed understanding of conditions. **Recall** • Psychiatrists = considered to be what gives CTO their power. Concerns about coercion. • Patients = = Felt there was little difference to involuntary detainment. • Family = reduced anxiety for caregivers. Earlier intervention opportunity. **Legal Clout** • All felt the power of law was what gave the CTO it's 'teeth'. **Effectiveness** • All groups desired medication adherence.	nature of CTOs, looking beyond psychiatrists could yield helpful data
Authors: Edan et al., 2018 Design: Qualitative	N: 6 participants on CTO, 3 staff interviewed Country/setting: Australia Data collection and Sampling: Interviews which were recorded, transcribed and provided to the participants for review. Data Analysis:	**Patients** • Lacking choice and control • Emphasis on medication • The threat of hospitalization • Absence of recovery oriented practice • Staying supported **Staff** • Recovery oriented practice while engaging in CTO	Strength of Design: **Moderate** Quality: **Medium** Issues: • Small sample size • Intervention (Recovery oriented practice) has not been in place for a significant period of time.

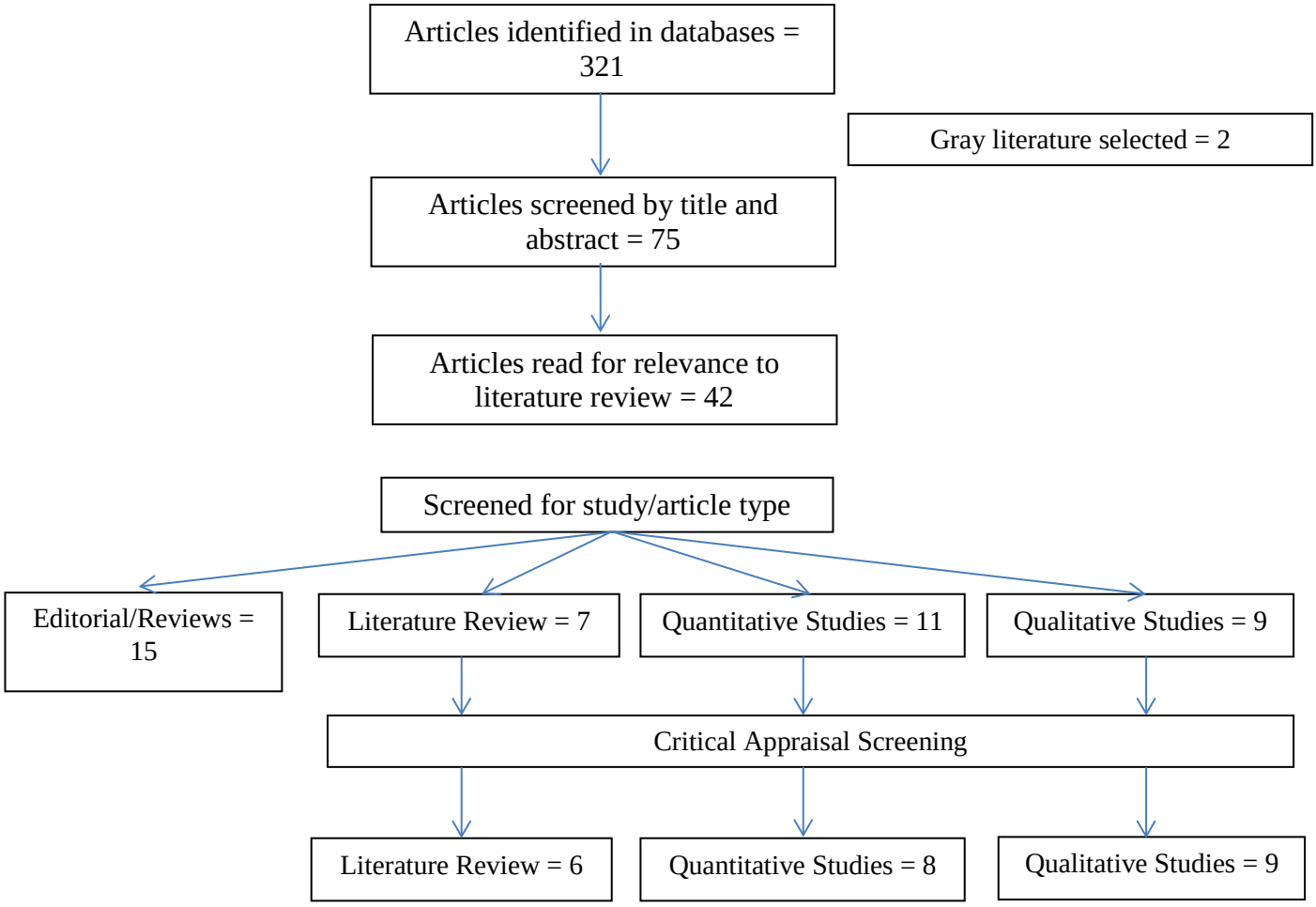
Study/Design	Methods	Key Results	Comments
	Analyzed by 2 authors, coded with thematic analysis. Outcomes: Categorized by themes as expressed by patients and staff. See key results	management is difficult • CTOs help mitigate risk • There is a lack of focus on recovery oriented practice • There is a lack of 'buy in' at the organizational level	• Five female patients and 2 female staff – unusual sample given the greater likelihood of males on CTO. Although brings a gender heavy perspective which could add to literature if repeated.
Authors: Jansson & Fridlund, 2016 Design: Exploratory phenomenographic method	N: 13 psychiatric staff (ranging from 6 years of experience to 39). Country/setting: Sweden Data collection and Sampling: semi structured, recorded interviews. Data Analysis: Five point process. 1) authors both read interview. 2) identified staff experiences 3) perceptions compared and categorized 4) created a frame of descriptions 5) created four metaphors Outcomes: Categorized by main themes which are presented as metaphors. Patients on CTO are often more challenging for staff.	**The persevering psychiatric staff** • To show commitment to the patient despite adversity or behaviours. **The Learning Psychiatric Staff** • Gaining understanding of the patient. **The Participating Psychiatric Staff** • Helping 'outside the box' and placing emphasis on the patient's external structure **The Motivating Psychiatric Staff** • Motivational conversations.	Strength of Design: **Moderate** Quality: **High** Issues: • Interview guides were created by both articles but conducted by only one (questions provided). Not weakened overall due to extensive reporting of their data analysis process.

Study/Design	Methods	Key Results	Comments
Authors: Light et al., 2015 Design: Qualitative	N: 38 participants: four groups: patients, caregivers, community mental health clinicians, and review board members. Country/setting: Australia Data collection and Sampling: Purposive sampling. Semi-structured interviews. Data Analysis: Recorded, transcribed and coded for anonymity. Analysis used grounded theory and inductive methods. Outcomes: Categorized by main themes. (see key results)	**General Practitioner** • 16 interviews identified theme of GP involvement including: o Instrumental role of GP o Primary caregiver = GP o GP as an outsider o Practical challenges for the GP	Strength of Design: **Moderate** Quality: **Medium** Issues: 38 participants yet the main theme was only identified within 16. Concerns re credibility of data.
Authors: Light et al., 2017 Design: Qualitative	N: 38 participants (patients = 5, caregivers = 6, clinicians = 15, review board = 12). Country/setting: NSW, Australia Data collection and Sampling: Semi structured interview about CTO experiences. Purposive sampling.	**CTOs increase care access** • Could be both a positive and negative aspect of care • Concerns about coercion **System Capacity** • Even if CTOs are implemented, if the system capacity isn't there then they will not be effective.	Strength of Design: **Moderate** Quality: **Medium** Issues: • Concerns over bias, lack of information around data analysis. • Concerns about purposive

Study/Design	Methods	Key Results	Comments
	Data Analysis: Grounded theory approach. Data collection, coding, and synthesis. Outcomes: Categorized by two main themes. (see key results)		sampling, greater emphasis on clinicians.
Authors: Riley et al., 2018 Design: Qualitative	N: 9 clinical decision makers Country/setting: Norway Data collection and Sampling: in-depth interviews which covered five topic areas. Data Analysis: Digitally recorded interviews, transcribed. Combination of intuition and structured analysis. Outcomes: Categorized by three main themes. (see key results)	**CTO as a treatment tool** • Tool for ongoing medication and treatment. • Less burdensome than hospitalization **Relationship between coercion and voluntariness** • Desire to build a good relationship without coercing. **Recognizing patient perceptions** • Burdens and restrictions	Strength of Design: **Moderate** Quality: **Medium** Issues: • Participants were only recruited from one facility. • Credibility of intuitive analysis which may be reflective of author biases.
Authors: Stroud et al., 2015 Design: Qualitative	N: 72 participants (patient = 21, practitioners = 35, relative = 7, service provider = 9). Country/setting: United Kingdom Data collection and Sampling:	**Legal recognition of need for care** • Increased motivation of 'law' **Structure** • Provides structure to patients **Medical Service** • Acceptance of service which	Strength of Design: **Weak-Moderate** Quality: **Low-Medium** Issues: • Did not fully explain all four

Study/Design	Methods	Key Results	Comments
	Semi structured interview. Data Analysis: Recorded, transcribed, thematically coded and analysed. Outcomes: Categorized by four main themes. (see key results)	keeps them out of hospital **Misunderstood powers**	themes, reduces credibility and transferability.
Authors: Stuen et al., 2018 Design Qualitative	N: 15 case file reviews, 8 interviews, 4 focus groups Country/setting: Norway Data collection and Sampling: thematic interview guide designed by author. Data Analysis: Modified grounded theory approach, informed by constructivist and interpretive framework. Coded and categorized. Outcomes: Categorized by a main theme of 'responsibility with conflicting priorities' in which there were three subthemes (see key outcomes).	**Conflicting priorities** • Treatment vs. patient autonomy • Importance of medication education **Support and Services** • Secure treatment adherence by patient • Opens the door to other services. **Rapport** • Provided opportunity for enhanced relationships over time.	Strength of Design: **Moderate** Quality: **Medium** Issues: • Validity of the thematic interview is not fully understood or explained.

Appendix D – Methodology



Appendix B- Consultation Report

Implementation of Assisted Community Treatment in Response to Serious Mental Illness: A Consultation Report

Megan Wood

Memorial University of Newfoundland

Implementation of Assisted Community Treatment in Response to Serious Mental Illness: A Consultation Report

In 2018 the Government of the Northwest Territories (GNWT) tabled the new *Mental Health Act* (the Act) (2018c). The Act was released to improve services for vulnerable citizens living with serious mental illnesses through the implementation of person-centred treatment and recovery oriented practices. Within the Act, a section was devoted to the capacity of medical practitioners to engage in assisted community treatment (ACTs) – more commonly known as community treatment orders (CTOs) in other jurisdictions (GNWT, 2018c). In the *Mental Health General Regulations*, the attending medical practitioner is defined as a member of the medical staff who "cared for, observed, examined, assessed, treated or supervised on an inpatient or outpatient basis" (p. 1, 2018). In the Northwest Territories (NT) this could include but is not limited to: physicians, psychiatrists, and nurse practitioners.

Despite the 18-month implementation period of this statute, there has been no uptake of ACTs in the NT to date. The overall goal of this practicum project is to complete an evaluation of the ACT section of the Act and identify the issues affecting the non-use of ACTs. With a clear understanding of the challenges that interfere with using a ACT, recommendations can be developed to promote their use while mitigating the barriers that prevent their implementation.

In order to develop an evaluation of the barriers and concerns related to ACT implementation in the NT consultations with key stakeholders were planned. These consultations were designed to provide guidance on the priorities and issues that should be addressed in the evaluation. Evaluation goals and outcomes were considered and discussed for both the departmental and operational sections of the GNWT. This project has importance for the Department of Health and Social Services (DHSS) as the Minister is responsible for the

standards of care and all health legislation in the NT. Knowing how to better support the needs of individuals with serious mental illness as well as the health professionals who provide care and treatment will establish the changes that are needed to fully operationalize the Act. To increase implementation of ACTs, it will also be necessary to consult with the three regional health authorities in NT to obtain their perspectives on ACTs and how to improve their use. The three authorities are: the Northwest Territories Health and Social Services (NTHSSA), Hay River Health and Social Services (HRHSSA) and the Tlicho Community Services Agency (TCSA).

Consultation Process

Consultations were completed following development of a consultation plan in collaboration with Dr. Joy Maddigan. This included the development of consultation goals, determination of settings and participants, and clear data collection methods.

Consultation Goals

In order to identify and fully explore pertinent issues related to implementation of ACTs in the NT, it was necessary to gain a full understanding of the DHSS and health authorities' expectations of an evaluation. Four goals were developed for the consultation process:

(1) To examine the vision, and historical and policy context for the introduction of ACTs in the NT in 2018;

(2) To determine the expected goals and outcomes for the evaluation;

(3) To assist in identification of priority evaluation issues and topics that will need to be addressed in the ACT evaluation; and

(4) To determine the strengths and limitations of different data collection methods to identify the most productive approach.

By meeting these goals through the consultative process, an evaluation plan can be created that fulfills the needs of key stakeholders and allows for the opportunity to gain a better understanding of the barriers and concerns related to the lack of implementation of ACTs. Recommendations for facilitating the effective use of ACTs including the mitigation of identified barriers will be developed at the conclusion of the evaluation.

Setting and Participants

The project setting is the NT as the Act covers the entire territory. Given that responsibility for the evaluation of the Act lies directly with the DHSS invitations for consultation interviews were sent to key informants through the official channels of the DHSS. This helped establish priority for the evaluation. Prior to disseminating the invitations, the DHSS invited the Departments of Policy, Legislation, and Communications (PLC) as well as Corporate Planning, Reporting, and Evaluation (CPRE) to provide feedback on the practicum project. Once approval was obtained, as well as support from the Assistant Deputy Minister (ADM) of Health Programs, invitations were sent to potential consultees.

Key informants were purposively selected based on their knowledge of the Act and the role they played during the development of ACTs, as well as those who are currently responsible for management of operations within the health authorities. These individuals would help ensure that the scope and depth of issues were appropriately identified, which would then be used to create a focused plan for a comprehensive ACT evaluation.

Consultation invitations were sent to appropriate DHSS representatives**,** which included the Director of Mental Wellness and Addictions Recovery and the Manager of Mental Health and Addictions, Quality and Integration. These positions are responsible for the planning, development, monitoring and ongoing improvement of standards and procedures as related to the

Act. Both individuals have the historical knowledge and vision for future development of mental health care in the NT.

Positions that were considered most applicable to this project at the NTHSSA were identified as the Director of Mental Health and Addictions and the Territorial Manager of Mental Health and Addiction Services as they are jointly responsible for planning, development, and improvement of operational service delivery for the NTHSSA. The ADM sent an invitation to the CEOs of the three regional health authorities asking that they identify employee(s) with responsibility for mental health in their organization to participate in the consultation. A copy of the letter for the identified participants is included in Appendix A. Identified participants were also provided with the interview questions in advance to ensure focus remained on the implementation of ACTs and the development of an evaluation plan.

Data Collection

The DHSS, NTHSSA, TCSA, and HRHSSA responded to the invitation. A total of five interviews were conducted. They provided verbal consent by way of email that they understood the project and were aware that it would be conducted via video conferencing. I provided numerous times and date that could be scheduled for consultation and they responded with a time that worked best for them.

Due to the current global pandemic of COVID-19, all interviews were conducted via video conferencing (Microsoft Teams) as the majority of employees were working from home and practicing social distancing. Questions focused on primary themes which included the vision of ACTs and historical development of the statute; engagement and policy development; goals and outcomes of an evaluation; and expected requirements for engagement in the evaluation process. A copy of questions asked of participants is included in Appendix B.

Data Management and Analysis

Data management was completed by the interviewer through note taking. During the interviews I took notes on an alternative computer. As a proficient typist, I was able to record participants' responses nearly word for word. This allowed for detailed note taking. Data for this project were held in my workplace laptop which is secured for privacy. Additional measures for safe storage of the information included the usage of the GNWT's virtual private network (VPN) which is only accessible by employees of the GNWT. Further, the information was held in my private drive, which is not accessible to other team members.

Following note taking, the data were analysed. Each interview was read in full several times and then examined line by line to identify & extract key information related to the consultation objectives. Key information from each interview was grouped into categories allowing for the development of themes.

Ethical Considerations

This project did not require review by the Health Research Ethics Review Board (HRERA) as the purpose of the project is to assess the quality of a new piece of legislation through the evaluative process. Please see appendix C for further justification. Permission for interviews was gained from my employer, the Mental Wellness and Addiction Recovery Unit (MWAR) at the Department of Health and Social Services (DHSS) through both the Director of the MWAR unit and the Assistant Deputy Minister (ADM) of programs.

Results

Results of the consultations were grouped in to four main themes. These four themes were created from the responses of participants and in alignment with the goals of the

consultation. The themes are: the vision, the development and implementation, moving forward, and future collaboration.

The Vision

Updates to the current Mental Health Act (2018) were politically motivated through a shared vision to improve supports for residents at the community level, thus reducing the need for in hospital acute care. This vision was partly driven by the increasing levels of inpatient admissions being tracked in the NT. For example, in the fiscal year of 2017, the percentage of admissions related to mental health concerns increased from 12.7% in 2016 to 14% in 2017; this equates to an increase of admission rates by 10.2% (GNWT, 2018a). Changes to the Act were also influenced by the discovery that only 66.4% of NT residents perceive their mental health to be very good or excellent, compared to the national average of 71.6% (GNWT, 2018a).

The DHSS and NTHSSA hoped that by adopting a more proactive, upstream approach to mental health care they would be able to improve services for individuals in the NT – this was the understanding of the goals by the TCSA and HRHSSA interviewees as well. The vision included looking at a stepped care approach, meaning individuals could enter the mental health system whenever they were deemed as needing care, and receive the type of service they needed at that time. Dr. Peter Cornish, of Memorial University has spearheaded this initiative throughout Canada. In 2014 Dr. Cornish released his proposal which outlines a mental health system that meets clients where they are at the time of presentation, using monitored access to ensure success at any point of entry in the system with the least utilization of intensive treatments.

The addition of ACTs is an important part of stepped care as it allows the client to engage in the least restrictive aspect of care with a multi-disciplinary team that responds to the needs of the specific individual, a vision that also aligns with the GNWT's 2017-2020 strategic

framework, *Caring for our People*. In stepped care individuals who are issued ACTs would fall within the complex needs step, which involves the utilization of specialist consultation, acute care, system navigation and advocacy for the client (Mental Health Commission of Canada, 2019). Ideally, use of ACTs would provide individuals with increased community support and mental health care while living independently in the community. Using recovery-oriented practices, community health providers could facilitate timely identification of clients requiring additional treatment and initiate early intervention through community or inpatient assessment.

The Development and Implementation of the Mental Health Act

Perceptions of how the legislation was developed and implemented illustrated some differences between the operational and governance sides of the NT health system. The perspectives of each group will be described and then all issues will be synthesized to identify key factors for further exploration in the evaluation.

Views of the Consultees from the Department of Health and Social Services

According to the government consultees, there were no specific policies that underpinned the development of ACTs; however, the vision and Act aligned with *Caring for our People* (2017) the strategic framework that had come in to force prior to the Act. Additionally, Policy, Legislation and Communication (PLC) completed a jurisdictional scan across Canada to ensure there were similarities in the vision and requirements for ACT implementation.

The government participants described the creation of a standing committee, which toured communities in the NT. This was to ensure the voices of residents were heard when creating the guiding principles of the Act. The standing committee was created following the first draft of the bill, but prior to the drafting of regulations. The committee confirmed that the guiding principles were in line with key stakeholder wishes which included seven guiding

principles. The guiding principles in the Act included: reduced delays in decision making; respect for the person; consideration of safety; least intrusion treatment approach; consideration of family involvement; respect of the person's wishes; and, respect for privacy (Mental Health Act, 2018).

Consultations were not only completed with community members, but also took place with those who would actively be involved in implementation, this included: the Association of Psychologists of the Northwest Territories; NTHSSA (including the territorial lead for psychiatry, chief executive officer, emergency room health care providers and psychiatry health care providers); and the Royal Canadian Mounted Police (RCMP) of the NT.

Following the Act coming in to effect, communications were released to the public which included information for the new Act; specifically, a webpage devoted to ACT issuance was published on the DHSS website (GNWT, 2018b). A companion hand out was also created in the form of a brochure. This brochure was provided to the designated mental health facilities in the NT: Stanton Territorial Hospital, Inuvik Regional Hospital, Hay River Health Centre, and Fort Smith Health and Social Services Centre. It is important to note, that although Inuvik Regional Hospital, Hay River Health Centre, and Fort Smith Health and Social Services Centre are considered to be designated mental health facilities – in the event that an individual is made an involuntary patient, they are transferred to Stanton Territorial Hospital. It could not be recalled if this communication was provided to the authorities and community counselling programs.

Development of a clinical practice guide was created by the DHSS for internal distribution and to provide the expected clinical standard of care related to the new Act. This guide was reportedly distributed to hospitals, doctors' offices, community health centres, social service offices, and public health units. Within this guideline are clearly outlined flow maps of the ACT

process for issuance, including the corresponding forms required for implementation. It will be important to verify if this clinical practice guide was communicated and advertised to operational staff throughout the evaluation.

Views of the Consultees from the Health Authorities Related to the Development and Implementation of ACTs

The authorities are expected to operationalize standards, legislation and other initiatives as developed by the DHSS. In discussing the development of the Act, and the subsequent implementation significant concerns were expressed about the content, expectations, and delivery of ACTs in the NT.

For example, representatives from the authority were unable to recall if or when consultations occurred with front line staff, senior management, or community members. Interviewees felt that due to this, many practicalities were not communicated that would be necessary for implementation, and that when tabled, the Act was presented ‘from left field’ with the expectation that it would be enforced by the authorities.

Staff were provided with training about the entirety of the Act, not just specific to ACTs. These sessions were provided over a period of one year and were not available to be repeated. This was seen as a significant concern for the authorities as when attempting implementation of any new process there is a significantly transient work force in the NT. Further, once the Act came in to force, it was unknown who should be developing standard operating procedures, policies and guidelines. Some interviewees described being provided with a contact person at the NTHSSA, but they were never made aware of operational guidelines for implementation.

Although provided with a clinical practice guideline document which outlined broad processes for implementing a ACT, there was a lack of policies, processes and procedures

developed to aid in the operationalization of ACTs. The evaluation will need to seek clarification around what health care providers feel is missing that would enable them to successfully implement orders.

Specific Considerations for the Evaluation

All consultation participants supported the need to better understand why there has been no implementation of ACTs thus far in the NT. Ideas were generated as to the underlying problems that might be influencing the non-use of ACTs. It was suggested from the DHSS specifically that either people and/or clinicians do not know it exists, there are no standard operating procedures, there is a lack of physician buy in, or the process is flawed in some manner. Although the DHSS created the clinical practice standard, as per their role, there has been no standard operating procedure developed by the authorities at this time.

Participants from the authorities has also brought to light that a lack of education, misunderstanding, and potential legalities that may be barriers which need further exploration. At this time, the authorities were optimistic that ACTs could greatly benefit their communities if implementation were to occur. It was suggested, however that greater support for implementation might be considered in order to remove the barriers. More access to education was identified. This issue, requirements for successful implementation will be explored during the evaluation.

While a range of barriers will be explored in the evaluation, assessing the level of knowledge and understanding of the clinicians involved in using ACTs is critical. Understanding if physicians are aware, familiar, and have ever tried to issue an ACT will be important for creating recommendations from the evaluation. One of the known barriers is that the NT has a high percentage of locum physicians which impacts the capability to deliver consistent care; the

most recent statistics estimate that we have a 30% vacancy rate for family practitioners and 11% for specialist practitioners (GNWT, 2018a). Clinical staff, such as nurses, are also impacted by vacancy rates in the NT which may also contribute to reduced service delivery in the communities. Most recent statistics show that the NT is experiencing a vacancy rate of 4.7% (GNWT, 2018a). Interestingly, only 18% (n=12) of essential mental health services are devoted to care planning and coordination of care in the NT, but with 41% (n = 28) devoted to support and aftercare it seems as though the resources are available in community but may be lacking the coordination required for a ACT (Elman et al., 2019). Interviews with clinical staff should provide further light on these concerns.

Based on the input of consultation participants, the goals for the evaluation include:

(1) Identify barriers to ACT implementation as perceived by health care providers;

(2) Identify perceived needs of physicians, psychiatrists, and staff to successfully implement or pilot ACTs in the NT;

(3) Develop recommendations for reducing barriers as identified by stakeholders in goals one through three; and,

(4) Determine if there are any amendments required to the legislation and regulations to improve issuance of ACTs in the NT.

Future Collaboration

Feedback from the participants indicated that the goals of evaluation may be best served using differing methodologies based on the discipline or entity to be consulted. It was suggested, for example, that information regarding awareness of ACTs was best collected through the use of a brief survey. Family doctors and nurse practitioners were targeted for this approach. Focus groups were recommended for inpatient psychiatric staff at the Stanton Territorial Hospital

where the majority of ACTs are expected to be issued. A focus group with the Community Mental Health Team (CMH) was also recommended as those clinicians would be involved with individuals who have an active ACT. For psychiatrists, one-on-one interviews were thought to be most effective.

A variety of data gathering tools will need to be developed to complete a comprehensive evaluation. A common concern throughout the consultations was the need for more training and information for the healthcare managers and clinicians who responsible for the operations of the MHA and particularly ACTs. Open communication, and flexible availability for participants to reach the evaluator were essential to gather evaluation data.

Document Review

A limited environmental scan was completed to determine if other jurisdictions in Canada had conducted evaluations of their mental health legislation or CTO outcomes. While there may be more evaluations completed, only Alberta, Newfoundland and Labrador, Nova Scotia and Ontario have made their evaluations publicly available. A brief overview of these evaluations will be provided to support the goals and chosen evaluation methods outlined above.

Review of Alberta CTOs

Orr et al. (2012) completed a review of Alberta's successful implementation of CTOs in the first 18 months. Their act, titled Bill 31, made CTO issuance possible as well as the implementation of two oversight mechanisms for CTOs, mental health act review panels, and mental health patient advocate's roles (Orr et al., 2012). Demographics of clients were collected over the 18 month span and included a total of 193 clients who were primarily male (65%), middle aged, and had primary diagnoses of schizophrenia (49%) or psychotic disorder (20%);

CTOs focused primarily on medication management (98%), and regular oversight by psychiatry (77%) (Orr et al., 2012).

Two of the biggest takeaways from this evaluation are the reasons for success behind the implementation; a dedicated administrative and clinical CTO team, and the provision of service enhancement funding (Orr et al., 2012). A dedicated administrative team was created to provide ongoing support, education, and coordination for issuance of orders and the service enhancement fund was dedicated to the development of assertive community treatment teams for case management and outreach (Orr et al., 2012). An important consideration is that while Alberta does allow CTOs to be issued without consent, only 11% of individuals were placed on CTOs against either their own or their substitute decision maker's wishes (Orr et al., 2012).

Review of Newfoundland's Mental Health Care and Treatment Act

In 2012, the Research and Evaluation Department of the Newfoundland and Labrador Centre for Health Information completed an evaluation of the Mental Health Care and Treatment Act. This publication is valuable as it provides their methodology for evaluation, including the use of surveys, focus groups, and interviews to gather information.

As with Alberta, Newfoundland had already begun to issue CTOs and so their report is more in depth than this evaluation process – particularly pertaining to the number of individuals certified on one or more occasions and patient interviews (Newfoundland and Labrador Centre for Health Information, 2012). These findings will be important for leading future evaluations, post-implementation for the NT. Their focus groups and interview findings lead to valuable information regarding the certification process and implementation of CTOs which will help in the guidance of an evaluation plan (Newfoundland and Labrador Centre for Health Information, 2012).

Of particular value is the information outlined around the liability of having two signing psychiatrists – particularly within more remote communities and the potential for nurses to have signing authority (Newfoundland and Labrador Centre for Health Information, 2012). Another limitation found was the lack of availability of community services outside of the regional center of St. John's area, and the requirement for education for all service providers who may interact with those during a CTO treatment plan – such as peace officers (Newfoundland and Labrador Centre for Health Information, 2012). In completing the evaluation, understanding if there are similar barriers will assist in the creation of recommendations to mitigate similar concerns in the NT.

Review of Nova Scotia's Mental Health Act

In 2013, the Honourable Justice Gerard V La Forest and William Lahey completed a fulsome report as an independent panel on the *Involuntary Psychiatric Treatment Act* and CTOs in NS. This report was provided to the ministry with significant recommendations to improve involuntary treatment and CTO issuance in the province (La Forest & Lahey, 2013). Similar to other evaluations, La Forest and Lahey (2013) completed public and stakeholder consultation and focus groups with selected individuals as required; their report yielded 11 recommendations specific to CTOs in the province.

Results and recommendations include the need for more rigorous data collection for involuntary and CTO clients; the capability to delegate responsibility from the inpatient physician to other practitioners; improvement of community services for those issued CTOs, and collaboration with the review board for affected clients (La Forest & Lahey, 2013).

Review of Ontario CTOs

In 2012, the Ontario Ministry of Health contracted a private consulting firm to complete a review of the legislated CTOs in Ontario. Similar to this planned evaluation process, they completed a brief comparison of Ontario's CTOs with other jurisdictions, a literature review, consultations, and evaluations (Malatest & Associates Ltd., 2012). As Ontario had successfully had clients who availed of CTOs, they were able to include demographic data of CTO users, barriers in implementation, and the effectiveness of CTO treatment before proposing recommendations for the ministry (Malatest & Associates Ltd., 2012). For this project, it was noteworthy that Malatest and Associates Ltd. (2012) had completed both a survey and interviews with identified health care providers to identify the benefits and detriments of issuing CTOs in Ontario.

Gaps that were found were similar to those in other evaluations, particularly a lack of education for practitioners, reduced community capacity to support CTOs, and a lack of public knowledge (Malatest & Associates Ltd., 2012). As seen in Nova Scotia's recommendations, Malatest & Associates Ltd. (2012) found that a lack of administrative data made review difficult and recommended more robust tracking of involuntary patient admissions and issued CTOs. They also recommended a CTO coordinator position which would assist in process, education, and administrative work such as determination of the need for client review, and the development of CTO standards of care (Malatest & Associates Ltd., 2012).

Conclusion

The consultation process was highly beneficial to understanding the historical context, and vision for ACT development and implementation of the Act in the NT. By understanding what key stakeholders in both the departmental and operational arms of government hope to

gather from the evaluation I am better able to design an evaluation plan which will yield accurate data, and thus recommendations to begin future issuance of ACTs in the NT. The evaluation will need to focus on the process of ACT issuance in the NT due to a lack of uptake – should the process evaluation be successful and lead to implementation, a future outcome evaluation could be developed (Pettigrew et al., 2014).

In order to complete the evaluation, in consideration of the consultation report, I will develop and share an evaluation plan with my supervisors at both DHSS and Memorial University. Following the development of an evaluation plan, it will be shared with both PLC, CPRE, and the ADM for feedback before engaging in the actual data collection for evaluation.

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Appendix A

Mental Health Act Evaluation

The Government of the Northwest Territories (GNWT) is committed to creating meaningful change for the mental wellness and addictions recovery of Northwest Territory (NT) residents through the delivery of a recovery oriented mental health and addictions system. As part of the Mental Wellness and Addictions Recovery Action Plan**,** the Department of Health and Social Services (DHSS) is committed to the improvement of quality, coordination and integration of services.

Part of our continuous quality improvement approach includes the evaluation of recovery initiatives. In 2018, the GNWT passed the new mental health act which provided capacity for issuance of Assisted Community Treatment (ACTs) in the NT. Since that time there has been no uptake of this service.

The DHSS is moving forward with an evaluation of why this service has not yet been used for the benefit of mental health service recipients. In preparation for the formal evaluation of the ACT component of the Mental Health Act, consultations are being planned to help ensure the evaluation is relevant and will meet the needs of the community. As a key informant, I am writing to ask if you would agree to be interviewed to help establish the content and process for a useful, and productive evaluation. Your perspective on the vision, goals and appropriate evaluation approach for ACTs will be invaluable.

By way of this email, I kindly request that you reply with a time and date that is convenient for you to engage in a 1-hour video consultation regarding this topic. For more information please email Megan Wood, Specialist – Mental Wellness and Addictions Recovery at megan_wood@gov.nt.ca. I am completing this evaluation on behalf of the DHSS and in partial fulfillment of my Master of Nursing Degree through the Memorial University of Newfoundland.

Thank you for your anticipated support of this request.

Kind regards,
Megan Wood, RN, BScN, CPHMN(c)
Specialist – Mental Wellness and Addictions Recovery
Strategic Programs Unit
Department of Health and Social Services
Government of the Northwest Territories

Appendix B – Consultation Questions

1. What was the vision for ACTs in the NT?
    a. Why were they included in the new MH Act?
    b. Was any opposition of ACTs expressed within the NT?
2. What was the context of policies for ACTs?
    a. What were the policy directions used to underpin the new ACT section in the Mental Health Act? What were they trying to achieve?
    b. What processes were used to communicate with the health and mental health community about the planned changes to the Mental Health Act?
    c. Were policies shared with key informants for the purposes of feedback prior to final development of the revised Act? How was community and stakeholder input obtained?
    d. Were the issuing practitioners engaged in setting the policy directions and requirements for ACTs?
3. What do you hope the evaluation can reveal regarding ACT uptake?
    a. What questions need to be asked to understand the current situation?
4. Are you aware of any barriers currently in place, or other reasons why uptake has yet to occur?
5. What do you think needs to change for ACTs to be effectively used to improve the quality of life for patients, families and communities?
    a. Are the ACT criteria problematic?
    b. Inadequate mental health clinicians to provide care and treatment in community?
    c. Patient/Family/Community lack of buy in?
6. What specific topics should be explored in the evaluation process to help accurately determine the barriers that are constraining the use of ACTs?
7. How do you think it would be most suitable to collect information from key stakeholders and clinicians?
8. Do you have any other thoughts or perspectives that are important for the development of an evaluation plan?

Appendix C: Health Research Ethics Authority (HREA) Screening Tool

Student Name: Megan Wood

Title of Practicum Project: Evaluation Plan to explore the Barriers and Potential Facilitators to Better Understand the Lack of Uptake of Community Treatment Orders in the NT.

Date Checklist Completed: July 31, 2020

This project is exempt from Health Research Ethics Board approval because it matches item number three from the list below.

1. Research that relies exclusively on publicly available information when the information is legally accessible to the public and appropriately protected by law; or the information is publicly accessible and there is no reasonable expectation of privacy.
2. Research involving naturalistic observation in public places (where it does not involve any intervention staged by the researcher, or direct interaction with the individual or groups; individuals or groups targeted for observation have no reasonable expectation of privacy; and any dissemination of research results does not allow identification of specific individuals).
3. Quality assurance and quality improvement studies, program evaluation activities, performance reviews, and testing within normal educational requirements if there is no research question involved (used exclusively for assessment, management or improvement purposes).
4. Research based on review of published/publicly reported literature.
5. Research exclusively involving secondary use of anonymous information or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information.
6. Research based solely on the researcher's personal reflections and self-observation (e.g. auto-ethnography).
7. Case reports.
8. Creative practice activities (where an artist makes or interprets a work or works of art).

For more information please visit the Health Research Ethics Authority (HREA) at https://rpresources.mun.ca/triage/is-your-project-exempt-from-review/

Appendix C - Evaluation Report

Implementation of Legislated Assisted Community Treatment in Response to Serious Mental Illness: An Evaluation Report

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Executive Summary

Through the evaluation of Assisted Community Treatment (ACT) in the Northwest Territories (NT), the Department of Health and Social Services (DHSS) is continuing to move forward in their commitment to the *Mental Wellness and Addictions Recovery Action Plan* (MWAR AP). The MWAR AP is working towards a system transformation which reflects person and family centered, recovery-oriented, trauma informed and culturally safe care. For patients and families this means having the opportunity to access the mental health system at any point in their treatment journey. The MWAR AP is dedicated to ensuring that recovery is the primary focus of treatment. Individualized care that is focused on healing and living a satisfying life is a core component.

This evaluation was designed to explore the lack of uptake of ACTs in the NT. In 2018, the new Mental Health Act was tabled, which allows for health care practitioners to work with patients and their families to ensure patients continue with their treatment once discharged from hospital. This involves the use of ACTs, which give designated health care providers the ability to discharge individuals from hospital while continuing to require that they adhere to an established treatment plan while living freely in the community.

Research on Community Treatment Orders (CTOs) in other jurisdictions shows promising, although mixed evidence, for the success of ACTs if they are implemented with a strong focus on recovery-oriented practice and individualized support plans. There are several important variables in the NT that support the need for implementation of ACTs, particularly high readmission rates, and high rates of involuntary inpatient admissions to the territorial psychiatric unit. By implementing ACTs, the NT has the opportunity to improve these outcomes while supporting individuals to live independently and with improved quality of life. These

improvements in health care would also reduce acute care burden and improve community mental health services.

The aim of this evaluation was to address the gap in service provision. In order to meet the aim of this evaluation it was necessary to explore pertinent issues related to implementation of ACTs and gain a full understanding of health care provider's experiences in order to determine if amendments are required for the legislation, and develop recommendations that would allow for issuance of ACTs. A total of 21 health care professionals participated in the evaluation. One to one interviews and online surveys were used with psychiatrists, community mental health nurses, inpatient psychiatric nurses, and community based Nurse Practitioners and Physicians to determine their perspectives as related to ACTs in the NT.

Main themes were derived from the interviews and surveys which would be used to create recommendations for the DHSS to move forward with implementing ACTs in the NT. Education and training concerns were identified as a main theme, particularly that health care providers wished for more consistent and focused training related to ACTs. The need for legislative amendments was identified as a main theme as health care providers felt that the current legislation is vague and inconsistent. The need for further cultural consideration was a main theme, as this would provide greater support and understanding for how to move forward with ACTs while remaining in alignment with the Truth and Reconciliation Calls to Action. Lastly, the main theme of community resources and connections was important as it identified potential system concerns that would not allow for the maintenance of ACTs once issued for individuals.

From these main themes, the following recommendations were created and include:

1. Develop and implement ongoing educating, consultation and training opportunities for existing, new and locum health care providers to ensure they have the knowledge and skills to effectively manage their role in ACT implementation;
2. Assign a DHSS employee or representative with the responsibility to provide support and oversight in the implementation of the Assisted Community Treatment Program;
3. Consult legal services regarding select provisions of the ACT and how they are currently interpreted within the health system to: i) clarify the policy intent of the select legislative provisions and ii) determine the need for amendments to the legislation;
4. Establish a territorial ACT implementation working group comprised of key stakeholders to provide support and expertise in actioning the evaluation recommendations and facilitating the use of ACTs; and
5. Initiate a collaboration between the DHSS and the Department of Justice to identify ways to better support and treat individuals with serious mental illness who are involved with the legal system.

Throughout this process and as recommendations are considered and actioned, the DHSS is working towards continuous quality improvement. This ensures that the mental health system remains responsive and effective by hearing concerns from patients and their families while considering health care providers needs to improve skills service delivery in the NT. Following the dissemination of this report, the DHSS will review and prioritize recommendations in collaboration with the health authority and department of policy, legislation and communication to begin facilitating changes which lead to successful implementation of ACTs in the NT.

Implementation of Legislated Assisted Community Treatment in Response to Serious Mental Illness: An Evaluation Report

The new *Mental Health Act* (the Act) was tabled by the Government of the Northwest Territories (GNWT) in 2018 to improve services for citizens living with serious mental illnesses (2018c). The Act was intended to guide health practitioners with the delivery of safe and ethical care while respecting the rights and wellbeing of individuals for whom it could be applied too (GNWT, 2018c). The Act was created on the principles of person-centred treatment and recovery-oriented practice and included provisions for Assisted Community Treatment (ACT) which are more commonly known as community treatment orders (CTOs) in other jurisdictions (GNWT, 2018c). The GNWT chose to use the term of Assisted Community Treatment or ACT to reflect their focus on reducing restrictive treatment measures and movement away from the perception of mandated orders due to the historical legacy of residential schools in the Northwest Territories (NT).

Although the Act has been in force for two years, there have been no individuals discharged from hospital with an ACT plan in place. ACTs are similar to CTOs, allowing designated health care providers to enter in to an agreed upon set of terms with their patients to deliver treatment in the community with lesser restrictions on their care and rights than while admitted to hospital. As ACTs were developed for the benefit of patients and families this lack of use is concerning. In fact, internationally there are more than 75 jurisdictions which currently utilize CTOs for patients who are living with a serious mental illness and have shown a repeated pattern of involuntary hospital admissions (Rugkasa, 2016). The Canadian Institute for Health Information (CIHI) reported that in 2018, 12.5% of Canadians who were admitted for mental health concerns experienced a subsequent repeat hospitalisation – this is important to note as

patients who would benefit from a CTO are often known to experience ‘revolving door’ patterns of readmission. In 2018 the NT saw 18% of admitted individuals, readmitted to mental health services, and in 2019 this number increased to 23%, or an increase from the national average by 44% and 84% respectively (J. Scarfe, personal communication, October 10, 2020). While the clinical effectiveness of CTOs is of ongoing debate, there is research which shows that when utilized appropriately, individuals required fewer readmissions, had decreased length of stay, and increased their use of community services (Harris et al., 2019).

To address the gap in service provision, this evaluation was developed to identify the perceived challenges and barriers to the implementation of ACTs in the NT. The aim was to achieve a deeper understanding of the root of the problem in order to develop effective solutions. Based on the evaluation findings, a broad set of recommendations are proposed to advance the current dilemma. The recommendations are not only important to the Department of Health and Social Services (DHSS), as the government determines any legislative or regulatory changes, but also to the health authorities who have responsibility for operationalizing the provisions of the Act. Most importantly, the proposed recommendations were developed to help ensure that patients and families are provided with the best mental health services possible to improve their health and well-being.

Background

Research related to the clinical effectiveness of CTOs has shown mixed results in other jurisdictions for patients, their families, and health care systems. The small number of randomized controlled trials (RCTs) plays a part in the weak evidence base but qualitative evidence illustrates the positive impact that appropriate community support can have, even when mandated (Stroud et al., 2015). An individualized support plan that is recovery focused is the

basis of the success of the legislated mental health service (Jansson & Fridlund, 2016). This is encouraging for the future of ACTs in NT. The new legislation has a strong focus on recovery and person-centered care, which extends into the community and on improving community services for individuals who may benefit from ACT certification. A previous review of literature was completed which provides guidance for ACT implementation (Wood, 2020). Five main themes were identified: i) reduction in length of hospital stay and readmission rates, ii) improvements in medication adherence and illness symptoms, iii) changes to health care services and clinical staff workload, iv) threats to autonomy, and education and rights. They are briefly described below.

Current quantitative evidence suggests that individuals who are discharged on a mandated order (CTO or ACT) will experience a longer, healthier time in the community before another hospital admission is required (Aware, 2013; Harris et al., 2019; Kallapiran et al., 2010; Kisely et al., 2013; Kisely, 2016; & Maughan, 2014). This would be a clear benefit in the NT as hospital readmission rates for those with mental illness are climbing. Statistics from 2018 and 2019 indicate 12-month readmission rates of 18% and 23% respectively (J. Scarfe, personal communication, October 10, 2020). For individuals who were readmitted within one year, the average length of time between the two admissions was 61 days in 2018 and 62 days in 2019. For at least half of those who were readmitted, however, the length of time from discharge to readmission was 41 days in 2018 and 38 days in 2019. This trend has the potential to be reversed with effective community assisted treatment. In addition, improvements achieved in reducing the length of hospital admissions in 2019 need to be continued. In 2018, 27% of individuals admitted for inpatient psychiatric treatment remained in hospital for two weeks or more. In 2019 that percentage had decreased to 20% (J. Scarfe, personal communication, October 10, 2020).

Changes or improvements to medication adherence, and symptomology are the goals of many mental health systems. Mandated community treatment has the potential to improve these outcomes for patients (Edan et al., 2019; Riley et al., 2018). A collaborative, individualized, recovery-focused approach for individuals who receive a CTO/ACT appears to have the most benefit. Supporting individuals to live productive, satisfying lives in the community also has the potential to decrease hospital use and impact readmission rates and length of hospital stays. These indicators have been identified for improvement throughout the NT.

Any change in health services will reverberate throughout the system. Experiences in other jurisdictions suggest that community services and resources may be strengthened while the acute care burden will be diminished (O'Donoghue et al., 2016; Kisely et al., 2013). With expansion of community services and the need for community teams to support those receiving community care, the nature of the work and workload of mental health professionals will also change. This finding has importance for NT as the sole, ten-bed inpatient psychiatry unit consistently operates at full capacity. In 2018, the total number of mental health admissions was 274, with 166 (61%) requiring involuntary status. In 2019, admissions reached 332, and 193 (58%) involved involuntary status. Rebalancing the system and shifting from a dominant, acute care hospital system to one that is founded on a strong network of primary health and mental health care will better serve the ongoing needs of the population.

The final theme identified in the literature addressed the ethical implications of mandated treatment for those with mental illness. Specifically, the threat to patient autonomy, limited understanding of the rights of patients and their families and the importance of comprehensive education for all involved in the CTO/ACT were recognized as priority concerns. Qualitative research has shown that some patients and their families experience coercion, lack of control,

and ambivalence towards mandated community treatment (Banks, 2016; Canvin et al., 2014; Edan et al., 2019; Jannson & Fridlund, 2016; Light et al., 2017; Stroud et al., 2015). The literature is clear that action must be taken on these issues to improve the effectiveness of mandated community care.

The integrative literature review (Wood, 2020) provided background information which was pertinent for this evaluation, particularly that ACTs have the potential to support individuals to live independently in their communities (Aware, 2013) while improving their quality of life (Edan et al., 2019). There are also significant opportunities to reduce acute care burden while improving community services (O'Donoghue et al., 2016). The potential for these outcomes further supported the need for this evaluation and future implementation of ACTs in the NT.

Evaluation Goals

In order to identify and fully explore pertinent issues related to implementation of ACTs in the NT, it was necessary to gain a full understanding of key health care provider's experiences. Three goals were developed for the evaluation process:

1. Identify barriers to ACT implementation as perceived by members of the health care team;
2. Determine if amendments are required to the legislation and/or regulations to facilitate the use of ACTs in the NT; and
3. Develop recommendations for facilitating the use of ACTs for those that could benefit from community supervision.

Evaluation Methods

Evaluation methods were determined in conjunction with Dr. Joy Maddigan, the DHSS and the health authorities. Ethical considerations were reviewed with the DHSS research team to ensure there were no conflicts or additional permissions required for the evaluation to be conducted.

Setting and Participants

The project setting was the whole of the NT as the Act covers the entire region. The NTs health system is overseen by the GNWT, and responsibilities for the development of standards and health system oversight rests with the DHSS. The DHSS works collaboratively with the three health authorities who are responsible for the operations and implementation of initiatives. The three authorities are Northwest Territories Health and Social Services (NTHSSA), Hay River Health and Social Services (HRHSSA), and Tlicho Community Services Agency (TCSA). While each of the health authorities functions as a separate entity, the NTHSSA provides clinical and administrative support to the HRHSSA and TCSA such as, sharing specialist physicians and locum health providers, and at times the sharing of policies and procedures (see figures 1 and 2).

Figure 1

Overview of GNWT Governance

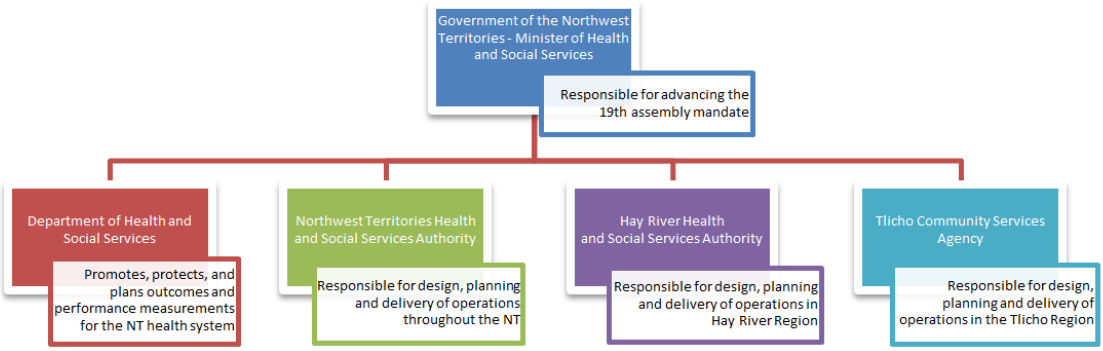
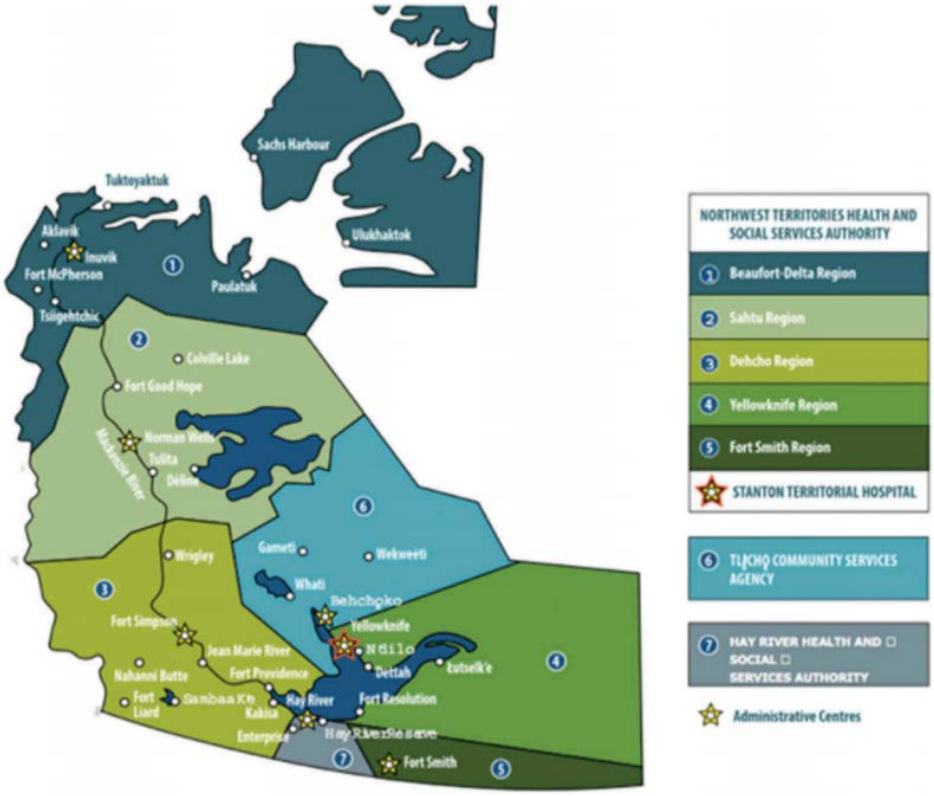


Figure 2

Overview of the NT Regions



Elman et al., 2019

Health professionals were the primary participants selected for the evaluation. They were identified based on their role in the issuing of ACT orders in the NT. These included psychiatrists, physicians, nurse practitioners, community mental health nurses (CMHN), and inpatient psychiatry nursing staff. Permission to distribute invitations to health providers was received from the DHSS and the health authorities. Contact was made directly with the senior management teams of the health authorities who then distributed the evaluation invitations to the identified health care providers.

Psychiatrists and CMHN were invited to participate in a video conference at a time and date that was convenient for them. An invitation was distributed by senior management for

physicians and nurse practitioners in the health authorities, along with a survey link requesting feedback as related to ACTs. Inpatient psychiatry senior management was consulted to determine the feasibility of conducting a focus group for inpatient psychiatry nursing staff. As staff meetings were held on a quarterly basis, the practicum time frame made it impossible to accommodate the unit schedule. As an alternative, a short electronic survey was created and circulated electronically to nursing staff by the unit manager.

Data Collection

Data collection was completed by the interviewer through note taking during the interviews. Due to the current global pandemic, all interviews with psychiatrists and CMHNs were completed via phone or video (Microsoft Teams). As many psychiatrists were locum physicians and resided in other jurisdictions, video conferencing was a necessity. CMHNs were located in various areas of the region and also required video conferencing. Invitations were extended to all health providers in these roles for a total of 12 psychiatrists, and five CMHNs. A total of five interviews with psychiatrists were completed (response rate of 42%), and five interviews with CMHNs (response rate of 100%). A copy of interview questions for psychiatrists and CMHNs can be found in appendix A.

The electronic survey for family physicians and nurse practitioners took about five minutes to complete and provided insight to their level of awareness of ACTs, as well as their understanding of the ACT processes and their confidence in using them. A request for participation was circulated to 21 physicians and 15 NPs on two occasions. This resulted in a total of seven responses to the survey. A copy of the survey questions for physicians and nurse practitioners can be found in appendix B.

The inpatient psychiatric nurses survey also took about five minutes to complete and provided information related to the nurses' education, role, and understanding of ACTs in the NT when working with patients experiencing serious mental illnesses. A total of four nurses responded to the survey for a response rate of 40%. A copy of these questions can be found in appendix C.

Data Management and Analysis

Interview data were collected and stored on the evaluator's workplace computer. It provided multiple levels of security through the GNWT's virtual private network (VPN), and private, password protected drives. Data collected from both anonymous electronic questionnaires were held in the DHSS Mental Wellness and Addictions Recovery user account where it was automatically compiled for analysis.

Data were analyzed and coded by themes on an iterative basis. Each interview was read in full and pertinent information was extracted and categorized broadly based on the interview questions, and in alignment with evaluation goals. When all relevant information was categorized, it was thoroughly reviewed and refined. Each category of information was then synthesized and labeled with a theme. The themes and corresponding synthesized information constituted the evaluation findings and provided the basis for the recommendations that were proposed.

Ethical Considerations

Permission for this evaluation was gained through the Assistant Deputy Minister (ADM) of Programs at the DHSS. Guidance on evaluation issues such as engagement with NT health care professionals was provided by the Director in the Mental Wellness and Addictions Recovery Unit (MWAR). In consultation with the DHSS Research team it was determined that

this project was a service evaluation, which did not require ethical review by the Health Research Ethics Board (HREB) or the Arctic Research Institute (ARI) of the NT. Further justification can be found in appendix D. Ethical principles, however, were followed throughout the evaluation.

Results

The results of the evaluation are outlined to provide a brief overview of the total number of evaluation participants, and the main themes which were determined throughout the data collection. Following the main themes, a brief overview of how this evaluation met the goals of the project is provided.

Evaluation Participants

A total of 21 individuals participated in the evaluation. Ten individuals were interviewed and a total of 11 surveys were returned. Table 1 summarizes the evaluation participants.

Table 1

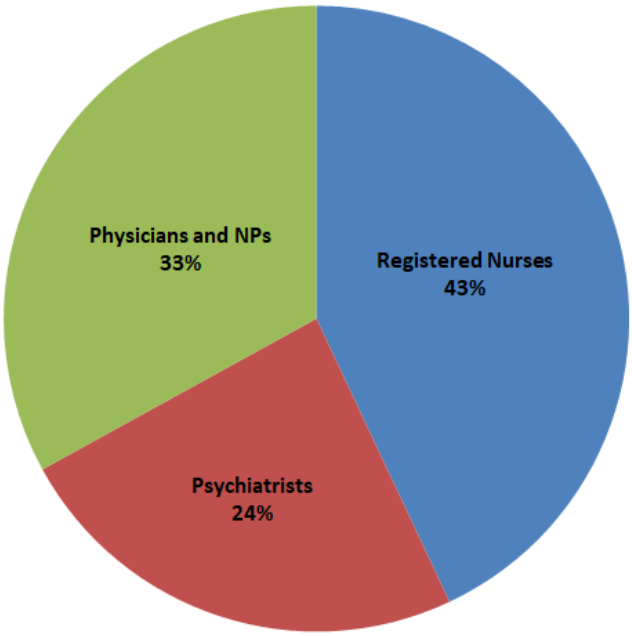
Overview of Evaluation Participants

Health Care Discipline	Number of Participants	Data Collection Method
Psychiatrists	5	Interview
Registered Nurses (Community Mental Health and Inpatient Psychiatry)	9	Interview or Survey
Physicians and Nurse Practitioners	7	Survey
Total participants	21	

Figure three provides a visual overview of the number of evaluation participants by health care discipline.

Figure 3

Visual of Evaluation Participants by Professional Discipline



Main Themes

There were a total of five themes identified from the evaluation data. These themes were: education and training barriers, legislative concerns for ACT issuance, cultural considerations, potential ACT continuance concerns, and community resources and connections. The data comprising each theme were synthesized to highlight key points, and are described below.

Education and Training Barriers

Following the tabling of the new Mental Health Act, training was offered to health care providers and management staff of all health authorities in the NT. The half day training was not

mandatory and staff could choose not to attend; however, it was encouraged for physicians, nursing, management and other decision makers. The training was comprehensive and covered all aspects of the mental health legislation. It was not specifically tailored to the needs of different groups who had responsibilities under the Act or were affected by the Act. Participants reported that there was a useful question and answer period during the session and that there was a good exchange of new information.

A number of concerns were raised about the adequacy of the education. Participants indicated that additional training and resources were needed to ensure they had the necessary knowledge and skills to carry out the ACT process. They expressed concern that there was no mechanism for follow up and further questions after the training session. Additional training would also be welcomed by participants as would closer, more regular contact with the DHSS. These concerns were voiced from multiple disciplines including: psychiatry, inpatient psychiatric staff, and community mental health nurses.

As ACTs may not be implemented with a great frequency it is important that health care providers be able to access basic information about the ACTs and how to issue an ACT as needed or on an annual basis. E-based learning is a fast-growing learning technique, which allows for the health care provider to engage in education through a virtual training known as the ‘practice improvement using virtual online training’ (PIVOT) design to improve knowledge retention through collaborative learning and clinical case scenarios (Floren et al., 2020). A study of the PIVOT learning method indicated that learner-participants improved their knowledge and understanding through case studies relevant to their clinical area (Floren et al., 2020) In addition, the added feature of having access to other students or a learning representative who could problem solve and work through the case studies was valued by participants. The majority of

health professionals indicated the need for regular educational opportunities or annual training that met the needs of their practice.

Lastly, the low response rate (n =7 of 36 possible responses or 19%) of physicians and nurse practitioners has resulted in a knowledge gap. Other opportunities to engage with these two professional groups will need to be developed as they are key to successful implementation of ACTs. Only two respondents within the primary care group were aware of ACTs in the NT and they believed that ACTs were ineffective and not enforceable in this jurisdiction. The majority of physicians and NPs (n=5) were not aware that ACTs existed. Further training and education is a priority to facilitate improvements in the effective use of ACTs.

Legislative Concerns Regarding ACT Issuance

The psychiatrists and Community Mental Health Nurses who completed separate evaluation interviews were unanimous that the new mental health legislation was problematic from an operational perspective. For example, psychiatrists identified a number of contradictions within the Act related to the criteria used to place an individual on an ACT. The following three subthemes: involuntary status, requirement for consent and ACT criteria for certification were identified as barriers to ACT uptake in the NT.

Involuntary Status. Involuntary status is described in several sections of the Act. For example, section 2.1, subsection 2(e) states that an individual who has involuntary status "... is entitled to make decisions on his or her own behalf, to the extent of his or her capacity to do so". In reference to the capabilities of a person when determining the need for a certificate of involuntary admission (section 13 [1], subsection a and b) the patient must meet the following criteria as assessed by a medical practitioner upon personal exam and reveals findings that the person is:

I. "suffering from a mental disorder";

II. "likely to cause serious harm to himself or herself or to another person, or to suffer substantial mental or physical deterioration, or serious physical impairment if he or she is not admitted as an involuntary patient"; and,

III. "not suitable to be admitted as a voluntary patient".

Use of section 13, therefore, would indicate that the extent of capacity has been severely reduced in some manner, resulting in an involuntary hospitalization. If, during the hospitalization, a medical practitioner wishes to issue a certificate of ACT at discharge they have two main responsibilities. They must examine the patient within 72 hours of discharge and ensure the patient meets the following criteria (MH Act, section 38, subsection 6a through e):

a) "the patient is suffering from a mental disorder for which the patient is in need of supervision and treatment or care that can be provided while the patient resides outside the designated facility";
b) "if the patient does not receive supervision and treatment or care while residing outside the designated facility, he or she is likely, because of the mental disorder, to cause serious harm to himself or herself or to another person, or to suffer substantial mental or physical deterioration, or serious physical impairment";
c) "the patient is capable of complying with the requirements for supervision and treatment or care included in the community treatment plan";
d) "the patient is willing to comply with the requirements for supervision and treatment or care included in the community treatment plan; and";
e) "adequate treatment, services and support are available and will be provided to the patient".

In section 38 (2) (g) the Act states that the certificate is ceased if the patient no longer meets the criteria to be an involuntary patient and subsection (5) that "a person's status as an involuntary patient is not affected by his or her release from a designated facility under the authority of an assisted community treatment certificate". All interviewed psychiatrists felt that the criteria for an ACT listed under section 38(6) (c) and (d) were contradictory to section 13 (1) (b) (ii) which states that the person is likely to cause serious harm to self, other, or suffer substantial deterioration unless they are made an involuntary status. Psychiatrists feel that a person who meets this criteria 13 (1) (b) (ii) cannot also meet 38 (6) (c) and (d) in which the patient is capable and willing to comply with the ACT. Two psychiatrists felt that for an individual to be made involuntary status would indicate that they were no longer considered safe or competent to engage in treatment, and thus they would be considered unsafe for community treatment and issuing an ACT would be contradictory to the intended purpose.

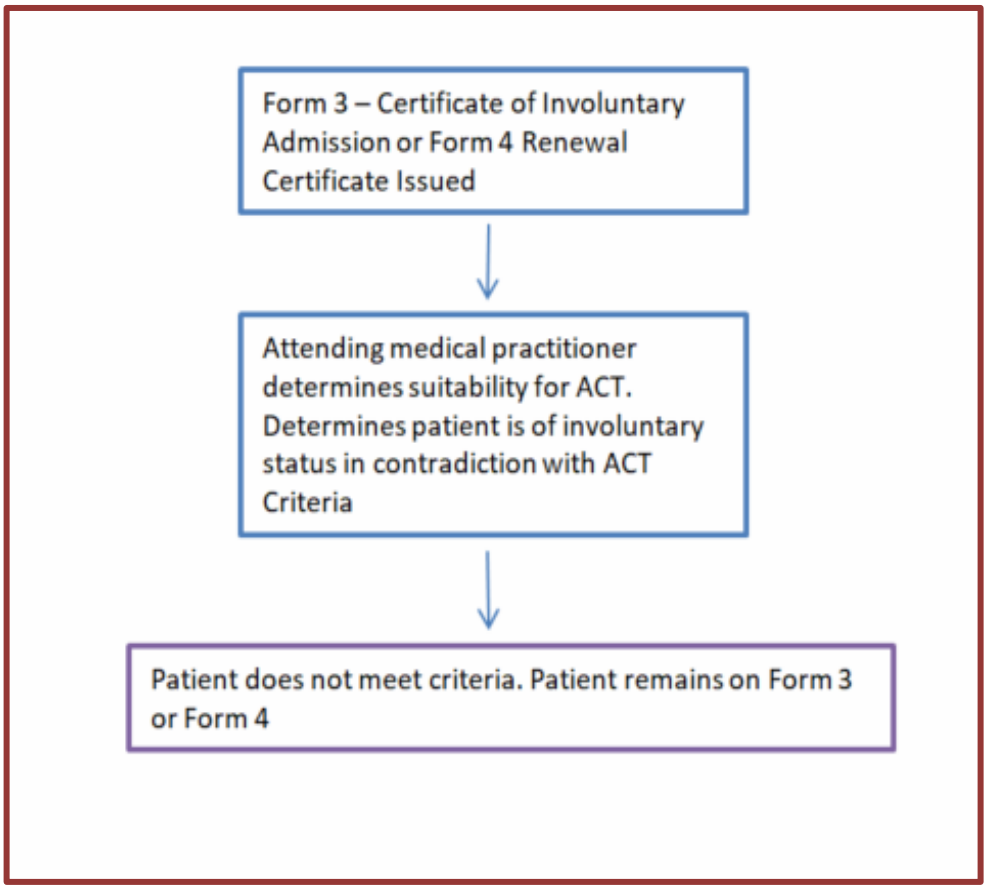
A brief scan of other jurisdictions' Mental Health Acts found that it is an inconsistent practice for a patient to remain involuntary when issued a CTO; however, that it is still plausible to action a CTO. In Nova Scotia's Involuntary Psychiatric Treatment Act (2005) section 43 (1) states, "notwithstanding any declaration of involuntary admission or declaration of renewal with respect to an involuntary patient, the psychiatrist of an involuntary patient may issue a certificate of leave for up to six months…" and in section 50, "where a person on a community treatment order no longer fulfils the criteria in sub clause 47(3)(a)(iii) the person may choose to voluntary continue with obligations of the community treatment plan until its expiry, but the psychiatrist shall terminate the community treatment order."

Contradictory to this is Alberta, in which the Mental Health Act states in section 9.1(1)(b) that one or more of the following should apply: (A) "been a formal patient in a facility; and (C)

“both been a formal patient in a facility and been in an approved hospital…”. In this case, ‘formal patient’ refers to a patient “detained in a facility pursuant to 2 admission certificates or 2 renewal certificates”. This can be interpreted that the patient does not need to meet involuntary status at the time of CTO issuance, but has required to have been so historically.

Due to section 38 (2) (g) of the Act which states that the ACT certificate is ceased if the patient no longer meets the criteria to be an involuntary patient and subsection (5) that “a person’s status as an involuntary patient is not affected by his or her release from a designated facility under the authority of an assisted community treatment certificate”. At this time medical practitioners do not feel confident that legally they can release a patient on an ACT while maintaining involuntary status for hospital admission.

Flow Map of Barrier. As a visual tool to aid in understanding of the current perceived barrier the following shows how medical practitioners feel the status of involuntary status disrupts the issuance of an ACT.



Requirement for Consent. Further concerns were raised related to section 38 (6) (c), i.e., patient is capable of complying with the ACT plan and (d) patient is willing to comply with the plan. Completion of the ACT certificate requires the patient's signature as indication of consent for the ACT. This can create a significant barrier as patients are sometimes unwilling or change their mind, and refuse to sign the form. Another concern voiced by some health care practitioners was that requiring consent defeats the purpose of ACT, which are intended for individuals who

are experiencing severe and persistent mental illnesses. The patients with whom this would apply would, by way of their disease, have little insight, impaired judgement, and are required to engage in compulsory treatment within other jurisdictions.

The creation of the Act was driven by the principles of recovery focused, person centered care and so reducing the risk of coercion, enabling autonomy and patient decision making, and improving human rights has led to the development of ACTs rather than CTOs. Health care providers held the belief that there would be greater capacity to recall patients to a health care facility in the event that they object to treatment, medications, or other terms of the CTO; however, ACTs do not permit for patients to be recalled unless there is evidence of deterioration. The increase in autonomy and decision making for the patients may have caused some misalignment and lack of understanding between the DHSS and authorities when it came to operationalizing the ACT process.

Related to this misalignment is the criteria as listed in section 38 (6) (a-e) which psychiatrists find vague and thus difficult to navigate. Other jurisdictions have more concrete requirements for the implementation of a CTO, such as the Government of Alberta (2012) who require a patient to:

1. “be suffering from a mental disorder”;
2. “AND one or more of the following must apply:”
    A. “over the past three-year period, on two or more occasions, or for a total of at least 30 days have:”
        a) “been a formal patient in a facility, or”

b) "been in an approved hospital or been lawfully detained in a custodial institution where there is evidence that, while there, the person would have met the criteria of being a formal patient, or"

c) Been both a) and b),"

B. "and/or within the past three years, have been subject to a community treatment order,"

C. "and/or in the opinion of the two physicians, have, while in the community, exhibited a period of recurrent or repetitive behaviour that indicates the person is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community;"

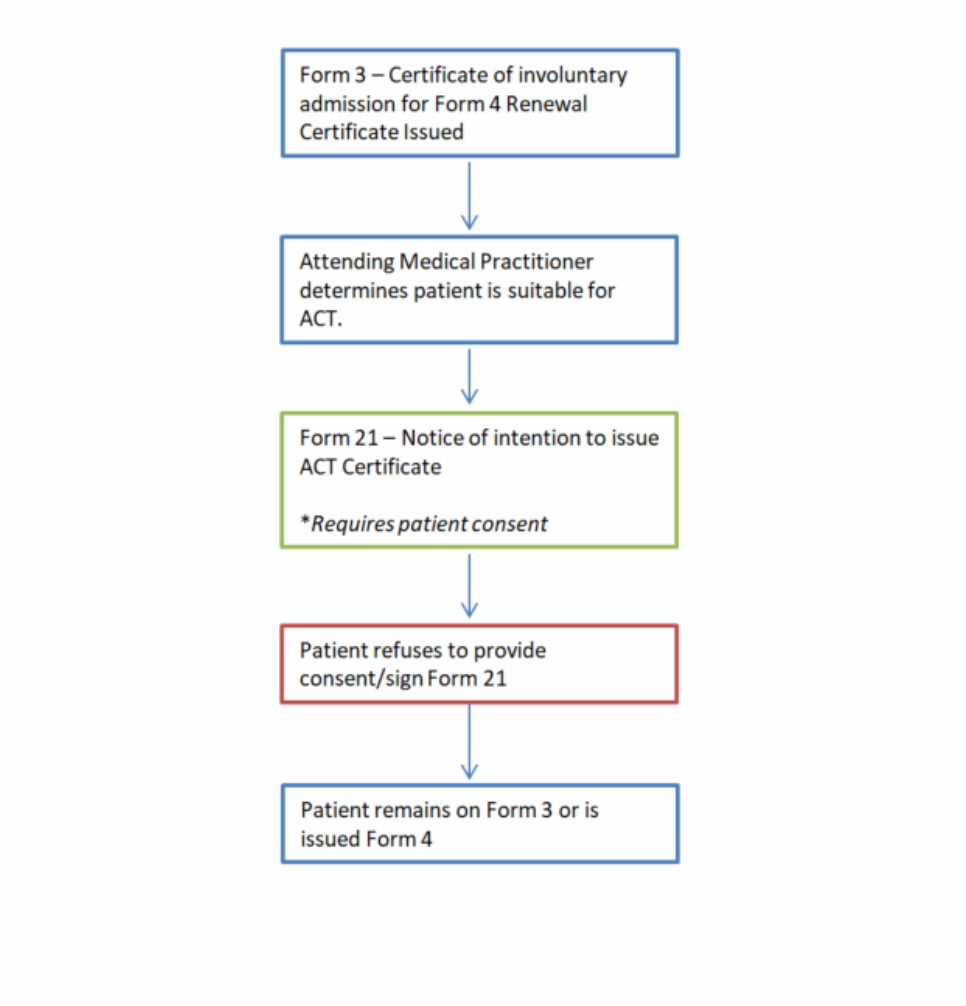
3. "AND in the opinion of the two physicians, be likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physician impairment if the person does not receive continuing treatment or care while living in the community;"
4. "AND be able to comply with the treatment or care set out in the community treatment order."

The majority of interviewed psychiatrists felt that it was contradictory to the intention of the ACT to require a patient's consent, particularly in the form of written evidence on the Form 21/22. Most felt that, if a patient were able to consent to the treatment then they would have the insight and judgement required to engage in community treatment – which is often not the case with individuals who require ACT treatment.

In addition to this concern, and the requirement for written consent by the patient or substitute decision maker (SDM), is the fact that other jurisdictions have consent as an optional requirement to the ACT/CTO of that area. Most psychiatrists felt that requiring a patient to consent would potentially involve coercion, and would then cause ethical concerns about practice and treatment. The vision of the Act is to stay within the principles of recovery-oriented practice as a mental health system, and thus it is worthy of consideration that the place of legal coercion, such as through an ACT could challenge the genuineness of treatment when applying recovery-oriented practices, reduced empowerment for the patient and risk their right to autonomy (Edan et al., 2019).

Riley et al. (2018) argue that although consent is ideal, in order to avoid coercion, it is possible to implement a CTO that utilizes both the compulsory treatment requirements while also placing an emphasis on the patient's rights and wishes for the community services delivered during the CTO. While there is little doubt that there will be tension between the possibility of coercion and the voluntariness required for a patient to enter an ACT, it is still able to be balanced through appropriate education and explanation of the benefits achieved through community treatment versus ongoing hospitalisation (Riley et al., 2018).

Flow map of barrier. As a visual tool to aid in understanding of the current perceived barrier the following shows how medical practitioners feel the status of required consent disrupts the issuance of an ACT.



ACT Criteria for Certification. As outlined in the Act section 38, subsection 6a through e the patient is expected to be examined within 72 hours by the medical practitioner and meets the criteria of:

a) "the patient is suffering from a mental disorder for which the patient is in need of supervision and treatment or care that can be provided while the patient resides outside the designated facility";

b) "if the patient does not receive supervision and treatment or care while residing outside the designated facility, he or she is likely, because of the mental disorder, to cause serious harm to himself or herself or to another person, or to suffer substantial mental or physical deterioration, or serious physical impairment";
c) "the patient is capable of complying with the requirements for supervision and treatment or care included in the community treatment plan";
d) "the patient is willing to comply with the requirements for supervision and treatment or care included in the community treatment plan; and";
e) "adequate treatment, services and support are available and will be provided to the patient".

All psychiatrists felt that this criteria was vague and lacked the conciseness required to issue an ACT certificate to a patient. Psychiatrists hoped for more concrete guidelines that would allow for two physicians to order an ACT certificate such as the criteria outlined by the Government of Alberta (2012).

The concerns voiced by psychiatry and Community Mental Health Nurses are important to for future implementation of ACTs in the NT. The barriers determined at this time, as related to involuntary status, requirements for consent and criteria for certification are currently preventing successful implementation and operationalization of this piece of legislation.

Cultural Considerations

Statistics Canada (2017b) reported that there was a total of 20,860 people residing in the NT who identify as Indigenous, accounting for a total of 50.7% of the territories entire population of 41,786. The proportion of Indigenous peoples in Canada as a whole is less than 5%. (Statistics Canada, 2017a). This distinction highlights the importance and strength of the

Indigenous culture and the need to build a health care system that is founded on the rights, traditions, and cultural history of the Indigenous. In the NT, there are three different Indigenous groups: First Nations, Metis and Inuit people (Statistics Canada, 2017b). These three groups have eleven, officially recognized languages including: Chipewyan, Cree, English, French, Gwich'in, Inuinnaqtun, Inuktitut, Inuvialuktun, North Slavey, South Slavey, and Tlicho (City of Yellowknife, 2019). This is but one indicator of the diversity in cultures that exists among the Indigenous people of the north.

Three Registered Nurses self-identified as Indigenous and volunteered their perspectives; particularly around the importance of cultural considerations when changing mental health services. Due to the history of health inequalities experienced by Indigenous people in Canada there is significant movement towards understanding the determinants of health that have the greatest impact on the health and well-being of Indigenous peoples. The social determinants of Indigenous health, as explained by the National Collaborating Centre for Aboriginal Health (2013) include proximal, intermediate, and distal social determinants. Proximal are those which are closest to the individuals necessity for life functioning such as employment, food security, and the physical environment; intermediate include those which may impact Indigenous people more so than other populations such as cultural considerations, health and educational systems rooted in Eurocentric background; and distal are those which have historically contributed to the social determinants such as colonialism, racism, social exclusion and self-determination (National Collaborating Centre for Aboriginal Health, 2013). Events related to the distal determinants which need to be considered include the legacy of residential schools, the sixties scoop – the mass removal of children from their families, and subsequent placement in foster care or adoption - and the history of murdered and missing Indigenous women (MMIWG). These

events have led to the federal government working towards facilitating the reconciliation of those impacted and resulted in the development of the Truth and Reconciliation Commission (TRC) of Canada (Government of Canada, 2019).

In working towards reconciliation, the TRC made several calls to action of federal and jurisdictional governments which need to be considered when implementing changes in health care. As the issuance of ACTs move forward within the NT, it will be important to remember the call to action 22 which states:

> We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients. (Truth and Reconciliation Commission of Canada, 2015, p.3)

Consideration of the social determinants of health, and the TRC are of vital importance for ACTs to be issued, and successfully implemented in the NT in a culturally safe and considerate manner. In order to begin to understand what that means the three Registered Nurses who voluntarily identified as Indigenous, provided their insights in to the importance of consent, autonomy, and traditional healing and what must be considered for ACTs in the NT. Further information regarding these cultural considerations and subsequent recommendations and future considerations are woven throughout the remainder of the evaluation. It is essential that we can continue to address the recommendations of the TRC and learn from other jurisdictions who are actively working to implement strategies that address specific mental health and cultural safety concerns. The Australian Government, for example, released their *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023* which outlines similar

social determinants of health and how these can be addressed in a culturally safe way. Not only does this provide an overarching vision for what health care can achieve, but it also provides the expectation and measurable outcomes that are necessary for true collaboration between government and Indigenous groups. Similarly, the *Whakamaua Maori Health Action Plan 2020-2025* by the New Zealand Ministry of Health is an another example of how governments can empower Indigenous bodies and collaborate to identify shared priorities and practices in their delivery of health care.

Potential ACT Continuance Concerns

Although no ACT certificates have been issued up to this time, medical practitioners identified a number of issues that could pose problems for the health system if individuals are subject to an ACT. Three main issues were discussed that have the potential to cause disruption in the system. These include: reassessment requirements, bed holding, and bypassing the hospital admission process. These subthemes are important to understand as they are factors which may be preventing health care providers from issuing ACTs as their confidence in the maintenance of such certificates is impacted.

Reassessment Requirements. Under the Act, when the date for the end of the ACT order approaches**,** which is a maximum of six months, the patient is provided with Form 29 which requires that the patient return to the designated facility where the ACT was issued. When the patient returns to the health facility, the medical practitioner completes an assessment and the future plan of care is determined at that time.

Psychiatrists described the problems with this process. While psychiatric reassessment is certainly required for the renewal of an ACT or cancellation of an ACT, it is not always feasible to have a patient return in person to the designated facility. Given the geographical challenges of

living in the NT, and the infrequency in which psychiatrists visit outlying communities, it seems reasonable that consideration be given to amending the Act to allow for ACT reassessments to be completed by telehealth or other virtual means. By utilizing virtual systems for reassessment, the requirement for psychiatrists to travel to communities for the reassessment would be decreased as would the need for the patient to fly to the regional center of Yellowknife for the appointment.

Bed Holding. Currently a patient who is subject to an ACT is still considered to be an involuntary patient and thus the system remains responsible for them when they are no longer receiving hospital treatment. Evaluation participants felt that the current interpretation of these provisions would require that a hospital bed to be held for the return of the patient for reassessment even if it was for the duration of the six-month certificate. Health care providers felt that this was an unreasonable and inefficient action to take considering the scarcity of mental health resources in the NT. Keeping a bed empty on the inpatient unit would limit needed inpatient services. Holding a bed for six or more months would reduce inpatient resources, increase travel and other costs for the individual under the mandated order, and would not be appropriate given the small size of the only psychiatric unit in the Territories, which is ten beds.

Bypassing of Admission Process. Psychiatrists identified that the ability to bypass the admissions process was a red flag and potential legal concern. The admission of a patient from community or from the emergency department allows for a medical practitioner to assess and rule out any medical concerns which may be impacting their mental status at the time of presentation. By allowing an individual to bypass this process, the opportunity for a medical assessment to rule out any potential concerns before admission to the psychiatric unit is missed.

Requiring in person reassessment every six months, physically blocking a bed for a patient on a CTO and the ability to bypass admission processes are significant barriers. These

barriers that would disrupt the ability of ACTs to be maintained seamlessly once implemented in the NT and are a deterrent for health care providers to begin implementation.

Community Resources and Connections

Multiple departments are involved with individuals who may be subject to an ACT and so inter-departmental collaboration is necessary for success. Additionally, community resources are required for the successful implementation of ACTs and thus having a robust team which is able to include the most likely patients, and aid in the delivery of community services is necessary. The following two sub-themes were voiced by psychiatry, community mental health nurses, and inpatient psychiatric staff and include: collaboration between health and justice, and assisted community treatment teams.

Collaboration between Health and Justice. Participants reported that the health authorities and the Department of Justice (DOJ) function with their own policies and guidelines. Many patients are common to both the mental health and justice systems, and it is likely that a portion of those with serious mental illness who are also involved with the justice system would benefit from an ACT. Psychiatrists and CMHNs felt that there was significant difficulty in navigating these two systems.

Inpatient psychiatric nurses also identified this as a concern, particularly as related to policies and procedures which may differ between health and forensic inpatient systems. For instance, policies differ for the transferring of patients, the restraints of patients, and the sharing of information. This was seen as a barrier for collaborative case management and the possibility for effective ACT implementation in this population.

Assisted Community Treatment Teams. A territorial assisted community treatment team could provide virtual or distance-based support for individuals, psychiatrists and families who

are issuing, or living under ACTs. Ensuring a team approach to the case management of these patients, was identified as vital by all psychiatrists, CMHNs and inpatient staff.

The development of a territorial assisted treatment team does not necessarily require a completely new team of practitioners. The addition of this portfolio for identified health care practitioners, and therapeutic practitioners could greatly benefit the implementation and maintenance of ACTs in the future. Providing a focus on the patients and families who are issued ACTs, and ensuring proper processes and guidelines are adhered too on a consistent basis could be managed by a territorial assisted treatment team.

The need for a closer connection between the health system and DOJ, as well as the lack of an ACT team for case management were determined to be barriers to effective implementation for ACTs in the NT. A cohesive team approach for the individuals who would most benefit from ACTs is a need and currently perceived as a potential gap in service delivery.

Achievement of the Evaluation Goals

The first goal for this evaluation was to identify any barriers to ACT implementation as perceived by members of the health care team. Through the evaluation, there were many disciplines engaged including: psychiatry, community mental health nursing, physicians and nurse practitioners, and inpatient psychiatric staff. Engagement with these disciplines provided a robust overview of the perceived barriers that would impact not only issuing practitioners but those most involved in the implementation process.

Collectively the main barriers, as perceived by health care professionals were around the need for more focused and frequent training opportunities with an appointed representative from the DHSS. It was also voiced that an increased focus on the cultural aspects of ACTs would be welcomed as this could benefit both the health care system and the care as provided to individuals with whom ACTs would apply. Finally, an increase in connections between community resources was identified as a barrier to health care providers.

The second goal was to determine if there are amendments that are required to legislation and/or regulations to facilitate the use of ACTs in the NT. The results of the evaluation indicated that there is a need for further exploration in this area. The perceived contradiction between criteria for involuntary patients and ACT patients was a major concern for psychiatrists as they felt that this would impede any patients from meeting ACT criteria. Further legislative concerns included the requirement for patient consent, the specificity of ACT criteria, the requirement for in-person reassessment and admission at six months of ACT treatment, and the potential for physical bed blocking in hospital were all concerns related to the current legislation. While this evaluation cannot determine the nature of any potential amendments to ease facilitation, it can bring concerns forward.

The third goal of this evaluation was to develop recommendations for facilitating the use of ACTs for those that could benefit from community supervision. These recommendations follow and are formed from the first and second goal of this evaluation in which barriers and legislative concerns were determined.

Recommendations

The evaluation findings outlined above were carefully considered in order to develop realistic recommendations that would address the evaluation goals and facilitate positive, plausible change. As this evaluation was focused on a gaining a better understanding of why ACTs were not being used by health professionals in the NT, the recommendations that respond to the evaluation findings are primarily the responsibility of the DHSS and the health authorities. Five recommendations are proposed.

Recommendation 1: Develop and implement ongoing educating, consultation and training opportunities for existing, new and locum health care providers to ensure they have the knowledge and skills to effectively manage their role in ACT implementation

Interviews were conducted with staff that had received the training, as well as with those who were new to the system and had not had the opportunity to do so. This recommendation could have positive outcomes for existing, new, and locum health care providers. Ongoing training, as delivered when the Act came in to force would be appropriate for new staff and locum staff entering the NT; particularly due to our transient work force the necessity of offering training on a regular basis cannot be undervalued.

Recommendation 2: Assign a DHSS employee or representative with the responsibility to provide support and oversight in the implementation of the Assisted Community Treatment Program

Communications as related to the Act, as publicized by the DHSS include email inquiries to a generic email of mentalhealth_act@gov.nt.ca and the unit phone number. While this

provides an avenue for questions to be answered by multiple practitioners on the mental wellness and addictions recovery (MWAR) team, it is not the sole responsibility of any one practitioner to gauge needs, answer questions and facilitate ongoing education. By assigning the ACT program to a DHSS position, operations could be better supported, training facilitated, questions answered, and support provided consistently.

Recommendation 2A: Explore the development of a territorial Assisted Community Treatment team to deliver virtual and in person case management for individuals living in the community under an ACT order

Future consideration of a team or identification of core members to lead the issuance and maintenance of ACTs would be beneficial to explore as a collaborative initiative between the DHSS, and health authorities. This team would aid in the collaboration between health and justice, while improving community connections and resources for individuals to whom the ACT applies.

Recommendation 3: Consult legal services regarding select provisions of the ACT and how they are currently interpreted within the health system to: i) clarify the policy intent of the select legislative provisions and ii) determine the need for amendments to the legislation

A legal opinion regarding the potential contradictions in the Act would be beneficial for both the DHSS and the issuing medical practitioners. As the Act is currently being interpreted in a manner that highlights the risks and barriers to the use of ACTs, it would be beneficial to have a clear understanding and legal guidance to aid in the understanding and application for physicians. Legal confirmation of the necessity for recommendations 3A-F would also aid in the comfort around ACT issuance in the NT.

Recommendation 3A: The maintenance of the individual's involuntary hospital status while living in the community under mandated community treatment and care

A legal opinion to the current wording of the Act will assist medical practitioners in their understanding of their grounds to issue an ACT to an involuntary patient. Psychiatrists feel that individuals who meet ACT criteria cannot also maintain involuntary status; however, with the consideration that an involuntary patient no longer is required to be of imminent risk to self or others, and may instead be at risk of deterioration, it could be interpreted that they do in fact meet both involuntary and ACT criteria. Confirmation with legal, and subsequent education at the time of training, onboarding, or consistently by a DHSS representative could increase comfort and knowledge pertaining to this and other abstract sections of the Act.

Recommendation 3B: The requirement for the individual to sign the ACT form prior to their release from hospital

The recommendation to consider reviewing the requirement for patient's written consent will need to be further explored. Removing the requirement for written consent would increase the utilization of ACTs, however it would need to be clearly documented that the patient was understanding and capable of engagement with the ACT. Further, with the requirement for consent –the patient maintains some level of autonomy regarding their care, and becomes a partner in the ACT process. Cultural considerations need to be thoroughly examined as well. To remove the consent requirement entirely would be working against the TRCs 22nd call to action for health care systems, and would potentially be reminiscent of significant historical events in which the rights of Indigenous people were disregarded. Potential safe guards could be established, such as the ability to bypass consent based on the recommendation of two health care providers or psychiatrists – and a diverse case management team which could include

representatives for the individual from their community such as an Elder to ensure cultural safety – if that was their wish.

Recommendation 3C: The effectiveness of the criteria used to determine the suitability of an individual to receive mandated assisted community treatment

A legal opinion regarding the criteria of the ACT orders, the potential for legal repercussions for medical practitioners and the benefit of stricter criteria as observed in other jurisdictions would be beneficial as ACTs begin to be issued in the NT by medical practitioners.

Recommendation 3D: The requirement for an in-person reassessment or readmission at the end of the six-month treatment order to determine their level of health and wellbeing and future treatment plan

An amendment to the guide should be considered which allows for the issuing health care provider to complete their reassessment of status at six months via telehealth or other electronic methods. These methods must allow for a fulsome exam; however, should not require the patient or physician to present in person causing unnecessary stress and resources on the mental health system.

Recommendation 3E: The requirement for the designated facility to keep an inpatient bed vacant while an individual on an ACT is living in the community

Clarification or an amendment to the guide should be considered which allows for hospitals to manage patients on an ACT in accordance with their facilities limitations and bed requirements. This would allow for creative problem solving in the event of re-presentation without withholding beds for acute patients.

Recommendation 3F: Review of the decision for individuals to bypass the admissions process upon readmission

An amendment to the guide should be considered which requires the patient to have, at minimum, a medical assessment prior to readmission to the psychiatric unit. This would follow best practice and reduce the potential concerns related to legality for medical practitioners. This may be resolved at the policy level rather than requiring legislative amendments.

Recommendation 4: Establish a territorial ACT implementation working group comprised of key stakeholders to provide support and expertise in actioning the evaluation recommendations and facilitating the use of ACTs

In order to move forward the recommendations as determined in this report, a collaborative, multidisciplinary, and system wide approach to implementation will be required. Identification of key stakeholders and agencies to move forward the recommendations should be coordinated by the DHSS to allow for ACT implementation in a timely fashion.

Recommendation 4A: When operational, engage the Mental Wellness and Addictions Recovery Advisory Group in a collaboration to build cultural safety and humility into the ACT process

At the time of this report the DHSS is in the development phase of a Mental Wellness and Addictions Recovery Advisory Group which will consist of NT residents who have lived experience with mental health and can provide their voices through engagement and consultation as related to cultural and contextual mental health issues that may arise. In the future, collaboration with this group would be beneficial for the ACT process as it could provide greater understanding to the impact in which ACTs will have on individuals, their families, and communities in the NT.

Recommendation 4B: In collaboration with relevant health care providers develop a policy manual and user guide to support health professionals in the implementation of ACTs

The DHSS released a guide to the Act in September of 2018 which included explanations of the roles and responsibilities of key individuals, understanding of the forms, the purpose and intended use of the mental health act review board and ACTs. While those interviewed felt that the guide was helpful for their understanding of the intended processes in the Act they did not feel it provided them with an overview that was beneficial as related to potential barriers and clinical scenarios which may present themselves as related to ACTs. The development of a user guide, in conjunction with recommendations one and two would be greatly beneficial.

Recommendation 5: Initiate a collaboration between the DHSS and the Department of Justice to identify ways to better support and treat individuals with serious mental illness who are involved with the legal system

In the future, a recommendation to mitigate some of these barriers would be to consider a collaborative network between the DHSS and DOJ to reconcile how best to approach collaboration in the mental health and justice systems in the NT. This would enable patients to receive care that is consistent and collaborative in nature whether in hospital, forensics, or community based care.

Conclusion

The evaluation process was highly beneficial to understanding the current real and perceived barriers to implementing ACTs in the NT. By understanding these barriers, recommendations have been created that can be implemented both in the near and later future that will improve issuance of ACTs. As some of the recommendations are related to amendments to the current legislation, recommendations will need to be shared with the DHSS's Department of Policy, Legislation and Communications (PLC) for consideration in advance to the ministerial review scheduled for 2023. With permission, these recommendations will be shared with the health authorities to make changes and begin execution of short term indicators which may improve confidence and capability of the health care providers included in this report.

This evaluation made it clear that health care practitioners want to provide this service for residents of the NT, but feel there are too many barriers at this time. Some of the most notable findings were the need for consistent education, concerns in the legislative wording which may require amendments, and the need for a collaborative approach to service delivery that would be impacted and utilized by ACTs. By mitigating these barriers, remaining focused on the principles of recovery focused care, and gaining clarity to any legislative amendments required then it will be possible to begin providing ACTs to residents. Although there are many recommendations in this report which will take time and system changes to enforce, the repercussions for service users, their families, health care providers and the health care system itself cannot be undervalued.

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Appendix A - Interview Questions for Psychiatrists and Community Mental Health Nurses

1. To what extent were the goals, expectations and processes of ACT issuance communicated to staff?
    a. To family and patients?
2. To what extent was the training for ACT delivery made available to health providers?
    a. What training did you receive regarding ACTs?
    b. Was it effective? Please explain.
3. Please describe your thoughts and ideas as to why ACTs have not been used?
    a. What do you think is going on?
4. Would you feel confident/competent to support a patient on a ACT at this time?
    a. Why or why not?
5. What do you think needs to change for ACTs to be effectively used to improve the quality of life for patients, families and communities?
    a. Do you think the legislated requirements for issuing an ACT are problematic?
    b. Are appropriate supports in place in the community to facilitate the issuance of an ACT?
    c. Are there appropriate treatment teams in place to facilitate the ACTs?
    d. Other?
6. Do you have any other thoughts or perspectives that are important for future implementation of ACTs in the NT?

Appendix B - Interview Questions for Physicians and Nurse Practitioners

We are gathering information from physicians and nurse practitioners to determine if they are aware of, or have attempted to issue an Assisted Community Treatment Order. The Assisted Community Treatment Orders - more commonly known in other jurisdictions as Community Treatment Orders were included in the 2018 Mental Health Act as a way of improving community treatment for patients who experience chronic mental illnesses and repeat hospitalizations.

1. Are you aware of Assisted Community Treatment orders in the Mental Health Act?
2. Please outline your understanding of the Assisted Community Treatment Orders (ACTs), including the expectations that are in place for physicians and nurse practitioners.
3. Were you provided training for issuing ACTs?
4. Is yes, was the training adequate?
5. Given that no ACTs have yet been issued in the NT, what do you think is preventing physicians and nurse practitioners from using ACTs?
6. If you had a client who committed to an ACT, would you feel confident in your knowledge, understanding and ability to support them? Please explain your answer.
7. What do you think needs to change in order for ACTs to be effective?
8. Do you have any other thoughts or perspectives that are important for future implementation of ACTs in the NT?

Appendix C - In-patient Psychiatry Focus Group/Questionnaire

Questions

1. To what extent were the goals, expectations and processes of ACT issuance communicated to the inpatient psychiatry staff?
    a. To family and patients?
2. To what extent was the training for ACT delivery made available?
    a. Did you receive any training? How effective was it?
    b. What is the role of nurses in facilitating ACTs?
3. What do you think is stopping physicians & NPs from using them?
4. Would you feel confident in supporting a patient to commit to an ACT at this time?
    a. Why or why not?
5. What do you think needs to change for ACTs to be effectively used to improve the quality of life for patients, families and communities?
    a. Do you think the legislated requirements for issuing an ACT are problematic?
    b. Are appropriate supports in place in the community to facilitate the issuance of an ACT?
    c. Are there appropriate treatment teams in place to facilitate the ACTs?
    d. Other?
6. Do you have any other thoughts or perspectives that are important for future implementation of ACTs in the NT?

Appendix D - Health Research Ethics Authority (HREA) Screening Tool

Student Name: Megan Wood

Title of Practicum Project: Evaluation Plan to explore the Barriers and Potential Facilitators to Better Understand the Lack of Uptake of Community Treatment Orders in the NT.

Date Checklist Completed: July 31, 2020

This project is exempt from Health Research Ethics Board approval because it matches item number three from the list below.

9. Research that relies exclusively on publicly available information when the information is legally accessible to the public and appropriately protected by law; or the information is publicly accessible and there is no reasonable expectation of privacy.
10. Research involving naturalistic observation in public places (where it does not involve any intervention staged by the researcher, or direct interaction with the individual or groups; individuals or groups targeted for observation have no reasonable expectation of privacy; and any dissemination of research results does not allow identification of specific individuals).
11. Quality assurance and quality improvement studies, program evaluation activities, performance reviews, and testing within normal educational requirements if there is no research question involved (used exclusively for assessment, management or improvement purposes).
12. Research based on review of published/publicly reported literature.

13. Research exclusively involving secondary use of anonymous information or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information.
14. Research based solely on the researcher's personal reflections and self-observation (e.g. auto-ethnography).
15. Case reports.
16. Creative practice activities (where an artist makes or interprets a work or works of art).

For more information please visit the Health Research Ethics Authority (HREA) at https://rpresources.mun.ca/triage/is-your-project-exempt-from-review/