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Research conducted at Regional Mental Health Care London and St. Thomas,
St. Joseph's Health Care, London
is part of Lawson Health Research Institute.

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www.lhrionhealth.ca/research/hohsr/

ISSN 1496-9971

Reforms to Ontario's Mental Health Act: Lessons from the story of the man who killed Brian Smith

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KEY WORDS

Community Treatment Order; CTO; Ontario; Bill 68; Arenburg.

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ABSTRACT

Purpose: The focus of this paper is Ontario's community mental health treatment legislation, which was named *Brian's Law* after Brian Smith, a popular sportscaster who Jeffrey Arenburg shot to death in 1995. At the time, Arenburg was not taking the medication that doctors had prescribed for his schizophrenic illness. The paper examines inconsistencies in the criteria for community treatment legislation that are crucial for its effectiveness.

Method: *Using materials available in the public domain*, we constructed Arenburg's clinical history. We drew information from several different sources: media, court records, coroner's inquest reports and reports from review board hearings. We used CanLi, LexisNexis and Google search engines. Where possible, court, inquest, criminal review board, and civil review board records were used as primary sources of information, and media reports were used as secondary sources. We describe five time periods: (1) Arenburg's life prior to his first psychiatric hospitalization; (2) Arenburg's clinical history before he killed Smith; (3) the murder trial; (4) treatment and supervision by Ontario's criminal review board; and (5) Arenburg's life after discharge by that Board.

Results: It was disconcerting to discover that Arenburg was arrested at the Canada-United States border

for assaulting an American customs officer, seven years after *Brian's Law* was proclaimed. Public records

indicate when he assaulted the officer, Arenburg was not being supervised and was not taking antipsychotic medication. Furthermore, an analysis of *Brian's Law* reveals that it is so narrow in scope that it would not have applied to Arenburg.

Conclusion: Ontario's community treatment order (CTO) requirements are more stringent than the requirements for inpatient committal even though inpatient committal imposes a much greater restriction on liberty. This is not the case in some other Canadian and most international jurisdictions. Arenburg's case history highlights the importance of ensuring that mental health reforms adequately address the needs of people with serious mental illness. It also demonstrates that antipsychotic medication can dissipate hallucinations and delusions, that when left untreated sometimes lead to serious violence.

INTRODUCTION

On August 1, 1995, Jeffrey Arenburg shot Brian Smith as he emerged from work at the CJOH radio station in Ottawa. Smith died the next day and the media took a keen interest in the killing of this popular sportscaster and ex-National Hockey League player. It was soon revealed that Arenburg had shot Smith in response to hallucinations and delusions. Furthermore, the media noted that Arenburg had previously assaulted a radio station manager in Nova Scotia as a result of similar psychotic symptoms, and that he was not receiving treatment when he killed Smith.¹

The incident generated considerable public concern and led to public calls for the introduction of community treatment orders (CTOs). These orders, created by statute, require patients with severe mental illnesses who meet specific criteria to attend appointments with mental health professionals and take recommended treatment. Failure to follow a CTO can result in the police bringing the person to a physician for an assessment to determine if he or she meets inpatient committal criteria. Essentially, CTOs allow patients, who would otherwise be detained in psychiatric facilities, the opportunity to live in the community if they accept clinical supervision and take the treatment needed to keep them well.

A coroner's inquest was held into Smith's death in 1997. The inquest jury recommended amending the Ontario Mental Health Act² to include CTOs and broaden the province's civil commitment criteria.³ In 2000, the Ontario government enacted these amendments and named the legislation Brian's Law⁴ in Smith's memory.

Naming these amendments in Smith's memory suggested that the new Ontario law would ensure that people like Arenburg would receive appropriate treatment and supervision. It was, therefore, disconcerting to learn in 2007, twelve years after killing Smith and seven years after the introduction of Brian's Law, that Arenburg had again been arrested for a violent assault while experiencing psychotic delusions. Arenburg attacked an American customs officer at the Peace Bridge in Fort Erie, Ontario.⁵ The

¹ Jacki Leroux, *Devastated friends try to reason why*, The Ottawa Sun, August 2, 1995, News 2; Maria McClintock, *Media drove maniac: Slain sportscaster 'random' victim*, The Toronto Sun, August 3, 1995, News 2; Sarah Green & Andrew Matte, *Suspect rated a risk: Held in sportscaster's death*, The Toronto Sun, August 4, 1995, News 2.

² Mental Health Act, R.S.O. 1990, c. M.7 (Can.).

³ Office of the Chief Coroner of Ontario, Province of Ontario, Inquest into the Death of Brian Smith Jury Verdict Explanation, recommendations 11 and 21, at pages 7 and 10, respectively (25 November 1997) [hereinafter *Jury Verdict and Recommendations*].

⁴ Brian's Law (Mental Health Legislative Reform), 2000, S.O. 2000, c. 9 (Can.).

⁵ *Arenburg lawyer ponders insanity defense*, The Ottawa Citizen, February 8, 2008, <http://www.canada.com/story.html?id=4d0c51ba-dfdf-4755-b2e5-09c0ca180645>; *Arenburg found guilty of assaulting officer*,

incident raised questions about both what happened to Arenburg following the killing of Smith and the efficacy of the law named in his memory. Had Arenburg been released from the criminal justice system without treatment and adequate supervision? Given that assaulting an armed American customs officer is unlikely to end well for the assailant, who was looking out for Arenburg's interests? Finally, would the legislation named after Smith have prevented Arenburg from killing Smith?

In an attempt to answer these questions, we reviewed Arenburg's clinical history. In previous work, we developed a method for constructing a clinical profile of individuals with mental illness using information available in the public domain.⁶ We anticipated that this method could be used in Arenburg's case, as his case had generated considerable media coverage, and we knew that additional public documents would be available from the Ontario Review Board.⁷

The confidentiality obligations of clinicians limit their ability to educate the public, policy makers and the legal profession about mental illness and its treatment. Given the volume of public information, the Arenburg case offers a rare opportunity to provide a detailed description of an individual's psychiatric illness, how it caused him to act violently and his response to treatment. Our research has also allowed us to examine previous media reports that Arenburg may not have met the criteria for a CTO under the legislation that was named after his victim.⁸ On a broader level, Arenburg's story underscores the importance of ensuring that mental health reforms actually address the ongoing needs of people with serious mental illness.

METHOD

Information was drawn from several different sources. The court records for Arenburg's murder trial were obtained from CanLii and LexisNexis. American court records were accessed through the Pacer Case

The Ottawa Citizen, May 22, 2008, <http://www.canada.com/ottawacitizen/news/story.html?id=76d2a4a0-e323-4901-a326-fe43a286ae94>

⁶ Robert Solomon et al, *Treatment Delayed - Liberty Denied*, 87:3 Can. Bar. Rev. at 690-91 (2008).

⁷ The Ontario Review Board, like the other provincial review boards, is a quasi-judicial agency that was created in 1992 under the Criminal Code, R.S.C. 1985, c. C-46 § 672.38 (Can.). Review boards are responsible for supervising suspects who have been found "unfit to stand trial" and individuals who have been found "not criminally responsible on account of mental disorder" (NCR) (*Id.* § 672.38(1)). The Criminal Code requires the review boards to assess each individual at least once a year and these assessments are generally in the public domain (*Id.* § 672.81(1)).

The Ontario Review Board must be distinguished from the Ontario Civil "Review Board" that adjudicated disputes about civil commitment, treatment and capacity issues under the Mental Health Act. This Ontario Civil Review Board was replaced by the "Consent and Capacity Review Board" in April 1995, which in turn was replaced by the "Consent and Capacity Board" in March, 1996. See respectively, Consent and Capacity Statute Law Amendment Act, 1992, S.O. 1992, c. 32, § 20(1) (Can.); and Health Care Consent Act, 1996, S.O. 1996, Schedule A, § 70(1) (Can.).

⁸ Scott Simmie, *When following an order would be wrong*, The Toronto Star, October 4, 1998; and Anita Szigeti, *Ontario Community Treatment Orders: How Did We Get There and Where Do We Go Now? An Advocate's Perspective*, 21 Health L. Can. 66 (2001).

Locator. We obtained the findings and recommendations of the coroner's inquest into Smith's death and the reports from Arenburg's criminal review board hearings from 1997 until 2006. We searched the internet search engine, Google, using the words "Jeffrey Arenburg" to find media sources. Where possible, court, inquest, criminal review board, and civil review board records were used as primary sources of information, and media reports were used as secondary sources.

Arenburg's Story

Our discussion of Arenburg's story is divided into five time periods: (1) Arenburg's life prior to his first psychiatric hospitalization; (2) Arenburg's clinical history before he killed Smith; (3) the murder trial; (4) Arenburg's life under Ontario Review Board supervision; and (5) Arenburg's life after discharge by that Board.

1. Arenburg's Life Prior to his First Psychiatric Hospitalization

Jeffrey Robert Arenburg was born in 1956 in Bridgewater, Nova Scotia. He completed grade nine and worked in several different jobs including as a fisherman for seven years.⁹ When he was thirty years old, Arenburg travelled to Ottawa and attempted to meet Joe Clark (the former Prime Minister of Canada) and Brian Mulroney (the then sitting Prime Minister). Parliamentary security staff identified Arenburg as a potential risk because he was talking about receiving radio broadcasts in his head, and they denied him entry to the Parliament buildings. This is the first reference in the record to Arenburg acting on his psychotic symptoms.¹⁰

In 1989, when Arenburg was thirty-two years old, he fell and suffered a spinal injury which resulted in a residual disability that necessitated using a cane while walking. He was unable to work and one year later entered Algonquin College in Ottawa to study materials management. Arenburg was still enrolled at the College when he killed Smith.¹¹

2. Arenburg's Clinical History Before he Killed Smith

In July 1990, at the age of thirty-three, Arenburg had his first psychiatric admission. Police brought Arenburg to the South Shore Regional Hospital in Bridgewater, Nova Scotia because he caused a disturbance at the local court house. Arenburg complained that his thoughts were being broadcast for everyone to hear. He believed that his ex-wife's family was selling his thoughts to MGM Studios and that

⁹ Arenburg (Re), Ottawa 8732-2475/97, at 2 (Can. Ont. Review Board June 3, 1997) [hereinafter *Arenburg (Re), 1997*].

¹⁰ Arenburg (Re), File 2475, at 2 (Can. Ont. Review Board, June 1, 2000) [hereinafter *Arenburg (Re), 2000*].

¹¹ *Id.*; and *Arenburg (Re), 1997, supra* note 9, at 2.

MGM intended to make a movie about them. Arenburg wanted this stopped and demanded that the court resolve the problem. He said that he had sought out Prime Minister Mulroney the previous year to find out why the court had delayed resolving the issue. Arenburg stated that if the broadcasting of his thoughts did not stop, he would burn down the house of his ex-wife's family or kill someone.¹²

Arenburg repeated these delusional beliefs while in hospital, but reportedly exhibited no other signs of mental disorder. Arenburg's physicians concluded that he had a paranoid psychosis.¹³ Arenburg promised to accept outpatient treatment and demanded to be discharged. He was allowed to leave hospital the day after he was admitted.¹⁴

In May 1991, Arenburg was admitted to the Royal Ottawa Hospital as an involuntary patient because he was threatening to harm the staff of the CHEZ radio station. He believed that CHEZ radio staff were broadcasting his thoughts on the radio, and he threatened to kill someone in order to bring the matter before a judge. Arenburg "eloped" from the hospital and went to the radio station where he talked about a government conspiracy and again threatened to kill the staff.¹⁵ The police were called and returned him to the hospital.

Arenburg applied to the Ontario Civil Review Board, as it was then called, to overturn his involuntary admission and the finding that he was incapable of consenting or refusing consent to treatment for his mental illness. Despite being informed of Arenburg's threats to harm the radio station staff, the Civil Review Board held that he could not be involuntarily detained. However, the Board confirmed that Arenburg was incapable of making treatment decisions. Following the ruling, Arenburg refused to remain in hospital and discharged himself against medical advice.¹⁶ He then returned to Nova Scotia.

In October 1991, Arenburg was admitted to the South Shore Regional Hospital in Bridgewater, Nova Scotia for the second time. This admission followed a second incident at the local court house. Arenburg broke windows because he was frustrated that he could not see a judge. He exhibited paranoid delusions similar to those he experienced during his previous admissions. Arenburg was transferred to a regional

¹² Arenburg (Re), No. 1437, para. 4 (Can. Ont. Review Board 2001) [hereinafter *Arenburg (Re), 2001*].

¹³ *Arenburg (Re), 1997, supra* note 9, at 3.

¹⁴ *Arenburg (Re), 2001, supra* note 12, para. 4.

¹⁵ *Id.* para. 6.

¹⁶ *Id.*

psychiatric hospital, where he was held as an involuntary patient and treated with antipsychotic medication.¹⁷

Arenburg's condition improved somewhat with treatment, but he continued to express delusions about a conspiracy involving court officials and the government. He was noted to have persistent hostility.¹⁸ After three weeks, Arenburg was returned to the South Shore Regional Hospital where he continued to describe auditory hallucinations, bizarre delusions and feelings of resentment about his mistreatment by authorities. He initially took antipsychotic medication after returning to the South Shore Regional Hospital, but then refused medication and demanded to be discharged. A doctor assessed Arenburg and concluded that he could not be detained involuntarily. Arenburg left the hospital the next day against medical advice. His discharge diagnosis was paranoid schizophrenia.¹⁹

Shortly after leaving the hospital, Arenburg attacked the manager of a local radio station. Arenburg believed that the radio station was broadcasting the voices that he was hearing.²⁰ Arenburg was arrested and charged with assault, but he left Bridgewater and returned to Ottawa before his case came to trial. From 1991 to 1994 he travelled back and forth from Ottawa to Bridgewater. In Ottawa, he tried unsuccessfully to meet with the new Prime Minister, Jean Chretien. In Bridgewater, he complained to the local sheriff about radio waves.²¹

When Arenburg returned to Nova Scotia in 1994, he was arrested on the outstanding assault charge. Even though Arenburg spoke incoherently at his trial about the radio waves, no psychiatric assessment was requested. Arenburg was convicted of assault and placed on probation. Apparently "*the court recognized that his antisocial behaviour had been directly related to his illness and it was assumed that psychiatric care would follow with him being placed on probation. Unfortunately, that did not occur.*"²² Arenburg went back to Ottawa, bringing with him a .22 calibre rifle.²³

¹⁷ *Arenburg (Re)*, 1997, *supra* note 9, at 3.

¹⁸ *Id.*

¹⁹ *Arenburg (Re)*, File 2475, at 4 (Can. Ont. Review Board May 10, 2005) [hereinafter *Arenburg (Re)*, 2005].

²⁰ *Arenburg (Re)*, 2001, *supra* note 12, para. 7.

²¹ *Id.*

²² *Arenburg (Re)*, 1997, *supra* note 9, at 4.

²³ *Arenburg (Re)*, 2001, *supra* note 12, para. 7.

Arenburg lived in Ottawa where he rented a two-bedroom apartment with a friend and his friend's girlfriend. He attended school regularly and “socialized with people he met at school, and went out for drinks, dinner and sports events.”²⁴

On August 1, 1995, Arenburg drove to the CJOH radio station in Ottawa. When Smith left the building at 6:50 p.m., Arenburg fired two shots at Smith using the rifle he had brought from Nova Scotia, one of which struck Smith in the forehead. Following the shooting, Arenburg drove away from the scene.²⁵ The next morning, Arenburg went to an Ottawa court and turned himself in. The Justice of the Peace described Arenburg as calm, cooperative and in full capacity of his senses. Arenburg was charged with attempted murder. He told the police officers that people did not understand that this was “a civil matter.”²⁶

3. The Murder Trial

After Smith's death, Arenburg's charge was changed to first-degree murder. The judge remanded Arenburg to the Royal Ottawa Hospital for sixty days to obtain a psychiatric assessment, including a determination of whether Arenburg was fit to stand trial.²⁷ This issue turns on whether an accused is able to communicate with his lawyer and to understand the nature, purpose and possible consequences of the criminal proceedings.²⁸ Arenburg was found fit to stand trial.²⁹

On September 29, 1995, Arenburg was discharged from the Royal Ottawa Hospital and presumably returned to jail to await trial.³⁰ On July 17, 1996, he was again admitted to the Royal Ottawa Hospital for a month. The available records do not indicate what led to this admission.³¹

Arenburg refused psychiatric treatment during the eighteen months following the homicide, despite being floridly psychotic with hallucinations and delusions.³² On February 17, 1997, a fitness jury agreed with defence counsel that Arenburg was unfit to stand trial.³³

²⁴ *Arenburg (Re)*, 2000, *supra* note 10, at 3-4.

²⁵ *Jury Verdict and Recommendations*, *supra* note 3, at 1.

²⁶ *Id.* at 2.

²⁷ A court may order an accused to be detained and subjected to a comprehensive psychiatric assessment if there is reason to believe that he or she is unfit to stand trial or was mentally ill at the time of the offence (Criminal Code, R.S.C. 1985, c. C-46 § 672.11 (Can.)).

²⁸ *Id.* § 2 *sub verbo* “unfit to stand trial”.

²⁹ *Jury Verdict and Recommendations*, *supra* note 3, at 2.

³⁰ *Arenburg (Re)*, 1997, *supra* note 9, at 6.

³¹ *Id.*

On February 18, 1997, the court ordered that Arenburg be admitted to the Royal Ottawa Hospital and treated for the limited purpose of attempting to make him fit to stand trial.³⁴ Arenburg was started on an injection of a long-acting antipsychotic medication, pipotiazine palmitate. After two months of treatment, Arenburg's auditory hallucinations were gone. By early April 1997, "he no longer felt justified in shooting Mr. Smith."³⁵ As of April 21, 1997, Arenburg was not exhibiting hallucinations or delusions. According to Dr. Bradford, a senior psychiatrist, it was apparent that Arenburg's schizophrenia was in full remission.³⁶

Arenburg was returned to court on April 28, 1997 and was found fit to stand trial. With the agreement of the Crown and defence, the jury trial began on April 29, 1997 and concluded the next day. Arenburg was found not criminally responsible on account of mental disorder (NCR) for first-degree murder.³⁷ On May 1, 1997, the trial judge ordered Arenburg detained at the Royal Ottawa Hospital, pending a hearing and disposition by the Ontario Review Board.³⁸

When an accused is found to be NCR, the court may make one of three dispositions – an absolute discharge, a conditional discharge or detention in a hospital. The court must make the least onerous and least restrictive disposition, taking into consideration the need to protect the public, the accused's mental condition, and his or her reintegration into society and other needs.³⁹ However, if the court does not make a disposition, the provincial criminal review board is authorized to do so.⁴⁰ As indicated, the criminal review boards are also responsible for the ongoing supervision of accused who are not fit to stand trial and individuals who have been found NCR.

³² Arenburg (Re), 2000, supra note 10, at 7. The Health Care Consent Act, 1996, S.O. 1996, Schedule A (Can.) does not authorize overriding a capable person's refusal of treatment in these circumstances. Pursuant to § 10(1) of the Health Care Consent Act, 1996, treatment cannot be initiated unless the patient is competent and has consented, or the patient is incompetent and his or her substitute-decision maker has consented. Capacity is defined broadly, and all individuals are presumed to be capable unless there are reasonable grounds to believe otherwise (Id. §§ 4(1), (3)). Presumably, Arenburg's treatment refusal was not overridden during this period because it had not been established that he was incapable.

³³ *Jury Verdict and Recommendations*, supra note 3, at 2.

³⁴ The Criminal Code does not generally authorize the involuntary treatment of mentally-ill suspects or prisoners (Criminal Code, R.S.C. 1985, c. C-46 § 672.55(1) (Can.)). However, a court may order an accused who is found unfit to stand trial to be detained and treated without consent for up to 60 days (Id. § 672.58). If the accused's condition remains unchanged, the criminal trial will be stayed. However, if the accused's condition improves and he or she becomes fit to stand trial, the criminal proceedings continue as if the fitness issue had never arisen (Id. § 672.28).

³⁵ Arenburg (Re), 2000, supra note 10, at 4.

³⁶ *Id.*

³⁷ *Jury Verdict and Recommendations*, supra note 3, at 2.

³⁸ *Id.* at 3.

³⁹ Criminal Code § 672.54.

⁴⁰ *Id.* § 672.47(1).

4. Arenburg's Life under Ontario Review Board Supervision

When the Ontario Review Board convened in June 1997, it ordered Arenburg to be detained at the Penetanguishene Mental Health Centre, a maximum security psychiatric facility.⁴¹ Dr. Bradford wrote in his report to the Board:

*“His illness is in remission [for] the first time probably since 1986. There is no question that when he was ill, Arenburg was dangerous; he threatened to commit homicide and ended up killing a complete stranger in a random killing. There is also no question that at this time he was floridly psychotic, driven by command hallucinations, and also had significant paranoid persecutory delusional beliefs. ... I would emphasize however that whatever disposition is continued, considerable caution and a slow and comprehensive process of psychiatric rehabilitation with Mr. Arenburg [is] necessary”.*⁴²

In September 1997, Arenburg was taken off injections of pipotiazine palmitate because of tremor and stiffness. In its place, he was treated with an oral antipsychotic, olanzapine, and was subsequently noted to be brighter and more mobile on the ward.⁴³ During the five years that Arenburg stayed at Penetanguishene, he continued to take olanzapine and did not experience hallucinations or delusions.⁴⁴

Arenburg was given increased privileges including community passes. In March 2003, he was released from the hospital: first staying at a group home and later in the year moving to live with his brother.⁴⁵ Despite leaving the hospital, Arenburg reported to the hospital every week and continued to be supervised by the Ontario Review Board.

In May 2005, after eight years under the Ontario Review Board supervision, Arenburg was conditionally discharged and the reporting requirement was reduced from weekly to monthly.⁴⁶ Arenburg's final Ontario Review Board hearing was held in November 2006.

At that hearing, Dr. Sheppard, Arenburg's psychiatrist, stated that if Arenburg stopped taking antipsychotic medication, his psychotic symptoms would likely return within weeks to months. However,

⁴¹ *Jury Verdict and Recommendations*, *supra* note 3, at 3.

⁴² *Arenburg (Re)*, 1997, *supra* note 9, at 7-8.

⁴³ *Arenburg (Re)*, File 0493-2475/98, at 2 (Can. Ont. Review Board 1998) [hereinafter *Arenburg (Re)*, 1998].

⁴⁴ *Arenburg (Re)*, No. 115, para. 10 (Can. Ont. Review Board 2007) [hereinafter *Arenburg (Re)*, 2007].

⁴⁵ *Id.* paras. 6, 10.

⁴⁶ *Arenburg (Re)*, 2005, *supra* note 19, para. 3.

Dr. Sheppard noted that Arenburg continued to respond to a low dose of olanzapine and that Arenburg's treatment team had no concerns about compliance. The treatment team recommended an absolute discharge.⁴⁷

The Ontario Attorney General retained a second psychiatrist, Dr. Klassen, to provide an independent assessment of Arenburg's mental state and risk to the public. Dr. Klassen concluded that Arenburg would likely take his medication after discharge and that he was not a significant risk to others.⁴⁸

Mr. Russell, counsel for the Attorney General, opposed an absolute discharge because of the risk to the public. He recommended that Arenburg remain on a conditional discharge order, but be subjected to a reduced reporting obligation. He contended that:

*“The risk arises because if the accused stops his medication, there will be an emergence of delusions, and that could lead to someone being killed as occurred in the index offence. ... [A]n absolute discharge would put the accused back into the same position he was prior to the index offence, and at that time, the accused was rejecting psychiatric treatment, was not on medication and was overtly psychotic in a manner that lead [sic] to the death of Mr. Smith”.*⁴⁹

Mr. Russell submitted that this risk was so high as to constitute a foreseeable and real risk.

The Ontario Review Board found no evidence to conclude that Arenburg was a significant risk to the public. The Board noted that Arenburg had been receiving new antipsychotic medication and had been free of symptoms for approximately nine years and granted him an absolute discharge. The granting of an absolute discharge ended Arenburg's obligation to accept any treatment or monitoring.

5. Arenburg's Life after Being Discharged

On November 29, 2007, one year after his absolute discharge, Arenburg was arrested for assaulting an American customs officer at the Peace Bridge in Fort Erie, Ontario. Arenburg did not have valid documentation to enter the US and was referred for a secondary inspection. When the officer attempted to conduct a “pat down” search, Arenburg punched him in the face.⁵⁰

⁴⁷ *Arenburg (Re)*, 2007, *supra* note 44, paras. 10, 14-15.

⁴⁸ *Id.* para. 18.

⁴⁹ *Id.* para. 22.

⁵⁰ *United States v. Arenburg*, W.L. 3286444, at 1 (W.D.N.Y. 2008).

Unfortunately, there are few details about Arenburg's life in the year between his absolute discharge and his arrest at the border. We do know that Arenburg had attempted to enter the United States earlier in the month, but was denied entry because he did not have the necessary documents.⁵¹

The American prosecutors believed that Arenburg had stopped taking antipsychotic medication before the assault,⁵² despite Arenburg's claims to the contrary.⁵³ Arenburg initially said that the incident had "*nothing to do with hearing voices in my head.*"⁵⁴ However, he subsequently stated, "*I'm not saying I didn't hit the man, I'm saying they're guilty of hiding the microwave channel in my name.*" Arenburg stated in court that he was cured of paranoid schizophrenia: "*I've worked my way out of it.*"⁵⁵

A forensic psychologist who assessed Arenburg reported that his paranoid schizophrenia was in remission. The psychologist also stated that Arenburg was fit to stand trial and was capable of appreciating the wrongfulness of the assault on the officer.⁵⁶

However, Arenburg's subsequent behaviour in court raised doubts about his fitness and generated legal proceedings that continued long after his initial trial.⁵⁷ In a letter to the court read at his indictment on April 3, 2008, Arenburg referred to "*radio stations airing my thoughts all over the world ... through TV channels.*"⁵⁸ During the trial, Arenburg was preoccupied with trying to confirm that there was a conspiracy to broadcast his thoughts.

Despite the trial judge's reservations, Arenburg dismissed his lawyer and chose to represent himself. In his opening statement, Arenburg told the jury that he was "*going to prove that MGM [Studios] is hiding the illegal drug trade in my name through the radio stations that you can call up or they can call you to*

⁵¹ Jackson Hayes & Josh Wingrove, *Journalist's killer arrested again*, The Toronto Star, December 3, 2007, <http://www.thestar.com/news/gta/article/281990--journalist-s-killer-arrested-again>.

⁵² *Arenburg lawyer ponders insanity defence*, The Ottawa Citizen, February 8, 2008, <http://www.canada.com/story.html?id=4d0c51ba-dfdf-4755-b2e5-09c0ca180645> [Lawyer ponders].

⁵³ *Arenburg insists he was taking medication when he assaulted guard*, The Ottawa Citizen, September 9, 2008, <http://www.canada.com/ottawacitizen/news/story.html?id=5fa6d8d3-00fc-482e-9ac8-137c224de383>.

⁵⁴ Lawyer ponders, *supra* note 52.

⁵⁵ *Arenburg found guilty of assaulting officer*, The Ottawa Citizen, May 22, 2008, <http://www.canada.com/ottawacitizen/news/story.html?id=76d2a4a0-e323-4901-a326-fe43a286ae94> [Arenburg found guilty].

⁵⁶ *US v Arenburg, 2008, supra* note 50.

⁵⁷ The final appeal on the issue of whether Arenburg had been competent to represent himself concluded on May 25, 2010, about eight months after he had served his sentence and was deported to Canada. *United States v. Arenburg*, 605 F.3d 164 (2d Cir. 2010).

⁵⁸ *United States v. Arenburg*, W.L. 3286444, at 2 (W.D.N.Y. 2008).

*tell people how to treat me or to find out about me because of MGM.”*⁵⁹ He questioned government witnesses about secret broadcasts, which he called the “*microwave channel*”, claiming that they began twenty years ago after he called a radio station and talked “*into a blank tape.*” He claimed that a major movie studio was turning his thoughts into films and accused the government of trying to cover this up.⁶⁰

On May 21, 2008, the jury found Arenburg guilty of assaulting a federal customs officer. Arenburg was sentenced to two years imprisonment and ordered deported upon release. On September 6, 2009, nearly two years after the assault, Arenburg was released from prison and deported to Canada.

DISCUSSION

Legislative Reform

The coroner’s jury in the inquest into Brian Smith’s death made seventy-two recommendations. Partly in response to these recommendations, the Ontario government proclaimed in force An Act, in memory of Brian Smith, to amend the Mental Health Act and the Health Care Consent Act, 1996.⁶¹ Brian’s Law, as it is commonly called, broadened the involuntary admission criteria and introduced CTOs. We will review whether these two key amendments would likely have prevented Smith’s death.

Prior to Brian’s Law, Ontario’s Mental Health Act restricted involuntary admission to individuals who were suffering from a mental disorder that was likely to result in: serious bodily harm to the patient; serious bodily harm to another person; or imminent and serious physical impairment of the patient. Brian’s Law eliminated the immanency for serious physical impairment of the patient, but left the other two criteria unchanged.⁶²

In addition, Brian’s Law introduced a new ground for involuntary admission based on a history of mental illness that, when not treated, posed a risk of serious bodily harm, substantial mental or physical deterioration, or serious physical impairment.⁶³ Section 20(1.1) of the Mental Health Act⁶⁴ authorizes physicians to invoke this provision if they are of the opinion that the patient:

⁵⁹ See *Arenburg*, 605 F.3d, at 4.

⁶⁰ Arenburg found guilty, *supra* note 55.

⁶¹ Brian’s Law (Mental Health Legislative Reform), 2000, S.O. 2000, c. 9 (Can.).

⁶² *Id.* § 6(4).

⁶³ *Id.* § 7(2).

⁶⁴ Mental Health Act, R.S.O. 1990, c. M.7 (Can.).

- (a) has previously received treatment for a mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person;
- (b) has shown clinical improvement as a result of the treatment;
- (c) is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;
- (d) is likely to cause serious bodily harm to him or herself or others, or is likely to suffer substantial mental or physical deterioration or serious physical impairment;
- (e) is incapable, within the meaning of the Health Care Consent Act, 1996⁶⁵ of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained; and
- (f) is not suitable for admission or continuation as an informal or voluntary patient.

Subsections (a), (b) and (c) restrict this new basis for involuntary admission to individuals who received treatment for a recurring mental disorder that had previously responded to treatment. Subsection (d) introduces a new factor in the involuntary admission criteria, namely a patient's substantial mental or physical deterioration. It is the addition of this "deterioration" factor that broadens the pre-existing involuntary admission criteria. Subsection (e), which requires the substitute decision maker's consent to treatment, ensures that incapable patients who are involuntarily detained can be treated. Presumably, subsection (e) was added because, unlike the legislation in some other provinces,⁶⁶ the *MHA* does not authorize the treatment of involuntary patients without their consent or that of their substitute decision maker.⁶⁷

The introduction of a deterioration criterion for involuntary commitment has played an important role in facilitating the use of CTOs, the second major change under Brian's Law.⁶⁸ To be placed on a CTO, Brian's Law requires that the patient meet the provincial involuntary inpatient committal criteria. However, physicians are likely to be reluctant to place a person on a CTO and treat that person in a community setting if they have assessed the person as posing a risk of physical harm to themselves or to

⁶⁵ Health Care Consent Act, 1996, S.O. 1996, Schedule A, § 4 (Can.); See also *supra* note 7.

⁶⁶ See for example, section 31(1) of the Mental Health Act, R.S.B.C 1996, c.288 (Can.).

⁶⁷ See for example, *Starson v. Swayze* (2003), 225 D.L.R (4th) 385 (Can. S.C.C); *Neto v. Klukach* (2004), 12 Admin. L.R. (4th) 101 (Can. Ont. Sup. Ct. J.).

⁶⁸ Brian's Law (Mental Health Legislative Reform), 2000, S.O. 2000, c. 9 (Can.).

others. Physicians are more comfortable treating patients in community settings when the identified risk is mental or physical deterioration - which can presumably be prevented by mandatory supervision and treatment.⁶⁹

In addition to meeting the involuntary committal criteria, a person being placed on a CTO for the first time must have been admitted to an Ontario psychiatric facility on two separate occasions, or have a cumulative period of hospitalization totalling thirty days or more within the previous three years.

Although Ontario introduced CTOs in response to Brian Smith's death, it is ironic that Arenburg would not have met the statutory requirements for a CTO before he killed Smith for two reasons. First, Arenburg would not have met the CTO requirement for two previous hospitalizations in Ontario. Arenburg was admitted to an Ontario psychiatric unit only once – not twice as required by Brian's Law. That single admission was to the Royal Ottawa Hospital from May 16 to June 11, 1991, a period of twenty-six days - less than the thirty days required by Brian's Law. While Arenburg had been admitted previously in Nova Scotia, these admissions occurred out of province and would not have counted toward the requirements under Ontario law.

Second, when Arenburg was hospitalized in Ontario, the Ontario Civil Review Board held that he did not meet the criteria for involuntary admission, and therefore could not have been placed on a CTO at the time of his discharge from hospital.⁷⁰ Moreover, Arenburg would not have met Ontario's broadened committal criterion, introduced under Brian's Law. Apparently, Arenburg did not undergo any psychiatric treatment during or after his first psychiatric admission in Nova Scotia, which lasted for a single day. Treatment with antipsychotic medication requires at least several days to take effect. Therefore, there would have been no evidence that Arenburg's mental disorder had previously responded to treatment, as required by the amended involuntary admission criteria.⁷¹

Nor would Arenburg have qualified for a CTO under Nova Scotia's 2007 legislation. He would not have satisfied Nova Scotia's previous psychiatric hospitalization requirements, namely a minimum of sixty days or two admissions within the previous two years.⁷² These are even more restrictive than Ontario's

⁶⁹ The limited research on this topic indicates that most CTOs are based on a risk of mental or physical deterioration. See Ann-Marie O'Brien, *Dangerousness or Deterioration: What Criteria are Psychiatrists Using to Issue CTOs?* Paper delivered at the 31st International Congress on Law and Mental Health, New York, NY. June 28, 2009 – July 3, 2009, <http://www.ialmh.org/template.cgi?content=NewYork2009/main.html> at 143.

⁷⁰ *Arenburg (Re)*, 2001, *supra* note 12, at para 6.

⁷¹ Mental Health Act, R.S.O. 1990, c. M.7, § 20(1.1)(a)-(b) (Can.).

⁷² Involuntary Psychiatric Treatment Act, S.N.S. 2005, c.42, § 47(3)(a)(iv) (Can.).

requirements. Moreover, as in Ontario, to be eligible for a CTO in Nova Scotia a person must first meet the requirements for involuntary admission.⁷³ During both of Arenburg's admissions in Nova Scotia, physicians concluded that he was not certifiable and allowed Arenburg to discharge himself.

It is generally accepted that mental health statutes should impose the least restrictive conditions on the liberty of the individual.⁷⁴ Indeed, the Ontario Mental Health Act explicitly adopts this principle, stating that: “[t]he purpose of a community treatment order is to provide a person who suffers from a serious mental disorder with a comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility.”⁷⁵

Since CTOs are less restrictive than inpatient committals, it is illogical to impose more stringent qualification requirements on CTOs than on involuntary admissions. Yet, this is exactly what Ontario has done by limiting CTOs to patients who meet a prior hospitalization requirement in addition to the involuntary committal criteria. Moreover, as Table 1: Requirements for Involuntary Admissions and Community Treatment Orders in Ontario⁷⁶ illustrates, Ontario has imposed several other limits on qualifying for CTOs that are not required for involuntary admissions.

⁷³ *Id.* §§ 17, 47(3)(a).

⁷⁴ Richard L. O'Reilly et al, *Principles Underlying Mental Health Legislation*, 55:10 *Can. J. Psychiatry* P1 (2010); Chih-Yuan Lin, *Ethical Exploration of the Least Restrictive Alternative*, 54:6 *Psychiatr. Serv.* 866 (2003).

⁷⁵ Mental Health Act, R.S.O. 1990, c. M.7, § 33.1(3) (Can.).

⁷⁶ *Id.* §§ 20, 33.1.

TABLE 1: Requirements for Involuntary Admissions and Community Treatment Orders in Ontario⁷⁶

ISSUE	INVOLUNTARY ADMISSIONS	COMMUNITY TREATMENT ORDERS
Purpose	Not stated	“Provide a comprehensive plan of community-based care and supervision that is less restrictive than being detained in a psychiatric facility”
Presence of a Mental Disorder	Yes	Yes
Risk Requirement	Risk of serious bodily harm OR substantial mental or physical deterioration	Risk of serious bodily harm OR substantial mental or physical deterioration
Prior Hospitalization	Not required	Must have two or more separate admissions or a total of >30 days in hospital in previous 3 years
Consent Regarding Treatment	Not required if committal is based on dangerousness criteria, but required if committal is based on deterioration criteria	Consent required from the patient (if capable) or from the substitute decision maker (if the patient is incapable)
Treatment Plan	Not required	Physicians must develop a treatment plan with the patient (if capable) or their substitute decision maker (if incapable) and other clinicians involved in the patient’s treatment or supervision
Duration	3-month maximum (renewable)	6-months maximum (renewable)
Discharge Criterion	Patient no longer meets any of the criteria	Patient no longer meets any of the criteria or the original consent is withdrawn

Some scholars have argued that CTOs are no less restrictive than involuntary hospitalization.⁷⁷ These scholars note that patients may remain on the CTOs for extended periods of time, whereas most inpatient hospital care is only available for short periods of time.⁷⁸ Therefore, while the locus of treatment and supervision under a CTO is less restrictive, the deprivation of liberty may be for a longer period of time. Ultimately, patients must weigh the importance of duration of compulsory supervision and treatment versus locus of treatment in determining whether inpatient or outpatient committal is least restrictive. The existing research data, albeit limited, indicate that patients view CTOs as less restrictive. When patients, suffering from schizophrenia, were asked whether they would prefer to be involuntarily hospitalized or placed on a CTO, they overwhelmingly chose placement on a CTO.⁷⁹ Moreover, a similar preference for compulsory treatment in the community, rather than hospitalization has been reported by patients in qualitative research studies.⁸⁰

⁷⁷ Shelley Trueman, *Community Treatment Orders and Nova Scotia: The Least Restrictive Alternative?* 11:1 Health L.J. at 16-20 (2003).

⁷⁸ Delphine Capdevielle & Karen Ritchie, *The Long and the Short of It: Are Shorter Periods of Hospitalisation Beneficial?*, 192:3 Br. J. Psychiatry 164 (2008). [The Long and the Short of It].

⁷⁹ Marvin S. Swartz et al, *Assessment of Four Stakeholder Groups’ Preferences Concerning Outpatient Commitment for Persons with Schizophrenia*, 160:6 Am. J. Psychiatry 1139 (2003).

⁸⁰ Anita Gibbs et al, *How Patients in New Zealand View Community Treatment Orders*, 14:4 J. Ment. Health 357 (2005); Richard L. O’Reilly et al, *A Qualitative Analysis of the Use of Community Treatment Orders in Saskatchewan*, 29:6 Int. J. Law Psychiatry

As is the case in Ontario, three of the remaining provinces with CTOs (Saskatchewan, Nova Scotia, and Newfoundland and Labrador) have a prior hospitalization requirement. In contrast, Alberta's legislation provides that a CTO may be issued if the person has been in an approved hospital, or "*lawfully detained in a custodial institution*" and two physicians agree that while there he or she would likely have met the involuntary admission criteria.⁸¹ The Act also provides an alternative criterion whereby a person may be placed on a CTO if he or she "*exhibited a pattern of recurrent or repetitive behaviour that indicates that 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.*"⁸²

The eight Australian jurisdictions with CTOs do not require prior hospitalization.⁸³ Nor do most of the forty-four US states that have legislated CTOs.⁸⁴ New Zealand's legislation not only eschews the need for prior hospitalization, it explicitly directs that the less restrictive option must be followed. When a New Zealand court determines that a person meets the civil commitment criteria, the legislation directs that the court "*shall make a community treatment order unless the court considers that the patient cannot be treated adequately as an outpatient, in which case the court shall make an inpatient order*".⁸⁵

Purpose of CTOs

Whether the CTO legislation includes a prior hospitalization requirement partially reflects different rationales for introducing CTOs. A review of the literature suggests that the major purposes of CTO legislation are to:

- (a) provide a less restrictive alternative to involuntary inpatient hospitalization;
- (b) reduce the "revolving door" phenomenon;
- (c) reduce harm to members of the public; and
- (d) maximize the potential for patient recovery.

524 (2006); Krysia Canvin et al, *A 'Bittersweet Pill To Swallow: Learning from Mental Health Service Users' Responses To Compulsory Care in England*, 10:5 Health Soc. Care Community 361 (2002).

⁸¹ Mental Health Act, R.S.A. 2000, c.M-13, § 9.1(1)(b)(i)(B)-(C) (Can.).

⁸² *Id.* § 9.1(1)(b)(iii).

⁸³ John Ellery Gray et al, *Australian and Canadian Mental Health Acts Compared*, 44:12 Aust. N. Z. J. Psychiatry 1126 (2010).

⁸⁴ The majority of the US states that require prior hospitalization use a lower standard for outpatient as opposed to inpatient committal. See *Assisted Psychiatric Treatment: Inpatient and Outpatient Standards by State*, Treatment Advocacy Center (June 2011), http://www.treatmentadvocacycenter.org/storage/documents/new_the_updated_state_standards_chart.pdf

⁸⁵ Mental Health (Compulsory Assessment and Treatment) Act 1992, SR 1992/46, § 28(2) (N.Z.).

As indicated, the Ontario legislation states that the purpose of a CTO is to provide “...a *comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility.*”⁸⁶ However, the section then focuses on the typical revolving door patient:

*“Without limiting the generality of the foregoing, a purpose is to provide such a plan for a person who, as a result of his or her serious mental disorder, experiences this pattern: The person is admitted to a psychiatric facility where his or her condition is usually stabilized; after being released from the facility, the person often stops the treatment or care and supervision; the person’s condition changes and, as a result, the person must be re-admitted to a psychiatric facility.”*⁸⁷

The phrase “[w]ithout limiting the generality of the foregoing ...” clearly indicates that addressing the needs of revolving door patients is only one of the purposes of the CTO provisions. Rather, the less restrictive community-based treatment option provided by CTOs should be available to all patients who meet the statutory criteria. The prior hospitalization requirement conflicts with the broader goals of CTOs by restricting their use to people who have at least started the revolving door pattern.

Naming the legislative amendments in Brian Smith’s memory adds to this confusion by suggesting that their primary purpose is to protect the public. However, the policy debate preceding the introduction of CTOs shows that their main proponents (family members represented by the Schizophrenia Society of Ontario and psychiatrists represented by the Ontario Medical Association) advocated for CTOs as a way of ensuring that patients received continued treatment and supervision so as to maximize their potential.⁸⁸

The Ontario experience of a government publically portraying CTOs as a means of reducing the risk of violence is not unusual. In several other jurisdictions, a random act of violence by a person with a mental illness was the final catalyst for legislative action, with legislation being named in the victim’s memory.⁸⁹ In our view, this approach unduly emphasizes the link between mental illness and violence, and is unnecessarily stigmatizing. While people with severe mental illness are more likely than other members

⁸⁶ Mental Health Act, R.S.O. 1990, c.M.7, § 33.1(3) (Can.).

⁸⁷ *Id.*

⁸⁸ *Community Treatment Orders: Is Patient Freedom Being Violated?*, Network. 14:2 4, at 6,8 (Summer 1998), <http://www.ontario.cmha.ca/network.asp?cID=1367>.

⁸⁹ In addition to Brian’s Law (Mental Health Legislative Reform), 2000, S.O. 2000, c. 9 (Can.), see in New York Kendra’s Law, N.Y. Mental Hyg. Law § 9.60 (2006); and in California, Laura’s Law, Cal. Welf. & Inst. Code §§ 5345-5349.5 (West Supp. 2007).

of the public to perpetrate violent acts,⁹⁰ serious assaults and homicides involving strangers are rare⁹¹ and hard to predict.⁹²

While the reduction of serious violence is unlikely to be the primary benefit of CTOs for the reasons outlined above, there is evidence that CTOs do reduce violent behaviour.⁹³ Moreover, we argue that Arenburg's history of threats and physical violence caused by delusions, coupled with the failure to treat these delusions, made further violence entirely predictable. Arenburg's subsequent clinical history shows that when he received sustained treatment with antipsychotic medication, his symptoms fully remitted. Moreover, Arenburg's psychotic symptoms only returned when he apparently stopped his medication. Therefore, it is difficult not to conclude that Smith's life could have been saved, and Arenburg's life could have been much less restricted, had he received appropriate psychiatric treatment earlier.

So what treatment did Arenburg need? Patients with psychotic illnesses, such as schizophrenia, start showing improvement in their hallucinations and delusions after several days of antipsychotic treatment.⁹⁴ However, complete resolution of symptoms sometimes takes up to eight weeks of treatment,⁹⁵ and some patients do not recover fully. The development of insight - awareness that the hallucinations and delusions are a product of illness - may require many months of additional treatment and again for many patients, full insight is never achieved.⁹⁶ A course of sustained treatment could have been administered during any one of Arenburg's three hospital admissions before he killed Smith. This did not happen on two admissions because a physician discharged Arenburg despite his recent threats to harm others and the

⁹⁰ Although this conclusion is still occasionally challenged in the literature, most scholars have accepted that there is an association. Prominent researchers, such as Professor John Monahan, who at one point had argued against an association, issued a consensus statement with mental health advocates acknowledging the association in 1994 (John Monahan & Jean Arnold, *Violence by People with Mental Illness: A Consensus Statement by Advocates and Researchers*, 19:4 *Psychiatr. Rehabil. J.* 67 (1996)).

Subsequent methodologically rigorous studies have confirmed the association. Overall, the association is modest and stronger among females than among male offenders. It is also stronger in cases of homicides as opposed to less severe violence (Patricia A. Brennan et al, *Major Mental Disorders and Criminal Violence in a Danish Birth Cohort*, 57:5 *Arch. Gen. Psychiatry* 494 (2000)); Seena Fazel et al, *Schizophrenia and Violence: Systematic Review and Meta-Analysis*, 6(8):e 1000120. *PLoS Med.* (Epub August 11, 2009)).

⁹¹ Olav Nielssen et al, *Homicide of Strangers by People with a Psychotic Illness*, 37:3 *Schizophr. Bull.* 572 (2011).

⁹² Jeffrey Swanson, *Explaining Rare Acts of Violence: The Limits of Evidence from Population Research* 62:11 *Psychiatr. Serv.* 1369 (2011).

⁹³ Bruce G. Link et al, *Arrest Outcomes Associated with Outpatient Commitment in New York State*, 62:5 *Psychiatr. Serv.* 504 (2011).

⁹⁴ *Drugs and Other Physical Treatments*, in Michael Gelder, Paul Harrison, & Philip Cowen, eds, *Shorter Oxford Textbook of Psychiatry*, 5th ed (Oxford, UK: Oxford University Press, 2006) 539 at 517-576.

⁹⁵ Robin Emsley et al, *Time Course for Antipsychotic Treatment Response in First-Episode Schizophrenia*, 163:4 *Am. J. Psychiatry* 743 (2006).

⁹⁶ Faith B. Dickerson et al, *Lack of Insight Among Outpatients with Schizophrenia*, 48:2 *Psychiatr. Serv.* 195 (1997).

continued presence of psychotic symptoms. The Ontario Civil Review Board also overturned Arenburg's involuntary hospitalization in very similar circumstances.

Based on the information in the public record, it is our view that Arenburg could have been detained at the time of those admissions under the existing Nova Scotia and Ontario mental health acts. It is possible that the Ontario Review Board documents, upon which we relied, omitted important details that convinced his doctors and the Civil Review Board that he did not meet the committal criteria on these occasions. However, it is difficult to understand how anything, short of factual error in the Ontario Review Board records, could satisfactorily explain why Arenburg was only hospitalized for one day after his first admission in Nova Scotia when he threatened to kill somebody as a result of his hallucinations and delusions.

We suspect that the shortage of inpatient psychiatric beds, brought about by the ongoing process of deinstitutionalization, influenced at least some of these decisions not to treat Arenburg in hospital for a longer period. Other scholars have noted that the application of committal criteria is dependent on the availability of psychiatric beds.⁹⁷ They have also questioned whether deinstitutionalization has reduced the number of available beds to levels where patients who pose a serious risk to themselves or others are either not admitted or are discharged prematurely.⁹⁸

Regardless of whether deinstitutionalization has gone too far, there is little likelihood that the next decade will see a reversal in the trend to reduce the number of psychiatric beds. The development of CTO legislation is a direct result of deinstitutionalization, which necessitated having to treat in the community patients who lack insight and develop dangerous behaviours when ill.

CONCLUSION

Clinicians are now required to manage individuals with serious mental illnesses who have no appreciation of their need for treatment in community settings. In many cases, this can only be safely achieved by employing some form of compulsory community treatment scheme. The details of the CTO legislation are critical in determining its effectiveness. Complex and restrictive CTO legislation tends to be ignored by clinicians.⁹⁹ The absence of, or failure to use, CTO legislation will leave people like Arenburg

⁹⁷ Nancy B. Engleman et al, *Clinicians' Decision Making about Involuntary Commitment*, 49:7 *Psychiatr. Serv.* 941 (1998).

⁹⁸ Povl Munk-Jorgensen, *Has Deinstitutionalization Gone Too Far?*, 249:3 *Eur. Arch. Psychiatry Clin. Neurosci.* 136 (1999); *The Long and the Short of It*, *supra* note 78.

⁹⁹ John Dawson, *Fault-lines in Community Treatment Order Legislation*, 29:6 *Int. J. Law Psychiatry* 482 (2006); Anita Wandzura, *Community Treatment Orders in Saskatchewan: What Went Wrong?* 71:2 *Sask. L. Rev.* 269 (2008).

unsupervised and untreated in the community. This will have serious consequences both for that person and for the public. We argue that it is illogical to make the CTO requirements more stringent than those for involuntary admission. More specifically, we recommend that prior hospitalization should not be a requirement of CTO statutes that require a person to meet the jurisdiction's inpatient committal standards.

ACKNOWLEDGEMENT

This study was supported by funding from the Department of Psychiatry and the Faculty of Law at Western University, London, Ontario. We greatly appreciate the assistance of Joanne Chapman, Jordan Schubert and Ailbish Skinner in preparing the manuscript.