Commentary: Framing People as the Problem: The Effects of Problem Definition in ‘Brian’s Law’ on People with Mental Illness

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INTRODUCTION

For several decades, Ontario stakeholders have recognized the need for mental health reform, expressing the need to shift focus away from psychiatric facilities and hospitals to more community-based services. Due to policy legacies and institutional constraints, as well as historical neglect and underfunding compared to other health care sectors, the pace of mental health reform has been slow. Nevertheless, a few landmark events have marked important steps towards mental health reform; the introduction of community treatment orders (CTOs) in the Ontario Mental Health Act (OMHA) amendments in 2000 (Section 33.1), known as ‘Brian’s Law’ or Bill 68, provides one such example. CTOs are contracts that outline comprehensive plans for community-based treatment with the goal of providing individuals suffering from serious mental disorder with less restrictive means of treatment rather than detainment in psychiatric facilities. However, the addition of CTOs to the OMHA may have had unanticipated consequences, particularly for those placed on them. Since CTOs have been on the provincial agenda, they have been subject to much debate and conflicting opinions.

Many studies and evaluations have been conducted on CTOs, including comprehensive provincially legislated reviews, which have shown both positive and negative results. These reviews are often limited to traditional outcome measures, such as the number of CTOs issued and their associated patient demographics, without deeper analysis of the engrained effects that result from the way the policy is framed. Policy literature states that at any given time an overwhelming number of problems compete for policy makers’ attention. Focusing events, like a crisis or disaster, can be strategically portrayed as powerful symbols of existing problems in order to rapidly bring issues to the attention of policy makers. In this way, problems do not merely exist waiting to be solved, rather, policy problems are actively created and framed by governments. Thus, the way in which the problem is represented has many important effects, including proposed solutions. In the case of CTOs, the problem is framed as ‘the untreated mentally ill living in the community pose a threat to society’ and CTOs are proposed as the solution. This problem representation creates underlying discursive, subjectification, and lived effects for those living with mental illness, their families, healthcare providers and the public that merit careful consideration.

DISCURSIVE EFFECTS

Discursive effects are the limits imposed through discourse, which result from the way a policy is framed. Ontario’s CTO legislation was dubbed “Brian’s Law” and was passed “in memory of Brian Smith” (a prominent Ottawa sportscaster) who was murdered by Jeffrey Arenburg, an individual diagnosed with paranoid schizophrenia. The very name and history of Brian’s Law serves as a constant reminder of the violent murder, and has the potential to create long-lasting discursive effects by framing untreated outpatients as a threat to society and a problem that must be addressed. This representation remains silent on several important points and perpetuates negative stigma surrounding mental illness. In fact, no compelling evidence suggests mental illness causes violence, and in reality, those with mental illness are much more likely to be victims of violence than the general population. A review of the media coverage revealed an imbalance in the narratives of Smith and Arenburg, which painted Smith as a model citizen with a loving family and rich life-history, while Arenburg was portrayed as a “mentally ill drifter”, “deranged”, and a “paranoid schizophrenic” in narratives that were “practically devoid of personal detail”. The enduring effects of stigma are difficult to quantify, yet they can still restrict opportunities for further policy reform and create devastating effects for
the lives of people with mental illness. Alternatively, the legislation amendments could have been framed as ‘Arenburg’s Amendment’, paying homage to the victim of an underfunded, neglected mental health system which might have proposed further increases in funding to support a more comprehensive range of services as the solution.

SUBJECTIFICATION EFFECTS

Subjectification effects result from the way in which policies organize social relationships, creating subjects and opposing groups. These effects are heavily based on ‘dividing practices’, pitting one group against another. By creating the dichotomies of patient vs. the community and threat vs. public safety, people with mental illness are further alienated from the rest of society. By perpetuating the dichotomy of us-them, being placed on a CTO may further alienate people with mental illness causing people to feel isolated and humiliated. In this regard, the evidence from Ontario suggests mixed findings; at one extreme, some people on CTOs report feeling like “criminals”, while others with few family members or friends, found appointments associated with the CTO were an opportunity for social interaction and thus felt less isolated.

The latest evaluation report suggests that a large and increasing majority of CTOs in Ontario are consented to by substitute decision makers and that for some individuals on CTOs, involuntary treatment has resulted in an even further sense of alienation, oppression, and helplessness. The majority (>50%) of stakeholder participants, including health care providers and CTO coordinators, surveyed in the evaluation of Ontario CTOs agreed that the legal safeguards in place to protect patient rights were inadequate. Treating patients as powerless subordinates can heighten their perceptions of increased scrutiny and isolation, decreased morale and feelings of decreased self-worth, ultimately reinforcing existing power relations.

LIVED EFFECTS

Lived effects are the concrete, day-to-day, materializations that emerge from problem representations. CTO legislation places physicians as central actors in the administration of CTOs. While other health care providers, substitute decision makers, and the person being placed on the CTO may be consulted, only physicians can officially issue a CTO. This can result in community treatment plans that emphasize the use of medical interventions without enough attention being paid to the use of complementary psychosocial models of treatment. Such complementary treatment modalities include psychoeducation, vocational interventions, peer support and self-help programs which, according to Canadian clinical guidelines, are necessary in most cases to achieve comprehensive recovery. The most recent review emphasizes that CTOs are only as effective as the community treatment plan upon which they are based, and finds that CTO treatment plans vary considerably throughout the province, with some referring only to administration of medication and necessary appointments, while others were more comprehensive.

A further set of lived effects is the additional burden on community health care providers and patient advocacy organizations stemming from CTO legislation. The Psychiatric Patient Advocate Office experienced a six-fold increase in requests for rights advice related to CTOs from 2002 to 2009. While an influx of funding to community-based mental health agencies was initially provided for the purposes of accommodating the increase in outpatient CTO cases, the number of outpatients has since disproportionately outgrown the given funding. The shift to community-based treatment cannot simply end at the ratification of legislation, but rather the increased cost and pressure on community services must be addressed to ensure future adequacy of care.

IMPLICATIONS & RECOMMENDATIONS

The way in which the OMHA CTO legislation frames the problem (1) serves to perpetuate negative stigma surrounding mental illness, (2) has the potential to impede post-discharge recovery and reintegration into society, and (3) emphasizes the importance of medication without giving due attention to the full spectrum of additional supports required to provide comprehensive community treatment plans that support recovery. On one hand, CTOs have supported a shift away from institution-based mental health care and provided a platform for community-based mental health care provision and treatment in less physically constricting settings. Indeed, many people who were initially reluctant to be on a CTO are subsequently grateful for their benefits, and many family members are relieved that CTOs can provide opportunity for treatment for their loved ones. These benefits should be recognized. Nevertheless, the negative effects arising from the problem representation of CTOs should be addressed.

Several concrete recommendations can be drawn from this analysis: (1) Future reference to the introduction of CTOs should deliberately seek to substitute ‘Brian’s Law’ with the less discursive, ‘Bill 68’ or simply ‘Section 33.1’. Even to date ‘Brian’s Law’ is still widely used in text by mental health care providers, such as the Canadian Mental Health Association and other health authorities. (2) Public education programs are needed to present the real facts behind mental illness and violence to reduce stigma and to promote full social inclusion of people with mental illness. (3) Community treatment plans should better incorporate the full range of medical treatments and psychosocial supports called for in clinical guidelines to support recovery. (4) Increased pressure on community services and inadequate funding must be addressed to ensure future adequacy of community care and effectiveness of CTOs.

CTOs provide a platform for reform which can bridge the gap between the general public and people living with mental illness. Although a negative focusing event may be
the necessary trigger to move mental health reform onto the policy agenda, policy-makers should be aware of potential effects arising from the problem representation, in this case, on stigma, social inclusion, and delivery of care. CTO policy developers in Ontario and elsewhere should carefully consider these effects, and find ways to encourage the widespread development of more comprehensive community treatment plans with corresponding support for the comprehensive range of services needed for recovery.

REFERENCES
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