

Everything You Want to Know About Changes to the Mental Health Act in Alberta

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The *Mental Health Amendment Act, 2007* received Royal Assent on December 7, 2007, and was proclaimed into force in stages.¹ The first set of amendments was proclaimed into force on September 30, 2009.² The remaining amendments were proclaimed into force on January 1, 2010.³ This article will provide an overview of the key amendments, as well as a brief explanation of the reasons for the amendments.

The three main areas covered by the amendments are as follows:

- changes in the criteria to become a formal patient;
- implementation of community treatment orders (CTO's); and
- disclosure of information to a family doctor.

These amendments have resulted in changes to the role and mandate of the Mental Health Patient Advocate and of the Review Panels.

A. Changes in Criteria to Become a Formal Patient

The criteria have undergone a substantial revision. As of September 30, 2009, a person must meet all three of the following criteria in order to be admitted and detained as a formal (involuntary) patient:

- suffering from a mental disorder; *and*
- likely to cause harm to that person or others, or to suffer substantial mental or physical deterioration or serious physical impairment; *and*
- unsuitable for admission to a facility other than as a formal patient.⁴

The first and third criteria remain the same; as well, the definition of “mental disorder” has not changed. Mental disorder is defined as “a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality, or ability to meet the ordinary demands of life.”⁵

The second criterion has undergone significant changes. Formerly, the person must have been “in a condition presenting or likely to present a danger to the person or others.”⁶ As of September 30, 2009, the person must be “likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment.”⁷ The changes are meant to allow for earlier intervention when a person’s condition is deteriorating. The amendments respond to concerns raised by families and clinicians that the former criteria only allowed for intervention after the person became dangerous. Criteria based on danger have been replaced with those based on “harm.” As well, the categories of



harm are not restricted; as such, the new criteria could be interpreted as applying to different types of harm, including physical, emotional, and financial. There is no reference to the immediacy or imminence of the harm. Finally, criteria based on deterioration or impairment have also been added. Under the previous criteria, in order to be admitted as an involuntary patient in Alberta, the patient had to present or be likely to present a danger to himself / herself or others. The interpretation of the *Mental Health Act* provisions was further constrained by case law. “Danger” was interpreted to mean a serious risk of physical harm, rather than mental or emotional harm. As well, there had to be some immediacy to the danger. This interpretation persisted despite legislative amendments that were intended to make the criteria less restrictive. The development of the case law was summarized in the Court of Queen’s Bench decision in *Russell v. Calgary General Hospital* as follows:

This court in *M. v. Alberta* (1985), 63 A.R. 14 (Q.B.) considered the requirement of danger to oneself or others. Justice McDonald found this to mean a present or imminent danger. A danger which might arise in a matter of weeks was insufficient. Despite a subsequent amendment to the legislation to include the words, “or likely to present a danger to himself or others”, this court has continued to require evidence of imminent risk of harm (See *Wurfel v. Alberta Hospital (Edmonton)*, [1999] A.J. No. 868).⁸

The purpose of changes to the involuntary committal criteria was explained as follows during second reading of what was then Bill 31:

Mr. Speaker, the first key amendment will revise the involuntary admission criteria. The current *Mental Health Act* allows for the apprehension, examination, and involuntary admission of persons who are, one, “suffering from mental disorder”; two, are unwilling to be admitted voluntarily; and, three, are “in a condition presenting or likely to present a danger to [self] or others.” The courts in Alberta have interpreted the last criterion to mean imminent physical danger. Family members of individuals with mental illness express concerns about this situation. They are also concerned that their loved ones often

do not receive the treatment they need until they reach the point of being a danger to themselves or others. In response to these concerns the admission criteria have been amended to say “likely to cause harm to the person or others” so that earlier intervention is permitted. The criteria have also been amended to include the concept of “substantial mental or physical deterioration” on the part of the patient, which again permits earlier intervention. Mr. Speaker, this is very, very important. This is something that, certainly, my constituents have been asking for, and in talking to other MLAs, many constituents across Alberta are asking for changes to the *Mental Health Act* that will allow earlier intervention.⁹

In the majority of other Canadian jurisdictions, the criteria for involuntary admission are less restrictive (e.g. the Ontario criteria include “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”).¹⁰ The new criteria in Alberta’s *Mental Health Act* will be interpreted in court decisions. Since these amendments to the *Mental Health Act* will bring Alberta closer to the criteria that are currently being used in other jurisdictions across Canada, court decisions from other provinces will prove useful as the new criteria are interpreted and implemented.

B. Community Treatment Orders (CTO’s)

1. Introduction

The *Mental Health Act* applies mainly to formal patients. There are some provisions that apply to all patients. For example, both formal and voluntary patients have the right to:

- send and receive communications from outside the facility without the communications being opened, examined, delayed or withheld;¹¹
- meet with visitors at approved times, unless a physician considers that a visitor would be detrimental to the patient's health;¹²
- meet with a lawyer at any time.¹³

Formerly, the *Mental Health Act* did not extend into the community except for provisions dealing with



formal patients and leaves of absence. Nothing in the *Act* specifies the length of time a leave may be granted, and it may be revoked at any time. However, when a patient no longer meets all of the criteria required to remain a formal patient, his or her admission or renewal certificates must be cancelled, and he or she must be discharged as a formal patient. As such, in practice, leaves of absence are for short duration.

2. Purpose of CTO's

The new provisions in the *Mental Health Act* regarding CTO's are intended to allow a person to reside indefinitely in the community. CTO's are specifically meant to address the situation where patients are caught in the "revolving

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door syndrome:" they are stabilized with medication while in the hospital, and then cease treatment upon release into the community. They are then readmitted when they have reached the stage where they meet the criteria as formal patients.

The "revolving door" syndrome has also resulted in untreated people living in the community, with attendant problems, and the movement of people from the mental health system to the criminal justice system. CTO's are one method of attempting to prevent persons who are mentally ill from ending up in the criminal justice system.

The provinces have used a variety of models in an attempt to address these concerns. For example, British Columbia has expanded its leave of absence provisions and involuntary committal criteria to allow formal patients to reside in the community for substantial periods of time (1999); Saskatchewan, Ontario, Nova Scotia and Newfoundland have introduced community treatment

orders (1995, 2000, 2005 and 2007, respectively); and Manitoba has expanded its leave of absence provisions to allow voluntary patients to reside in the community (1999).

Community treatment orders are intended to be a "less restrictive alternative" to involuntary hospitalization. As stated in Nova's Scotia's *Involuntary Psychiatric Treatment Act*, one of the guiding principles is that "treatment and related services are to be offered in the least-restrictive manner and environment with the goal of having the person continue to live in the community or return to the person's home surroundings at the earliest possible time."¹⁴

Ontario's *Mental Health Act* states as follows:

The 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. 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.¹⁵

Although Alberta's *Mental Health Amendment Act, 2007* does not contain a purpose statement stating that CTO's are being implemented to provide a less restrictive alternative to being detained in a psychiatric facility, there were statements made in the legislature during the introduction and debate of the bill that provide information about the purpose of the amendments and the target population. For example, the following statement relating to the purpose of the amendments was made during second reading of Bill 31:

Mr. Speaker, the second set of key amendments will allow community treatment orders, or CTOs. Some individuals with serious mental disorders are caught in what we call the



revolving door syndrome. They are admitted to hospital when they meet the criteria for involuntary admission, but then they're subsequently discharged when they're stabilized and no longer meet those criteria. After discharge they cease treatment in the community and are again readmitted when they meet the criteria again. So that's the revolving door. Community treatment orders will assist revolving-door patients and provide an additional treatment option that is less restrictive than remaining as an involuntary patient in a facility.¹⁶

3. Process for Issuing CTO's

(a) Who may issue a CTO

In the United States, CTO's are generally issued pursuant to a court order. In Australia, some states provide for courts to issue CTO's, while other states allow CTO's to be issued by physicians. In every Canadian jurisdiction with CTO's, physicians are responsible for issuing a CTO when specified criteria are met. The amendments to the *Mental Health Act* have followed this model. If a psychiatrist is unavailable to issue, renew, amend or cancel a CTO, a board or a regional health authority may designate a physician to assume this responsibility.¹⁷ The designated physician must consult with a psychiatrist.

(b) Criteria for CTO

A key issue is what type of specific history of hospitalizations and / or CTO's should be required for the issuance of a CTO. The criteria for issuing CTO's are consistent across Canada and include:

- (a) a recent medical examination (e.g. within the previous 72 hours)
- (b) a diagnosis that the person is suffering from a mental disorder
- (c) a recent history of hospitalizations and / or CTO's
- (d) the person is likely to cause harm to himself / herself or to others, or to suffer substantial mental or physical deterioration or serious physical impairment if he or she does not receive treatment in the community
- (e) the services that the person requires exist in the community, are available to the person, and will be provided to the person
- (f) the person is able to comply with the requirements in the CTO.

The amendments to the *Mental Health Act* contain criteria that are consistent with other jurisdictions, and are specifically tailored to address patients who are caught in the "revolving door syndrome."

Section 9.1 of the amended Act identifies the criteria that must be met when two physicians issue a CTO. To be placed on a CTO the physicians must each believe that the person is suffering from a mental disorder.¹⁸

Additionally, the two physicians must be of the opinion that one or more of the following three conditions apply:

- within the immediate past three years the person has on two or more occasions, or for a total of at least 30 days: (i) been a formal patient in a facility; and/or (ii) been in an approved hospital or been detained in custody, where it is evident that they would have met the criteria to be detained as a formal patient;
- the person has within the past three years been subject to a CTO;
- the person has, while living in the community, exhibited a pattern of recurrent or repetitive behaviour that indicates that the person is likely to cause harm to themselves 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.¹⁹

The two physicians, after separate examinations within the preceding 72 hours, must be of the opinion that all of the three following conditions apply:

- the person must be likely to cause harm to themselves or others, or to suffer substantial mental or physical deterioration or serious physical impairment if they do not receive community-based treatment or care;
- the treatment or care the person requires exists in the community, is available to the person and will be provided to the person; and
- the person must be able to comply with the treatment or care requirements in the CTO.²⁰

Finally, the person must either be willing to consent to the CTO or the circumstances are such that consent is not needed.²¹



4. Consent and Competence

(a) *Consent to the CTO:*

A CTO may be issued under the following circumstances:

- if the patient is competent and consents;
- if the patient is not competent, and a substitute decision-maker consents; or
- regardless of competence, if the person has exhibited a history of not obtaining or continuing with treatment or care that is necessary to prevent the likelihood of harm to others; and a CTO is reasonable in the circumstances and would be less restrictive than retaining the person as a formal patient.²²

(b) *Consent to Treatment*

Since CTO's require patients to undergo specific treatments while in the community, the issues of competency and consent are engaged. Other provinces use a variety of legislative models to address the issue of competency and consent to treatment. In Saskatchewan, only patients that are not able to "fully understand and ... make an informed decision regarding his or her need for treatment or care and supervision" are eligible for CTO's.²³ The attending physician may treat the patient in any manner that is necessary and consistent with good medical practice, without the patient's consent. In Nova Scotia, only patients that do not "have the full capacity to make treatment decisions" are eligible for CTOs, although consent from a substitute decision-maker is required.²⁴ In Ontario, competent and incompetent patients are eligible for CTO's. Consent to treatment must be sought from the patient (if competent) or the patient's substitute decision-maker (if incompetent).²⁵

The findings in the Galloway/Ostapovich fatality inquiry were an important factor during the consideration of amendments to the *Mental Health Act*. The fatality inquiry concerned the deaths of an RCMP officer and a former patient. An RCMP officer (Galloway) and a former patient (Ostapovich) were both killed following a confrontation at the former patient's home. The judge's report was issued in November 2006.²⁶ Judge Ayotte recommended that the *Mental Health Act* be amended to permit CTO's, and concluded that if CTO's had "been in place in the years leading up to this incident, the tragedy it spawned might well have been avoided."²⁷

The judge's report in the Galloway and Ostapovich fatality inquiry discusses the difficulty of accommodating the patient's right to refuse treatment as follows:

The most tragic aspect of the events which spawned this inquiry is the knowledge that the incident itself, and the deaths which resulted, might well have been avoided if Martin Ostapovich had received the treatment he needed for the mental illness which had taken hold of him. The history of that illness and the inability of the mental health system to adequately deal with it bring into stark relief the difficult challenges confronting a society which must attempt to balance the need to ensure that those with mental illness receive adequate treatment against the right of those very same people to withhold their consent to that treatment. If we do not find an acceptable compromise, the inevitable consequence will be the sadness and suffering of those who care most about the patient and sometimes, as occurred here, unnecessary deaths. There will be added to that tragedy the inherent social cost of disillusioned family members, frustrated and angered by their inability to access proper treatment for their loved ones. In the end, if we do not deal with the problem, our very credibility as a caring society is brought into question.²⁸

The criteria for determining mental competence have not changed. Section 26 provides that a person is mentally competent if he or she "is able to understand the subject-matter relating to the decisions and able to appreciate the consequences of making the decisions."²⁹ If a patient is not mentally competent, consent to treatment is provided by a substitute decision-maker, for example, the patient's guardian.³⁰ Similarly, consent is provided by a substitute decision-maker for persons who are not mentally competent and who are subject to CTO's.³¹ The *Mental Health Act* permits a review panel to override the wishes of a competent formal patient.³² However, there are no provisions for overriding the wishes of a competent person who is subject to a CTO.

5. Failure to Comply with a CTO

No Canadian jurisdiction allows for forcible treatment if a patient fails to comply with the provisions of a CTO.



Instead, patients may be apprehended and conveyed to a facility for an examination to determine whether or not they meet the criteria for involuntary committal. In Ontario and Nova Scotia, prior to apprehension, the physician must believe that the patient continues to meet the original criteria for issuance of a CTO.³³ As well, reasonable efforts must first be made to locate the person, inform him or her or the substitute decision-maker of the failure to comply, and provide assistance to the person to comply.³⁴ Similar provisions are in force in Alberta. The amended *Mental Health Act* provides that if a patient is not in compliance with the CTO, an apprehension order may be issued.³⁵ The legislation requires that, prior to issuing an apprehension order, a psychiatrist must be satisfied that reasonable efforts have been taken to inform the patient and, if applicable, the substitute decision-maker, that there is non-compliance and the need for compliance.³⁶

The person subject to the CTO must be provided with reasonable assistance to enable them to comply with the CTO and must be advised of the consequences of non-compliance.³⁷

6. Roles of the Review Panel and the Mental Health Patient Advocate

The provisions allowing for CTO's are consistent with the provisions in the *Mental Health Act* granting rights to formal patients. As such, the statutory provisions that give formal patients certain rights, such as the right to review and the right to contact the Mental Health Patient Advocate, apply with necessary modifications to CTO's.

Similar to the rights granted to formal patients, an individual subject to a CTO can request cancellation of their CTO by completing Form 12.³⁸ The Review Panel does not amend CTOs.

The Mental Health Patient Advocate has jurisdiction to investigate complaints regarding:

- patients under one admission certificate or one renewal certificate;
- formal patients (e.g. patients under 2 admission certificates or renewal certificates); and
- persons who are subject to CTOs.³⁹

The Advocate does not have the jurisdiction to investigate complaints regarding voluntary patients.

Without receiving a complaint, section 4 of the *Patient Advocate Regulation* enables the Advocate to investigate:

- any procedure relating to the admission of a person detained in a facility pursuant to the Act;
- any procedure for 1) informing a patient of their rights, and 2) providing information as required by the Act to a patient and to guardians, nearest relatives or designates of a patient; and
- any procedure of a regional health authority or an issuing psychiatrist relating to the issuance, amendment or renewal of a CTO.⁴⁰

C. Disclosure of Information to Family Doctor

Provisions were added to encourage communication with the family doctor when a patient is discharged or a person is no longer subject to a CTO. Specifically, s. 14(5) states that when a CTO expires or is cancelled, notice of the expiry or cancellation, along with any recommendations for treatment, must be provided to the person's family doctor, if known.⁴¹ As well, s. 32(1) provides that, when a patient is discharged from a facility, "the board shall, where reasonably possible, give notice of the discharge ... to the patient's family doctor, if known, along with the discharge summary, including any recommendations for treatment."⁴²

Conclusion

The successful implementation of the legislative amendments is dependent upon adequate resources being available. The importance of community services was noted during second reading of the bill as follows:

This bill will be supported by accompanying measures to enhance community-based mental health services that will help Albertans living with mental illness and their families to access early intervention services and to enjoy full and productive lives.⁴³

Section 24 of the *Mental Health Amendment Act, 2007* provides that within five years of the CTO provisions coming into force (i.e. January 1, 2015), a committee of the Legislative Assembly must "begin a comprehensive



review of the amendments.”⁴⁴ A report must be submitted to the Assembly within one year of beginning the review. The report will include recommendations relating to amendments. This review will provide an important opportunity to consider whether the CTO provisions have been effective and whether further amendments to the legislation are necessary.

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Endnotes

- 1 S.A. 2007, c. 35, amending R.S.A. 2000, c. M-13.
- 2 A. Gaz. 2009.I.1062.
- 3 A. Gaz. 2009.I.1304.
- 4 *Mental Health Act*, R.S.A. 2000, c. M-13, s. 2, as am. by *Mental Health Amendment Act, 2007*, S.A. 2007, c. 35, s. 3 [Amended MHA].
- 5 *Ibid.*, s. 1(g).
- 6 *Mental Health Act*, R.S.A. 2000, c. M-13, s. 2(b).
- 7 *Supra* note 4, s. 2(b).
- 8 2004 ABQB 102 at para. 50, 352 A.R. 168.
- 9 Legislative Assembly, *Alberta Hansard* (1 May 2007) at 747 (Rev. Abbott).
- 10 *Mental Health Act*, R.S.O. 1990, c. M.7, s. 20(1.1)(d) [ON MHA].
- 11 *Supra* note 4, s. 15.
- 12 *Ibid.*, s. 16(1).
- 13 *Ibid.*, s. 16(2).
- 14 S.N.S. 2005, c. 42, s. 2(c) [NS Act].
- 15 *Supra* note 10, s. 33.1(3).
- 16 *Supra* note 9.
- 17 *Supra* note 4, s. 9.7; *Community Treatment Order Regulation*, Alta. Reg. 337/2009, s. 5.
- 18 Amended MHA, *ibid.*
- 19 *Ibid.*, s. 9.1(1)(b).
- 20 *Ibid.*, s. 9.1(1)(c)-(e).
- 21 *Ibid.*, s. 9.1(1)(f).
- 22 *Ibid.*, s. 9.1(1)(f)(i)-(ii).
- 23 *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 24.3(1)(v).
- 24 *Supra* note 14, s. 47(3)(iii).
- 25 *Supra* note 10, s. 33.1(4)(f).
- 26 *Report to the Attorney General – Public Inquiry into the death of Corporal James Galloway and Martin Ostopovich* (Edmonton: Justice and Attorney General, 2006), online: Justice and Attorney General <http://justice.alberta.ca/programs_services/fatality/Documents/fatality_inquiry_report_galloway_2006_11.21.pdf>.
- 27 *Ibid.* at 20.
- 28 *Ibid.* at 14.
- 29 *Supra* note 4.
- 30 *Ibid.*, s. 28.
- 31 *Ibid.*
- 32 *Ibid.*, s. 29.
- 33 *Supra* note 10, s. 33.3(2)(a); *supra* note 14, s. 56(2)(a).
- 34 ON MHA, *ibid.*, s. 9.6(2); NS Act, *ibid.*, s. 56(2)(b).
- 35 *Supra* note 4, s. 9.6(1).
- 36 *Ibid.*, s. 9.6(2).
- 37 *Ibid.*
- 38 *Ibid.*, s. 38(1.1); *Mental Health Act Forms Regulation*, Alta. Reg. 136/2004, s. 15(1).
- 39 *Ibid.*, Amended MHA, s. 45(1).
- 40 Alta. Reg. 148/2004.
- 41 *Supra* note 4.
- 42 *Ibid.*
- 43 *Supra* note 9.
- 44 *Supra* note 1.

