November 16, 2015

Standing Committee on Families and Communities
c/o Committee Clerk
3rd Floor, 9820 - 107 Street
Edmonton, Alberta, T5K 1E7
FamiliesCommunities.committee@assembly.ab.ca

To Whom It May Concern:

Please find attached Alberta Health Services Submission for the Mental Health Amendment Act Legislative Review.

If the Committee requires information or clarification, please forward the request to:

Alberta Health Services
Barry Andres, Interim Executive Director
5th Floor, 10909 Jasper Avenue
Edmonton, AB T5J 3M9
Direct Line: (780) 415-0374
Barry.andres@albertahealthservices.ca

Sincerely,

David O'Brien CMA
Senior Program Officer
Community, Seniors, Addiction and Mental Health
Alberta Health Services

29th Alberta Legislature

Standing Committee on Families and Communities

Review of Alberta *Mental Health Amendment Act, 2007*

Alberta Health Services

Written Submission

November 16, 2015

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INTRODUCTION

Alberta Health Services (AHS) has been invited to submit input to the Standing Committee on Families and Communities regarding the amendments to the *Mental Health Act* made by the *Mental Health Amendment Act*, 2007. This document is the response to that invitation.

A brief background is provided regarding the development of the original amendments to the MHA for Community Treatment Orders and the subsequent implementation.

In March 2004, the Minister of Health and Wellness, the Honourable Gary Mar, requested that in its role as policy advisor, the Alberta Mental Health Board (AMHB) review the information that is available on community treatment orders. Accordingly, a review of other jurisdictions – both in Canada and internationally – was conducted to establish which models might be most appropriate for Alberta. It was determined that Ontario's was most closely aligned to the thinking in Alberta.

In anticipation of the MHAA legislation being proclaimed, Alberta Health provided some initial funding to the former AMHB, which was later transferred in 2009 to Alberta Health Services. This funding allowed for infrastructure to be developed, which has been instrumental in supporting clients, physicians and service providers using CTOs across the province. AHS has worked collaboratively to:

- develop core provincial processes in relation to the legislation address queries related to the application of the MHA CTO legislation,
- determine levels of service enhancement funding required by each zone to support CTO clients
- provide information/education sessions to stakeholders and develop resources
- conduct evaluation activities, including the impact of CTOs on client, families and system.

Over the past six years of the MHAA implementation, significant experience and knowledge have been gained regarding the strengths and areas for improvement. The Provincial Addiction and Mental Health CTO Administrative Team has worked with physicians and zone CTO clinical leads, AHS legal services and key stakeholders to compile the findings, which include issues with administrative pressures, clinical demands, and CTOs processes. Efforts have been made to consider the Charter of Rights and Freedoms and the intersection of the Criminal Code of Canada when outlining issues and recommendations to ensure rights and safeguards counterbalance any infringements on an individual's liberty. These findings were brought together into a comprehensive document outlining recommendations for the legislative review and submitted to Alberta Health in 2014.

This current written submission focuses on the top priorities identified in the implementation over the past 6 years. The document has been structured to include:

- Issue related to MHAA
- Relevant sections of the MHA and/or Regulations
- Specifics of each issue
- Recommendation(s) for each issue.

As referenced in the background, there are select items included in the document where the recommendations go beyond the MHAA 2007 amendments. Primarily, these are items that are associated with CTO processes and issues, such as apprehension, conveyance and transfer, but impact other sections within the MHA. It is recommended that changes be made to these other portions of the MHA to ensure consistency in practice, avoid confusion for police and health services personnel (e.g., emergency department staff) and to capitalize on the opportunity presented by this review to improve some longstanding issues.

CRITERIA FOR INVOLUNTARY ADMISSION

CHANGES TO CRITERIA

There are specific criteria that must be met for an individual to become a formal patient under the MHA.

RECOMMENDATION(S)

- Maintain legislation

MHA	ISSUES	RATIONALE
MHA s.2	Findings identify that there were no issues to be addressed with the change of criteria	The change to the criteria aligns with other jurisdictions across the country and reflects where clinical practice was moving. Patients can be admitted sooner in the cycle of admission, discharge, deterioration and re-admission which allows provision of treatment and care for a wider range of presenting issues.

NOTIFICATION TO PHYSICIANS

The MHA specifies that the board shall, where reasonably possible, give notice of discharge of a patient from a designated facility to the patient's family doctor, if known.

RECOMMENDATION(S)

- Maintain legislation

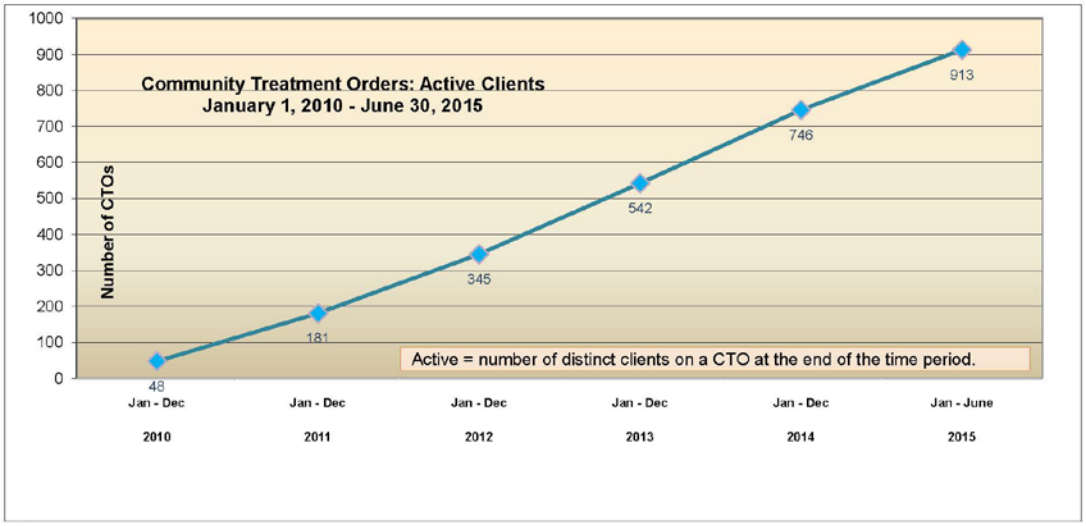
MHA	ISSUES	RATIONALE
MHA s.32(1)	Some patients do not have a family physician and some may use only walk-in clinics, which does not guarantee that a patient will see the same physician at each visit. Questions have been raised whether information can be shared with other health professionals. There is some confusion who this amendment applies to i.e. "patient"	Parameters for information sharing are identified under the *Health Information Act*; changes to the MHA are not required. The majority of the MHA applies to formal patients or individuals subject to a CTO. However this section applies to *any* patient that is discharged from a facility. Identified issues can continue to be addressed through education.

COMMUNITY TREATMENT ORDERS

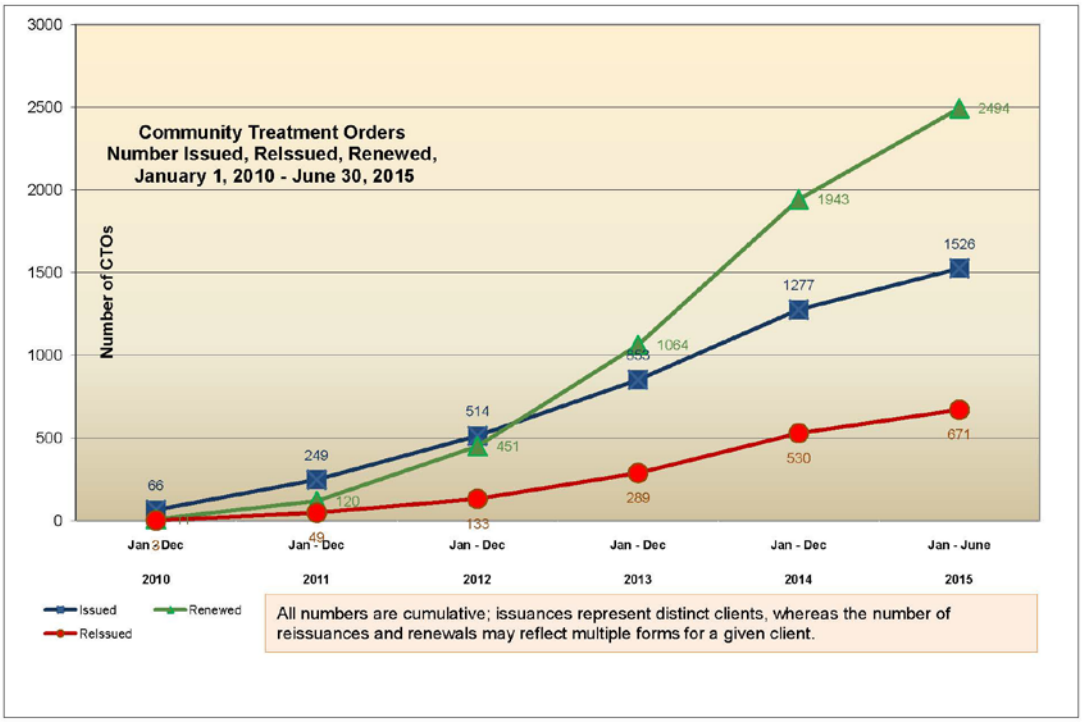
Individuals subject to a CTO represent a vulnerable client population with severe and persistent mental disorders who often require a comprehensive plan for their treatment and care. CTOs have become an effective treatment and care tool to reduce the risk of a client's deterioration and support his/her stability in the community.

Since implementation in Alberta the number of individuals on CTOs has increased steadily across the province and exceeded the original projections. It is expected that CTOs will continue to be utilized with new clients, as well as being extended through renewals for many individuals who are already on one. From the time they came into effect (January 1, 2010) through July 31, 2015 CTOs have been issued for 1567 individuals and have supported clients in over 150 communities. At the end of July 2015, there were 919 individuals on a CTO in Alberta. The following graphs demonstrate the growth and utilization of CTOs over time.

Number of Clients on a Community Treatment Order (at a point in time)



Cumulative Number of Community Treatment Orders Issued, Reissued and Renewed



Additionally, preliminary evaluation has demonstrated that there is promising impact on the hospitalization rates for clients on CTOs when comparing health system resource utilization one year pre CTO to one year post, as well as three years pre to post. Client and service provider surveys are demonstrating that CTOs are a positive clinical tool to helping keep our severe and persistent mentally ill well in a community setting for longer period of time.

There is agreement overall that CTOs should continue to be available as a clinical tool in Alberta. The issues and recommendations that follow reflect the key areas identified throughout the implementation

that need to be addressed in the legislation.

EXAMINATIONS - 72 HOUR TIMEFRAME

The MHA specifies that examinations must be completed by two physicians within 72 hours for CTO issuance and renewal.

RECOMMENDATION(S)

- Amend MHA to allow for examination period to be extended from 72 hours to 7 days for CTO *renewal*

MHA	ISSUES	RATIONALE
MHA s.9.1(1)(c) MHA s.9.3(3)	It can be very challenging to complete the two examinations within the required 72 hour timeframe, especially for renewals which mostly occur in a community setting. In the community and particularly in the rural / remote areas, two physicians may not be easily accessible. The amount of paperwork and administration is often cited as a significant resource pressure and in some cases a deterrent for physicians to issue or supervise a CTO.	Unlike the certification process, which occurs fairly quickly, CTO renewal processes often takes place over a number of days or weeks as the various components are arranged. Criteria for CTO renewal is based on history and background of individuals, not on the individual's current level of functioning as with Form 1. Stakeholders agreed to keep the time period at 72 hours for issuance, as the majority of CTOs are first issued from an inpatient setting. Extending the time period for issuance could have the unintended consequence of causing delays in discharging patients from the inpatient unit. However, extending the time period for renewals would relieve some of the pressures to get all the required arrangements made for the examinations and signatures – particularly in areas where physician / psychiatric coverage is provided by visiting physicians or tele-health.

COMPETENCE - DOCUMENTATION

The MHA describes mental competence to make treatment decisions as the ability "to understand the subject-matter relating to the decisions and able to appreciate the consequences of making the decisions."

If a CTO is being issued *with consent*, it must be determined whether the individual who will be subject to the CTO is *competent* to consent; otherwise a substitute decision maker must be identified.

RECOMMENDATION(S)

Note: the points below include recommendations that go beyond the MHAA 2007 amendments.

- Amend MHA to include a process to assess and document competence to consent to CTO.
- Amend additional section of the MHA to remove the requirement for a Form 11 to be completed when a guardianship order or enacted personal directive that includes decision making for health matters is in place for a formal patient.

MHA	ISSUES	RATIONALE
MHA s.27 MHA s.28	Although the MHA defines competence for an individual being considered for a CTO, there is no required process or form. For formal patients a Form 11 Certificate of Incompetence is required to document that an individual has been assessed and found not competent to consent. The inconsistency in processes for formal patients and persons subject to a CTO results in confusion. There is no mechanism for expiry or cancellation of Form 11. This results in further confusion when an individual is assessed as competent to consent to a CTO after being on a Form 11. Requiring a Form 11 to be completed when there is a guardianship order or personal directive in force results in confusion whether the patient can be found to be competent to make treatment decisions.	There have been instances where individuals who are subject to Form 11 as a formal patient are asked to consent to a CTO. While a guardianship order or personal directive is in force, it must be followed. Therefore the Form 11 is not necessary to document that a formal patient is not competent. If it is felt that the person has capacity to make their own health care decisions and a guardian or agent is in place, this should be discussed with the guardian or agent. Subsequently if deemed appropriate, steps may be taken to change the guardianship order or to follow the processes set out in the *Personal Directives Act* when a person regains capacity.

CONSENT TO CTO - WITHDRAWAL

There are two situations that have been identified as problematic in relation to the withdrawal of consent to a CTO.

1) In most circumstances, consent to a CTO must be obtained from the individual or their substitute decision makers.
2) The MHA specifies that in a review panel hearing the onus is on the physician or psychiatrist to show that that the individual subject to a CTO meets criteria set out in section 9.1(1)(a) to (e); the section that speaks to consent is not listed (section 9.1(1)(f).

RECOMMENDATION(S)

- Amend MHA to specify whether an individual subject to a CTO or their SDM may withdraw consent to the CTO without applying to a review panel for cancellation.
- Amend MHA to specify whether the review panel has a role when an individual or their alternate decision-maker withdraws consent.

MHA	ISSUES	RATIONALE
MHA s.9.1(1)(f) and MHA s.41(1)(a.1) MHA s.42(2)	There are discrepant interpretations regarding whether or not individuals subject to a CTO (or their SDM) are able to withdraw consent to the CTO once it has been issued. Review Panels have experienced issues regarding what to do when a	An interpretation has been put forward that a client or their SDM may withdraw their consent to the CTO, which would result in the CTO ceasing to exist. An alternate interpretation is that withdrawal of consent does not automatically cancel the CTO; rather, the client must go through the review panel process

	client applies for a hearing because they are withdrawing consent to the CTO. There has been confusion whether a review panel should hear the application or not. The Form 12 Application for a Review Panel Hearing does not indicate a reason for application; therefore Chairs do not know reason (withdrawing consent) until individual appears before the panel.	There are significant implications if clients or their SDM are able to withdraw consent to the CTO at any time, and leave in question what recourse there may be. For example, a client may consent to a CTO if it is offered as an alternative to remaining in hospital as a formal patient and then withdraw their consent immediately following discharge. This in turn could reduce the future use of CTOs if the CTOs can be discarded by the client. Conversely, patients have the right to refuse treatment.

REVIEW PANEL TIMING AND TIMEFRAMES

The MHA specifies that review panel hearings will occur at the time of the first renewal (6 months) and every second renewal thereafter (18 months, 30 months, etc.). These are known as “deemed hearings”. The MHA also specifies that the review panel shall give at least 7 days’ notice of the hearing.

RECOMMENDATION(S)

- Amend MHA to extend deemed hearing period for first hearing from 6 months to 12 months
  Note: This recommendation must be coordinated with the recommendation regarding the duration of a CTO
- Amend MHA to extend notice period to 14 days.
- Amend MHA to extend period of when review panel shall hear and consider an application to 21 business days instead of 21 calendar days.

MHA	ISSUES	RATIONALE
MHA s.39(2) and MHA s.40(1) MHA s.40(4)	Many individuals subject to a CTO find the review panel hearing process stressful which can exacerbate their symptoms. It is difficult to arrange the hearings to include all necessary persons to be present within the current timeframes. Review panel hearings for CTOs are not as straightforward to arrange as hearings for formal patients, as they often occur in the community. Additional coordination is required that can include for example: service providers from different organizations, health records gathered from several locations, and video- conferencing arrangements. CTO clients are not always receiving the required notice for the hearing (at least 7 days)	Many individuals subject to a CTO are choosing not to attend review panel hearings at renewal due to their agreement for continuation of the CTO. There are significant costs and resource pressures associated with holding the review panel hearings. In addition to the “deemed hearings”, persons subject to a CTO may apply at any time for cancellation of their CTO pursuant to s.38. Clients are not always aware that their hearing is going to occur or may not have time to seek legal counsel.

CTO DURATION

A CTO expires six months after the day it is issued unless it is renewed or cancelled.

RECOMMENDATION(S)

- Amend MHA to extend the duration of a CTO to 12 months.

MHA	ISSUES	RATIONALE
MHA s.9.2	Given the complex history of most individuals who become subject to a CTO, the 6 month duration is often not sufficient time for a client to stabilize in the community and establish linkages to treatment, social and support systems	Administration of CTOs is resource intensive. There is potential reduction in resource pressures and cost by extending the time period from 6 to 12 months. Individuals subject to a CTO may apply to a review panel at any time for cancellation of their CTO pursuant to s.38. Consultation with other jurisdictions across Canada indicate the same concerns regarding the duration of a CTO i.e. that it would be in the clients' interests to extend the duration to 12 months to allow time for them to stabilize and adjust to the treatment and care in the community. Consideration must be given whether extending the duration of a CTO would have a negative impact on individuals' rights and freedoms. * Note: This recommendation must be coordinated with the one regarding deemed review panel hearings

INDIVIDUAL SUBJECT TO A CTO WHILE IN HOSPITAL

The MHA states that a CTO should be cancelled when and individual subject to a CTO is apprehended and conveyed to a designated facility following non-compliance with their CTO.

RECOMMENDATION(S)

- Amend MHA to clearly state that an individual can be on a CTO and in the hospital at the same time (as a formal *or* voluntary patient)
- Amend MHA to allow for the CTO to be "put on hold" during the hospitalization rather than cancelled and reissued upon discharge.
- Amend MHA to include a maximum time-frame (to be determined) for how long an individual can be in hospital as either an involuntary or voluntary patient and on a CTO at the same time.

MHA	ISSUES	RATIONALE
MHA s.9.1(3) MHA s.9.6(4)	The MHA is unclear if, or when, an individual can be in hospital and subject to a CTO at the same time. The lack of clarity causes confusion whether a CTO remains in effect whilst in hospital and upon discharge. When an individual is apprehended and conveyed to a designated facility following non-compliance to their CTO, the MHA articulates that a CTO "*should*" be cancelled, not "*must*" be cancelled. This wording results in inconsistent approaches with formal patients on CTOs. The MHA does not articulate whether an individual can remain subject to a CTO when they are voluntarily admitted, or b) arrive at a facility on their own or under other MHA apprehensions and are admitted as a formal patient.	There may be times when it is appropriate to have a patient be in hospital for a short period of time for medication adjustments or stabilization, and have CTO remain in effect. Admitting an individual subject to a CTO may put them in a position of not being able to comply with their CTO e.g. they would not be able to attend community appointment stipulated on the CTO while in hospital. Re-issuing a CTO requires a significant amount of resources to complete the processes involved including: identifying, engaging, planning and acquiring signatures from all parties. However, upon discharge, consideration should be given whether the CTO should remain in as it is or be amended. It is essential that individuals subject to the CTO as well as the service providers and supervising physician understand whether the CTO is in effect when the individual is discharged.

CONVEYANCE TO A DESIGNATED FACILITY

The MHA specifies that when an individual subject to a CTO has been apprehended for non-compliance they must be conveyed to a facility for examination to determine the next steps required for their care.

The legislation and processes for apprehensions related to CTOs (Form 23) are essentially the same as the components for individuals apprehended through other MHA provisions (Forms 1, 8 and 10).

RECOMMENDATION(S)
Note: the points below include recommendations that go beyond the MHAA 2007 amendments.

- Amend MHA to specify that the examination process following apprehension can occur at a location other than a designated facility (as currently defined).
- Amend MHA to provide for patients to be detained in non-designated AHS/Covenant facilities to allow for medical stabilization, observation and /or further assessment for up to 72 hours prior to being conveyed to a designated facility for admission as a formal patient.
- Amend additional sections of the MHA to align the legislation and processes for all apprehensions, conveyance and detention. Sections included as applicable in the table below.
- In addition to the above, revise MHA sections 2 & 5 to explicitly allow for examinations to be held remotely via video conference or other technology – as they are for CTOs.

MHA	ISSUES	RATIONALE
MHA s.4(2) MHA s.5 MHA s.9.6(1) MHA s.9.6(4) MHA s.10(5) MHA s.12	Due to limited resources and time restraints, law enforcement is not always able to convey an individual to a designated facility, which may be hours away from where the individual is apprehended. Issues arise in terms of scope of the definition of a "facility" Not all designated facilities have emergency departments or medical units. This has an impact when an individual requires medical clearance for physical health before being examined for mental health issues. If an individual is intoxicated or under the influence of substances, they may be refused admission until medically cleared. This may require the individual be taken to another hospital or medical facility to ensure they are medically stable prior to being conveyed to the designated facility. It can be challenging (resources, availability of transportation) to return a client to their home community when they have been conveyed to a designated facility for examination and then released, which often occurs when they accept treatment.	Challenges related to apprehension and conveyance of individuals under the MHA are longstanding. The legislative review of the amendments presents an opportunity to address these issues and ensure consistency in processes. Expansive rural areas and the limited number of designated facilities across the province contribute to the difficulties. This has significant impact on client care, and health and law enforcement resources for apprehension, conveyance and examination. There are circumstances when it is challenging or may not make sense from a practical point of view to convey individuals to a designated facility. For example, when an individual has been non-compliant with their CTO and an apprehension order issued, it is most important that they be examined by a physician. However, they may not have deteriorated to the point where an admission as a formal patient would be required. Therefore, following the examination, the individual would be released. These recommendations reflect an underlying question of "does the examination have to occur at a designated facility?" or, can other options be considered? If a determination is made that the individual requires certification, they can be transported to a designated facility. This would decrease unnecessary stress on the patient in addition to reduced stress on resources such as transportation and associated costs. **Changes to the legislation that result in shifts of roles / responsibility between law enforcement and health could have significant resource implications.** For example, not all non-designated facilities have the necessary staffing (security, clinical expertise) to manage individuals brought in under the MHA. Therefore it is critical that any changes to the wording reflect an ability to identify appropriate locations.

DETENTION IN A DESIGNATED FACILITY FOLLOWING APPREHENSION

The MHA gives authority to apprehend and convey an individual to a facility for examination.

RECOMMENDATION(S)
Note: the points below include recommendations that go beyond the MHAA 2007 amendments.

- Amend MHA to clarify responsibility related to transfer and handoff between law enforcement and the facility
- Amend MHA to include express language that the Board has the authority to detain at a facility for the purpose of examination following conveyance like there is in sections 4(1) and 12(2) MHA.
- Amend *additional* sections of the MHA to align the legislation and processes for all apprehensions, conveyance and detention. Sections included as applicable in the table below.

MHA	ISSUES	RATIONALE
MHA s.5(1) MHA s.9.6 MHA s.10(6) MHA s.12	Once at a facility, and particularly in urban centres, wait times in the emergency department can be lengthy. When a patient is apprehended and conveyed to a designated facility the transfer of care or handoff is unclear between law enforcement and the facility. MHA does not expressly give facilities the authority to detain a patient while waiting for the examination after apprehension and conveyance. Express authority to detain is preferred over implied authority.	**Changes to the legislation that result in shifts of roles / responsibility between law enforcement and health could have significant resource implications.** The MHA articulates what is authorized during the period of conveyance, not to the detention period following conveyance upon arrival at a facility, which then leaves a facility relying on implied authority under s.9.6(4) to detain the patient at the facility for the 72 hours if the individuals declines voluntary admission while awaiting examination by the two physicians. Similarly, the facility must rely on implied authority under s.5 to detain, examine, etc. when a patient is brought in per section 10 or 12.

CTO EXPIRES BEFORE FORM 23 APPRENSION ORDER EXPIRES

An apprehension order expires 30 days after the date it is issued.

RECOMMENDATION(S)
Note: the points below include recommendations that go beyond the MHAA 2007 amendments.

- Amend MHA to include a provision for CTOs similar to that for formal patients in s.21(3) allowing for examination without consent upon apprehension even if the CTO has expired during the Form 23's 30-day period.
- Amend MHA to include a provision for the Form 23 to be cancelled by a psychiatrist.
- Amend additional sections of the MHA to align the legislation and processes for all apprehensions, conveyance and detention i.e. Form 3. Sections included as applicable in the table below.

MHA	ISSUES	RATIONALE
MHA s.9.2 MHA s.9.3 MHA s.9.6 MHA s.21(3)	The MHA is unclear regarding whether the Form 23 Apprehension Order continues to be in force when a CTO has expired during the 30 day period of the apprehension order.	The MHA has identified a process for this situation for formal patients who have eloped where certificates have expired during the period of absence

	There is no process identified within the MHA to cancel a Form 23 (or Form 3 for formal patients) which results in different interpretations as to whether the order *can* be cancelled.	Consistency across CTO (Form 23) and other MHA processes (Form 3) would assist understanding and proper adherence to the legislation.

REVIEW OF CTO LEGISLATION

The MHA stipulated that a review was to be completed within 5 years of the coming into force of Section 8 of the MHAA 2007.

RECOMMENDATION(S)

- Amend MHA to require an *additional* review of the CTO legislation in 5 years, at the 10 year mark.

MHA and REG	ISSUES	RATIONALE
MHA s.54	The requirement included in the current legislation indicates one review only.	The first 5 years of the implementation focused on learning, applying the legislation, and creating structure and establishing processes. Additional review of Alberta's legislation would be informed by a deeper level of understanding and application of the legislation. Informal communication with other Canadian jurisdictions indicated the utility of additional reviews as knowledge and experience matures.

CONCLUSION

We, Alberta Health Services, thank you for the opportunity to provide input regarding the changes introduced by the *Mental Health Amendment Act, 2007*. By way of our responsibility in implementing the changes we have gained significant experience with the legislation over the past 6 years.

As described in the document above, there are areas that have been identified for improvement. However, the amendments have been well received and supported overall. The change to criteria for involuntary admission has generally been accepted without concern. Providing a discharge summary to family physicians promotes continuity of care. CTOs are perceived as a useful clinical tool for a portion of the individuals requiring treatment for a mental disorder and should continue to be available.

This submission highlights the areas that have emerged throughout the implementation of the MHAA, 2007 as the most concerning. Often issues related to CTOs are similar to those experienced with pre-existing challenges with the MHA such as those related to apprehension and conveyance. Amending only the sections relevant to CTOs could cause inconsistencies in processes for CTO versus other component of the MHA. This could lead to confusion and unintended interpretation of similar sections relating to certifying patients e.g. silence in those sections could be interpreted as having more significance than intended. Therefore, a few items that go beyond the *Mental Health Amendment Act, 2007* are included in this submission to ensure consistency in the application of the MHA and address longstanding issues.

The implementation of CTOs to date has focused on learning and applying the legislation as well as establishing structure and processes. Informal communication with other Canadian jurisdictions and Ontario in particular, has highlighted the utility of additional reviews as knowledge and experience matures. A second review of the Alberta legislation in 5 years would be informed by a deeper level of understanding and application of the legislation and provide the opportunity to address any issues that arise from amendments made as a result of this review.

It should be noted that recommendations for changes to the regulations associated with the MHA were *not* included in this submission. It is expected that these will be addressed when the regulations are reviewed in a separate process, and will include items pertaining to the MHAA, 2007 as well as any required as a result of changes from this current review.