From: Linda Panos
To: FamiliesCommunities Committee
Subject: Submission of ACLRC on Mental Health Act Amendment Act
Date: Tuesday, November 17, 2015 3:50:06 PM
Attachments: MENTAL HEALTH ACT.docx

Dear Sir or Madam:
Please see attached. Thank you, Linda McKay-Panos

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"A human being is a part of the whole called by us universe, a part limited in time and space. One experiences oneself, one's thoughts and feelings as something separated from the rest, a kind of optical delusion of one's consciousness. This delusion is a kind of prison for us, restricting us to our personal desires and to affection for a few persons nearest to us. Our task must be to free ourselves from this prison by widening our circle of compassion to embrace all living creatures and the whole of nature in its beauty." - Albert Einstein

REVIEW OF THE MENTAL HEALTH AMENDMENT ACT

SUBMISION BY ALBERTA CIVIL LIBERTIES RESEARCH CENTRE

November 17, 2015

The dilemma of mental health legislation

The fundamental issue raised by mental health legislation in general, and the Alberta *Mental Health Amendment Act, 2007* in particular, is the dilemma of respecting the *Charter of Rights and Freedoms* (*Charter*) rights of mental health patients on the one hand, and, on the other hand, ensuring that mental health patients receive the requisite care and treatment required by their condition, particularly when these patients do not voluntarily submit to treatment.

Persons with mental disorders do not have lesser *Charter* rights relative to all other persons. They are and remain entitled to the equal protection of our laws. Their civil liberties and entitlement to human dignity remain intact despite their mental health challenges. However, they are undoubtedly unwell. They need care and treatment without which their condition might deteriorate. Worse, their illness might result in harm befalling them. Or they might harm other people. The urgency of the need for treatment may not always be appreciated by persons with mental disorders. Their condition may render them clinically incompetent to make decisions on their own behalf; a situation that at once raises the stakes for their own safety and wellbeing as well as possibly engaging the rights and safety of the wider society.

The majority of persons with mental disorders are not a danger to or at risk of harming others. There is often no need to confine them in treatment institutions. Their failure or delay in taking required treatment may not have obvious public consequences. Some persons with mental disorders who delay treatment still remain productive in their work and careers, and remain responsible family members. Yet, we are told that about 1 in 5 of us (some say 1 in 3) suffer from some mental disorder.

For a significant and increasing number of persons with mental disorders, the matter is more serious. Institutionalization may be required for varying lengths of time. Prolonged treatment is often necessary. And relapses do occur. Moreover, tragic incidents of grievous harm, including homicides, have been recorded.

Nobody can wish away the challenges posed by a mental health disorder—both to the patients and those who live with them or come in contact with them. Mental health legislation must seek to grapple with these challenges, and find workable resolutions within the wider ambience of civil rights and fundamental freedoms.

There is absolutely no necessary contradiction between *Charter* liberties and patients' rights on one hand, and treatment regimes and institutional confinement on the other. It bears repetition to say that like all sick people, persons with mental disorders remain entitled to and do enjoy the rights and choices available in our society. However, the availability and enjoyment of these rights do not, in themselves, deal with the unique complexity of problems posed by mental health disorders; problems rarely experienced with any other ailment. Only *treatment*, whether voluntary or involuntary, can respond to some situations encountered by persons with mental disorders.

Mental health legislation, while constantly striving to protect the civil liberties of patients, must address itself to the reality that some forms of mental disorder pose grave risks to both the patient and the wider society. These risks demand prompt and urgent action to avert or prevent them; societal intervention may require forcible confinement of patients for varying durations for treatment purposes; and, the patient may not always be in a state of mind to understand his/her own condition or the actions being taken for his/her benefit, let alone consent to them.

It is at this point, when the liberties and fundamental freedoms established by our *Charter* may appear to serve no meaningful purpose to a badly stricken person; when their condition may deteriorate if there is a failure or delay of decisive intervention; when life, limb and (*Charter*) liberties are at grave risk both for patient and community. At this point, in drafting mental health legislation, legislators must accept the difficult task of in

laying down policies and guidelines that balance the rights of patients with the overall interests of society.

Mental Health Amendment Act, 2007

The amendments introduced in 2007 by the *Mental Health Amendment Act* were a response to the trend towards deinstitutionalisation which had established itself not only in Canada but also throughout the Western world. They were also a response to a phenomenon that is impossible to overlook as more and more persons with mental disordered are deinstitutionalised, viz: the frequency and brazenness of tragic incidents orchestrated by persons with mental disorder resulting to varying degrees of harm to themselves or, often, to innocent people.

Deinstitutionalisation recognised that confining patients in treatment facilities indefinitely did not, in the long term, result in their integral wellness. While institutionalisation serves undeniable benefits, later stages of treatment after the disorder has been more-or-less contained promises better outcomes when the patient is allowed to resume normal life in his/her community, among his/her family and friends, provided their treatment continues (in the community) and is not interrupted or relegated. But the problem becomes: how do you realistically continue the treatment in those cases where the patients refuse treatment or would not comply with treatment regimes?

Some patients who are released to their communities for continuation of treatment often do not feel a strong obligation to remain on or comply with treatment regimes. Often the result is a relapse in their condition, followed by a return to the institution. The community treatment order is the legislated answer to this situation. The CTO seeks to harness an enforcement mechanism to a regime of treatment for the patient while at home, ensuring that they leverage community support and services for continuing care and recovery. (The CTO in various designs are in place in Saskatchewan, Ontario, British Columbia, Manitoba, Australia, New Zealand and several American states.)

Similarly, incidents of violent crimes, including homicides, by persons suffering from mental disorder leaves family and community members in need of protection. Early intervention is a ready answer to that situation. An amendment to the *Mental Health Act*

which aims at opening wider the doors of early intervention in clear cases of risk seems to respond realistically to the need for proactive action.

Criteria for involuntary admission

Before the 2007 amendments, involuntary admission of persons with mental health disorders to health-care facilities was allowed under a set of criteria including that the person is:

> likely to present a danger to themselves or to others

The amended law now provides, among other criteria, that the person be:

> likely to cause harm to [themselves] or others or to suffer substantial mental or physical deterioration or serious physical impairment

This amendment does open wider the door of involuntary admissions of patients to health-care facilities; it is fair to say that it is responsive to concerns expressed by family members of persons who are not following their treatment regimes (often because there are difficult side effects from the medication or they are currently lacking symptoms). Thus, in order to assess whether this broadening of criteria for involuntary commitment is appropriate, evidence needs to be gathered that demonstrates that, on the whole, the scheme of the amended *Act* represents a proper balancing of the rights of persons with mental illness against their need for treatment and care. For example, does the *Act* provide adequate appeal procedures and representation available for individuals who wish to challenge the commitment?

As a matter of both principle and policy, whenever voluntary treatment is not a viable option, persons with severe mental illness should be assisted before their condition deteriorates. It is entirely consistent with the interests of the patient, as with those of society, that a person with mental disorders receive the care and treatment they need before anything worse occurs.

Even a purely civil libertarian approach to mental disorder issues must not overlook the reality that nothing ensures the widest and richest enjoyment of civil liberties and freedoms by patients with mental disorders more than the expeditious recovery from

their mental order. No one is more committed to the rights and liberties of patients with mentally disordered patients than those who labour to set them free from their pain.

The *Mental Health Act*, as amended, does not prescribe involuntary admission or treatment regime for every case of mental disorder. As noted earlier in these submissions, involuntary admissions are designed to operate at the point where voluntary treatment is not a viable option, at the point when the likelihood of harm to the patient or to other persons in the community is palpable, at the point when failure or tardiness in intervention will most probably lead to a deterioration of the condition.

A debate pursuing the alleged difference between the phrases *likely to present danger* and *likely to cause harm* seems to overlook entirely our lived experience. We must be careful not to split semantic hairs over serious matters like this. At the same time, we must ensure that every effort to bring needed treatment to a person with a mental disorder, considers and utilizes the least restrictive methods, adheres to humane practices, and is most calculated to promote the rights, liberties and dignity of the patient.

Community treatment orders

As mentioned earlier, the introduction of the mechanism of community treatment orders is a necessary companion to deinstitutionalization. When patients are no longer within the supervision of treatment institutions, yet continue to require treatment and care, the experience of several decades teaches us that leaving them to their own counsel and choices may merely be a preparation for their eventual return to institutions. The reluctance of mental health patients to take their medication, or otherwise comply with treatment regimes, can be problematic. What is required is a practical response to the problem. There is nothing inconsistent with rights and freedoms to insist that mental health patients living among the population should do their best to continue with appropriate treatment, especially where community services and support systems have been provided for their benefit.

Community treatment orders are a necessary tool of mental health-care delivery. However, they should not be used as if they are the only available “tool in the box”.

Deinstitutionalization requires more than CTOs as effective partners in mental health-care delivery. There should also be adequate support services within the communities for persons with mental disorders and their families. Indeed subsection 9.1 (1) (d) of the Act provides, as one of the requirements before a community treatment order may be made, that:

> the treatment or care the person requires exists in the community, is available to the person and will be provided to the person.

This means that the availability in the community of treatment facilities and support initiatives for persons with mental disorders is a precondition, among others, of a community treatment order.

In addition, every effort should be made to make the patient the pivot of the whole project of treatment continuation. This ensures that any patient's resistance to or inhibitions about the continuation of treatment are creatively responded to in a manner that builds confidence and trust in the system and assists the patient to play their part in the process in a spirit of genuine involvement. After all, it is the patient that the treatment is about.

In this vein, social welfare services and programs of economic security which assist the patient to readjust meaningfully to life in the community should be enhanced. A patient who is released from a hospital facility to continue their treatment at home may have be placed in a crisis if she/he cannot find work or access to opportunities for self-maintenance and social respect. Such a person can hardly be expected to comply with any treatment order no matter how well intended.

Conclusion

The amendments to the *Mental Health Act*, as regards involuntary admission of patients and community treatment orders, appear clearly rational and in proportion to the need they were designed to meet. What is required in order to obtain better outcomes in mental health-care delivery to augment them through ancillary policies and procedures that translate the scheme of the *Mental Health Act*, as a whole, into a charter of mental

health and wellness. The Act, as amended, taken as a whole, contains many safeguards against abuses of the rights of mental health patients. A proper balancing of those rights with the need for treatment or continuing treatment, the use of the least invasive or restrictive techniques, unless they are clearly not feasible, and the provision of adequate community support services and social welfare programs will combine to serve the interests of mental health patients and the wider society.

It seems that there is an acute lack of evidence/statistics about civil commitment, its efficacy and the outcomes of community treatment orders. Perhaps there should be a Commission of Mental Health that could be tasked with gathering evidence and drawing conclusions about treatment plans and the supports needed in the community, and this information could be shared with the Alberta Government (Standing Committee on Families and Communities) in order to inform their considerations.