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VIA EMAIL

September 9, 2015

Standing Committee on Social Programs,
Government of the Northwest Territories
Attention: Danielle Mager, Clerk

Re: Bill 55, Mental Health Act

Dear Members of the Standing Committee on Social Programs,

I am writing on behalf of the British Columbia Civil Liberties Association (BCCLA). We are Canada's oldest and most active civil liberties and human rights organization. I am writing in response to your call for submissions on Bill 55, the proposed new Mental Health Act (MHA).

Firstly, we congratulate you on your work in developing a new MHA and the very thoughtful and useful series of discussion papers for the new act that you commissioned and published. While our submission will focus on concerns and proposed amendments, we wish to acknowledge that there are many improvements in the new act which we support. In particular we commend you for avoiding many of the worst features of BC's legislation.

Our organization has a position paper on *Suggested Changes to BC's Mental Health System regarding Involuntary Admission and Treatment in Non-Criminal Cases* (https://bccla.org/wp-content/uploads/2013/01/2012-BCCLA-Paper-BC-Mental-Health-System.pdf) which informs our comments on Bill 55.

We are primarily commenting on three aspects of the legislation: 1) involuntary admission and consent to treatment 2) liability and 3) community treatment orders (CTOs).

Involuntary Admission and Treatment Decisions Under Bill 55

In Bill 55 the criteria for involuntary admission is in section 13 which requires that the person (i) is suffering from a mental disorder, (ii) is likely to cause serious harm to himself or herself or to another person, or to suffer substantial mental or physical deterioration, or serious physical impairment if he or she is not admitted as an involuntary patient, and (iii) is not suitable to be admitted as a voluntary patient.

A medical practitioner who issues a certificate of involuntary admission authorizes (s. 18):

(a) care for and observation, examination, assessment and treatment of the patient who is subject to it for a period not exceeding 30 days after the certificate is issued; and

(b) detention and control of the patient who is subject to it for the purposes of paragraph (a).

Subsequent certificates can be issued, first, for a period not exceeding 60 days and after for a period not exceeding 90 days (s.18). The attending medical practitioner must conduct psychiatric assessments of the patient on a reasonably ongoing basis to determine whether the involuntary admission criteria continue to be met (s.20) and cancel the certificate if the criteria are not met (s.21).

Regarding treatment and consent, Bill 55 provides:

26. Subject to this Act and to other exceptions under the law in respect of the requirement for consent to medical treatment, a patient who is subject to this Act has the right to consent to or refuse psychiatric and medical treatment.

27. A patient and, if applicable, his or her substitute decision maker, has the right to be informed by the attending medical practitioner of the purpose, nature and effect of diagnostic procedures to be performed and treatment to be provided.

Emergency treatment when a patient lacks capacity to consent and a substitute decision maker cannot be accessed is provided for in section 28. Emergency treatment is for cases where delay "will prolong suffering by a patient who is subject to this Act, or put the patient at risk of sustaining serious bodily harm…"

In determining the mental competency of patients to make treatment decisions, the medical practitioner shall consider:

29(2) (a) whether the patient understands
  (i) the conditions for which treatment is proposed,
  (ii) the nature and purpose of the treatment,
  (iii) the risks and benefits involved in undergoing the treatment, and
  (iv) the risks and benefits involved in not undergoing the treatment; and
(b) whether the mental condition of the patient affects his or her ability to appreciate the consequences of making treatment decisions.

29(3) An attending medical practitioner who is of the opinion that a patient is not mentally competent to make treatment decisions shall issue a treatment decision certificate in respect of the patient, with reasons for the opinion.

If a treatment decision certificate is issued, reasonable inquiries must be made to find a substitute decision maker for the patient (s. 29(4)). Persons eligible to be substitute decision makers for a patient are: a person with lawful custody (in respect of a minor), a legal guardian, an agent of the patient under a personal directive within the meaning of the *Personal Directives Act*, and, if none of those apply, the nearest relative of the patient.

Patients must be informed of who the substitute decision maker would be and, notwithstanding a section setting out the priority for determining the nearest relative, a different substitute decision maker may be designated, including an adult friend, if the patient objects to the nearest relative as a substitute decision maker and the medical practitioner or director is satisfied that the person requested by the patient is appropriate (s.30(7) and (8)).

The substitute decision maker must make decisions in respect of treatment in accordance with the known wishes, if any, expressed by the patient when he or she was mentally competent (s. 32(1)). The substitute decision maker must make treatment decisions in accordance with what the substitute decision maker believes are the best interests of the patient if the patient's wishes expressed when mentally competent are not known, or if following the patient's express wishes would endanger the physical or mental health or safety of the patient or other person (s.32(2)).

The substitute decision maker must consider the following factors when determining the best interests of the patient (s.32(3)):

(a) whether the condition of the patient will be or is likely to be improved by the treatment;
(b) whether the condition of the patient will deteriorate or is likely to deteriorate without the treatment;
(c) whether the anticipated benefits from the treatment outweigh the risks of harm to the patient;
(d) whether the treatment is the least restrictive and least intrusive to meet the treatment objectives;
(e) wishes expressed by the patient when he or she was mentally competent to make treatment decisions.

However, the medical practitioner can provide treatment that has been refused by an involuntary patient who is mentally competent to make treatment decisions or refused on behalf of a patient by a substitute decision maker if a review panel orders the treatment (s.33).

We believe these provisions could be improved and clarified in the following ways.

Presumption of Competence

The MHA should clarify that patients are presumed competent. There is need for express language on this point to counter the widely held notion that mental health patients are presumptively without the capacity for informed consent. All adults are presumed competent unless determined to be otherwise. Stating this expressly in the Act will better protect those who are involuntarily admitted who are capable of informed consent (estimated to be a sizeable minority, see: Okai D et al. "Mental capacity in psychiatric patients." *The British Journal of Psychiatry* (2007) 191 (4): 291-297).

Informed Consent includes Information about Alternatives

Currently section 27 describes the right of a patient or their substitute decision maker "to be informed by the attending medical practitioner of the purpose, nature and effect of diagnostic procedures to be performed and treatment to be provided." This is too limited for the purposes of informed consent. For informed consent, the medical practitioner must also provide information about alternative treatments. This should be expressly set out in this section.

Information about alternative treatment is needed for genuinely informed consent and is also information that is implicitly required for the fulfillment of substitute decision makers' duties, which may include a determination of whether the treatment proposed for the patient, "is the least restrictive and least intrusive to meet the treatment objectives."

Liability Exemptions Should be Narrow

Section 101 of Bill 55 provides:

> No action or proceeding lies or may be commenced against the Minister, the director of a designated facility or other health facility, a health professional, a member of the Review Board or any other person or body for anything done or not done in good faith in the exercise of powers or the performance of duties or functions under this Act, the regulations or a community treatment plan.

This immunity from liability for "anything done or not done" is overly broad. Capable patients and substitute decision makers are entitled to be informed of the risks and benefits of proposed treatments and made aware of alternative treatments. As well, patients are entitled to a standard of care that is contextualized by a physician's specialty.

This provision fails to provide patients an appropriate means of redress for negligence or malpractice. This overly-broad liability waiver is made more problematic by covering community treatment plans which may span many years of patients' lives.

Community Treatment Orders

Bill 55 provides for assisted community treatment certificates, which are more generally referred to as community treatment orders (CTOs). The BCCLA does not have a formal position on CTOs, but as they clearly raise civil liberties concerns they warrant comment.

Section 37 of Bill 55 reads:

> (1) The attending medical practitioner of an involuntary patient may, in accordance with this section and section 38, issue an assisted community treatment certificate authorizing the patient to reside outside a designated facility while receiving supervision and treatment or care.
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> …
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> (6) A medical practitioner may only issue an assisted community treatment certificate for an involuntary patient if the medical practitioner has examined the patient within 72 hours before issuing the certificate and is of the opinion that
>
> > (a) the patient is suffering from a mental disorder for which the patient is in need of supervision and treatment or care that can be provided while the patient resides outside the designated facility;
> >
> > (b) if the patient does not receive supervision and treatment or care while residing outside the designated facility, he or she is likely, because of the mental disorder, to cause serious harm to himself or herself or to another person, or to suffer substantial mental or physical deterioration, or serious physical impairment;

> (c) the patient is capable of complying with the requirements for supervision and treatment or care included in the community treatment plan;
> (d) the patient is willing to comply with the requirements for supervision and treatment or care included in the community treatment plan, and
> (e) adequate treatment services and support are available and will be provided to the patient.

The intuitive attraction of CTOs as a less restrictive alternative to hospitalization is obvious and we would want to be generally supportive of such alternatives. However, there are legitimate concerns that they may be used not as a less restrictive alterative to hospitalization but as a more restrictive alternative to voluntary care in the community.

As of Ontario's statutory review of CTOs in 2012 (the "Ontario Review") there was little or no evidence for the effectiveness of CTOs, with two random controlled trials subsequently reviewed by RAND and the Cochrane Review showing no evidence for the effectiveness of this type of legislation. More recent evidence echoes these same findings. In 2014, UK and Norwegian researchers examined the results of the Oxford Community Treatment Order Evaluation Trial (OCTET) and found that CTOs "do not have benefit on any of the tested outcomes, or for any subgroup of patients."

While widely used in some jurisdictions, CTO remain controversial. So much so that Dr. Tom Burns, head of social psychiatry at Oxford University, who originally advised the UK government on implementing CTOs has reversed his position and called for their suspension, stating "The evidence is now strong that the use of CTOs does not confer early patient benefits despite substantial curtailment of individual freedoms."

Despite the lack of evidence supporting the use of CTOs, the Ontario Review strongly recommended continuing to use CTOs, largely on the basis of reports from stakeholders. We note several methodological shortcomings and problems with the Ontario Review's survey of stakeholders, including that only a scant 60 of the 539 views captured were those of mental health consumers. As well, the survey instruments did not distinguish between benefits achieved because of enhanced community services and those achieved because of forced medication.

The concerns about CTOs really centre on forced medication, as no one objects to the enhanced access to community services that are part of community treatment plans, and such access is typically seen as key to the effectiveness of such plans. As the Ontario Review notes, the main reasons given by consumers and substitute decision makers to resist CTOs isn't the treatment plans generally, but specifically being compelled to take medications with very negative side-effects.

The question is whether legislation that provides for this compelled medication is justified in the face of the evidence that, as the OCTET study found, there is no significant difference between patients being subjected to forced medication and those who were not.

Given that CTO patients are required to continue to meet the criteria for involuntary committal, the aim of which is to save lives and prevent grievous harms, there are only a few ways to interpret the data about the efficacy failure of CTOs. Either many patients are included who do not in fact meet the criteria for involuntary committal (as per concerns raised by the consumer stakeholders in the Ontario Review who reported CTOs increasingly being used as a preventative measure rather than as a last resort) and/or forced medication is less efficacious or necessary than is often believed.

Given this, we suggest that Bill 55 be amended so community treatment plans do not require forced medication, as it currently appears. Section 40 states that community treatment plans must include "a plan for treatment of the patient". While "treatment" is not a defined term in the Act, "treatment" is elsewhere in the Act distinguished from "care", indicating that treatment is read as "active treatment", typically meaning medications. An involuntarily admitted patient who is competent could decline medication, or a substitute decision maker could decline on their behalf. But as it currently reads, if this same patient were eligible for a community treatment plan, medications (active treatment) are a required part of the community treatment plan. At a minimum, the current wording creates confusion on this point and the wording should be changed to reflect that the community treatment plan must include a plan for medication *if* medication is part of the treatment plan.

Finally, we note that despite the generally positive results of the Ontario Review, there was an astoundingly poor satisfaction rating for the independent tribunal process (their Consent and Capacity Board) which only 31% of all stakeholders agreed was satisfactory and only 15% of the consumer group agreed was satisfactory. The Ontario Review's summary states bluntly that "Information gathered for this review suggests that stakeholders did not think the appropriate balance between mandating CTOs because of clear benefits to some consumers and protecting the rights of all consumers has been reached."

Given that the Ontario Review has already found that Ontario's legislation's current safeguard need to be revisited, confidence in the efficacy of substantially similar safeguards is eroded. Further, there is not only evidence of general over-use and inappropriate use of CTOs, there is also very troubling data regarding the disproportionate use of CTOs for patients from racialized communities (see, for example, the Ontario Review's finding of the above average number of CTOs issued for patients described as 'black').

Presumably the 'lesson learned' is that the invitation to make an application to a review body is insufficient for the purposes of safeguarding vulnerable patients' rights. At a minimum, in order for a review body to be a meaningful safeguard, patients need resources and recourse to timely assistance for applications and representations before the board. Without access to advocacy services, the right to engage the review process is merely theoretical.

Not being in a position to assess the various unique factors in the NWT, including geographical challenges and, as described in your discussion papers, the "limited and diverse services in [your] communities", we cannot say what form a robust and accessible advocacy service would take in your jurisdiction. But we do stress that such advocacy is *absolutely necessary* in order for vulnerable patients to exercise their rights and urgently needed in the face of the expansion of medical authority through CTOs.

Mental illness poses formidable challenges for patients, families of the mentally ill and society. Patients with severe mental illness are not only vulnerable, but uniquely vulnerable and require diligent attention to the upholding of their rights. We hope you will consider our recommendations.

Summary of our recommendations

1) **Include an express presumption of patient competence;**

2) **Require informed consent to include information about treatment alternatives;**

3) **Narrow the liability exemptions to allow for meaningful redress for negligence and malpractice;**

4) **Allow for community treatment plans that do not included forced medication;**

5) **Provide robust patient advocacy services to make meaningful patients' recourse to the Review Board.**

Respectfully submitted,

M. Vonn

Micheal Vonn
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