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Perspective

Clinically Significant Differences among Canadian Mental Health Acts: 2016

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Differences in mental health laws in Canadian jurisdictions determine if a person with a serious mental illness, who refuses voluntary hospitalization and treatment, can receive the treatment needed to alleviate symptoms and assist in their recovery. The objective of this article is to examine the clinically significant differences of Canadian mental health acts, in effect as of January 15, 2016. This article also updates our study of reforms that occurred prior to 2001 in Saskatchewan,[1] Manitoba,[2] British Columbia,[3] and Ontario.[4,5] Amendments made between 2001 and 2016 in Nova Scotia, Newfoundland and Labrador, Alberta, and Saskatchewan are also examined. Rights mechanisms, such as providing rights information, renewals of detention, and appeals, are not addressed in this article.

Method

We compared involuntary admission criteria, treatment authorization mechanisms, and compulsory community treatment provisions in the 13 Canadian mental health acts in effect as of January 15, 2016, noting significant amendments.[6] To analyze clinical effects of the laws, we used the same fictional illustrative case in our 2001 article.

Illustrative Case

Victoria, a 25-year-old law school student, experiences auditory hallucinations and paranoid delusions that result in her leaving university and becoming homeless. She is diagnosed with schizophreniform disorder. Victoria does not assault or threaten to harm anyone or herself, but she refuses voluntary outpatient or inpatient treatment. A person, like Victoria, who is experiencing her first episode of psychosis, has a good prognosis if treated but a poorer prognosis when treatment is delayed.[7]

Results

Involuntary Admission Criteria

To be involuntarily admitted, a person must meet all the criteria of the jurisdiction. In all jurisdictions, a person must "not be suitable" for voluntary admission. The additional criteria and their content differ among jurisdictions on the definition of mental disorder, harm/deterioration criteria, whether a need for treatment is required, and whether incapacity for admission or treatment decisions is required.

By 2016, 7 provinces had made significant amendments to their involuntary admission criteria. Table 1 shows criteria for all jurisdictions including the 4 with changes prior to 2001. Between 2001 and 2016, 3 additional provinces, Nova Scotia,[8,s.17] Newfoundland and Labrador,[9,s.17] and Alberta,[10,s.6] made significant changes to their involuntary admission criteria. Each of these provinces' changes was similar: expanding the criteria to include broadly defined harms, rather than just dangerousness, and introducing a substantial mental or physical deterioration criterion as an alternative to the harm criterion. Some provinces also incorporated a requirement that the person be incapable of making admission or treatment decisions to be admitted involuntarily.

Would Victoria, who would not accept voluntary admission, meet the criteria for involuntary admission in different jurisdictions?

Must Meet the Definition of Mental Disorder (All Jurisdictions). With a serious mental illness, Victoria would meet the mental disorder criteria for all jurisdictions despite differences between "broad" and "specific" definitions. Only Quebec and Ontario retain broad definitions (e.g., Ontario: "any disease or disability of the mind."[4,s.1] All the others are specific (e.g., Nova Scotia: "a substantial disorder of

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Table 1. Criteria for involuntary admission and community options, 2016.

Jurisdiction	Definition of mental disorder	Harm criterion	Deterioration as alternative to harm	Need for treatment	Incapable of treatment decision	CTO/ leave
British Columbia	Specific	Broad	Yes	Yes	No	Leave
Alberta	Specific	Broad	Yes	No	No	CTO
Saskatchewan	Specific	Broad	Yes	Yes	Yes	CTO
Manitoba	Specific	Broad	Yes	Yes	No	Leave
Ontario	Broad	Bodily	Yes (partial)	No for bodily harm. Yes for deterioration.	No for bodily harm. Yes for deterioration.	CTO & Leave
Quebec	Broad	Bodily	No	No	No	CTO
Nova Scotia	Specific	Broad	Yes	Yes	Yes	CTO
New Brunswick	Specific	Broad	No	No	No	No
Prince Edward Island	Specific	Broad	No	No	No	Leave
Newfoundland	Specific	Broad	Yes	Yes	Yes	CTO
Yukon	Specific	Bodily	No	No	No	Leave
Northwest Territories/ Nunavut	Specific	Bodily	No	No	No	No

CTO = community treatment order. CTO jurisdictions also provide for leave.

behaviour, thought, mood, perception, orientation or memory that severely impairs judgment, behaviour, capacity to recognize reality or the ability to meet the ordinary demands of life, in respect of which psychiatric treatment is advisable").[8,s.3(q)]

Likely to Cause Harm (All Jurisdictions, but the Type of Harm Differs). Victoria is not likely to cause physical harm to herself or others. She therefore cannot be admitted under the current "serious bodily harm" or "serious physical impairment" criteria in Ontario,[4,s.20(5)] Northwest Territories,[11,s.13] and Yukon.[12,s.5(1)] Although there are decisions of Ontario's Consent and Capacity Board that support "psychological harm" as a valid form of "bodily harm,"[13] Victoria would not likely meet the required threshold, in her present state. Prior to amendments, she also could not have been admitted in Alberta ("present a danger")[14,s.6] or Nova Scotia. However, Victoria could probably now be admitted under broad harm criteria in 8 jurisdictions (Table 1; e.g., Alberta, "likely to cause harm"[10,s.6]).

These broader harm criteria have been found by courts to be in accordance with the *Canadian Charter of Rights and Freedoms.*[15-17]

(Alternative to Harm) Likely to Suffer Substantial Mental or Physical Deterioration (7 Jurisdictions). By 2016, 7 provinces—British Columbia,[3,s.22(3)] Alberta,[10,s.6(d)(ii)] Saskatchewan,[1,s.24(2)] Manitoba,[2,s.17(1)] Ontario under specific circumstances,[4,s.20(1.1)] Nova Scotia,[8,s.17(c)(ii)] and Newfoundland and Labrador[9,s.17(1)(b)(ii)]—included substantial mental or physical deterioration as an alternative to the harm criterion. Thus, even if Victoria does not meet the harm criterion of these jurisdictions, her untreated illness might be found to be likely to cause substantial mental or physical deterioration, thereby meeting this involuntary admission criterion.

Although Ontario has a deterioration criterion, it applies only if the person has previously responded to treatment for the same or a similar condition and is judged to be incapable of making a treatment decision. This excludes Victoria because it is her first episode, and she has not yet received treatment. To access treatment in Ontario, she would have to deteriorate until she was likely to cause serious bodily harm.

Committal provisions based on the likelihood of significant mental or physical deterioration have been found to be in accordance with the *Canadian Charter of Rights and Freedoms* in Manitoba[17] and in Ontario.[18]

In Need of Psychiatric Treatment (6 Jurisdictions). Victoria meets the "need for treatment" criterion that 6 provinces now have: British Columbia,[3,s.22(3)(c)(i)] Saskatchewan,[1,s.24(2)(a)(i)] Manitoba,[2,s.17(b)(ii)] Ontario,[4,s.20(1.1)] (required only with deterioration), Nova Scotia,[8,s.17(d)] and Newfoundland and Labrador.[9,s.17(1)(b)(ii)(A)]

Victoria would also qualify where the jurisdiction does not specifically mention a need for treatment, provided she met the other criteria. However, in jurisdictions that do not include a specific need for treatment criterion, people who do not have a treatable mental disorder may be detained.[19]

Not Capable of Making an Admission or Treatment Decision (4 Jurisdictions). Saskatchewan,[1,s.24(2)(a)(ii)] Nova Scotia,[8,s.17(e)] and Newfoundland and Labrador[9,s.17(1)(b)(ii)(B)] include a lack of "full" capability to make an admission or treatment decision as a committal requirement. If Victoria was considered "fully" capable of making an admission or treatment decision, she could not be involuntarily admitted in these jurisdictions, but she could be where incapability is not a requirement. Presumably, this high level of capability ("fully") is required because lower levels of capability would exclude dangerous people with treatable mental disorders. In Ontario, an "ordinary" capability criterion is

required under the "deterioration" criterion, but capability is not considered under the dangerousness criterion.[4,s.20(1.1)(e)]

Treatment Authorization and Refusal

Once a person is involuntarily admitted, how is the treatment necessary for their release authorized? Can treatment be refused for involuntarily detained patients? Jurisdictions have markedly different approaches: some do not allow refusal; some allow refusal, which can be overruled in the person's best interests; others honour a competent contemporaneous refusal; and some comply with a previously expressed capable wish applicable to the circumstances, even if the refusal greatly prolongs detention and suffering. The options chosen were found to be associated with the purpose of the mental health act, state or private authorization procedures, and the criteria of "best interests" or "capable wishes."

Purpose of Involuntary Admission. If the primary objective of involuntary admission is to provide treatment to reduce harmful consequences, then treatment refusal is inconsistent with that objective.[20] However, if the objective is to protect the person or others from harmful behaviour, detention can achieve this by itself, and treatment refusal is consistent with that objective. Court interpretations of British Columbia and Ontario Mental Health Act objectives illustrate this difference. In Ontario, in relation to the bodily harm criterion, the Ontario Court of Appeal held that "the fact that she has been detained for well over a year without treatment is contemplated by the Act, which provides for the detention of dangerous persons who suffer from mental illness, without necessarily compelling them to be treated."[21] In contrast, a Supreme Court in British Columbia wrote, "The *Mental Health Act* involuntarily detains people only for the purpose of treatment: the punitive element is wholly absent."[22] Consistent with this conclusion, the British Columbia statute includes a need for treatment committal criterion and does not allow treatment refusal.

In relation to the deterioration admission criterion and community treatment orders, the Ontario Superior Court found that the province's legislative revisions "had a dual purpose of safety *and* treatment" (emphasis in original).[18(para 85)]

Treatment Authorization (State or Private)

State authorization of treatment. Five provinces use an appointee of the state (province or territory) to authorize treatment. In Saskatchewan,[1,s.25(2)] and Newfoundland and Labrador,[9,s.35(1)] the attending physician authorizes the treatment. In British Columbia, the director of the psychiatric unit consents.[3,s.8] New Brunswick uses a tribunal for both mentally incompetent patients and competent patients who refuse.[23,s.8.11(3)] Quebec uses the court to authorize treatment.[24] Compared with private authorization of treatment, these state mechanisms usually result in minimal delay in initiating treatment, with the possible exception of court involvement. These mechanisms also appear to reflect a purpose of the mental health act as providing treatment for the involuntary patient.

Private authorization of treatment. In all other Canadian jurisdictions, private substitute decision makers (SDM) consent or refuse to consent in a similar manner as for a voluntary medical patient who is not capable of consenting.

Criteria to Guide Substitute Decision Making. The SDM is guided by different criteria in different jurisdictions. This can have significant effects on whether or not a patient is provided with timely treatment.

Best interests. All jurisdictions that use a state appointee require the treatment decision to be made in the patient's best interests. Alberta[10,s.28(3)] and Prince Edward Island[25,s.23(9)] also require the SDM to make the decision in the person's best interests.

Capable wishes. A wish (how to be treated or not to be treated), applicable to the circumstances, that the incapable person expressed while capable, cannot be overturned by the SDM or tribunal in some jurisdictions (e.g., Ontario,[4,s.13] Northwest Territories,[11,s.19.4(7)] or Yukon[21(1)]). If Victoria had told her SDM before she became ill that under no circumstances was she to be treated with any antipsychotic, she could not be treated and would likely suffer significant harm and be detained for a considerable period of time, as have others who refused treatment.[26,27]

Modified best interests. Manitoba has a "modified best interests" test for consenting to treatment that addresses the potential harm caused by treatment refusal. The SDM must adhere to the patient's previous capable wishes unless "following the patient's expressed wishes would endanger the physical or mental health or safety of the patient or another person." The decision then shall be made "in accordance with what the person believes to be the patient's best interests."[2,s.28(4)] Nova Scotia[8,s.39] has a similar provision. In New Brunswick, the review board can overrule a refusal on a best interest basis but must consider previous refusals.[23,s.30.1(6.1)]

Review and Appeal Procedures Related to Treatment. All jurisdictions provide for a tribunal or court to review the validity of involuntary hospitalization, but some jurisdictions also review capability. If found to be capable, a detained patient can refuse treatment. In Ontario, when a patient appeals a finding of incapability, treatment cannot be started until the matter, including any court appeals, is resolved. This can result in extremely long periods of detention.[28] However, in Nova Scotia, treatment continues during the appeal process unless the court specifically rules it must stop.[8,s.79(4)]

Conditional Leave and Community Treatment Orders

Let us assume that Victoria is hospitalized and treated and that her hallucinations and delusions partially remit. She does not, however, regain insight, fails to take medication to prevent relapses, and has further involuntary admissions. Victoria has developed a classic revolving door pattern. She may benefit from a community treatment order (CTO) or conditional leave from hospital that require patients to receive treatment in the community. Nine provinces now have compulsory community treatment provisions: 3 with conditional leave and 6 with CTOs (Table 1).

Conditional Leave from Hospital (3 Jurisdictions with Renewable Conditional Leave). Victoria could be returned to the community for a limited time on a conditional leave in Alberta,[10,s.20] Ontario,[4,s.27] Nova Scotia,[8,s.43] and Yukon,[12,s.26] provided that she continues to meet the admission criterion. If she does not comply with the conditions of the leave, she could be returned to hospital for an examination.

British Columbia,[3,s.37] Manitoba,[2,s.46(2)] and Prince Edward Island[25,s.25] have renewable conditional leaves, which can be used like community treatment orders but may not be in Prince Edward Island. However, Victoria would not qualify in Manitoba because she does not have the required 3 admissions or 60 days in hospital in the previous 2 years.

CTOs (6 Jurisdictions). Legislation in Saskatchewan,[1,s.24.3] Ontario,[4,s.33.1] Quebec,[24] Nova Scotia,[8,s.47] Newfoundland and Labrador,[9,s.40] and Alberta[10,s.8] allow for CTOs. All provinces with CTOs, except Alberta, Quebec, and Saskatchewan, require extensive previous hospitalization as a precondition to being placed on a CTO even though the person meets the other involuntary community treatment criteria. For example, Newfoundland and Labrador require at least 3 involuntary admissions to hospital in the previous 2 years.

In 2015, Saskatchewan amended its legislation to allow a person to be placed on a CTO following their first admission. This would include people, like Victoria, who could benefit from a CTO by reducing the preconditions from 3 admissions or 60 days in the previous 2 years to 1 admission, including the current admission, with no length of stay specified.[29,s.25(1)] Similarly, Alberta has a CTO option for people who have never been hospitalized.[30]

Discussion

Our perspective on Canadian mental health laws is that they are becoming more responsive to the needs of people with severe mental illnesses who do not access hospitalization and treatment voluntarily. Access to hospital treatment has improved because in most jurisdictions, people who are not physically dangerous but whose untreated illness will cause significant harm or deterioration can now access earlier treatment, assuming it is available. Access to treatment in the community has also improved. CTOs or conditional leave, designed to reduce relapses and provide treatment in the least restrictive setting, are now present in the majority of jurisdictions. These recent changes in mental health laws are consistent with the Canadian Psychiatric Association's principles underlying mental health legislation.[31] As well, legislated independent reviews have generally been supportive of these changes.[32-35]

Clinical Implications

- Most Canadian provinces' committal criteria are now broader than physical "dangerousness" and include, as an alternative, "likely deterioration"; four provinces' committal criteria include a capacity test.
- Community treatment orders or their equivalent are available in most provinces.

Limitations

- The implementation of laws can differ because of resource availability and varying knowledge and attitudes among practitioners.
- There are few studies on inpatient committal or consent legislation, and little research has been conducted on the impact of legislative schemes on the families of persons with mental illness.

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References

1. Mental Health Services Act, SS 1984-1285-86, c. M-13.1.
2. Mental Health Act, CCSM c. M110.
3. Mental Health Act, RSBC 1996, c. 288.
4. Mental Health Act, RSO 1990, c. M. 7.
5. Gray JE, O'Reilly RL. Clinically significant differences among Canadian mental health acts. Can J Psychiatry 2001;46(4): 315-321.
6. The Canadian Legal Information Institute. Available from: http://www.canlii.org/en/index.html.
7. Malla AK, Norman R, Joober R. First-episode psychosis, early intervention, and outcome: what have we learned? Can J Psychiatry 2005;50(14):881-891.
8. Involuntary Psychiatric Treatment Act, SNS 2005, c. 42.
9. Mental Health Care and Treatment Act, SNL 2006, c. M-9.1.
10. Mental Health Act, RSA 2000, c. M-13.
11. Mental Health Act, RSNWT 1988, c. M-10.
12. Mental Health Act, RSY 2002, c. 150.
13. The Newsletter of the Consent and Capacity Board, March 2010, Volume 8, Number 2.
14. Mental Health Act, SA 1988, c. M-13.1.

15. Reference re Mental Health Act (1984), 5 DRL (4th) 577 (PEICA).
16. McCorkell v. Riverview Hospital, (1993), 81 BCLR (2d) 273, 8 WWR. 169, at p. 300.
17. Bobbie v. Health Sciences Centre (1988), [1989] 2 WWR. 153, 56 Man. R. (2d) 208, 49 CRR 376 (QB).
18. Thompson and Empowerment Council v. Ontario, 2013, ONSC.
19. Starnaman v. Penetanguishene Mental Health Centre (1994), OJ 1958 (QL) (Gen. Div.), affd. (1995), 24 OR (3d) 701. 83 OAC 95, 100 CCC. (3d) 190 (CA).
20. Saskatchewan Law Reform Commission. Proposals for a Compulsory Mental Health Care Act (1985) at 7.
21. Khan v. St. Thomas Psychiatric Hospital (1992), 87 DLR. (4th) 289, 52 OAC 166, 7 OR (3d) 303, 70 CCC (3d) 303 (C.A.); leave to appeal to SCC. refd (1992), 93 DLR (4th) vii, 59 OAC 240, 10 OR (3d) xv, 75 C.C.C. (3d) *vii*.
22. McCorkell v. Riverview Hospital, [1993] 8 WWR 169, 81 BCLR (2d) 273 (SC) at 295-96 (BCLR.).
23. Mental Health Act, RSNB 1973, c.M-10.
24. Certain Personality Rights 1991, C.C.Q. 1991, c. 64, art 16.
25. Mental Health Act, RSPEI 1988, c.M-6.1.
26. Gray JE, Shone MA, Liddle PF. Canadian mental health law and policy. 2nd ed. Toronto: LexisNexis; 2008. p 226-246.
27. Solomon R, O'Reilly R, Gray J, et al. Treatment delayed-liberty denied. Canadian Bar Review 2008;87:679-719.
28. Kelly M, Dunbar S, Gray JE, et al. Treatment delays for involuntary psychiatric patients associated with reviews of treatment capacity. Can J Psychiatry 2002;47(2):181-185.
29. The Mental Health Services Amendment Act, 2013. §§ 1984-85-86, c.M-13.1.
30. Gray J, Shone M, O'Reilly R. Alberta's community treatment orders: Canadian and international comparisons. Health Law Review 2012;20(2):13-21.
31. O'Reilly RL, Chaimowitz G, Brunet A, et al. Principles underlying mental health legislation. Can J Psychiatry 2010;55(10): Insert 1-5.
32. LaForest GV, Lahey W. Report of the independent panel to review the involuntary psychiatric treatment act and community treatment orders submitted to the Minister of Health and Wellness, Nova Scotia. July 10, 2013.
33. Dreezer & Dreezer Inc. Report on the legislated review of community treatment orders, required under section 33.9 of the *Mental Health Act* For the Ontario Ministry of Health and Long-Term Care. December 2005.
34. Malatest RA & Associates Ltd. Legislated review of community treatment orders. Prepared for the Ministry of Health and Long-Term Care. May 23, 2012.
35. Newfoundland and Labrador. Mental Health Care and Treatment Act evaluation final report. Research and Evaluation Department Newfoundland and Labrador Centre for Health Information; April 2012.