Treatment

A Discussion Paper Series for a New Mental Health Act

Discussion Paper 3 of 4

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Treatment Decisions of Involuntary Patients

The current Act requires a physician to examine a voluntary or involuntary patient to determine if they are competent to give valid consent to the treatment. If there is a significant change in the treatment plan, a new exam is required. If the patient is found to be mentally incompetent to give valid consent, the doctor is required to tell the patient that they have the right to appeal the finding of mental incompetence to the Supreme Court. The Act sets out a process where the doctor must make a reasonable effort to look for a substitute consent giver and must inform the patient of whom it will be. A hierarchy is laid out to determine who the substitute consent giver will be:

- A guardian appointed by the court
- Agent designated by the *Personal Directive Act*
- A representative (someone appointed by the patient when they were mentally competent)
- The spouse or common-law partner
- A child of the patient
- A parent
- Sibling (brother or sister)
- Any other relative
- A friend

If the substitute consent giver is a spouse, child, parent, sibling, other relative or friend and the patient objects, the doctor must give consideration to the patient's concerns. The patient also has the right to apply to the Supreme Court for a review of that decision. If the substitute is unwilling, the doctor can move down to the next person on the list. The substitute consent giver has to confirm in writing that they have had personal contact with the patient in the preceding 12 months and has a "friendly relationship", that the patient won't object to them, and that they will act in the benefit of the patient.

If the doctor cannot find a substitute consent giver, the person is "no longer suitable", or there is a disagreement as to who can be the substitute, the doctor may apply to the Supreme Court for instructions.

In situations where there is no substitute decision maker or they are unavailable, the current Act allows a doctor to give emergency medical or psychiatric treatment where that treatment is necessary to preserve the life or mental/physical health of a person, the failure to give the treatment or delay in giving the treatment would create a 'reasonably foreseeable' risk of injury to the patient or another person, and the treatment cannot reasonably be delayed through an alternative means of detention. The patient has the right to appeal to the Supreme Court but there is a notwithstanding clause that says emergency

treatment will continue while the appeal is being heard. The same is true for Registered Nurses except there is an additional clause requiring nurses to try and transfer the patient to the care of a doctor. Otherwise treatment may only be given to a patient if s/he consents or if their substitute consent giver has consented. That treatment would NOT include any psychosurgery, lobotomy or any other 'irreversible' forms of treatment unless the patient is mentally competent and has consented. There is also a prohibition on experimental treatments involving any significant risk of physical/psychological harm to the patient.

There are two approaches available for those situations where a patient is deemed mentally incompetent and cannot participate in treatment decisions: a substitute decision maker model which may result in delays or refusals for treatment (this is the model used in the current Act as described above and by Nova Scotia and Alberta) or a treatment model (used in BC and Newfoundland) which will have no delay or refusal but may impinge the patient's freedoms. Both approaches are described below.

In British Columbia, the director of the mental health facility can authorize treatment for mentally incompetent patients. The patient/substitute decision maker may request a second medical opinion on the appropriateness of the treatment authorized by the director once per detention period. On receipt of a second medical opinion, the director must consider if changes should be made to treatment. The benefit of this model is that there is no delay in providing treatment and it prevents situations where patients refuse to be treated but end up being detained indefinitely, thereby having their right to health and liberty impinged upon by their illness. BC's Act gives patients the right to request a second medical opinion at different intervals (either one month, three months, or six months) as a 'check and balance' to the authority of the director. In Newfoundland, if a patient is not mentally competent, the physician may take into account the best interests of the patient, perform or prescribe the necessary diagnostic procedures to determine the existence or nature of a mental disorder and may administer/prescribe medication or other treatment without the consent of the involuntary patient. The legislation requires that the physician take into account the "best interests" of the patient and consider:

- whether the mental condition will be or is likely to be improved
- whether the patient's condition would (or is likely to) improve without the treatment
- whether the anticipated benefit outweighs the risk of harm to the patient
- whether the treatment is the least restrictive/intrusive treatment and the wishes of the involuntary patient expressed when the involuntary patient was competent.

When performing diagnostic procedures or administering treatment, the physician and other health care professionals involved must (where appropriate) consult with the involuntary patient and his/her representative, explain to the patient and his/her representative the purpose, nature and effect of the diagnostic procedure or treatment, and give consideration to the views of the patient and his/her representative with respect to the diagnostic procedure or treatment and alternatives and the way these may be provided. Psychosurgery must not be performed on an involuntary patient.

Alberta and Nova Scotia rely on a substitute decision-maker model but have minor variations. All outline the points that must be taken into consideration to determine the "best interests" of the patient (similar to Newfoundland). Alberta and Nova Scotia's legislation lists a descending hierarchy of potential substitute decision makers but in Alberta, if there is no one referred to in their list, then a Public Guardian is used. In Nova Scotia, a substitute decision-maker must make treatment decisions in accordance with the patient's prior competent informed expressed wishes (also known as a "Ulysses contract"). If that is unknown or if following the patient's prior wishes would endanger the physical or mental health/safety of the patient or another person, the treatment decision must be in accordance with what the substitute decision-maker believes to be in the patient's best interests.

In Alberta, if a mentally competent patient or a substitute decision maker for a mentally incompetent patient objects to a treatment, the physician must not administer the treatment unless following a Review Panel order. Psychosurgery is prohibited unless the patient consents and a Review Panel order directs psychosurgery to be performed. In Nova Scotia, where a substitute decision maker approves or refuses treatment, the attending psychiatrist or patient may request a review with the Review Board. In addition, the Review Board may find that the substitute decision maker has not 'rendered a capable informed consent' and then the next person in the hierarchy becomes the substitute decision maker.

The new MHA could continue to use the substitute decision maker model similar to that used on Alberta and Nova Scotia. The proposed legislation would include criteria for the physician when considering the "best interests" of the patient such as:

- whether the mental condition will be or is likely to be improved
- whether the patient's condition would (or is likely to) improve without the treatment
- whether the anticipated benefit outweighs the risk of harm to the patient
- whether the treatment is the least restrictive/intrusive treatment and the wishes of the involuntary patient expressed when the involuntary patient was competent.

A Review Board (see appropriate discussion paper) could be the body that would hear appeals.

Question for consideration:

1. *Which approach should the NWT take: a substitute decision maker model or a treatment model?*
2. *If the NWT uses the substitute decision maker model, what if that individual cannot be found? What would be a reasonable time (48 hours? 72 hours?) before the physician could order treatment?*

Transfer, Discharge and Leave of Involuntary Patients

Transfer

In the current Act, a doctor may apply to the Commissioner to have the patient transferred to a hospital outside of the Territories if they believe that an NWT hospital is not equipped to "restrain, observe, examine or treat the patient". The Act also allows for the Minister to forward an application for transfer to the Commissioner after processing the involuntary admission request. If a patient has applied to the Supreme Court for a review of the Involuntary Admission, then they cannot be transferred unless the medical practitioner is of the opinion that an NWT hospital or health care facility is not equipped to restrain, observe, examine, or treat the patient. The Commissioner has the authority to enter into agreements with the government of other provinces respecting mental health services.

All the jurisdictions reviewed allow for the transfer of involuntary patients where it is in the best interest of the patient. The variation occurs in who may authorize such a transfer. In Alberta, the Minister has authority for patients that are being transferred in or out of Alberta. In British Columbia, the authority rests with the duly-appointed Director of a mental health facility. Nova Scotia permits psychiatric facilities to transfer patients from other jurisdictions but if a patient is to be transferred out of Nova Scotia, the Minister must grant permission.

The new MHA could allow the Medical Director to arrange for a transfer of the involuntary patient, upon the recommendation of the physician, when she/he believes it is in the best interests of an involuntary patient to be treated in another mental health facility if there is an agreement in place with the receiving mental health facility. When a transfer originates in the NWT, the originating facility must immediately notify the patient's substitute decision-maker of the transfer and disclose all relevant documents and information to the new mental health facility.

A mental health facility may admit a patient, who is in another jurisdiction's facility or in a hospital under the jurisdiction of the Government of Canada, in order to detain the patient for an involuntary psychiatric assessment and, if required, involuntary admission in order to continue to detain the patient. When it appears to the Minister that a patient has come into the NWT and the patient's care and treatment is the responsibility of another jurisdiction or it would be in the best interests of the patient to be cared for in another jurisdiction, the Minister may transfer the patient to the other jurisdiction.

The Minister would be granted the authority to enter into agreements with other jurisdictions respecting the admission or transfer of patients.

Questions for consideration:

1. *Who should have the authority to authorize the transfer of a patient to another jurisdiction? The CEO of the facility? Or should the authority rest with the Minister?*

Discharge

The current Act requires that patients be discharged if they are deemed to be no longer suffering from a mental disorder that will likely result in serious bodily harm to themselves or others. Patients must also be discharged if the Supreme Court or the Court of Appeal makes an order or if the period of detention has expired and there has been no renewal. The Act also requires that the substitute decision maker be notified of the discharge, unless the patient requests otherwise and the physician agrees.

The proposed Act could require a patient to be discharged if the attending physician or nurse practitioner is satisfied that the patient no longer meets the criteria for involuntary admission. The patient must be notified that their status as an involuntary patient is terminated and they may leave the mental health facility or may remain as a voluntary patient. Where an authorized detention period has expired and an Involuntary Admission Renewal has not been issued, the person in charge of the mental health facility must ensure that the patient is notified that his/her status as an involuntary patient is terminated and the patient may leave the mental health facility or may remain as a voluntary patient. The Review Board would also have the authority to order the discharge a patient.

Questions for consideration:

- *Should a nurse practitioner be able to determine when a patient no longer meets the criteria for involuntary admission and should be discharged? Or should only a physician be able to determine this?*

Leave

The current Act deals only with 'Absence without Leave' and provides the hospital the authority to have a peace officer return a patient to the hospital if that patient has left the hospital without a leave of absence. Alberta's Act allows the board of a facility to grant a leave of absence to a patient with terms and conditions. BC provides the director of a facility with the authority to release a patient on leave provided there are appropriate supports within the community.

The proposed legislation could allow the attending physician to grant a leave of absence with terms and conditions. If a patient has left the hospital without a leave of absence, the physician may request a peace officer to return the patient to the hospital.

Questions for consideration:

1. *Who should have the authority to grant a certificate of leave? Should the Medical Director also play a role in the authorization? Only a psychiatrist or physician and only following an assessment to ensure safety. What is the check and balance? What is the liability for the facility? Have been issues with this in the NWT before,*

Community Treatment Order (CTO)

A Community Treatment Order (CTO) is essentially mandatory out-patient treatment and is used in many Canadian provinces such as Alberta, Saskatchewan, Manitoba, Nova Scotia, Newfoundland and Labrador, and British Columbia. It provides continuing psychiatric treatment and care while monitoring patients following their discharge from an in-patient facility. It targets a specific group of individuals who have:

- severe mental disorder,
- limited ability to grasp the nature and/or consequences of their disorder,
- an established track record of not complying with treatment post-discharge,
- high risk of destabilizing and becoming seriously ill if they stop treatment.

CTOs are increasingly being used as they help reduce the traumatic aspects of hospitalization, improve prognosis by reducing periods of untreated psychosis; assist with integration into the community by providing a community comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained. The new Act could include provisions for the regulatory authority to use CTO's as they may be prescribed by the physician.

Criteria and Requirements

Provinces have established different requirements respecting the issuing of CTOs. For example, Alberta requires that if a CTO is to be issued, it must be done by two physicians, one of whom must be a psychiatrist. In addition, the individual must be suffering from a mental disorder and one or more of the following conditions must apply:

- the individual has been a formal patient in a facility on 2 or more occasions for a total of at least 30 days in the preceding 3 years;
- the individual has already had a CTO in the last 3 years; and/or
- the individual is showing a pattern of behavior indicating they are likely to harm themselves or others again.

If both physicians think the individual may harm themselves or others or will suffer substantial mental or physical deterioration or serious physical impairment, and:

- the treatment/care they need is in the community,
- both doctors agree the individual can comply with treatment/care requirements,
- and either they have the consent of the individual; OR
- the patient has not consented but both doctors feel the individual, while living in the community, has a history of not complying with treatment/care necessary to prevent the likelihood of harm to others and a CTO would be less restrictive than retaining the individual as a formal patient and thus is a more reasonable alternative.

Manitoba uses a similar concept in their legislation but uses the terminology of 'leave certificates'. The leave certificate must be issued by a psychiatrist and may be issued for patients that were detained in a facility for at least 60 days (consecutive or not), or have been patients on three or more separate occasions, or if they have been the subject of a previous leave certificate. The psychiatrist must have examined the patient within 72 hours of issuing the leave certificate and be of the opinion that:

- the patient has a mental disorder and needs continuing treatment or care and supervision while living in the community and
- if the patient does not receive continuing treatment, then she may cause harm to themselves or to others or suffer substantial mental or physical deterioration, and/or
- the patient is capable of complying with the requirements (i.e. the requirements are realistic) and/or
- the treatment or care and supervision described exist in the community etc.

- the treatment/care and supervision can and will be provided to the patient.

Nova Scotia and Newfoundland's requirements are similar with some differences. Both:

- Require that a psychiatrist issue the CTO and s/he must examine the patient within the immediately preceding 72 hours.
- Require that the patient must have a mental disorder and needs to have continuing treatment or care and supervision which, if they don't receive, may lead to the patient causing harm to themselves, others or suffer further deterioration.
- Stipulate that because of the patient's mental disorder, the patient lacks the full capacity to make treatment decisions (although Newfoundland adds that the patient would therefore be unlikely to voluntarily participate in a comprehensive community treatment plan).
- Require that the services required by the patient must exist in the community, be available, and be provided to the patient.

In the immediate preceding two year period, Nova Scotia requires that the patient was detained for 60 days or more, or was detained on 2 or more separate occasions or has been the subject of CTO's before while Newfoundland requires that the individual to have been detained for 3 or more occasions or have been the subject of a prior CTO. Nova Scotia adds that the substitute decision maker must consent while Newfoundland requires that there is a community treatment plan and everyone has agreed to the plan.

The proposed NWT legislation could allow a physician to issue (or renew) a CTO if s/he had examined the individual in the immediate preceding 72 hours and deemed that the patient met the following criteria:

- the individual has a mental disorder and needs continuing treatment or care and supervision;
- the individual may harm themselves others or may suffer serious physical and/or mental impairment because of the mental disorder if she/he doesn't get the care;
- the individual may not be able to fully grasp the nature and/or consequences of their mental disorder and is unlikely to voluntarily comply in a comprehensive community treatment plan on their own;
- the services exist in the community and are available to the individual and will be provided to the individual; and
- the patient will be able to comply in a reasonable way if circumstances (e.g. transportation, babysitting, work schedules) are taken into account.

Questions for consideration:

1. *Should the NWT use CTOs?*
2. *If yes, who should have the authority to issue CTOs? (physicians, two physicians, psychiatrist, or a combination?)*
3. *If the NWT were to use CTOs, what should the criteria be?*

Renewals, Reviews and/or Termination

Renewals

The provinces listed above provide that a CTO expires after 6 months but may be renewed prior to the expiry date, although Nova Scotia allows for a renewal if it is done within 1 month of the expiry date. In Saskatchewan, CTO's are valid for 3 months at a time. None of the provinces place a limit on the number of renewals. Authority to renew rests with the psychiatrist or attending physician although Alberta requires two physicians.

The new legislation could allow for CTOs to be valid for a period of 6 months. They could be renewed prior to the expiry date. The attending physician could have the authority to renew a CTO.

Questions for consideration:

1. *How long should a CTO remain valid before needing renewal (assuming the NWT follows this model)?*

Reviews

Reviews of a CTO may be made to determine if:

- a CTO can be stopped,
- a new CTO and revised community treatment plan is needed; or
- the patient is capable of continuing the community treatment plan under the CTO or should be returned to a mental health facility for an involuntary assessment.

The provinces of Nova Scotia, Newfoundland, Manitoba, Saskatchewan and Alberta have legislation that provides for the establishment of Review Boards (see next discussion paper). The review panels established by the Review Board have the authority to review the renewal, change, and termination of CTOs upon request of the patient, the substitute decision maker, or the attending physician. However, the provinces named above also have included an automatic review of CTOs (i.e. no application is required). Saskatchewan limits renewals of CTOs to 3 months at a time and requires that if CTOs extend beyond six months

that the Review Board automatically participate in a review. BC has a similar provision but the time is if the leave (aka CTO) extends beyond 12 months.

Manitoba also provides that upon the request of the patient/ substitute decision maker, the attending psychiatrist must review the patients' condition to determine if the criteria continue to be met. If the physician determines that the criteria are no longer met or the requirements of the leave certificate need to be amended, the physician must either terminate the existing order, cancel the leave or amend the requirements and must notify all parties named of the changes.

The proposed Act could contain automatic reviews when a patient has been on a community treatment order for a continuous period of 6 months and has not applied for a review within that time. There would also be a requirement for an automatic review of CTOs for the first renewal (at the 6 month mark) and for every second renewal which means there will be an automatic review of CTO renewal on an annual basis. Patients may also request a hearing respecting the denial of a right (for example, access to counsel) and the board would be required to review and make recommendations.

In addition, the Review Board may make an order cancelling a CTO or a renewal and either allow the patient to live in the community without the order or require the individual to return to a mental health facility. The Review Board may also refuse to cancel an order/renewal.

Questions for consideration:

1. *Should the authority to review rest only with the Review Board or should there be flexibility to additionally request a physician/psychiatrist to conduct a review?*
2. *Should reviews take place solely on an application basis or include a mandatory review of CTO extension at some point (e.g. at one year)?*
3. *Should the term "Extended Leave" or "Community Treatment Order" be used?*

Termination/Cancellation

There will be instances where the patient fails to comply with a CTO or the circumstances or conditions of the CTO have changed. In those times, provinces have included provisions allowing for the termination or cancellation of the CTO.

Nova Scotia and Newfoundland have a provision requiring that if the services required for a CTO become unavailable, the physician must terminate the order, notify all parties, and notify the patient that his/her condition will need to be reviewed. That review must occur within 72 hours so a determination can be made as to whether s/he is able to continue to

live in the community without a CTO. If the patient fails or refuses to permit a review and the physician believes the criteria for a CTO continues to be met, the physician may request that a peace officer bring the patient to a physician for an involuntary psychiatric assessment to determine if the patient should be released, if a new CTO should be issued, or whether the patient should be admitted as an involuntary patient. The request to the peace officer is valid for 30 days and must be made within 72 hours of the patients' failure or refusal to permit a review.

The provinces of Alberta, Nova Scotia, Newfoundland, Saskatchewan and Manitoba also include provisions for those instances where the physician believes that the patient is failing in a significant or a harmful way to comply with the community treatment plan/CTO, the physician is required to make a reasonable effort to find the individual, notify the substitute decision maker, and provide assistance to the patient so they can comply with the CTO. If that attempt is unsuccessful, then the physician must issue an order for apprehension which gives a peace officer the authority to take the individual into custody and bring them in for an assessment. This order is valid for 30 days. The assessment will determine if the patient should be released and allowed to live in the community without a CTO, if another CTO should be issued or if a patient should be re-admitted as an involuntary patient and an assessment must be completed within 72 hours of arriving at the facility.

Additionally, Alberta allows patients or substitute decision makers to apply to the review boards to cancel CTOs and anyone with reasonable grounds to believe an individual is non-compliant may bring that information under oath to a judge. Nova Scotia has a similar provision but allows the psychiatrist to refuse such a request if a similar request was made within 3 months of performing a similar review.

The proposed NWT legislation could include provisions allowing for the termination or cancellation of the CTO if the patient is not complying with the CTO or if conditions of the CTO have changed. A physician could issue an order for a peace officer to convey the patient for the purpose of an assessment, and that order would be valid for 30 days. Once the patient is brought in, the assessment must be conducted within 72 hours.

Patients and/or their substitute decision makers may apply to the Review Board to cancel the CTO. Anyone with reasonable grounds to believe an individual is non-compliant may bring that information under oath to the Review Board or the courts.

Questions for consideration:

1. *Do you agree with the ability to terminate or cancel a CTO if the patient is not complying or if the conditions of the CTO have changed?yes*

Community Treatment Plan

Nova Scotia and Newfoundland have taken the extra step of adding the requirement for a community treatment plan (CTP) into their legislation. In these provinces, a CTO requires a CTP that involves the patient and/or the substitute decision maker, the physician, and any other health and/or social services professional, person or organization involved in the individual's care and supervision. The plan must be in written form and all parties must agree to the plan in writing.

There are minor variations respecting the required elements of the CTP, but essentially both provinces allow the psychiatrist to vary any part of the plan and must notify persons named in the plan of:

- the obligations of the patient;
- the name of the psychiatrist who has issued the order and is responsible for its general supervision and management;
- the names of the health professionals, person and organization who have agreed to provide treatment or care and supervision under the plan;
- their obligations under the plan; and
- any conditions relating to the treatment or care and supervision.

Nova Scotia's legislation requires that CTPs also include a plan of treatment, any obligations of the substitute decision-maker, and a provision for the naming of an alternate psychiatrist to take on the psychiatrist's responsibilities. Additionally, Nova Scotia has a provision that if a patient no longer meets the criteria for a CTO, the patient may choose to voluntarily continue with the obligations of the plan until it expires, but the psychiatrist must terminate the CTO. If a CTO expires and is not renewed, the patient or substitute decision maker, all parties named in the community treatment plan, and the Rights Advisor must be notified. The psychiatrist may vary any part of the plan but is required to notify persons who are named in the plan.

Newfoundland's Act requires that the plan include the necessary medical and other supports, including income and housing, required for the individual to live in the community, and that if a CTO is issued, or renewed, or expires, and is not renewed, all parties in the CTP must be notified too. The psychiatrist who is responsible for its general supervision and management may require reports on the condition of the patient from those named in the CTP.

While other provinces use CTPs as part of their case management system, they haven't legislated it as a requirement. For example, Manitoba references the 'proposed treatment plan' but does not go into detail about what the plan must include.

Questions for consideration:

1. *Should the NWT include Community Treatment Plans in the legislation or incorporate Community Treatment Plans as good clinical practice? yes. I think this is the only real way to ensure that a CTO is realistic given the limited and diverse services in our different communities. A locum psychiatrist in YK may have no clue what types of things may be unrealistic in a CTO.*