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The New Definition of a ‘Mental Disorder’ in the *Mental Health Amendment Act*: A Potential Gap in Care for ‘Persistent’ Mental Disorders?

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Bill 17, the *Mental Health Amendment Act (MHAA)* was introduced to the legislature on June 4, 2020, with an anticipated proclamation date set for September, 2020. While presented by Tyler Shandro, the Minister of Health, as aimed at “strengthening the rights of these patients and assuring their rights are provided for and respected while they receive care” ([Alberta Hansard, June 4, 2020](#) at 1125), this Bill also represents the province’s response to *JH v Alberta Health Services*, [2019 ABQB 540 \(CanLII\)](#), which found several provisions of Alberta’s *Mental Health Act, RSA 2000, c M-13 (MHA)* an infringement on a person’s rights under sections 7, 8, 10(a) and (b) of the [Canadian Charter of Rights and Freedoms](#).

In particular, the legislature recognized the Court’s concern in *JH* as to the suitability of the *MHA*’s provisions for involuntary detention and treatment for persons suffering from mental disorders that are untreatable, and has sought, in the *MHAA*, to refocus, and perhaps narrow, these provisions upon persons who are suffering from severe mental illness that are capable of being resolved by treatment. This change finds expression in the *MHAA*’s change to the definition of a “mental disorder”, which now excludes “a disorder in which the resulting impairment is persistent and caused solely by an acquired or congenital irreversible injury.” In this post, I want to consider the potential effects of this change in caring for persons now excluded under the *MHAA*’s definition. My concern is that this new definition may create a gap in the current legislative scheme for the care of persons suffering from “persistent” mental health disorders, and place such persons – and others – at risk. This would certainly be an ironic – and I am sure unintended – outcome of legislation which has as its aim the strengthening of the rights of persons suffering from mental disorders.

Mental Disorder

Under the *MHA*, a person can only be involuntarily detained when they are:

- (a) suffering from a mental disorder;

(b) likely to cause harm to the person or others or to suffering substantial mental or physical deterioration or serious physical impairment; and

(c) unsuitable for admission to a facility other than as a formal patient. (s 2)

If all three conditions are met, the *MHA*'s powers of detention may be applied (in the language of the *MHA*, a person is suitable for "formal" admission). What constitutes a "mental disorder" is therefore the threshold consideration when determining whether or not a person is suitable for the involuntary detention provisions under the *MHA*. This is currently defined in the *MHA* as:

A substantial disorder of thought, mood, perception, or memory that grossly impairs judgment, behaviour, capacity to recognize reality or meet the ordinary demands of life.
(s 1 (g))

Notably, this definition does not adopt psychiatric-diagnostic terms (such as schizophrenia, or bipolar disorder) but rather attends to symptoms a person is suffering from and the potential functional impairment which may ensue from such symptoms. The Court in *JH* found this definition overbroad, in that it could potentially apply to persons who, while experiencing "gross" impairment in function, suffered from a mental illness that was not receptive to treatment. The Court stated that:

When an individual is not suffering from an acute ailment that can be treated in a psychiatric setting, but is still detained because of an untreatable organic disorder which may at some future point cause potential harm to themselves, then arguably the impact of the legislation is "out of sync" with its object – so that it is grossly disproportionate to its effect. (at para 237)

The legislature's response to this appears to be a revised definition of a mental disorder (for the purposes of the *MHA*):

"Mental disorder" means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs (i) judgment, (ii) behaviour, (iii) capacity to recognize reality, or (iv) ability to meet the ordinary demands of life but does not include a disorder in which the resulting impairment is persistent and caused solely by an acquired or congenital irreversible brain injury. (s 2(a)(ii))

This new definition appears to move away from the purely functional definition under the *MHA* towards something that distinguishes the application of the *MHA* depending not so much on the nature of the disorder, but rather on whether or not it causes "persistent" impairment. In doing so, this definition appears to adopt the reasoning of the Court in *JH*, which suggested that that the detention (and treatment) provisions of the *MHA* infringed upon the *Charter* rights of persons suffering from "untreatable" mental health disorders (although it is noteworthy that the legislature did not go as far as perhaps the Court would have suggested: the Court stated that "a

move towards a definition that involves a “serious psychiatric disorder” as defined under the DSM-V [Diagnostic and Statistical Manual of Mental Disorders, 5th Edition] for instance may be more limiting and tied to the purpose of the *MHA* to detain for treatment purposes (*JH* at para 196)).

At this point it is worth pausing to consider what kinds of mental disorders, from a medical perspective, would be excluded under the *MHAA*’s definition. This new definition emphasizes the “persistent” nature of such disorders, and would arguably include persons suffering from a brain injury (as a result of trauma, or a stroke), cognitive impairment as a result of dementia, persons with developmental delay (that cause gross impairments in judgment and behaviour), or impairments in judgment and cognition that arise from unspecified, or mixed causes, such as substance misuse or a general medical condition.

By excluding persons suffering from such disorders from detention (and perhaps treatment) under the *MHA*, the *MHAA* implicitly accepts the Court’s understanding of the purpose of detention under the *MHA* as to “temporarily detain acutely mentally ill persons for the purpose of treatment and release back in to the community” (*JH* at para 189).

Although the legislature uses the word “persistent” for what in *JH* is stated as “untreatable”, I think the effect is the same. Curiously, though, neither the *MHAA* nor the *MHA* define what is meant by treatment. *JH* gestures towards this, in that the judgment appears to use the medical word “acute” as interchangeable with what we would understand as “treatable”, although ultimately an attempt of defining this becomes somewhat circular: an acute, or treatable, mental illness is one in which a person “benefits from treatment” (*JH* at para 231). I think it can be inferred that what the Court intends by “treatment” is any medical means (usually, but not always, by way of psychotropic medication) that effects a change in a person’s mental health (although again, whether such treatment is able to resolve a person’s mental health presentation above a point of “gross” impairment remains unclear). But I would suggest that “treatment” in a psychiatric setting involves more than simply effecting a change; rather, it can also involve interventions intended to prevent a person from harming themselves or others (by providing constant supervision), or assisting a person in meeting the ordinary demands of life.

Care for Persons Suffering from Persistent Impairment

I think it is established that under the *MHAA*, provisions for involuntary detention would not apply to those persons suffering from a mental disorder that causes “persistent” impairment, and that is “irreversible” in nature. Given the previous centrality of the *MHA* for the detention of persons suffering from such disorders, we may wish to consider how hospitals – and other potential caregivers – may seek and obtain care for such persons. My concern is that a legislative

gap has now been created, which will have the unwitting effect of excluding such persons from such care.

JH suggested that provisions under the *Adult Guardianship and Trusteeship Act*, [SA 2008, c A-4.2 \(AGTA\)](#) were more appropriate, in that they better preserved the autonomy of persons suffering from such mental disorders (*JH* at paras 185 – 188). I wonder, though, if this new definition has not created a gap in the continuum of psychiatric-medical care for such persons, which places them and others at risk. There are practical and legal considerations that give pause when considering guardianship (under the *AGTA*) as an effective alternative for a hospital's detention powers under the *MHA*. For one thing, persons suffering from such disorders often do not have guardians appointed until their condition becomes sufficiently serious (and causing of impairment), resulting in attendance at hospital, usually after a period of deterioration in the community. Upon admission to hospital, the wheels for the appointment of a guardian often begin to turn. It is frequently in hospitals, who employ social workers skilled in preparing such applications, and physicians who can opine as to a person's capacity, where guardianship orders originate. In other words, a person may require admission to hospital – often involuntarily – *before* an application for guardianship can be initiated. This raises a second consideration, the powers of detention under the *MHA* *vis a vis* the powers available to a guardian appointed under the *AGTA*. While the *MHA* gives a hospital (provided they are a “designated facility” under the *MHA*) the powers to detain a person, a guardian's powers are limited to determining where a person may live. This is not the same thing, in that a hospital is permitted to restrain a person should they attempt to leave hospital, while a guardian's powers of detention (and if necessary, apprehension in the community) are more limited.

But perhaps the most pressing practical consideration relates to the current dearth of appropriate supportive living facilities in the community for such persons, which has resulted in hospitals becoming the necessary residence for such a person until appropriate arrangements in the community have been determined. In this context, the word “warehousing” is used, which has pejorative connotations. I would suggest, though, that in such a situation hospitals are providing an essential service, in that they are the necessary – and of course, interim – placement for such a person until a more suitable living situation is determined. These stays in hospital, unfortunately, have become increasingly lengthy, as a result of both the shortage of appropriate community placement and the complex medical needs of such persons. Alberta Health Services, in their annual report (2018 – 2019) indicate that the average wait time for placement in a designated supportive living facility ranged from 62 days in 2014 – 2015 to 95 days in 2018 – 2019. There is (necessarily) anecdotal evidence of much longer delays, as a result of the complex medical and other care needs of such persons. Many of these persons will lack the ability to meet the ordinary demands of life in the community (without support), yet under the *MHAA*, they will lack access to hospitals (at least under involuntary detention, which may be necessary). Simply put, I express doubt as to the capacity of both current community supports and existing legislation, to meet the

needs of such persons. I am concerned that in drawing such a clear line between those disorders which are amenable to treatment and those that are “persistent” will deprive individuals – and their community caregivers – of the supports that only a hospital can provide. In my view, the interim step of involuntary detention is no longer available under the *MHAA*, and this may create risk for such a person.

Under our current health care system, many persons are hospitalized following a period of impairment in the community brought about as the result of a mental disorder. Although perhaps medically “irreversible” (consider, for example, a person suffering from dementia, or a brain injury of medical origin), hospitalization under the *MHA* has served as a necessary step towards ultimate placement in the community. Until now, the detention procedures under the *MHA* have been used as an interim measure to buy time until community supports are determined. Unfortunately, because of both the shortage of such facilities and the complex needs of these persons, detention periods have become increasingly lengthy, significantly engaging section 7 *Charter* rights. The legislature’s answer to this dilemma is to remove these persons entirely from the detention provisions under the *MHA*, but, as I hope I have shown, this may lead to a significant gap in the care available to such persons, and lead to risk of harm to both themselves and others.

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