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Standing Committee on
Social Development

NORTHWEST TERRITORIES
LEGISLATIVE
ASSEMBLY

Report on the Statutory Review of the *Mental Health Act*

20th Northwest Territories Legislative Assembly

Chair: Ms. Jane Weyallon Armstrong

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SPEAKER OF THE LEGISLATIVE ASSEMBLY

Mr. Speaker:

Your Standing Committee on Social Development is pleased to provide its Report on the Statutory Review of the *Mental Health Act* and commends it to the House.

MLA Jane Weyallon Armstrong
Chair, Standing Committee on Social Development

P.O. Box 1320 | Yellowknife | Northwest Territories | XIA 2L9 | Tel: 867-767-9130 | Fax: 867-920-4735
C. P. 1320 | Yellowknife | Territoires du Nord-Ouest | XIA 2L9 | Tel.: 867-767-9130 | Telecopieur: 867-920-4735

STANDING COMMITTEE ON
SOCIAL DEVELOPMENT

REPORT ON THE STATUTORY REVIEW OF THE *MENTAL HEALTH ACT*

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STANDING COMMITTEE ON SOCIAL DEVELOPMENT

REPORT ON STATUTORY REVIEW: *MENTAL HEALTH ACT*

EXECUTIVE SUMMARY

The Standing Committee on Social Development (Committee) was tasked with undertaking the first statutory review of the *Mental Health Act* (Act). Committee sought feedback on the Act to inform its statutory review.

Committee appreciates everyone who offered their feedback at public meetings and in written submissions. Committee thanks the Department of Health and Social Services for their willingness to work with us, and for providing great insight on the current operations of the Act, including challenges and strengths. Committee believes the fourty (40) recommendations listed in this report will help improve the Act and its operations.

Recommendation 1: The Standing Committee on Social Development recommends the Government of the Northwest Territories conduct a comparative analysis of the Northwest Territories' *Mental Health Act* against other jurisdictions' mental health care legislation, to significantly reduce and mitigate the administrative burdens and procedural complexities of the *Mental Health Act* (including Forms under the *Mental Health Act*) and present constructive amendments to the *Mental Health Act* for consideration.

Recommendation 2: The Standing Committee on Social Development recommends the Government of the Northwest Territories allow flexibility to the Mental Health Act Review Board to hold hearings outside of the current notice requirement of seven days with the consent of all parties by reviewing Section 70(1) of the *Mental Health Act* to remove the seven-day notice requirement and defer the minimum notice requirement to the *Mental Health Act Review Board Regulations.*

Recommendation 3: The Standing Committee on Social Development recommends the Government of the Northwest Territories review Section 10(2) of the *Mental Health Act* to determine a more realistic timeline to issue a *Certificate*

of Involuntary Assessment, in consultation with the Royal Canadian Mounted Police and physicians including psychiatric professionals.

Recommendation 4: The Standing Committee on Social Development recommends the Government of the Northwest Territories review Section 17 of the *Mental Health Act* and compare to similar provisions in other jurisdictions to determine the appropriate length of time before a certificate expires in order to issue a renewal certificate.

Recommendation 5: The Standing Committee on Social Development recommends the Government of the Northwest Territories assess the addition of a provision added to the *Mental Health Act* for the Mental Health Act Review Board to review a certificate after a cancelled hearing based on best practices and national standards.

Recommendation 6: The Standing Committee on Social Development recommends the Government of the Northwest Territories review Sections 66(1)(a) and Section 74(1)(a) and (b) of the *Mental Health Act* to remove the ability to apply to the Mental Health Act Review Board to cancel Form 2 – *Certificate of Involuntary Assessment*.

Recommendation 7: The Standing Committee on Social Development recommends the Government of the Northwest Territories review the *Mental Health Act* and its regulations (e.g. Section 16(1) of the *Mental Health Act Review Board Regulations*) to reflect timelines in days or business days, rather than hours, where appropriate.

Recommendation 8: The Standing Committee on Social Development recommends the Government of the Northwest Territories work with the Mental Health Act Review Board to clarify where and how the *Interpretation Act* applies to the *Mental Health Act* and determine if the current two-day timeline in Section 67(2) remains a challenge despite the flexibility afforded by the *Interpretation Act*.

Recommendation 9: The Standing Committee on Social Development recommends the Government of the Northwest Territories work with the Mental Health Act Review Board to find ways to streamline the hearing process and evaluate the time it takes to conduct a hearing and reasons why the hearing process may be deemed too long.

Recommendation 10: The Standing Committee on Social Development recommends the Government of the Northwest Territories review and expand the role of the cultural advisor under Section 71(5) and Section 68(1) of the *Mental Health Act* including adjusting the wording “to a review panel” in the *Mental Health Act* to “a time deemed appropriate for patient needs”.

Recommendation 11: The Standing Committee on Social Development recommends the Government of the Northwest Territories include a specific provision in the *Mental Health Act* that outlines that the Mental Health Act Review Board panel may disclose information to the cultural advisor to the extent the panel deems necessary or wording that outlines how and when the cultural advisor will receive information.

Recommendation 12: The Standing Committee on Social Development recommends the Government of the Northwest Territories provide training to staff and Mental Health Act Review Board panel members on the disclosure of information provisions held within the *Mental Health Act*, and the processes that follow them.

Recommendation 13: The Standing Committee on Social Development recommends the Government of the Northwest Territories review, compare and adjust definitions and terminology in the *Mental Health Act* against healthcare operations and language to promote appropriate and streamlined operationalization of the *Mental Health Act*.

Recommendation 14: The Standing Committee on Social Development recommends the Government of the Northwest Territories review the suitability of the Inuvik Regional Hospital and the Hay River Health Centre as designated facilities (including an analysis of environmental and staffing capacity) under the *Mental Health Act* and review the ability to add different classes of designated facilities within the *Mental Health Act* and its regulations, using other jurisdictional models as an example.

Recommendation 15: The Standing Committee on Social Development recommends the Government of the Northwest Territories review and expand the definition of “mental disorder” in the *Mental Health Act* by conducting a jurisdictional review of definitions.

Recommendation 16: The Standing Committee on Social Development recommends the Government of the Northwest Territories establish an ongoing territorial working group with involvement from the Royal Canadian Mounted Police and health staff/professionals to ensure legislation, mandates and processes align in administering the *Mental Health Act* and providing services for mental health crisis emergency response in communities.

Recommendation 17: The Standing Committee on Social Development recommends the Government of the Northwest Territories evaluate whether the definition of the acceptance of a patient after conveyance can be moved to the *Mental Health Act*'s regulations.

Recommendation 18: The Standing Committee on Social Development recommends the Government of the Northwest Territories review the definition of "health professional" within the *Mental Health Act* to determine if the list can be further expanded where appropriate.

Recommendation 19: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review provisions related to the apprehension, conveyance, and transfer of patients under the *Mental Health Act,* including consulting with Royal Canadian Mounted Police and medical staff to have agreement on proper protocols and the development of a flow diagram for the transport of patients under the *Mental Health Act* in and out of territory.

Recommendation 20: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review provisions of the *Mental Health Act* and its regulations related to the apprehension, conveyance, and transfer of patients to specify the responsibility of peace officers in these processes.

Recommendation 21: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review provisions related to Short Term Leave in the *Mental Health Act*, especially related to the enforcement of a lack of compliance and streamlining administration so that Short Term Leave is less burdensome on staff, and that the review of these provisions be done with the lens of reviewing similar provisions in other jurisdictions.

Recommendation 22: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review Section 52(1.2) of the *Mental Health Act*, Section 7 of the *Apprehension, Conveyance and Transfer Regulations*, and other sections of the *Mental Health Act* related to the temporary detention of patients, and bring forward changes to the *Mental Health Act* that provide solutions to issues related to the temporary detention of patients. This review should be completed in collaboration with the Royal Canadian Mounted Police, designated facilities, and relevant staff.

Recommendation 23: The Standing Committee on Social Development recommends that the Government of the Northwest Territories create a strategy to analyze and close the gap in pediatric psychiatric care in the Northwest Territories.

Recommendation 24: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review and amend the *Mental Health Act* to specify an authority who is responsible for oversight of the *Mental Health Act*, while also allowing flexibility to the Minister of Health and Social Services to designate such responsibility.

Recommendation 25: The Standing Committee on Social Development recommends that the Government of the Northwest Territories significantly reduce the administrative burden on the Director of Designated Facilities as defined in the *Mental Health Act* through legislative amendments and regulatory change.

Recommendation 26: The Standing Committee on Social Development recommends that the Government of the Northwest Territories consider amending Section 9.1 and Section 28(2) of the *Mental Health Act* after evaluating their capacity and operational effectiveness.

Recommendation 27: The Standing Committee on Social Development recommends that the Government of the Northwest Territories provide additional education materials and training support to staff responsible for providing patients with information about their rights under the *Mental Health Act*.

Recommendation 28: The Standing Committee on Social Development recommends that the Government of the Northwest Territories explore the possibility of an independent rights advisor or neutral party that vocalizes and reviews patient rights under the *Mental Health Act* with the patient, including whether this responsibility can be added to the cultural advisor role.

Recommendation 29: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review, amend and simplify Form 1 – *Notification of Patient Rights and Other Information* using an operational lens and a lens of persons with lived experience while also evaluating the benefits of creating a separate form specific to patient rights, as depicted in Alberta and British Columbia's mental health care legislation.

Recommendation 30: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review Section 37(6)(d) of the *Mental Health Act* and in particular, the use of the word "willing" within this section.

Recommendation 31: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review and amend the requirement of assessment and appointments for patients under Assisted Community Treatment and Short Term Leave prior to the expiry of a *Certificate of Involuntary Assessment* or a *Renewal Certificate* to ensure better coordination, streamline information, and reduce the number of forms and administrative tasks.

Recommendation 32: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review and amend provisions in the *Mental Health Act* related to Assisted Community Treatment to expand Assisted Community Treatment to align with Community Treatment Orders as seen in other jurisdictions, including:
-Removing the requirement that a person be an involuntary patient to qualify for Assisted Community Treatment;
-Ensuring that care is decentralized from an institutional setting, and;
-That there is a greater commitment to culturally safe and decolonized practices in health care.

Recommendation 33: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review Section 40(1)(b) of the *Mental Health Act* to ensure clear information on the extent to which housing and income supports are available to patients under Assisted Community Treatment.

Recommendation 34: The Standing Committee on Social Development recommends that the Government of the Northwest Territories ensure external

stakeholders involved in community care understand their obligations to support the operationalization of Assisted Community Treatment under the *Mental Health Act*, including increasing awareness of obligations to ensure efforts are made to inform patients of non-compliance and the consequences of non-compliance.

Recommendation 35: The Standing Committee on Social Development recommends that the Government of the Northwest Territories establish more supports and funding to action Assisted Community Treatment as defined in the *Mental Health Act* in small communities across the Northwest Territories.

Recommendation 36: The Standing Committee on Social Development recommends that the Government of the Northwest Territories establish the addition of a public facing navigator role for *Mental Health Act* processes.

Recommendation 37: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review the role of the psychiatrist during hearings under the *Mental Health Act* and provide information about their role to the Mental Health Act Review Board, psychiatrists and other staff to ensure there is a clear understanding of their role.

Recommendation 38: The Standing Committee on Social Development recommends that the Government of the Northwest Territories create internal processes to mitigate concerns regarding discharging mental health patients under the *Mental Health Act* too early by working with physicians.

Recommendation 39: The Standing Committee on Social Development recommends that the Government of the Northwest Territories improve on the ability to cancel certificates on involuntary assessment issued under the *Mental Health Act* through policies, procedures and legislative change.

Recommendation 40: The Standing Committee on Social Development recommends that the Government of the Northwest Territories embrace technological change by implementing procedures for Forms under the *Mental Health Act* to be signed electronically or verbally, as well as implementing secure file transfer processes for Forms under the *Mental Health Act*.

INTRODUCTION AND BACKGROUND

The *Mental Health Act* (Act) requires the Legislative Assembly or one of its committees to commence a review of the Act, and any other related legislation, policies, guidelines, or directives considered appropriate by September 1, 2023, and every five years thereafter (s.105).

The Standing Committee on Social Development (Committee) has conducted the review process for the Act's first statutory review.

The Northwest Territories (NWT) *Mental Health Act* was passed on October 8, 2015, and came into force September 1, 2018. This Act repealed and replaced the *Mental Health Act* from 1985, which came into force January 1, 1988.

The Act sets the processes and rules that must be applied to the way people living with a mental disorder receive care and treatment. The Act aims to protect and support the rights of people living with a mental health disorder and those acting on their behalf.

PUBLIC ENGAGEMENT

Between March 2024 to April 2024, Committee engaged the public.

On March 25, 2024, Committee received a public briefing from the Mental Health Act Review Board (MHARB)[1]. Committee also received a technical briefing from Department of Health and Social Services (the Department) on the *Mental Health Act*[2]*.*The MHARB and the Department's presentation is included in Appendix A. Committee also received written submissions from:

- Association of Psychologists of the Northwest Territories
- Royal Canadian Mounted Police – G Division
- Canadian Psychiatric Association
- Raymond Pidzamecky – Registered Social Worker
- Department of Health and Social Services – Materials to support the review of the Mental Health Act and Technical Briefing

These submissions and presentations are included in Appendix B.

Committee appreciates everyone who offered their feedback at public meetings and in written submissions.

Committee categorized public comments received into ten (10) themes.

Before presenting each theme, Committee would like to note the importance of an Act that both protects the rights of individual patients and others, while also ensuring that its' administrative processes are streamlined and avoid instilling more burden on the health care and emergency services sectors. Committee believes that the *Mental Health Act* is in need of numerous updates and therefore presents its first recommendation:

Recommendation 1: The Standing Committee on Social Development recommends the Government of the Northwest Territories conduct a comparative analysis of the Northwest Territories' *Mental Health Act* against other jurisdictions' mental health care legislation, to significantly reduce and mitigate the administrative burdens and procedural complexities of the *Mental Health Act* (including Forms under the *Mental Health Act*) and present constructive amendments to the *Mental Health Act* for consideration.

The themes are listed below:

1. Issues with timing

There were a few issues in the *Mental Health Act* raised to Committee that were related to timing.

Firstly, the MHARB and the Department both highlighted that as currently legislated, the 7-day requirement to hold a hearing is very stringent, and more flexibility is required. The MHARB emphasized that a review of Section 70(1) is required to allow for the process of scheduling a hearing to proceed at a quicker pace which in turn would make greater strides in addressing the needs of the patient. Their recommendation was to remove the wording "give seven days" and replace it with "on consent of all parties". Whereby the consent of all parties cannot be obtained, their recommendation was for there to be a minimum wait time-period set in the Act's regulations. As noted above, the Department presented similar concerns regarding the seven-day notice requirement and recommended that a shorter time period be set out in regulations, with an added ability to shorten the notice period with the consent of all parties.

Committee notes these concerns and presents the following recommendation:

Recommendation 2: The Standing Committee on Social Development recommends the Government of the Northwest Territories allow flexibility to the Mental Health Act Review Board to hold hearings outside of the current notice requirement of seven days with the consent of all parties by reviewing Section 70(1) of the *Mental Health Act* to remove the seven-day notice requirement and defer the minimum notice requirement to the *Mental Health Act Review Board Regulations.*

The second issue related to timing is related to timelines in issuing a *Certificate of Involuntary Assessment*. The Royal Canadian Mounted Police (RCMP) noted to Committee that there are issues when no involuntary assessment can be reasonably issued within 24 hours, and as it is currently required under the Act. They presented that the current 24-hour requirement may be an issue for nursing stations that are busier and/or with minimal or stretched resources.

The Canadian Psychiatric Association (CPA) noted that the 24-hour requirement seems to be excessively short, and that in many jurisdictions it is one week. They described an example whereby a health professional may conduct an assessment, conclude that a person may meet the criteria and want more information before completing a certificate. They note that attempts to contact a secondary person to obtain collateral information can easily take a few days.

Committee would like to mitigate these concerns and therefore presents the following recommendation:

Recommendation 3: The Standing Committee on Social Development recommends the Government of the Northwest Territories review Section 10(2) of the *Mental Health Act* to determine a more realistic timeline to issue a *Certificate of Involuntary Assessment*, in consultation with the Royal Canadian Mounted Police and physicians including psychiatric professionals.

Another issue related to timing relates to Form 4 – *Renewal Certificate,* which can only be issued within 72 hours of the *Certificate of Involuntary Admission* or previous *Renewal Certificate* expiring. The Department made it clear to Committee that in other jurisdictions, renewals may occur within seven days of the form expiring.

Committee therefore presents the following recommendation in hopes that this review will be conducted with an operational lens and the review will analyze data respecting the length of admissions to inform appropriate timelines:

Recommendation 4: The Standing Committee on Social Development recommends the Government of the Northwest Territories review Section 17 of the *Mental Health Act* and compare it to similar provisions in other jurisdictions to determine the appropriate length of time before a certificate expires in order to issue a renewal certificate.

Another issue raised to Committee by the MHARB is that they would like to determine or understand why hearings are being cancelled. They note in their presentation to Committee that out of approximately 70 applications received in the past five and a half years, they have conducted approximately 15 hearings while the rest of the applications were cancelled before a hearing occurred – and three quarters of those cancellations occurred within 48 hours of the hearing date. It was noted by MHARB that they currently have no authority to review a certificate after its cancellation, and because of this they lack statistics and research that may be helpful to strengthen the hearing process.

Committee therefore recommends:

Recommendation 5: The Standing Committee on Social Development recommends the Government of the Northwest Territories assess the addition of a provision added to the *Mental Health Act* for the Mental Health Act Review Board to review a certificate after a cancelled hearing based on best practices and national standards.

Currently under the Act, applications can be made to the MHARB to cancel any certificate issued. Due to this ability, patients admitted under Form 3 – *Certificate of Involuntary Admission* could potentially be required to apply to the MHARB twice within the span of only a few days if they had applied for their initial Form 2 – *Certificate of Involuntary Assessment* to be cancelled. In short, the review of Form 2 – *Certificate of Involuntary Assessment* would not result in an automatic review of their Form 3 – *Certificate of Involuntary Admission* as it is currently legislated.

The Department noted to Committee that there have been several instances when a patient on Form 2 – *Certificate of Involuntary Assessment* has applied to the MHARB; however, a hearing could not be arranged due to the legislated timelines for the review as well as the short duration of the certificate (currently 72 hours). It was suggested to Committee by the Department that the ability to apply to the MHARB for a review of Form 2 - *Certificate of Involuntary Assessment* be removed as it cannot be reasonably provided.

Noting the above reasons and issues related to the timing of certificates, Committee presents the following recommendation:

Recommendation 6: The Standing Committee on Social Development recommends the Government of the Northwest Territories review Sections 66(1)(a) and Section 74(1)(a) and (b) of the *Mental Health Act* to remove the ability to apply to the Mental Health Act Review Board to cancel Form 2 – *Certificate of Involuntary Assessment*.

The Department let Committee know that the timelines for screening applications to the MHARB may be too short, especially if a weekend or holiday intervenes. Currently, the Act requires that the chairperson of the MHARB review an application within two days of receiving it, and either refer it to a review panel or dismiss it. Committee clarified with the Department that the *Interpretation Act* currently applies to the two-day timeline set out in Section 67(2) of the *Mental Health Act.* Although, it was emphasized by the Department that work is needed to confirm with the MHARB that the *Interpretation Act* applies were there is a time of office closure during the two-day timeline. Another piece of clarification is needed to determine whether the two-day timeline remains a challenge despite the flexibility afforded by the *Interpretation Act*.

Committee notes that timeline requirements stated in hours versus days, may lead to confusion and inconsistent application. Committee therefore recognizes that the *Mental Health Act* and its regulations requires review to change timelines of hours to business days or days, where appropriate.

Committee presents the following two recommendations:

Recommendation 7: The Standing Committee on Social Development recommends the Government of the Northwest Territories review the *Mental Health Act* and its regulations (e.g. Section 16(1) of the *Mental Health Act Review Board Regulations*) to reflect timelines in days or business days, rather than hours, where appropriate.

Recommendation 8: The Standing Committee on Social Development recommends the Government of the Northwest Territories work with the Mental Health Act Review Board to clarify where and how the *Interpretation Act* applies to the *Mental Health Act* and determine if the current two-day timeline in Section 67(2) remains a challenge despite the flexibility afforded by the *Interpretation Act*.

Another issue related to timing brought to Committee by the Department is that hearings need to be shorter, especially because longer hearings have an impact

on psychiatrists, patients and families, and their time. The duration of hearings is not set out in legislation, but Committee finds it important for the Department and MHARB to work together to streamline the hearing process. Committee therefore presents the following recommendation:

Recommendation 9: The Standing Committee on Social Development recommends the Government of the Northwest Territories work with the Mental Health Act Review Board to find ways to streamline the hearing process and evaluate the time it takes to conduct a hearing and reasons why the hearing process may be deemed too long.

2. Cultural support

Currently under Section 71(5), on request by a patient, by their substitute decision maker or by the medical practitioner, the MHARB shall engage an Elder or cultural advisor to a review panel. During their public meeting with Committee, MHARB emphasized that cultural advisors can make an important contribution to the patient-centered approach and help the MHARB conduct its business in a culturally sensitive manner. It was brought forward to Committee by MHARB that the role of the cultural advisor is not clearly delineated and the procedures for their duties during a hearing are not set out.

During their presentation, MHARB suggested to modify the wording in Section 71(5) of the Act, specifically the wording “during the hearing”, to afford the MHARB the flexibility in bringing in the cultural advisor at a time deemed more appropriate for patient needs. The Department also suggested to Committee that clarity is required regarding the role of the Elder/cultural advisor, specifically that the current “vagueness” of their role could be addressed by expanding Section 68.1 in the Act so that they can be engaged to the extent for any purpose(s) requested by the patient.

Committee understands the importance of an Elder/cultural advisor to support the patient, and therefore presents the following recommendation:

Recommendation 10: The Standing Committee on Social Development recommends the Government of the Northwest Territories review and expand the role of the cultural advisor under Section 71(5) and Section 68.1 of the *Mental Health Act* including adjusting the wording “to a review panel” in the *Mental Health Act* to “a time deemed appropriate for patient needs”.

It was brought to Committee's attention by the Department that information being disclosed to the Elder/cultural advisor may be too broad, and at this point, they may receive every relevant or relied upon record which could be interpreted as being the patient's chart. It was noted that this disclosure of information could be detrimental to the patient – and requires review to determine how the disclosure of information fits within the cultural advisor role under the *Mental Health Act* and in accordance with the *Health Information Act*.

The MHARB suggested that a provision be added to clarify that the panel may disclose information to the extent the panel deems necessary for the cultural advisors to perform their role. Related to the same issue, the Department suggested to Committee that a provision be added to outline what information may be disclosed to the cultural advisor, and that consent of the patient or their substitute decision maker be required prior to disclosing information. It was also proposed by the Department that staff and MHARB members may need education on the disclosure of information provisions and processes for withholding information.

Committee hears these concerns and presents the following two recommendations to help mitigate challenges related to the disclosure of information:

Recommendation 11: The Standing Committee on Social Development recommends the Government of the Northwest Territories include a specific provision in the *Mental Health Act* that outlines that the Mental Health Act Review Board panel may disclose information to the cultural advisor to the extent the panel deems necessary or wording that outlines how and when the cultural advisor will receive information.

Recommendation 12: The Standing Committee on Social Development recommends the Government of the Northwest Territories provide training to relevant staff and Mental Health Act Review Board panel members on the disclosure of information provisions held within the *Mental Health Act*, and the processes that follow them.

3. Clarification on terms and definitions

It was highlighted to Committee during the Department's briefing, that a review and clarification of terms and definitions within the Act is required, and more specifically to review and compare terminology for consistency with current operational language. It was reiterated that some of the language in the Act can be quite confusing operationally. For example, under the Act, a patient can be Involuntarily

Assessed or Involuntarily Admitted. Therefore, if they are Involuntary *Assessed*, they are admitted to the hospital, but they are *not admitted* as a patient under the Act. It was suggested to Committee by the Department that there needs to be an assessment of the Act for clarity and simplification of definitions for the ease of appropriate operationalization. In hearing this feedback, Committee recommends:

Recommendation 13: The Standing Committee on Social Development recommends the Government of the Northwest Territories review, compare and adjust definitions and terminology in the *Mental Health Act* against healthcare operations and language to promote appropriate and streamlined operationalization of the *Mental Health Act*.

The Department made Committee aware of concerns regarding "Code Gridlock status" – meaning that bed allocation is over capacity and may impact the ability of healthcare staff to provide critical care services, especially at Stanton Territorial Hospital (Stanton). This can be seen as a barrier to transferring clients from a designated facility to receive acute psychiatric treatment at Stanton, which has the only inpatient psychiatric unit in the NWT. Committee notes that there are challenges in providing appropriate standard of care for inpatient psychiatric treatment when there are consistent fluctuations in environmental and staff capacity at designated facilities across the NWT.

For this reason, the Department suggests that there be a review of the suitability of the Inuvik Regional Hospital and the Hay River Health Centre as designated facilities under the Act, with an assessment as to whether their designations need to be revoked. It is recommended by the Department that the Act be evaluated to consider different classes of designated facilities based on the levels of service provision available, standards of inpatient psychiatric treatment and care, and levels of responsibility.

Committee takes in this feedback, and presents the following recommendation:

Recommendation 14: The Standing Committee on Social Development recommends the Government of the Northwest Territories review the suitability of the Inuvik Regional Hospital and the Hay River Health Centre as designated facilities (including an analysis of environmental and staffing capacity) under the *Mental Health Act* and review the ability to add different classes of designated facilities within the *Mental Health Act* and its regulations, using other jurisdictional models as an example.

It was recommended by the Department at the public technical briefing that the definition of "mental disorder" in Section 1 of the Act be reviewed and compared

against Alberta's recent new definition. It was suggested to Committee that changes to the definition could be reviewed against other jurisdictions where recent changes have occurred to determine if updates should be made to the NWT's legislation. Committee notes this suggestion, and presents the following recommendation:

Recommendation 15: The Standing Committee on Social Development recommends the Government of the Northwest Territories review and expand the definition of "mental disorder" in the *Mental Health Act* by conducting a jurisdictional review of definitions.

In a written submission by the RCMP, they note that there is no clarification as to what the meaning of the word "accept" is, when conveying patients to a designated facility under Section 90(d) of the Act. The RCMP state that it is their position that "accept" means that the patient has been conveyed to a designated facility and that it is up to the facility to safeguard the patient as a duty of care. They go on to emphasize that often RCMP personnel have been required to remain at the facility as the patient is not deemed to be "accepted" until they have been fully assessed. In their submission, the RCMP stress that this is a medical situation, and the involvement of the police should end with the conveyance to a designated facility.

Similarly, the RCMP also note that the term "other authorized persons" listed in numerous sections of the Act requires review as there is no definition of "other authorized persons". In response to this uncertainty and need for clarification, the Department suggests that consideration should be given to the establishment of an ongoing territorial working group to ensure legislation, mandates and processes align in administering the *Mental Health Act* and providing services for mental health crisis emergency response in communities. Committee therefore presents the following two recommendations:

Recommendation 16: The Standing Committee on Social Development recommends the Government of the Northwest Territories establish an ongoing territorial working group with involvement from the Royal Canadian Mounted Police and health staff/professionals to ensure legislation, mandates and processes align in administering the *Mental Health Act* and providing services for mental health crisis emergency response in communities.

Recommendation 17: The Standing Committee on Social Development recommends the Government of the Northwest Territories evaluate whether the definition of the acceptance of a patient after conveyance can be moved to the *Mental Health Act*'s regulations.

It was brought forward to Committee by the Department that there are challenges for health and social services professionals who are not authorized to complete forms under the Act in reporting mental health crises to the RCMP. Committee was informed that in some cases, despite the summary of concerns of persons meeting the criteria for involuntary assessment under the Act, the RCMP's assessment overrides the health and social services professionals' concerns.

It is suggested by the Department that this issue could be addressed by reviewing the definition for "health professional" under the Act to better determine if the list can be further expanded – whether it be in the legislation or its regulations. This review may require the evaluation of the scope of practice of various health and social services professions to determine if it is within their scope to issue a *Certificate of Involuntary Assessment*. In particular, it was noted that there is no guidance or process for a Community Mental Health Nurse or other health professionals to fill out forms. There may also be a lack of awareness or support for registered nurses and registered psychiatric nurses to issues forms under the Act and this leaves a gap in facilitating emergency mental health care in communities. It was suggested by the Department to Committee that a jurisdictional review to evaluate how other health and social services professionals are able to complete forms under their legislation, may also be of value. The Association of Psychologists in the NWT suggested that there may be some confusion over the terms "Health Professionals" and "Medical Practitioner", which may be helpful in clarifying. It was also suggested by the Department that a review of the current Standard Operating Procedures and scope of the Community Mental Health Nurse and/or other Registered Nurse roles be conducted in relation to the implementation of the *Mental Health Act*.

Noting the above, Committee presents the following recommendation:

Recommendation 18: The Standing Committee on Social Development recommends the Government of the Northwest Territories review the definition of "health professional" within the *Mental Health Act* to determine if the list can be further expanded where appropriate.

4. Responsible custody, transfer, and detainment of patients

In their written submission, the RCMP note that Section 23(1) of the Act does not specify who is responsible for the transport of the patient to a designated facility or to another health facility. They also note that when "authorized persons" is not described within the Act, it tends to default to the police. The RCMP also brought

forward to Committee that Section 10(3)(a) of the Act does not state who the patient should be delivered to, and they suggest that there could be a provision whereby peace officers turn over the patient to a specific person to take over custody. They provide an example that other provinces have an Institution Safety Officer who takes over custody of the patient.

The Department was also made aware that it is unclear whether or not a peace officer remains with an involuntary patient who has been apprehended and is being conveyed/transferred to a designated facility. Moreover, no one is specified as responsible for the "care" of the patient while they are being conveyed, only until they have arrived at a designated facility. Committee notes that this responsibility could be given to the peace officer, but also understands the importance of not overburdening the police with more responsibilities. Committee therefore finds it important to use the word "supervise" in replacing the word "care" in relation to the duration of the conveyance of the patient to a designated facility and the role of the peace officer under the Act, as to balance the responsibility to the patient and the ongoing duties of peace officers.

Related to the comments by the RCMP, it was brought forward by the Department that the transportation of patients under the Act from the Inuvik Regional Hospital to Stanton Territorial Hospital and/or a facility in Edmonton is reasonably common and unreasonably complex. It was suggested that a dedicated flow diagram be created to help explain the processes for the transport of patients under the Act - both for in and out of the territory.

Committee notes this feedback and presents the following two recommendations:

Recommendation 19: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review provisions related to the apprehension, conveyance, and transfer of patients under the *Mental Health Act,* including consulting with Royal Canadian Mounted Police and medical staff to have agreement on proper protocols and the development of a flow diagram for the transport of patients under the *Mental Health Act* in and out of territory.

Recommendation 20: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review provisions of the *Mental Health Act* and its regulations related to the apprehension, conveyance, and transfer of patients to specify the responsibility of peace officers in these processes.

In their written submission, the RCMP mentioned to Committee that there is no clearly defined role for who enforces lack of compliance if there is an Absent WithOut Leave (AWOL) person during Short Term Leave. They highlighted that Section 47(2)(a) and 52(1) of the Act place the responsibility for compliance on the police, and suggest that health professionals should be the first consideration. They continue by saying that decisions to release patients rest with health professionals, while the consequences of non-compliance defaults to the police.

It was also brought forward by the Department that processes related to Short Term Leave are administratively burdensome, often requiring multiple passes to allow involuntary patients to leave the facility for short periods of time for walks, smoke breaks, etcetera. It was highlighted by the Department that provisions related to Short Term Leave were created to allow leave from the facility for up to 30 days, but do not account for shorter leaves of absence that most, if not all, patients should have for daily fresh air breaks, errands, to attend appointments, etcetera.

Committee presents the following recommendation:

Recommendation 21: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review provisions related to Short Term Leave in the *Mental Health Act*, especially related to the enforcement of a lack of compliance and streamlining administration so that Short Term Leave is less burdensome on staff, and that the review of these provisions be done with the lens of reviewing similar provisions in other jurisdictions.

In their written submission, the RCMP note that Section 52(1.2) of the Act was written without their consultation. They note that the default in the circumstances of temporary detainment of patients under the Act, is the incarceration of patients in jail cells, even though in most cases they have committed no crime, and this is strictly a medical situation. The RCMP emphasize that this Section should be either repealed or reworded to emphasize that this should only occur if there are criminal circumstances associated to a particular situation. They also highlight that there may be medical alternatives to control unruly or intoxicated patients awaiting conveyance.

It was also brought forward to the Department that there is a lack of safe and appropriate space to hold clients during waiting periods for conveyance to a designated facility, especially from rural and remote communities.

Committee hears their feedback, and presents the following two recommendations:

Recommendation 22: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review Section 52(1.2) of the *Mental Health Act*, Section 7 of the *Apprehension, Conveyance and Transfer Regulations*, and other sections of the *Mental Health Act* related to the temporary detention of patients, and bring forward changes to the *Mental Health Act* that provide solutions to issues related to the temporary detention of patients. This review should be completed in collaboration with the Royal Canadian Mounted Police, designated facilities, and relevant staff.

Committee believes it is a significant issue that there is no youth psychiatric unit in the NWT. The lack of a designated unit may relate to staff and institutional capacity issues; however, it has concerning impacts on the quality of youth patient care. It was also brought forward by the Department during this statutory review that there are concerns about the safety of pediatric psychiatric patients both under the Act and not under the Act at Stanton, as well as the suitability of the Pediatric Unit at Stanton to provide care to psychiatric patients under the Act.

Committee believes that not having a suitable youth psychiatric unit in the NWT is a serious problem, and therefore presents the following recommendation:

Recommendation 23: The Standing Committee on Social Development recommends that the Government of the Northwest Territories create a strategy to analyze and close the gap in pediatric psychiatric care in the Northwest Territories.

5. Oversight of the *Mental Health Act*

During their presentation to Committee, the MHARB suggested that there should be an authority with a specific oversight role for the *Mental Health Act*. The Department also noted to Committee that this suggestion warrants further review, and added to it by mentioning that a larger oversight role could allow for more comprehensive reporting to identify trends and outcomes, identify gaps in the healthcare system, and inform future service delivery improvements. The MHARB also requested statistics and data that may inform whether the number of applications they receive seems reasonable, which correlated with the Department's recognized need to substantiate data that could help inform MHARB's annual reports to the Minister of Health and Social Services. Committee notes that this information could be part of the role of the body charged with oversight of the Act.

Therefore, Committee makes the following recommendation:

Recommendation 24: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review and amend the *Mental Health Act* to specify an authority who is responsible for oversight of the *Mental Health Act*, while also allowing flexibility to the Minister of Health and Social Services to designate such responsibility.

The Department informed Committee that there is overall concern about the role of the "Director of the Designated Facility", and specifically what roles can and cannot be delegated or shared. The current processes and roles may cause delays in the review of forms and is administratively burdensome. Committee believes it is important to clarify and streamline their role to prevent burnout, and presents their recommendation as follows:

Recommendation 25: The Standing Committee on Social Development recommends that the Government of the Northwest Territories significantly reduce the administrative burden on the Director of Designated Facilities as defined in the *Mental Health Act* through legislative amendments and regulatory change.

6. Patient rights

In their written submission, the Canadian Psychiatric Association (CPA), notes that while unusual, Section 9.1 of the Act is "good from a rights perspective". They highlight that many patients are discharged prematurely, and a case could be made for giving families more of a say in the timing of discharge and perhaps a substitute decision-maker could be given the same right to ask for a second opinion. They provide insight that there may also be a downside to this section at the system level, where there is already a trend of too few psychiatric beds.

The CPA also commented that Section 28(2) of the Act seems unnecessarily restrictive. Currently, the provision requires a second medical opinion before administering emergency treatment, and they go on to note that in an emergency, even the time required to contact a second physician could result in a bad outcome. The CPA suggests to Committee that they review this provision as it could be problematic, and at the least consider the word "readily" be inserted before "available". Committee hears their concerns, and presents the following recommendation:

Recommendation 26: The Standing Committee on Social Development recommends that the Government of the Northwest Territories consider amending Section 9.1 and Section 28(2) of the *Mental Health Act* after evaluating their capacity and operational effectiveness.

The Department told Committee that postage of information about patient rights under the Act as a permanent part of the individual space may not be appropriate, particularly for the Pediatric Unit rooms that are designated for psychiatric admission at Stanton as they are adaptive spaces that may be utilized for acute medical treatment as needed. The Department also informed Committee that it is unclear whether patients are being informed of their rights to retain and instruct counsel without delay, and whether their access to counsel is being facilitated. It was suggested that it is critical that patients know their rights upon admission – and in particular, that it is communicated to the patient that should they wish to be discharged and there are any immediate safety concerns, they may be held involuntarily for further assessment. The Department suggests that further education and awareness is needed for staff who are responsible for providing patients with information about their rights under the Act.

A suggestion was brought to Committee by the Department to establish an independent rights advisor, as patients may be too upset at their doctors or physicians to fully understand their rights under the Act. The Department described that the explanation of rights often falls onto the responsibility of nurses to provide, and issues arise when high turnover of staff causes issues in ability to adequately provide this information. The Department also notes that there have been operational challenges in cases where patients on a voluntary hold are then placed on an involuntary hold if they want to or try to leave – which can create a false narrative for patients who may not understand that the Act balances addressing acute mental health needs with the safety of themselves as patients, and of others.

To help with the explanation of rights to patients and to help monitor change in patient status and potential interventions, it is suggested to review and amend Form 1 – *Notification of Patient Rights and Other Information* to simplify language and layout, and consider including information on how to access advocacy and/or legal supports. A suggestion by the Department was to create a separate form specific to patient rights, as depicted in Alberta and British Columbia's mental health care legislation. It was also noted that when reviewing Form 1, attention be made to including the ability to monitor change in patient status and potential interventions. They also suggested to make it standard that the patient is given a copy of the patient rights poster along with Form 1.

Committee presents the following three recommendations related to patient rights:

Recommendation 27: The Standing Committee on Social Development recommends that the Government of the Northwest Territories provide additional education materials and training support to staff responsible for providing patients with information about their rights under the *Mental Health Act*.

Recommendation 28: The Standing Committee on Social Development recommends that the Government of the Northwest Territories explore the possibility of an independent rights advisor or neutral party that vocalizes and reviews patient rights under the *Mental Health Act* with the patient, including whether this responsibility can be added to the cultural advisor role.

Recommendation 29: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review, amend and simplify Form 1 – *Notification of Patient Rights and Other Information* using an operational lens and a lens of persons with lived experience while also evaluating the benefits of creating a separate form specific to patient rights, as depicted in Alberta and British Columbia's mental health care legislation.

7. Community Treatment Plans

In relation to Section 37(6)(d), the Canadian Psychiatric Association raised that the use of the word "willing" is very problematic. The CPA noted that in Ontario, the wording is "is able to comply". The word "willing" could suggest to clinicians that the person is consenting and that if they do not agree then they are not eligible for Assisted Community Treatment. They highlighted to Committee that if this is the intention of this Section, then the Assisted Community Treatment has a very limited function. Committee recommends the following:

Recommendation 30: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review Section 37(6)(d) of the *Mental Health Act* and in particular, the use of the word "willing" within this section.

The Department brought forward to Committee the issue of administrative burdens related to the required coordination of assessments prior to the expiry of a Certificate of Involuntary Assessment or Renewal Certificate, as well as the assessments and appointments required under the Assisted Community Treatment Certificate are needlessly cumbersome and often results in more

appointments than is necessary. It was noted that this issue could be addressed through reviewing current process and assessment requirements in the Act and its regulations to allow for better coordination of timelines and requirements, streamlining information and the duplication of administrative tasks. Therefore, Committee proposes this recommendation to the Government of the Northwest Territories (GNWT), in an effort to streamline administration of the Act:

Recommendation 31: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review and amend the requirement of assessment and appointments for patients under Assisted Community Treatment and Short Term Leave prior to the expiry of a *Certificate of Involuntary Assessment* or a *Renewal Certificate* to ensure better coordination, streamline information, and reduce the number of forms and administrative tasks.

The Department raised the issue that a patient, under the NWT's *Mental Health Act*, must be involuntary admitted in order to be eligible for Assisted Community Treatment (ACT). Furthermore, this restriction has been causing confusion for patients and their families, and distress to staff. The Department informed Committee that the issue may be that Assisted Community Treatment, as stated in the NWT's *Mental Health Act*, is sometimes being equated with Community Treatment Orders, as seen in legislation in southern jurisdictions. In comparison, Community Treatment Orders (as depicted in southern jurisdictions) are designed for individuals, who may or may not be admitted under the Act, but allows for reasonable treatment to be provided without the consent of the person when it is considered less restrictive than keeping the person in hospital. Community Treatment Orders are typically used for individuals who are frequently re-admitted.

The Department made Committee aware that there are challenges in administering Assisted Community Treatment in the NWT as there is not enough operational guidance for staff to confidently manage care for patients on ACT. It was highlighted by the Department that most small communities in the NWT do not have the required services to manage clients who would benefit from ACT and therefore ACT has not been effectively utilized. The issue of ACT plans and forms located on Electronic Medical Records was also brought forward, stating that current information is not available for community staff and practitioners, including processes to flag changes in medications or other aspects of the plan.

The Department informed Committee that changes to provisions regarding Assisted Community Treatment are necessary so that ACT is available to those who are not or are no longer involuntary patients under the Act, similar to

Community Treatment Orders as shown in southern legislation. It was recommended to Committee by the Department that a review of provisions is necessary to align ACT to the Community Treatment Order model, including removing the requirement that a patient be involuntary. Notably, this review should be conducted using a northern lens, and should consider the differences on the impacts of services in small communities, the rural/remote and northern context, and operational requirements inevitably placed on the only designated facility with a dedicated psychiatric unit (Stanton). Committee recognizes the importance of properly implementing community treatment, and that making changes to Assisted Community Treatment provisions is an important step in making a greater commitment to culturally safe and decolonized practices in health care. Changes to Assisted Community Treatment provisions may aid in making the *Mental Health Act* less administratively burdensome to acute care and community services.

Committee recognizes all these elements at play, and presents the following recommendation:

Recommendation 32: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review and amend provisions in the *Mental Health Act* related to Assisted Community Treatment to expand Assisted Community Treatment to align with Community Treatment Orders as seen in other jurisdictions, including:
- Removing the requirement that a person be an involuntary patient to qualify for Assisted Community Treatment;
-Ensuring that care is decentralized from an institutional setting, and;
-That there is a greater commitment to culturally safe and decolonized practices in health care.

Similar to the above, it was noted to Committee by the Department that the exact requirement for providing housing and other supports under provisions related to Assisted Community Treatment is not immediately clear and can be confusing. Questions were raised about whether these supports were required to be available for patients prior to their eligibility for ACT, what is considered adequate, and concerns about patients who have unstable housing and income. Committee believes it is crucial for staff and patients to feel prepared when operationalizing ACT, and therefore Committee proposes the following:

Recommendation 33: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review Section 40(1)(b) of the *Mental Health Act* to ensure clear information on the extent to which housing and income supports are available to patients under Assisted Community Treatment.

An issue brought forward to the Department is that the nonadherence to the required monitoring and treatment under ACT would typically lead to the apprehension and conveyance of the patient to the closest designated facility for patients who reside in small communities. There are concerns by the Department that this may lead to an overuse of emergency transportation services which may impact the available resources in the communities for other emergencies, could be costly, and may not reflect principles of recovery-oriented care. While Committee understands that there needs to be a balance between protecting the patient and potential harm to themselves or others, Committee also recognizes the need to ensure that the patients are made aware of non-compliance, and that external stakeholders are equipped to adequately provide this information:

Recommendation 34: The Standing Committee on Social Development recommends that the Government of the Northwest Territories ensure external stakeholders involved in community care understand their obligations to support the operationalization of Assisted Community Treatment under the *Mental Health Act*, including increasing awareness of obligations to ensure efforts are made to inform patients of non-compliance and the consequences of non-compliance.

8. Staffing capacity, resources, and programs available

In his written submission to Committee, Raymond Pidzamecky, registered social worker, highlights that there is research that shows the most effective models for intervention, which are multisystemic in nature. Mr. Pidzamecky encourages the GNWT to create a multi-departmental team for children, adolescents, and families that include membership from at least health, social services, education, and justice. Committee understands that the GNWT is currently developing models of integrated service delivery to create multi-departmental responses to complex matters. Committee is interested in knowing the results of the development of these models, and is also researching healthcare sustainability and accountability in NWT's healthcare system.

The Department made Committee aware of burnout of some staff members related to the operations of the *Mental Health Act*. Committee would like to ensure that GNWT staff, including staff in smaller communities, feel supported so that there is

proper and meaningful action for patients under the Act, including for actioning certificates such as Assisted Community Treatment. Committee notes that there is a need for more community mental health services to be provided in partnership with Indigenous Governments and non-government organizations for additional supports necessary for meaningfully providing Assisted Community Treatment. Committee brings forward the following recommendation, in an effort to increase supports to small communities in the NWT:

Recommendation 35: The Standing Committee on Social Development recommends that the Government of the Northwest Territories establish more supports and funding to action Assisted Community Treatment as defined in the *Mental Health Act* in small communities across the Northwest Territories.

The Department brought to Committee's attention that there is a lack of guidance for families and caregivers to apply for Orders under the Act, and there was a suggestion to explore the addition of a public facing navigator role to help explain processes related to the *Mental Health Act*. This navigator role would involve reviewing, and revising public facing resources and guides to the *Mental Health Act* and assisting families in applying for Orders under the Act. It was suggested by the Department that this position could be housed at the Office of the Client Experience or within the Mental Health Act Review Board Officer Manager role. Committee agrees that this type of support is greatly needed for patients and their families, and proposes the following:

Recommendation 36: The Standing Committee on Social Development recommends that the Government of the Northwest Territories establish the addition of a public facing navigator role for *Mental Health Act* processes.

Additional feedback the Department provided to Committee was that more clarity is required around the psychiatrist's role during hearings. There seems to be uncertainty about whether they are to be a hospital representative, or a general witness. They highlighted that there is worry that at times, the psychiatrist is being asked legal questions which is beyond their scope. Committee believes it is important to determine their role so to better streamline the hearing process:

Recommendation 37: The Standing Committee on Social Development recommends that the Government of the Northwest Territories review the role of the psychiatrist during hearings under the *Mental Health Act* and provide information about their role to the Mental Health Act Review Board, psychiatrists and other staff to ensure there is a clear understanding of their role.

9. Assessment, admission, renewals, and discharging

It was brought forward by the Department that in some cases, involuntary patients that are disagreeable to care are being discharged from the facility. The Department highlighted that the Act currently requires attending medical practitioners to conduct ongoing assessments of involuntary patients to determine whether they continue to meet the criteria for involuntary admission. If the patient is not meeting the criteria, the physician must cancel the certificate of involuntary admission and any renewal certificate, allowing the patient to be discharged.

Committee notes this concern, and finds it important to ensure that patients are not being discharged too early. Therefore, Committee puts forward the following recommendation:

Recommendation 38: The Standing Committee on Social Development recommends that the Government of the Northwest Territories create internal processes to mitigate concerns regarding discharging mental health patients under the *Mental Health Act* too early by working with physicians.

It was noted that by the Department during their briefing to Committee that currently, there is an inability to cancel a *Certificate of Involuntary Assessment*. Related to this issue, , there may be struggles with access to an immediate assessment by a medical practitioner in small communities, and this may result in a medevac to have that assessment – even if the patient's condition has improved. It was suggested that this goes against the principles of the Act and person-centered care to hold and transport a person unnecessarily based on legislative requirements.

Committee presents the following recommendation:

Recommendation 39: The Standing Committee on Social Development recommends that the Government of the Northwest Territories improve on the ability to cancel certificates on involuntary assessment issued under the *Mental Health Act* through policies, procedures and legislative change.

10. Streamlining forms

It was raised by the Department that there is overall concern about the number and complexity of forms, as well as duplication across forms. There are also

concerns that when forms are not filled out correctly, they are considered to be invalid. More specifically, there was a comment of discrepancy between Form 23 – *Community Treatment Plan* and the requirements for the form set out in Section 19 of the *Forms Regulations*. It was stated that currently, Form 23 requires the patient *or* the substitute decision maker to initial Part 3 (Patient Agreement), while the entire Form 23 does not require a patient signature where there is a substitute decision maker place. Moreover, Section 19 of the *Forms Regulations* requires acknowledgement from the patient that they understand the requirements or obligations set out in Part 3 of Form 23, yet the Form does not require their signature.

Another example of reviewing consistency between Forms and Regulations includes Form 22 – *Assisted Community Treatment Certificate,* which currently indicates that the signature of both the patient and a substitute decision maker (if applicable) are required. However, as per Section 17(2) of the *Forms Regulations*, where there is a substitute decision maker in place, the Form is only required to be signed by the substitute decision maker.

It was brought forward that formatting changes also need to occur to the Forms, including adding the form name to the page number location, and ensuring forms have room for a 3-hole punch when filing.

There were also comments of difficulties and delays in retrieving signatures from substitute decision makers. It was suggested to allow for the substitute decision maker to consent verbally, instead of relying on faxes or other means to obtain signatures – especially if this is in the best interest of the patient. There is also an issue of forms that cannot be sent electronically. An example was provided for Form 10 – *Summary Statement Respecting Apprehension or Conveyance* which must physically accompany the client to the designated facility.

In the first recommendation of this report, Committee has recommended the GNWT streamline elements of the Act that are deemed administratively burdensome, including reviewing and amending all forms under the Act to ensure they are appropriate, efficient and reduce unnecessary make-work for staff, patients, and families. It was also suggested by the Department that staff are educated on secure file transfer, and internal procedures to address concerns about form completion. Committee also puts forth the following recommendation, related to technological change:

Recommendation 40: The Standing Committee on Social Development recommends that the Government of the Northwest Territories embrace technological change by implementing procedures for Forms under the *Mental Health Act* to be signed electronically or verbally, as well as implementing secure file transfer processes for Forms under the *Mental Health Act*.

CONCLUSION

This concludes the Standing Committee on Social Development's statutory review of the *Mental Health Act*.

Recommendation 41: The Standing Committee on Social Development recommends the Government of the Northwest Territories provide a response to this report within 120 days.

ENDNOTES

[1] Video of Committee May 8, 2024, public meeting with the Mental Health Act Review Board is available at: https://www.youtube.com/watch?v=Uw_0cEk1yEY&list=PLZiv8lTEMg4dqZsYMEW_--kMWhEAsBGae&index=11&t=2s

[2] Video of Committee June 12, 2024, public technical briefing on the *Mental Health Act* is available at: https://www.youtube.com/watch?v=HtazIo9MpjM&list=PLZiv8lTEMg4dqZsYMEW_--kMWhEAsBGae&index=8&t=2s

APPENDIX A

PRESENTATIONS

The NWT *Mental Health Act*

Standing Committee on Social Development – Technical and Operational Briefing
By DHSS and NTHSSA

June 12, 2024

Government of
Northwest Territories

Overview

- Charter of Rights and Freedoms
- What the *Mental Health Act* (MHA) is and what it isn't
- Regulations
- Principles
- Main components of the MHA
- Patient Care and Supports
- Stakeholders
- Potential Areas for Amendments

DHSS – JM

Introduction to the *Mental Health Act* (MHA)

Government of Northwest Territories

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DHSS – JM

- The Northwest Territories, like all jurisdictions in Canada, has legislation guiding the treatment, care and protection of individuals with acute or severe mental health needs.

- It is important to know that there are various types (and levels) of supports for people on the continuum of mental well-being and mental illness.

- The *Mental Health Act* is only one component of mental health support for people with mental illness who are experiencing low levels of mental well-being.

- The *Mental Health Act* is on the far end of this continuum; it is only used during a time of crisis or acute need. During this time, the person needing services, support or care is at their most vulnerable state; therefore, having a law that guides care and treatment is important to ensure their rights are protected.

- The Act provides guidance for people who require care and treatment (either voluntary or involuntary) for acute and severe mental health disorders.

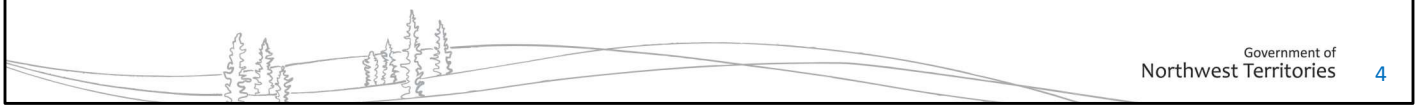
- The *Mental Health Act* and supporting regulations provides direction and guidance around who can be admitted to hospital, when and how a person should be

admitted, while making sure the person's rights are protected to the greatest extent possible.

Canadian Charter Rights and Freedoms

- *"Everyone has a right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice"*

- No one is allowed to discriminate against someone for any reason including, a mental disability.



Government of Northwest Territories 4

DHSS – JM

- In Canada, we have many protections from discrimination, including discrimination due to a mental disability. The Canadian Charter of Rights and Freedoms states: "[e]veryone has a right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice"

- Section 15 of the Canadian Charter of Rights and Freedoms guarantees the rights and freedoms of everyone in Canada. Each person can expect to be treated fairly even though there may be differences of nationality, race, colour, religion, sex, age, mental or physical disability.

What The *Mental Health Act is* ***NOT***

- **DOES NOT** legislate the continuum of mental health services that exist in communities.
- **IS NOT** usually the first step when a person is struggling with their mental health.

Government of Northwest Territories

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DHSS – JM

- It is not intended to legislate the continuum of mental health services that exist in communities and other parts of the system that are designed to meet the needs of others with mental health issues.
- It is rarely the first step when a person is struggling with their mental health - it is just one of many ways that residents' mental wellness can be supported in the NWT.
- Mental wellness support looks different for everyone. The Department and the HSSAs work to provide a range of options to individuals across the NWT including formal supports (i.e., counselling) and informal supports (i.e., peer support).
- Offering a "buffet" of services helps match individuals and families with the right care at the right time as defined by them.
- However, it is important to highlight that the NWT has limited programming or supports in place for individuals experiencing acute mental health crises, especially outside of Yellowknife. This is further exacerbated by other socio-economic factors outside of the HSS system, such as low and unstable income and access to housing, which impacts our ability to provide wrap around supports to residents

who interact with the MHA so that they can live safely in community.

- SCOSD was provided with a summary of mental health and wellness programs and services available in the NWT. While we won't go into detail on other mental wellness programs and services in the NWT in this presentation, we would be happy to answer any questions SCOSD may have afterwards.

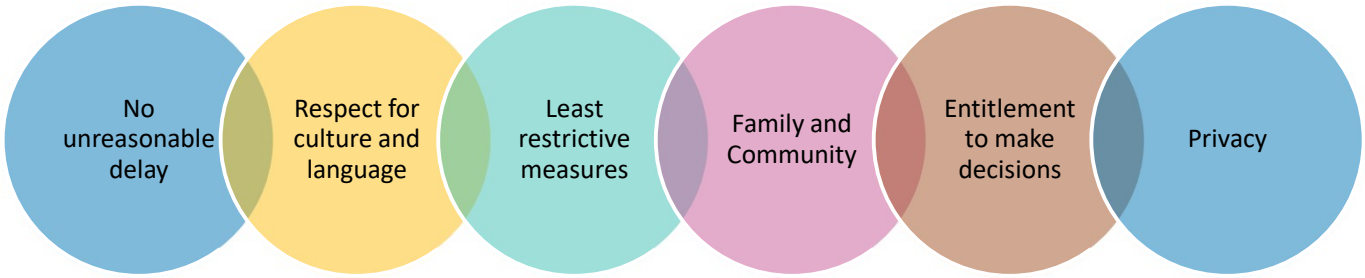
Corresponding Regulations

Name of Regulation	Purpose
Designation of Facilities Regulations	Lists the designated facilities in the NWT, which are: • Hay River Health Centre • Inuvik Regional Hospital • Stanton Territorial Hospital
General Regulations	• Outlines patient rights • Notice requirements • Administrative matters • Designation of responsible medical practitioner
Apprehensions, Conveyance, and Transfer Regulations	• Defines peace officer • Allows for issuance of a summary statement relating to a person being conveyed • Extension of time allowed to transport a person
Assisted Community Treatment Regulations	• Community treatment plans • Requirements when community treatment plans are amended or obligations in the plan cannot be met • Designation of medical practitioners responsible for persons on community treatment plans
Review Board Regulations	• Composition of Board • Terms of Members • Review Board Orders • Review Board Annual Report
Forms Regulations	• Information to be contained on 29 forms

DHSS – JM

The Mental Health Act: Principles for Implementation

The Act must be administered and interpreted according to the following principles:



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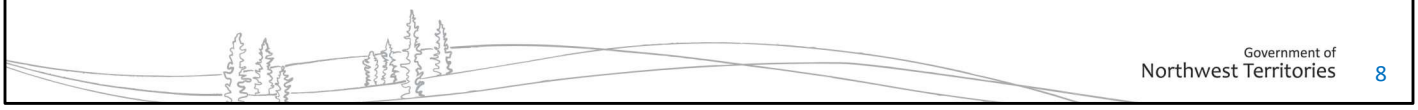
There is a set of 6 guiding principles in the Mental Health Act that must be followed when health professionals are administering the Act:

- There should be no unreasonable delay in making or carrying out decisions affecting a person who is subject to this Act;
- Decisions that affect a person who is subject to this Act should respect the person's cultural, linguistic and spiritual or religious ties;
- The least restrictive measures should be used when actions are taken or decisions are made in respect of a person who is subject to this Act, taking into consideration the safety of the person and other persons;
- The importance of family and community involvement in the care and treatment of people suffering from mental disorders is recognized;
- A person who is subject to this Act is entitled to make decisions on his or her own behalf, to the extent of his or her capacity to do so;
- The privacy of persons who are subject to this Act should be respected.

The Mental Health Act: Main Components

- Mental Disorder
- Designated Facilities
- Entry Points for Voluntary and Involuntary Admissions
- Treatment Decision Certificates and Substitute Decision Makers
- Transfers
- Mental Health Act Review Board
- Patient Rights
- Short Term Leave and Assisted Community Treatment



DHSS – JM

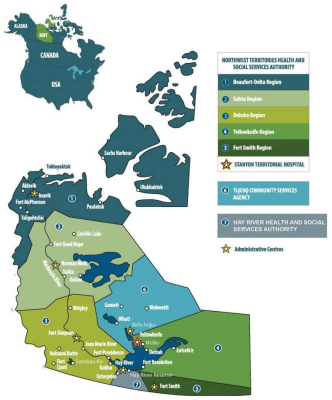
Mental Disorder

- Mental disorder: “a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life”.
- General threshold for involuntary detention under the MHA, **due to a mental disorder**:
  - The person:
    - Is likely to seriously hurt themselves or another person, or is likely to seriously mentally or physically deteriorate or become seriously physically impaired; or
    - Has recently caused serious harm to themselves or another person or has threatened or tried to do so; AND
  - The person is unwilling to receive care or be examined or is not mentally competent to provide such consent.

DHSS – JM

Designated Facilities

- Hay River Health Centre – Hay River
- Inuvik Regional Hospital – Inuvik
- Stanton Territorial Hospital – Yellowknife



Director of the Designated Facilities:

- The person in charge of the administration and management of the facility they work at

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DHSS – JM

- A "designated facility" means a facility designated by the regulations for the examination, care and treatment of persons with mental disorders. There are currently 3 in the NWT:
  - Hay River Health Centre
  - Inuvik Regional Hospital in Inuvik
  - Stanton Territorial Hospital in Yellowknife

- Fort Smith Health Centre had been previously designated, but its designation was removed due to limited capacity to act as a designated facility under the Act.

- The Director of a designated facility is defined in the MHA as “the person employed in the facility that is in charge of the administration and management of the facility.” It is typically the CEO or COO.
  - They have certain responsibilities outlined in the Act, such as ensuring that an involuntary patient is informed of their rights at the earliest opportunity after admission, authorizing the transfer of an involuntary patient to another designated facility, and maintaining a record of the diagnostic and treatment services provided to each person detained in the facility.

- The vast majority of involuntary admissions occur at Stanton as it has the most

staff (including psychiatrists) and better space to accommodate the needs of involuntary patients. However, having designated facilities in other regional centres ensures individuals held under the Act can be conveyed to a designated facility for an involuntary psychiatric assessment as quickly as possible, and where appropriate, can be involuntarily admitted for further treatment and care, or they can be transferred to Stanton if they have more complex care and treatment needs.

Entry Point: Voluntary Care

- A person can be admitted as a voluntary patient under the MHA if a doctor:
  - Has examined the person and assessed their mental condition; and
  - Believes the person would benefit from in-person admission and treatment.

DHSS – JM

- Although the intent of the MHA is to regulate the provision of involuntary mental health care to ensure that individuals' rights are protected to the greatest extent possible, it also recognizes that voluntary admission is possible. This is important, as one of the criteria for involuntary admission is that the person is not suitable to be admitted as a voluntary patient.

- In many instances, an individual's mental disorder impacts their ability to fully understand and appreciate their illness and treatment options available to them. This may lead them to refuse treatment or assessments from their care team. In such cases, they may be admitted on an involuntary basis.

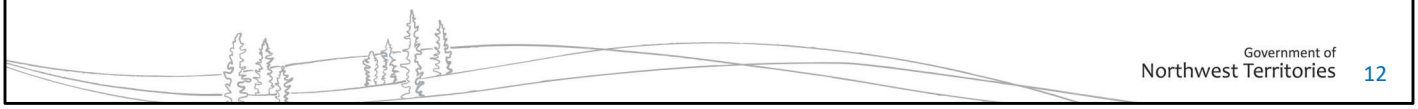
- You will notice that the criteria for voluntary admission are very broad and do not require the same level of serious risk that involuntary admission requires. This is to ensure that those struggling with their mental health can access in-patient care before they reach this point, if they are willing to do so.

Entry Points: Involuntary Care

There are three ways to access involuntary care under the Act when a person is experiencing a mental health emergency:

1. ***Health Professional Examination (MD, Psychiatrist, NP, RN, RPN, Psychologist)****
2. Voluntary Admission to Involuntary Assessment
3. Court Order
4. RCMP Officer

required for all entry points

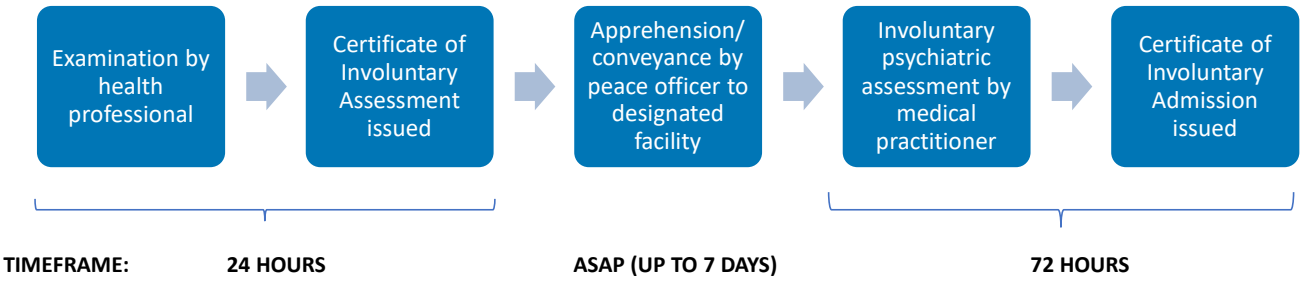


DHSS – JM

There are four ways under the Mental Health Act to receive an examination.

1. A health professional examines the person to determine if they should be examined by a medical practitioner to determine if involuntary admission is necessary. ***This step is required for all entry points. ***
2. A voluntary patient requesting to leave may be held involuntarily for further assessment to determine whether an involuntary admission is required
3. Any person who believes another person is suffering from a mental disorder and is aware the person is refusing to seek help, may apply to the court for an order to have the person examined
4. Peace officer may apprehend a person and bring them to a health facility for examination by a health professional

Entry Point: Health Professional Examination



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DHSS-JM

- Following an examination, a health professional (including registered nurses) can issue a Certificate of Involuntary Assessment, requiring a person to be brought to a designated facility for an involuntary psychiatric assessment.

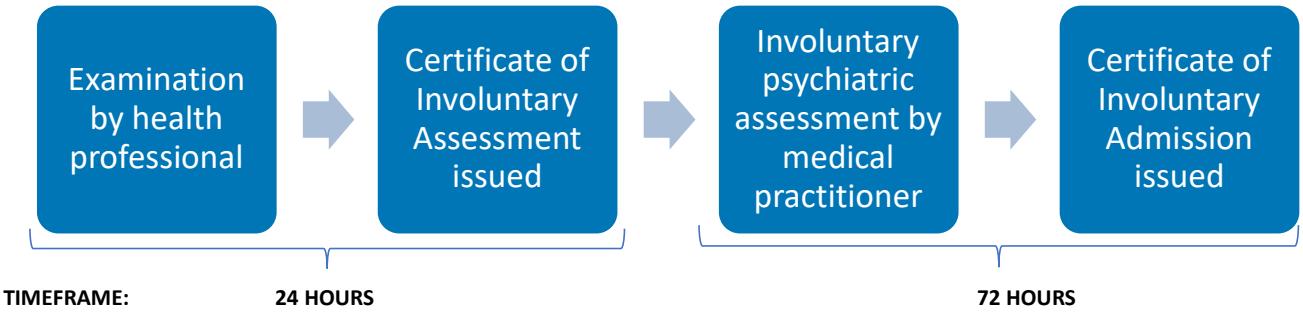
- To issue this certificate, the health professional would need to be of the opinion that:
    - The person is suffering from a mental health disorder
    - Because of the mental health disorder, the person:
        - Is likely to cause serious harm to themselves or to another person, or to suffer substantial mental or physical deterioration, or serious physical impairment, or
        - Has recently caused serious harm to themselves or another person, or has threatened or attempted to cause such harm; and
    - The person should undergo an involuntary psychiatric assessment to determine whether they should be admitted to a designated facility as an involuntary patient.

- The certificate of involuntary assessment must be issued within 24 hours of the examination.

- The patient will then be transported to a designated facility (it not already at one), for a psychiatric assessment. The authority to apprehend and convey a patient to a designated facility with a certificate of involuntary assessment expires after 7 days. It is important to remember that, even though the peace officer has up to 7 days to pick up the person and bring them to a designated facility, they still must do so as soon as possible. This 7 day time frame is in place to ensure there is enough time to locate the person (if needed), and bring them to the designated facility that may be located in a different community from where the person is currently located.

- Once the person is at the designated facility, a medical practitioner has 72 hours to complete an involuntary psychiatric assessment of the person to determine if they require involuntary admission. If the patient meets the criteria for an involuntary admission, a medical practitioner/psychiatrist will issue a Certificate of Involuntary Admission. Once the certificate of involuntary admission is issued, the hospital can hold the patient for up to 30 days, with the option to extend the involuntary admission through a Renewal Certificate

Entry Point: Voluntary to Involuntary Assessment



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DHSS – JM

- Voluntary patients can request to leave at any time.

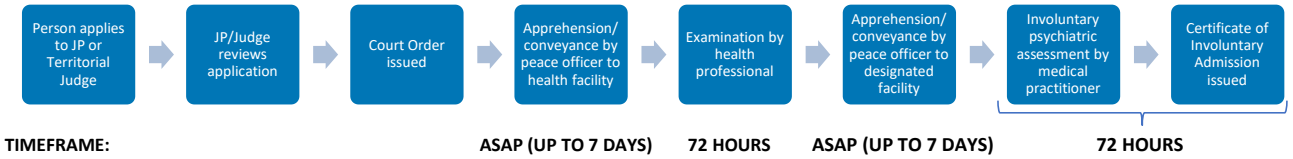
- However, there are cases where voluntary patients would meet the involuntary admission criteria if they were not willing to be at the facility on a voluntary basis. The Act accounts for this and sets out what must happen if a voluntary patient requests to leave but it is not safe for them to do so.

- If a voluntary patient declines treatment and wants to leave the facility, a member of the treatment staff can detain a voluntary patient who has requested to be discharged if they believe that:
    - The patient is suffering from a mental disorder;
    - The patient is likely to cause serious harm to themselves or another person, or suffer substantial mental or physical deterioration, or serious physical impairment, if they leave the facility; and
    - A medical practitioner should examine the patient to determine if a certificate of involuntary assessment should be issued.

- A medical practitioner must examine the patient and issue a Certificate of Involuntary Assessment within 24 hours of the patient being detained, or discharge the patient.

- Changing a patient's status from voluntary to involuntary must follow the regular involuntary assessment and admission process.

Entry Point: Court Order



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- Any person who believes another person is suffering from a mental disorder and is a risk to themselves or others and is aware that the person is refusing to seek help may apply to a justice of the peace or territorial judge for an order to have that person examined by a health professional.

- JP's have two roles to play under the Mental Health Act – they can:
    1. Issue a court order for a person to be involuntarily examined by a health professional
    2. Issue a warrant to authorize a peace officer to enter a dwelling for the purpose of apprehending a person

- The person who makes an application to a JP or Territorial Judge must have reasonable grounds to believe that:
    - The person is suffering a mental disorder
    - Because of the mental disorder the person 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, OR
        - has recently caused serious harm to himself or herself or to another

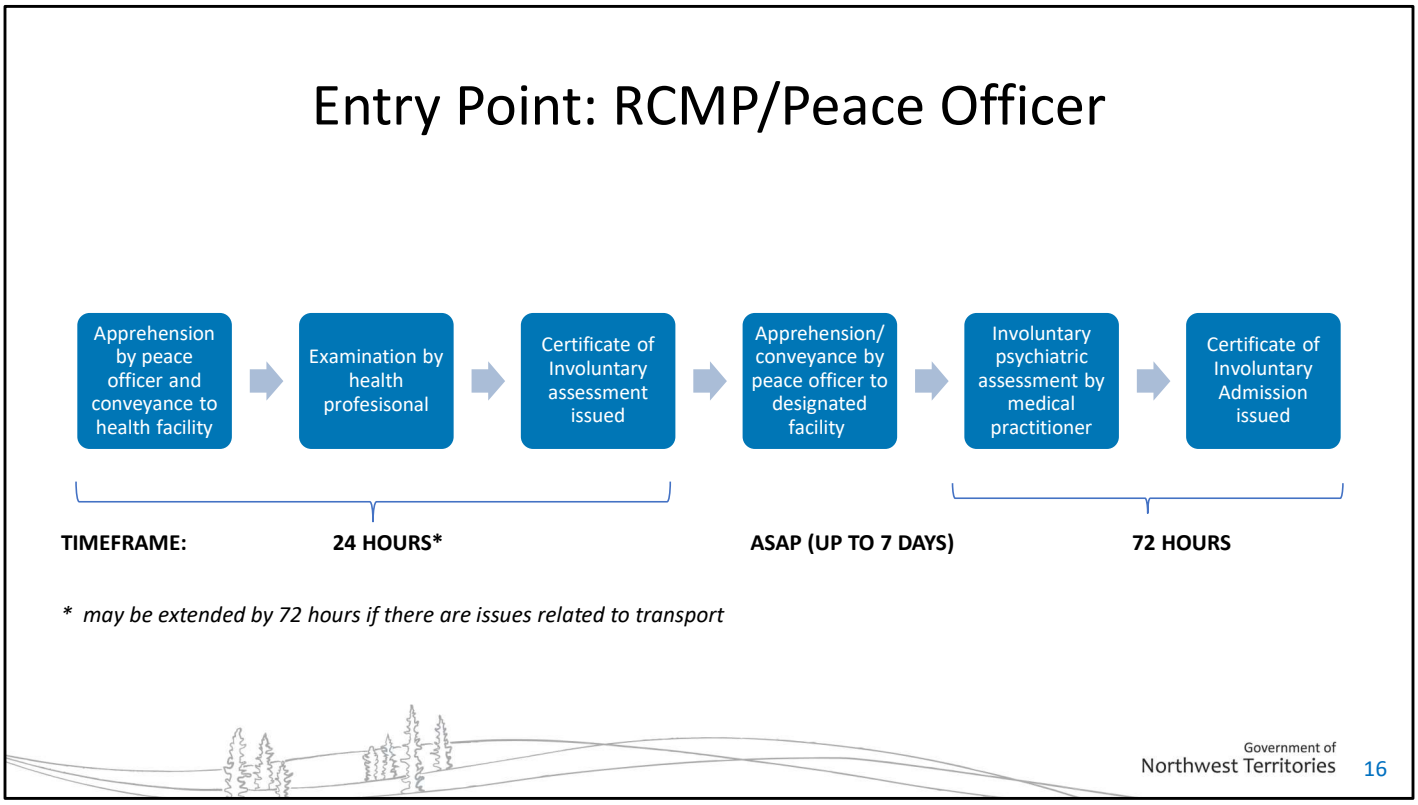
person, or has threatened or attempted to cause such harm, AND
    - The other person has refused to undergo or appears not to be competent to consent to an examination by a health professional to assess their mental state.

- An application for an order must be made in writing, must state the grounds upon which they are making the request and must be supported by an affidavit made under oath or affirmation.

- There is no legislated form to be completed to apply to the court for a Court Order related to the Mental Health Act.

- An Order provide authority for a peace officer to apprehend and convey the person to a health facility to be examined by a health professional to determine if a Certificate of Involuntary Assessment is needed to authorize further involuntary psychiatric assessment. Once at the person is at the health facility, they can be detained for up to 72 hours to complete the initial exam. This timeframe is longer than the process previously described, because there has been a legal instrument issued to authorize the person's detention under the Act. The rest of the assessment and admission process must be followed.

- As you can see, this process is quite lengthy. Due to the urgent nature of individuals' mental health needs under the MHA, this route is not usually used.



DHSS – JM

- RCMP = “Peace Officers” under the MHA

- Peace Officers are responsible for apprehending and conveying persons held under the MHA, and detention and control of persons for those purposes

- RCMP have specific duties under the Act when they apprehend and/or convey a person:
    - Take reasonable measures, including entering premises and using physical restraint, to apprehend and convey a person;
    - Promptly inform the person of the reasons why they were apprehended;
    - Inform the person of their rights to instruct legal counsel without delay, and must try to facilitate the person’s access to counsel;
    - As soon as possible, convey the person to the facility;
    - In the event of a delay in conveyance, provide the person with an opportunity to contact a family member, health professional, or other person;
    - Convey the person using the least intrusive means possible, without compromising the safety of the person or public;
    - Remain with the person or arrange for another peace officer to do so until

a facility or other authorized person accepts custody of the person

- A peace officer can detain a person without an Order for Involuntary Examination and bring them to a health facility for an involuntary examination if the peace officer has reasonable grounds to believe that:
    - The person has a mental disorder; and
    - Because of the mental disorder, the person:
        - is likely to seriously hurt themselves or another person, or suffer serious mental or physical deterioration, or serious physical impairment; or
        - has recently caused serious harm to themselves or another person, or has threatened or tried to do so; and
    - The person:
        - should be examined by a health professional to determine if an involuntary psychiatric assessment is needed; and
        - the person has refused to be examined by a health professional to assess their mental state, or does not appear to be mentally competent to consent to an examination; and
    - Because of the seriousness of the situation, it is not possible to get an Order.

- Where a Peace Officer apprehends a person under the Act, the person can be held for up to 24 hours in order to bring them to a health facility and for a health professional to complete an examination of the person to determine if a Certificate of Involuntary Assessment needs to be issued.

- This time may be extended by an additional 72 hours if there are issues related to transporting the person to the facility (for example, the person needs to travel to a different community because there is no health professional in that community available to do the examination).

- If a Certificate of Involuntary Assessment is not issued within that time, the person must be released.

Involuntary Admission

- When a Certificate of Involuntary Assessment has been issued, a doctor completes an involuntary psychiatric assessment of the person and can issue a Certificate of Involuntary Admission if they believe that the person:
  - Is suffering from a mental disorder; and
  - Is likely to cause serious harm to self or others, or suffer serious mental or physical deterioration or serious physical impairment if not admitted to hospital; and
  - Is not willing or able to be admitted as a voluntary patient.
- Authorizes involuntary admission for up to 30 days.
- Can be renewed with a Renewal Certificate for longer periods if necessary.

DHSS - JM

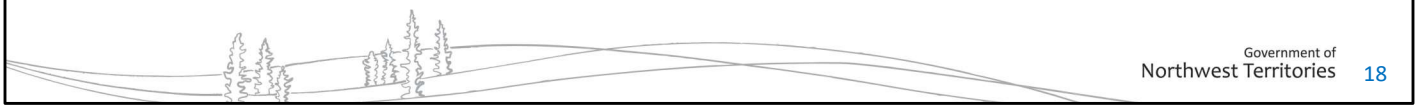
- A doctor completes a psychiatric assessment of the person and issues a Certificate of Involuntary Admission if:
  - A Certificate of Involuntary Assessment is in effect;
  - They believe the person:
    - Is suffering from a mental disorder; and
    - The medical practitioner has examined the person and is of the opinion that the person
      - Is suffering from a mental disorder
      - Is likely to cause serious harm to themselves or to another person, or to suffer substantial mental or physical deterioration or serious physical impairment if they are not admitted as an involuntary patient; and
      - Is not suitable to be admitted a voluntary patient.
- The person who completes this assessment must be different from the one who completed the Certificate of Involuntary Assessment.
- A Certificate of Involuntary Admission allows a designated facility to hold a patient for up to 30 days.

- The person's involuntary admission can be renewed with a Renewal Certificate for longer periods if necessary.
  - First renewal = 30 days
  - Second renewal = 60 days
  - Third + renewals = 90 days

- The majority of involuntary admissions occur at Stanton Hospital on the inpatient psychiatry unit.

Treatment Decision Certificates

- When a patient has been assessed by a doctor as not mentally competent to make treatment decisions, the doctor must issue a Treatment Decision Certificate
- When a Treatment Decision Certificate is issued, efforts are made to find a substitute decision maker for the patient.
- The patient's ability to make treatment decisions must be periodically assessed.



DHSS – JM

- As reasonably possible after the patient is admitted to a designated facility, the attending medical practitioner of a patient must assess the patient and determine whether the patient is mentally competent to make treatment decisions.

- In determining the mental competence of a patient to make treatment decisions, the medical practitioner must consider:
  (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.

- An attending medical practitioner who is of the opinion that a patient is not mentally competent to make treatment decisions must issue a treatment decision certificate with reasons for the opinion

- Where a treatment decision certificate is issued, the attending medical practitioner

or the director of the designated facility where the patient is admitted must make reasonable inquiries to find a substitute decision maker for the patient.

- The attending medical practitioner of a patient who is subject to a treatment decision certificate must cancel the certificate if the medical practitioner is of the opinion that the patient has gained mental competence to make treatment decisions

Substitute Decision Makers

- The following can be a substitute decision maker:
  - Person with lawful custody or authority of a patient who is a minor;
  - Legal guardian of the patient;
  - Agent of the patient under a personal directive
  - If none of the above apply, the patient's nearest relative.
- If a nearest relative is being pursued as the substitute decision maker, the patient must be given the opportunity to choose their substitute decision maker if they have the capacity to do so.

DHSS – JM

- A substitute decision maker must be designated, in writing, to make treatment decisions on behalf of a patient who is subject to a treatment decision certificate, by the attending medical practitioner or the director of the designated facility where the patient is admitted

- Each of the following persons is eligible to be designated as a substitute decision maker for a patient:
  a) a person who has lawful custody of or lawful authority in respect of a patient who is a minor;
  b) a legal guardian of the patient;
  c) an agent of the patient under a personal directive within the meaning of the Personal Directives Act;
  d) if paragraphs (a), (b) and (c) do not apply, the nearest relative of the patient.

- "nearest relative" means:
  a) the living relative of the patient who is the adult relative first listed in the following subparagraphs and who is the eldest of two or more relatives of the same category:
     i. spouse,

ii. child,
iii. parent,
iv. sister or brother,
v. grandparent,
vi. grandchild,
vii. aunt or uncle,
viii. niece or nephew; and

a) in the absence of a relative referred to in paragraph (a), an adult friend of the person

Substitute Decision Makers

- To be eligible as a substitute decision maker, a person must be:
  - ❑ available to make treatment decisions on behalf of the patient
  - ❑ willing to make treatment decisions on behalf of the patient
  - ❑ apparently mentally competent
- A "nearest relative" (or adult friend) can only be chosen if they have been in contact with the patient in the last 12 months.
- The substitute decision maker must always consider any previous wishes of the patient and the best interests of the patient when making treatment decisions on their behalf.

DHSS – JM

- To be eligible for designation as a substitute decision maker, a person must be
  - available to make treatment decisions on behalf of the patient
  - willing to make treatment

decisions on behalf of the patient
    - apparently mentally competent

- A potential substitute decision maker that is considered the "nearest relative" of the patient may not be designated as the substitute decision maker for a patient unless they:
    - (a) have been in personal contact with the patient within the previous 12-month period;
    - (b) are willing to assume responsibility for making treatment decisions on behalf of the patient; and
    - (c) make a written statement

certifying

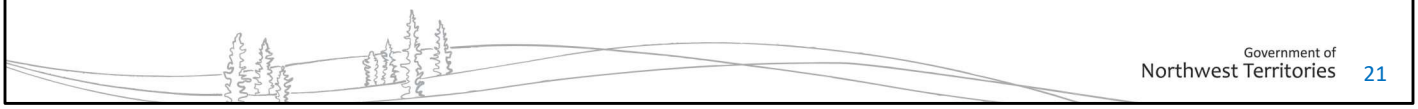
- (i) his or her relationship with the patient,
- (ii) that he or she has been in personal contact with the patient within the previous 12-month period, and
- (iii) that he or she is willing to assume responsibility for making treatment decisions on behalf of the patient.

- A substitute decision maker must make treatment decisions on behalf of a patient in accordance with expressed wishes in respect of treatment when the patient was apparently mentally competent to make treatment decisions. If expressed wishes of the patient are not known, or would endanger the physical or mental safety of the patient or another person, the substitute decision maker must make decisions in accordance with what the substitute decision maker believes to be in the best interests of the patient.

Transfers

An involuntary patient may be transferred:

- Within the NWT
- Outside the NWT
- Into the NWT



DHSS – JM

Transfer of involuntary patients within the NWT:

- The director of a designated facility may, in writing, authorize the transfer of an involuntary patient to another designated facility or to another health facility, if
  a) the director is satisfied that the transfer is in the best interests of the patient; and
  b) an agreement to admit the patient has been entered into with the receiving facility.

Transfer of involuntary patient outside the NWT:

- The director of a designated facility may issue a certificate authorizing the transfer of an involuntary patient to a psychiatric facility or hospital outside the Northwest Territories where hospitalization has been arranged, if
  a) the patient has come to or been brought into the Northwest Territories from elsewhere and the hospitalization is the responsibility of the jurisdiction to which the patient is to be transferred;
  b) the director is satisfied that the transfer is in the best interests of the patient; or
  c) a medical practitioner certifies that the patient cannot be properly cared for, observed, examined, assessed, treated, detained or controlled in a designated facility or health facility in the Northwest Territories.

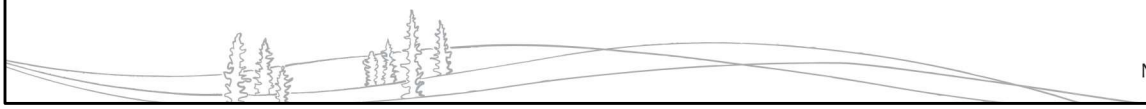
- ***A transfer under (a) or (b) requires consent of the patient or substitute decision maker (if applicable)***

Transfer of a patient into the NWT:

- The director of a designated facility may, in writing, authorize the transfer of a patient to the facility from a health facility outside the Northwest Territories, if the director is satisfied that:
  a) the Northwest Territories is responsible for the patient's hospitalization; or
  b) it would be in the best interests of the patient to be in a designated facility in the NWT .
- A patient transferred to a designated facility from a health facility outside the NWT must be examined by a medical practitioner as soon as possible to determine whether a certificate of involuntary assessment of the patient should be issued .

Mental Health Act Review Board (MHARB)

- The MHARB helps protect the rights of people who are held under the Act.
- If a patient or someone on their behalf wishes to appeal a decision made by their medical practitioner, they can apply to the Review Board.

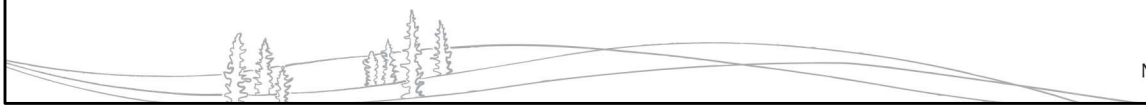


DHSS – HMY

- The Mental Health Act Review Board is a group of people who may review a patient's situation and their status as an involuntary patient. They ensure that individual rights are protected.
- They are impartial and have the best interests of the person in mind when they make decisions.
- The MHARB protects the rights of people held involuntarily in a health facility under the Mental Health Act

MHARB Composition

- Currently 12 Board Members, including the Chair.
  - Public Representatives – 4 members residing in Yellowknife, Fort Smith and Inuvik
  - Lawyers – 5 members (including the chair) residing in Yellowknife
  - Physicians – 3 members residing in Calgary and Ottawa
- The Board is chaired by a lawyer (who does not sit on any Review Panels.)
- The Board reflects the diversity of the NWT as much as possible.
- When there is a hearing, three of these members make up the Review Panel, which must include a lawyer, physician, and public representative.



DHSS – HMY

- Currently, there are 12 appointed Board Members.

- The Review Board is chaired by a lawyer licensed to practice in the NWT; the Chair does NOT sit on Review Panels.

- Review board members include lawyers, physicians, and public representatives. Only three members sit on a Review Panel (the body that decides each hearing) – a lawyer, physician and public representative.

- The board members reflect the diversity and gender balance of the NWT. The Act and regulations do not set out further requirements on this the process for seeking members requires individuals to put their names forward. If there were specific membership requirements to ensure representation across the NWT, it is likely that we would be unsuccessful in filling the required positions, jeopardizing the establishment of the Board.

- Physician members are chosen from the south to ensure they have no previous relationship with the patient.

Applying to the MHARB

Reasons To Apply:

- Cancel a certificate
- Appoint/change substitute decision maker
- Remove limits on patient rights
- Permission for medical treatment that's been refused
- Permission for psychosurgery
- Community treatment terms, conditions, etc.

Who Can Apply:

- Patient/person subject to the certificate
- Patient's substitute decision maker
- Patient's legal guardian
- Family member of the patient
- Patient's medical practitioner
- Director of the designated facility
- Public Trustee
- Any other person if the Chairperson gives permission

DHSS - HMY

- A person can make an application to the Review Board for many reasons, including:
  - Request to remove limits on the patient's rights
  - Cancel a certificate, such as:
    - If a patient wishes to leave the hospital and there is:
      - A Form 2: Certificate of Involuntary Assessment, a Form 3: Certificate of Involuntary Admission or Form 4: Renewal Certificate in place, a patient can apply to the Review Board to cancel the Certificate
    - If a patient feels they are competent to make treatment decisions, but a medical practitioner has determined they are not, a patient may apply to the Review Board to cancel the Form 11: Treatment Decision Certificate.
    - Or Form 14: Certificate of Mental Incompetence: to have the patient make their own decisions about their estate.
  - Appoint or change a substitute decision maker if there is a disagreement over the designation of a substitute decision maker or a specific treatment decision (for example, decision to not take medication prescribed).
  - A doctor can make a request to the Review Board to authorize a

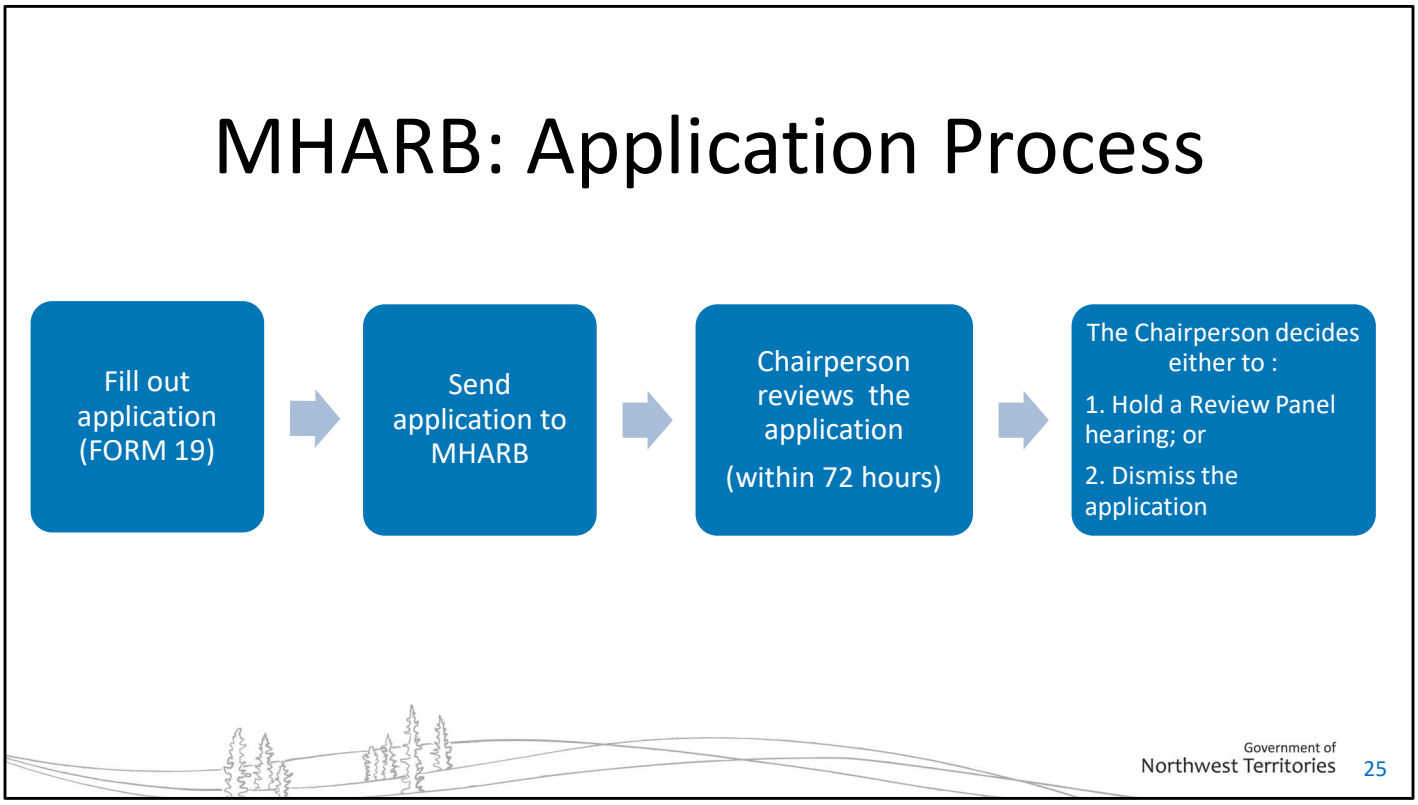
treatment or a procedure that the involuntary patient or their substitute decision maker has refused.
    - Issues regarding Form 22: Assisted Community Treatment Certificate or the conditions in Form 23: Community Treatment Plan. For example, for the Assisted Community Treatment Certificate: to have the patient return to the hospital for care and treatment, instead of receiving care and treatment in the community.
    - To cancel limits placed on patient rights

- It is also important to know that the Review Board will hold a mandatory hearing without an application for patients who have been involuntary for 6 months in a row without any prior hearings. These mandatory hearings assess if the person still meets the criteria to be an involuntary patient, or if the certificate can be cancelled.

- The MHARB does NOT have legal power to hear general complaints, such as about the food, or complaints about staffing. The patient can be directed to talk to the HSS System Navigator or the facility Patient Services representative if they have any other types of concerns or complaints.

- **Many people can apply to the review board:**
    - Patient/person subject to the certificate
    - Patient's substitute decision maker
    - Patient's legal guardian
    - Family member of the patient
    - Patient's medical practitioner
    - Director of the designated facility
    - Public Trustee
    - Any other person (besides the Chairperson or Review Panel) if the Chairperson of the Review Board gives permission

- If it is someone not on the list, then the Chairperson would have to decide if the application is warranted. Examples of things that would likely be taken into consideration would include the presumed capacity of the applicant, their relationship to the patient, etc.



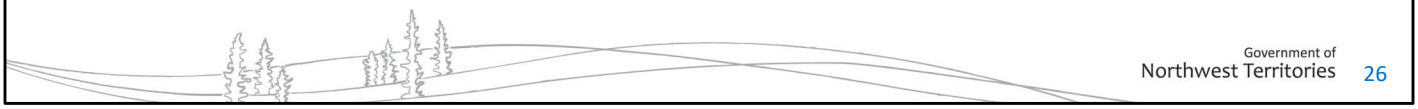
DHSS – HMY

- Form 19: *Application to Review Board* is available on the Review Board's website under Resources.
- Nurses and medical practitioners at the hospital also have copies of the application.
- Anyone can help the patient fill out an application – the office of the Review Board, a health professional or any other person.
- The application can be faxed or emailed to the Review Board by the applicant or someone at the facility. Staff at the facility can also help an individual send in Form 19 to the Review Board.
- The Review Board Chairperson will review the application, and decide to:
    - Hold a hearing OR
    - Dismiss the application.
        - Applications will be dismissed if they are deemed frivolous, vexatious or not made in good faith, for example, someone in Canada outside of the NWT applies to the Review Board.
- The Chairperson will send the person who applied for the hearing a written notice of their decision **within 72 hours**.
- If a decision is made to hold a hearing, it must be held **within 14 days**.
- If the patient would like support as they go through the process of applying to the Review Board,

there is a lawyer who is available at no charge to the patient to provide that support. Each of the designated facilities has the contact information for the lawyer. For example, the Mental Health Coordinator at Stanton Territorial Hospital has a Release of Information form available so if an applicant is at Stanton, it is ready for the patient to sign so their name can be passed along to the lawyer. The lawyer will then reach out and connect with the patient to discuss their need.

MHARB: Panel Hearing

- All patients participating in a review panel hearing will have access to legal counsel
- A review panel is made of up 3 board members:
  - ❑Medical practitioner
  - ❑Legal member
  - ❑Public representative
- An Elder, cultural advisor, family member and/or support person can be present at the hearing



DHSS – HMY

- The Act states that any party to an application may be represented by legal counsel

- Patients specifically have the right to consult with and instruct legal counsel
  - The Department has chosen to fund legal counsel for patients applying to the Review Board in order to uphold their Charter rights.
  - There is currently a lawyer assigned for applicants who will represent the patient free of charge. The patient can also hire and pay for a different lawyer. The patient may also choose not to have a lawyer.
  - If they choose to have one, the patient's lawyer is there to advocate for them. They can speak for the patient, or the patient can speak for themselves or the patient can have others speak on their behalf.

- A Review Panel hearing is not adversarial.
  - The Review Panel is there to listen and be supportive.

- The Review Panel may ask for information from the health facility, doctor(s), the patient under involuntary care, substitute decision maker (if applicable), and others.

- Where a Review Panel is assembled, the chairperson must notify the patient of their right to request that an elder or cultural advisor being engaged as part of the review panel process.

- An elder, cultural advisor, family member and/or (with permission) a friend can be present at the hearing.

- The Review Panel will make a decision and issue a written order **within 48 hours after** the completion of the hearing. A written decision will follow within one week.

- The Review Panel decision is binding. This means the health facility, doctor, and patient must comply with the decision.
    - If a person disagrees with the decision of the Review Board, they may:
        - Contact a lawyer and apply to the Supreme Court of the Northwest Territories within 30 days; or
        - Wait 30 days and make a new application to the Review Board for this same matter

- If the patient decides to appeal the decision of the Review Board and if they have used the lawyer who is available to them, that lawyer can provide case specific advice and opinions. The lawyer would also write a memo summarizing their thoughts / opinions on the specific case and if they feel that the appeal has grounds to proceed to the Supreme Court. The contract with legal counsel does not include representation at the Supreme Court.

- **It is important to note that the patient may apply to the Review Board before the 30 days for a different reason or matter.**

MHARB Contact Information

Location: 5015-49th St, 6th Floor, YK
Phone: 867-767-9061, ext. 49177
Email: MHAct_ReviewBoard@gov.nt.ca

Website: https://mharb.hss.gov.nt.ca
Application to Review Board Forms:
https://mharb.hss.gov.nt.ca/en/resources

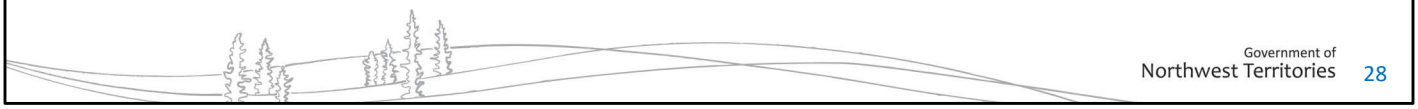
DHSS - HMY

Patient Rights

Any person subject to the Act is afforded basic rights that they must be informed of, and that health professionals must respect and promote.

**** These are in addition to basic privileges available to all patients ****

- People must be informed of their rights ASAP
- Information is given in written and verbal form in a language and manner they can understand
- Attempts to provide patient with information on their rights is ongoing
- If there is a risk of harm to the patient or others, there may be limitations placed on patient rights
- Patient rights must be visibly posted where patients can see them in a designated facility



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- A person who has been detained under the Act cannot be deprived of any right or privilege enjoyed by others because they are receiving or have received mental health services, unless their medical practitioner has reasonable grounds to believe that exercising a specific right would put the patient or others at risk of physical, emotional, or mental harm.

- All people admitted to a hospital, not just those under the MHA, are afforded basic privileges, such as fresh air breaks – these do not need to be set out in legislation.
    - An important distinction between a right and a privilege, is that:
        - A privilege is **granted** based on the circumstances and may be limited if necessary. For example, any patient admitted to a hospital has the privilege of fresh air breaks, but must be granted permission to do so. A limitation could be placed on this privilege to reduce potential risks. For example, a MHA patient might only be allowed to have fresh air breaks under supervision if they have a history of absconding.
        - A right is available **without needing any special permission**. Rights can be also limited, but only under certain circumstances.

The Act sets out clear requirements around the rights of individuals who are held under the Act, and places obligations on the health care team to make sure

individuals are aware of these rights and understand them. This includes:

- All people must be informed of their rights as soon as they are detained involuntarily

- Rights must be presented to the patient and/or their substitute decision maker in written form (Form 1, Patient Rights Card) and verbally, in a language and manner they can understand.

- If the medical practitioner is unsure whether the patient/SDM understands their rights, they must inform the director of the facility or designate and attempts to provide the patient with information is ongoing until they have demonstrated an understanding

- Rights are typically explained by the health professional issuing a certificate or on apprehension by a peace officer.

- A director of a designated facility, designate or another health professional involved in the person's care may provide this information if the medical practitioner is unsure the patient understands their rights and ongoing attempts are required

- Some rights may be limited if the doctor believes, based on information (either directly observed or provided by the patient or others) that there is a risk of harm to the physical, emotional or mental health of the patient or another person.

- Patient rights must be posted in the designated facilities where patients can see them.

- A director of a designated facility is ultimately responsible for taking measures to ensure patients are informed of and understand their rights

- Health Professionals must examine the patient regularly to see if they continue to meet the criteria to be involuntarily detained or admitted

Patient Rights

Apprehension	Detention Under Certificate	Admission	Voluntary and Involuntary Patients
The right to: • be informed promptly of the reasons for the apprehension • retain and instruct counsel without delay • communicate with a family member, health professional or other person in the event of any delay in conveying the person to a designated facility.	To be provided with verbal and written information on: • the authority under which the certificate was issued • the reasons the certificate was issued • the function of the Review Board • the right to apply to the Review Board for an order cancelling the certificate • the address of the Review Board • Consult with and instruct legal counsel in private	The right to (*subject to reasonable limits) • identify a person who is to be notified of the involuntary admission • access to his or her substitute decision maker* • access to visitors during scheduled visiting hours* • access to a telephone to make or receive calls* • access to materials and resources to write and send correspondence* • access to correspondence sent to him or her*	• A second opinion, where a patient objects to being discharged • To be informed of the purpose, nature, and effect of diagnostic procedures and treatment • To consent to or refuse psychiatric and other medical treatment.

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- Rights vary based on a person's status under the MHA.

Persons who are apprehended under the Act:

- must be informed of their rights **on detention.** This includes the right to:
    - Be informed of the reasons they were apprehended
    - Retain and instruct counsel without delay
    - Communicate with a family member, health professional or other person in the event conveyance to a designated facility is delayed

On detention under a Certificate issued under the Act (Certificate of Involuntary Assessment, Certificate of Involuntary Admission, or Renewal Certificate):

- The person must be informed, both verbally and in writing in a language and manner that they understand, about their rights to:
    - the authority under which they are being detained
    - the reasons why the certificate was issued
    - Know about the functions of the Review Board, and how and where to apply
    - Consult with and instruct legal counsel in private

Once admitted under a Certificate of Involuntary Admission or Renewal Certificate, or where a voluntary patient is temporarily detained pending an involuntary

examination:

- patients have the right to:
    - Identify who is to be notified of their involuntary admission/detention
    - Access their SDM*
    - Access visitors during visiting hours*
    - Use the telephone*
    - Send and receive correspondence*

- The Asterix indicates what rights can be restricted.
    - Rights can only be restricted if the doctor believes that exercising those rights would result in a risk of harm to the physical, emotional, or mental health or well-being of the patient or another person.
    - Where rights are restricted, they may only be restricted to the extent necessary to protect the patient or others from harm, and the restriction of rights must be documented and provided to the patient and substitute decision maker (if applicable) verbally and in writing, including:
        - An explanation of how the right is being limited;
        - The reasons for limiting the right;
        - How long the right will be limited; and
        - The right to apply to the Review board for an order cancelling the limitation.

- Patients who have a Treatment Decision Certificate cancelled must be re-informed of their rights.

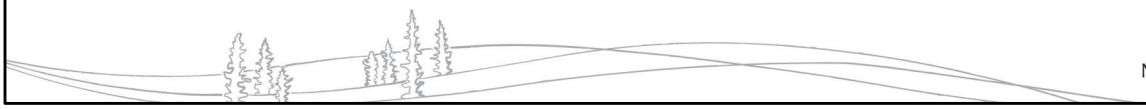
Both voluntary and involuntary patients also have the right to:

- A second medical opinion if they object to being discharged,
- Be informed (and their SDM, if applicable), by their medical practitioner about the purpose, nature, and effect of diagnostic procedures to be performed and treatment to be provided
- Consent to or refuse medical or other treatment, unless they have been deemed as lacking the capacity to make treatment decisions (i.e., have had a Treatment Decision Certificate issued).

Short Term Leave

- A short term leave certificate can be issued to allow an involuntary patient to leave the facility for up to 30 days, under any conditions the doctor considers appropriate.
- Requires patient or substitute decision maker consent.
- Can be cancelled if the patient does not comply with the conditions, or their mental condition changes.
- Regular access to fresh air is considered a basic patient privilege typically included in a person's plan of care on arrival to a designated facility* and is not considered short term leave.

*** may be limited if there is a risk of harm to the patient or others**



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- The attending medical practitioner of an involuntary patient admitted to a designated facility may issue a short term leave certificate authorizing the patient to be released from the facility on short term leave, subject to any conditions that the medical practitioner considers appropriate, for a period not exceeding 30 days after the certificate is issued.

- A short term leave certificate for an involuntary patient may not be issued unless the patient or, if applicable, their substitute decision maker consents.

- An involuntary patient released on short term leave shall, by the date and time of expiration specified in the short term leave certificate, return to the designated facility from which the patient was released, unless he or she ceases to be an involuntary patient before that time.

- The attending medical practitioner of an involuntary patient who is subject to a short term leave certificate may cancel the certificate, if the medical practitioner
  a) is of the opinion that the patient's mental condition may result in harm to the patient or another person if the patient does not return to the designated facility; or
  b) determines that the patient has failed to comply with one or more

conditions of the certificate.

- On receiving notice of the cancellation of a short term leave certificate, an involuntary patient shall immediately return to the designated facility from which he or she was released on short term leave

- Regular access to fresh air is considered a patient privilege and is not considered short term leave

- If the involuntary patient does not return to the designated facility from which they were released on short term leave, an “unauthorized absence statement” authorizing the apprehension and conveyance must be completed and is valid for up to 30 days from the date it is issued

Assisted Community Treatment (ACT)

- ACT is a type of extended leave that allows an involuntary patient to live and receive treatment and supervision in the community for up to six months at a time.
- It must be considered safe for both the patient and the public.
- ACT requires a comprehensive Community Treatment Plan (CTP) with agreement from all parties to participate in the plan.
- Patient must be willing to comply and participate in the development of the CTP.

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- A patient must be assessed by a medical practitioner to determine if they can live safely in the community where there are appropriate community supports available.

- The patient must be willing to participate in the development of a community treatment plan and agree to comply with it.

- Community Treatment Plans include various components

- Stable income and housing must be in place
    - Informal supports – family, Elders, employers, etc.
    - Formal supports – health professionals
    - The involuntary patient

ACT: Community Treatment Plans

- CTPs include:
  - Plan for treatment
  - Plan for other supports, including income and housing
  - Conditions relating to the supervision and treatment or care of the patient
  - Obligations of the patient
  - Identification of the supervising medical practitioner
  - Identification of person who has agreed to monitor the patient, assist the patient with complying with the plan, and report to the supervising medical practitioner
  - Names of health professionals and other persons/bodies who have agreed to provide supervision, treatment, care or other supports, and their obligations
  - Agreement of the patient or substitute decision maker (if applicable) to comply
- The patient is required to attend regular assessments while in the community.
- ACT Certificates and CTPs can be amended or cancelled.

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- A medical practitioner is designated as the person responsible for the overall supervision and management of the community treatment plan ("supervising medical practitioner") and persons or bodies named in the plan to provide support to the patient.

- ACT requires the development of a community treatment plan. CTPs must include:
  - Plan for treatment
  - Plan for other supports, including income and housing
  - Conditions relating to the supervision and treatment or care of the patient
  - Obligations of the patient regarding supervision, treatment, and other matters
  - Identification of the supervising medical practitioner (physician responsible for the overall supervision and management of the CTP)
  - Identification of a substitute decision maker, family member or other person who has agreed to monitor the patient, assist the patient with complying with the plan, and report to the supervising medical practitioner
  - Names of health professionals and other persons/bodies who have agreed to provide supervision, treatment, care or other supports, and

their obligations under the plan
    - Agreement of the patient or substitute decision maker (if applicable) to comply with the plan.

- Within 24 hours after issuing an ACT Certificate, the supervising medical practitioner must provide the CTP to the patient and, if applicable, to the patient's substitute decision maker.

- The ACT Certificate (or Cancellation of ACT certificate) must be filed with the director of the designated facility within 24 hours.

- The supervising medical practitioner is responsible for assessing the patient at regular intervals to:
    - Assess compliance with the plan;
    - Assess the effectiveness of the plan; and
    - Determine if the patient continues to meet the involuntary admission criteria.

- Roles and responsibilities of CTP members
    - Health professionals, other persons, or bodies named in the plan are responsible for implementing the plan to the extent they agreed to and reporting to the supervising medical practitioner, in accordance with the plan.
    - CTP members need to advise the supervising medical practitioner within 24 hours if the patient is not complying with the plan.

- Measures are in place to make sure ACT can respond to the changing needs of the patient. For example:
    - The supervising medical practitioner can make changes to the community treatment plan, in consultation with the health professionals and other persons/bodies named in the plan, to make sure that adequate treatment, services, and support remain available for the patient.
    - The supervising medical practitioner can issue a certificate requiring the patient to attend a psychiatric assessment if they feel the patient is not complying with the plan, sufficient efforts have been made to help the patient comply, the patient has been told they are not complying and about the possible consequences of not complying, and the patient isn't willing attend an assessment voluntarily.
    - The supervising medical practitioner can cancel an ACT Certificate, requiring the involuntary patient to immediately return to the designated facility, if they believe the patient's mental condition has changed and they can no longer live safely in the community.

What ACT is **NOT**

- A community treatment plan is **NOT** the same as a community treatment order (CTO), which does not require involuntary admission.
- ACT is not the same as short term leave, which is limited to 30 days and has no comprehensive treatment plan associated with it.
- A patient on ACT is not discharged. They remain an involuntary patient and the designated facility is still responsible for them. If the patient needs to return to a facility, they do not have to go through the admission process again.

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ACT/CTPs are NOT the same as a community treatment order (CTO)

- CTOs are used in many southern jurisdictions. This sometimes causes confusion for staff who are used to working under southern mental health frameworks.
- In southern CTOs, they are not limited to involuntary patients – they are available to voluntary patients as well as those who are not admitted under the MHA.
- A CTO requires the person to comply with the Order for treatment – if they do not comply, they are detained under the MHA and brought to a facility for an involuntary examination and admission if .
- CTOs are used to break the cycle of involuntary hospitalization, decompensation, and re-hospitalization. It includes the following important elements:
    - **Consent of the person is not required**
    - It is for people who:
        - have a history of not obtaining or continuing with treatment or care in the community that is needed to prevent the likelihood of harm to self or others
        - Are suffering negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of their mental disorder

- A CTO is reasonable for in the circumstances, and **less restrictive than retaining them as an involuntary patient**.

Patient Care and Supports

- Care team consists of mental health nurses, psychiatrists, recreational therapists, occupational therapist, Indigenous Wellness Team, Indigenous client advocate, mental health social worker
- Individual treatment plans are developed for each patient following initial psychiatric assessment
- Patients under involuntary admission typically have access to:
  - Fresh air breaks and passes
  - Recreation activities
  - Daily cultural activities
  - Regular outings to community organizations and cultural programs
  - Visits and engagement with family and/or friends as decided by the client.

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- The majority of involuntary admissions occur on the inpatient psychiatry unit at Stanton.

- In most cases, patients are informed of their rights at the time of admission, the only exception to this would be if there was an immediate safety concern or risk or if there was a need to identify a substitute decision maker.
  - Information about patient rights is posted throughout the inpatient unit, and in all patient rooms.
  - Patients are provided a handout on admission that outlines the daily routine on the unit, how to access services, what activities are available, etc.

- At the time of Involuntary Admission, patients have already undergone a psychiatric evaluation and assessment (form 2) where a treatment plan has already been initiated. Therefore, when the medical practitioner has determined the patient meets criteria for Involuntary Admission, the treatment team typically has a very good understanding of risk. This allows the treatment team and patient to openly discuss their care plan and treatment goals.
  - Typically, the treatment plan includes a number of activities such as recreation activities, cultural activities, outings to community

organizations such as the Arctic Indigenous Wellness Camp, fieldhouse, multiplex, etc. All of these activities are critical in assessing the patients to determine their readiness for discharge or transition to voluntary status.
    - It is worth flagging that some patients are not permitted fresh air breaks off hospital grounds or passes due to heightened risk of harm or absconding (leaving without permission). Although the psychiatry unit has a patio space available, for patients who smoke this can present a challenge because the current smoking legislation (*Smoking Control and Reduction Act)* does not allow smoking anywhere on hospital grounds.

- While on the inpatient psychiatry unit, the care team consists of a number of multidisciplinary team members who support the client in establishing a care plan and treatment goals. The team typically consists of mental health nurses, psychiatrists, recreational therapist, occupational therapist, Indigenous Wellness team, Indigenous client advocate, mental health social worker, behavioural health workers.

- Stanton also has a Clinical Mental Health Coordinator:
    - The role's focus is the MHA - emphasizing integrated case management via ACT, protecting patient rights, and practicing person-centred care.
    - Their caseload consists of patients admitted to Stanton for treatment of mental health disorders. Primarily, the patients served are on the Psychiatric Unit, but may also include patients on other units in the hospital.
    - The Social Worker ensures patients are discharged from hospital with pre-arranged, community-based support plans. This will also involve facilitating collaboration between residents and professionals, such that best practice is followed across the health system.

- There are formal safeguards within the Act to ensure that, should the client status change during an outing, they are able to return the facility to maintain safety

The Mental Health Act: Stakeholders

- Persons/families who access Mental Health Services under provisions of the Act
- Indigenous Governments, Advisory Bodies and Wellness Programs
- Justices of the Peace
- Mental Health Act Review Board members
- COO's of Designated Facilities
- Area Medical Directors
- Psychiatrists – Inpatient and Outpatient
- Primary Care Practitioners (Physicians, NP's, CHN's)
- Emergency Department and Acute Care Physicians
- Health Care Providers in Acute Care Settings
- Community Mental Health Nurses
- Medical Social Workers
- RCMP
- Community Support Programs (Salvation Army, Adult Services, Integrated Service Delivery, Community Counseling Program, Outreach Nursing, Housing First, Shelter Services, Office of the Public Guardian, Withdrawal Management Services)
- Office of the Client Experience
- Department of Health and Social Services

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Ongoing and structured consultation with stakeholders involved in operationalizing and supporting persons who are or have been subject to the Act is essential to evaluation of MHA legislation impacts on service delivery.

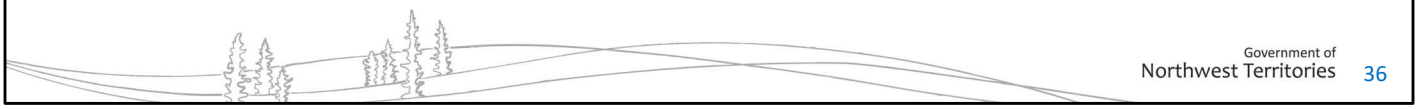
Measures should be taken to ensure engagement is conducted in respect and consideration of the unique culture, history and needs of peoples of the NWT and persons with lived experience. Ensuring person centred, trauma informed and recovery oriented approaches to engagement promotes relationship building toward trust, culturally safe service delivery, improved access to mental health care services, and overall health outcomes for persons, families and communities across the NT.

It is important to highlight that this list is not exhaustive, but demonstrates the need for integrated services and collaboration across GNWT departments and agencies and NGOs, not just the health and social services system. Without integrated and collaborative care, we will continue to experience frequent re-admissions and have people struggling with their mental health and wellness falling through the cracks.

Potential Areas for Amendments

16 areas have been identified that warrant further review for potential amendments to address operational challenges

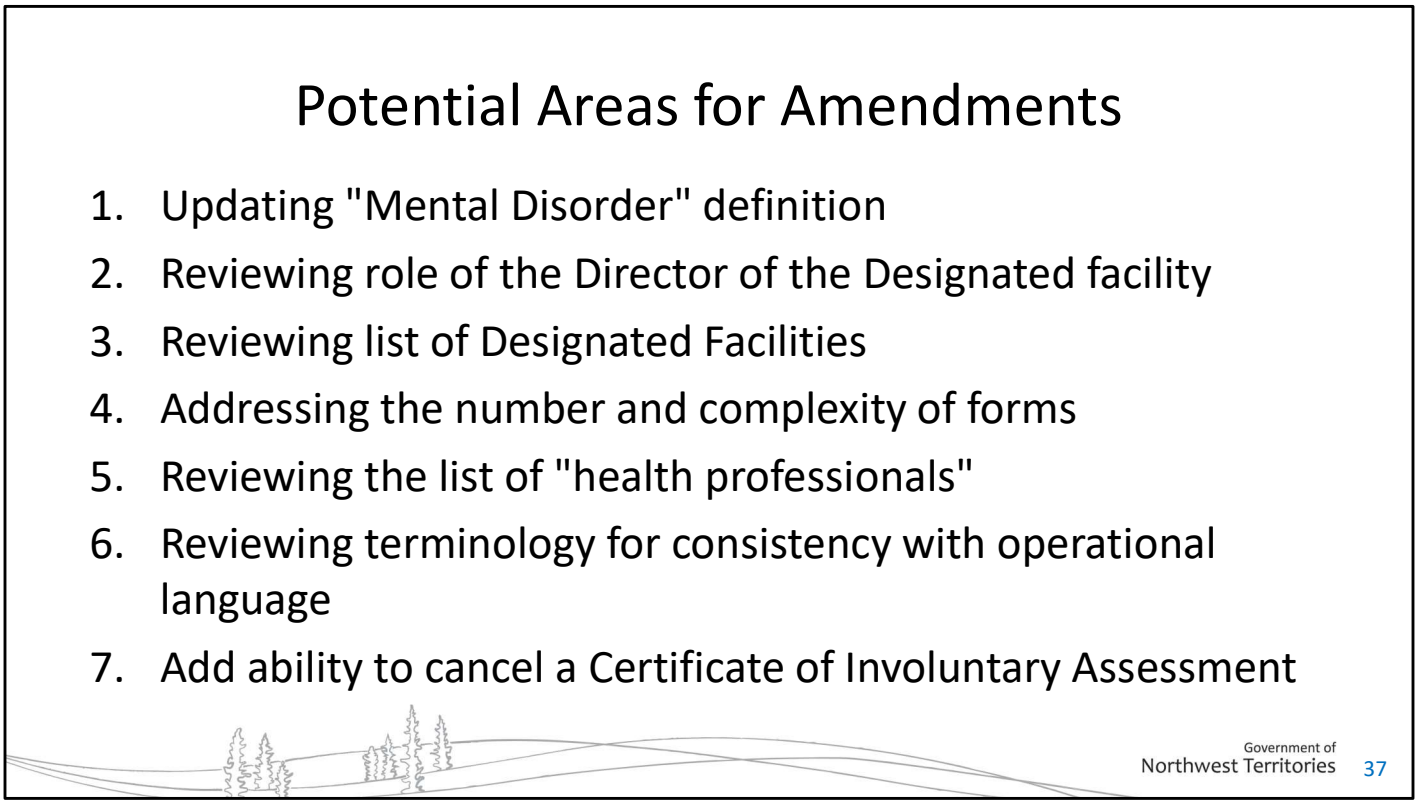
While Amendments to the Act and operational improvements will lead to better care under the Act, improved mental health and wellness for NWT residents requires a whole of government response and appropriate funding and resources.



NTHSSA

- The Operational Issues document provided to SCOSD outlines operational issues that have been identified to date as well as those that have been brought forward by staff who frequently work with the MHA.
- Many of the operational issues can be addressed by developing or improving on SOPs, increasing use of nursing staff and their role within the Act, and through staff education.
- Today we will focus on the issues that the Department and Authorities believe require further review to inform necessary amendments to the legislative framework.
- **Committee should note that a couple of areas for amendments have been added to this presentation that were not in the document previously provided to SCOSD, as the need to include them was identified following submission of that document.**
- As noted earlier, the NWT has limited programming or supports in place to support mental health and wellness across the continuum, especially outside of Yellowknife. This is further exacerbated by other socio-economic factors outside of

the HSS system, such as low and unstable income and access to housing, which impacts our ability to provide wrap around supports to residents who interact with the MHA so that they can live safely in community. Addressing these challenges cannot be done through changes to the legislative framework or operational processes alone – supports and capacity, both human and financial, across government is required.



- "Mental Disorder" definition
    - Alberta changed their definition in 2021. Alberta's definition, and definitions that have been more recently updated elsewhere in Canada, should be reviewed to determine what changes may be required to the NWT MHA to ensure it remains aligned with best practice.

- The role of the Director of the Designated facility
    - Many of the Director's responsibilities are shared with others; however, the Director does have sole responsibility for a number if things in the Act (authorizing transfers, maintaining a record of patients ensuring patients are informed of their rights), some of which the Act states can be delegated in writing. This leads to confusion about if or how the Directors responsibilities can be delegated. These responsibilities should be reviewed to reduce the administrative burden on the director to the greatest extent possible. This could include removing the delegating provisions and instead specifying what duties, if any, *cannot* be delegated.

- List of Designated Facilities
    - Inuvik and Hay River have fluctuating capacity to accept involuntary

patients under the MHA. Their designation as designated facilities should be reviewed, and their delegations rescinded if it is determined that they cannot safely detain, restrain, examine, treat, and care for patients under the MHA.

- The number and complexity of forms
    - Overall there is a large number of forms that are long and require a lot of complex information that is not always easy to follow. Some forms have duplicate information, or there is unnecessary duplication across forms. Forms should be reviewed to reduce the number of forms, limit the complexity of information, and make them more plain language and accessible. Because health professionals may work through some forms with patients, it is important that this review include both an operational lens and lens of persons with lived experience.

- The list of "health professionals"
    - With the scope of practice of many HSS professions expanding, the current list of "health professionals" should be reviewed to determine if other professionals can be added to the list. This will require a review of each profession's scope of practice and what other professions are designated as "health professionals" under other jurisdictions' MHAs.

- Terminology review
    - There is confusion caused by the terms "Involuntary Assessment" and "Involuntary Admission", as during the assessment phase a client is operationally admitted to a hospital, but not yet 'admitted' as an involuntary patient under the Act.

- Cancellation of Certificate of Involuntary Assessment
    - There is currently no ability to cancel a certificate of involuntary assessment. However, there are cases where a person is being held under a certificate of involuntary assessment and their condition substantially changes while they are waiting to be brought to a designated facility. For example, an individual may be in a situational crisis and quite distraught and suicidal or experiencing psychosis induced by alcohol or drugs, but once they become sober their situational crisis resolves. It goes against the principles of the Act and person-centred care to hold a person longer than is necessary.
    - To mitigate this issue in the interim, legal advice has been provided that

rather than conveying the person to a designated facility simply to release them, a medical practitioner should complete a virtual psychiatric assessment of the person to confirm the appropriateness of release. If that assessment indicates that the person does not meet the criteria for involuntary admission, then the person could be released.

- To ensure the health professionals involved are not liable should the person be released and later harm themselves or another person, explicit ability to cancel a certificate of involuntary assessment should be added to the Act.

Potential Areas for Amendments

8. Reworking Assisted Community Treatment model to align with the Community Treatment Order model, including removing requirement that person be an involuntary patient.

9. Allowing the substitute decision maker to provide verbal consent instead of written, where appropriate

10. Reviewing time required to complete an assessment before a Certificate of Involuntary Admission/Renewal expires (currently 72hrs)

11. Reviewing the oversight role(s) and most appropriate place/scope for the role

12. Reviewing short term leave provisions to reduce administrative burden

NTHSSA

- Assisted Community Treatment vs. Community Treatment Orders
    - The current ACT provisions lead to a lot of confusion amongst front line staff, as they are perceived to be the same as CTOs that are used in the south for individuals who are not being held involuntarily under the MHA. Instead, ACT is intended to be a form of extended leave with a comprehensive plan for community support and treatment.
    - These provisions should be reviewed to more clearly delineate ACT/extended leave from CTOs.
    - Consideration should be given to reworking the ACT provisions to better align with the intent of southern CTOs and removing the eligibility requirement that the person be an involuntary patient.
    - This should include considering the services and supports that are available in the NWT and how community treatment can be set up to allow patients in smaller, more remote communities to succeed.

- Allowing the substitute decision maker to provide verbal consent instead of written
    - Substitute decision makers often reside outside of Yellowknife, where most involuntary patients are admitted. Obtaining written consent or signatures from a substitute decision maker can be challenging and lead

to delays, such as delays in short term leave. Where written consent is required should be reviewed and the ability to provide verbal consent should be provided for, where appropriate.

- The time required to complete an assessment before a certificate expires (currently 72hrs)
    - It has been suggested that the current timeline is too short. This should be reviewed and compared to timelines provided in other jurisdictions and updated if appropriate.

- Reviewing the oversight role(s) and most appropriate place/scope for the role
    - At the Review Board's public briefing, they recommended that the Review Board play a broader role in oversight of the MHA. The Department would like to explore this recommendation further.
    - Currently, the Director of Mental Health, appointed by the Minister, receives copies of forms related to involuntary admissions to keep a registry of involuntary patients. The intent of this role is unclear and it's not always known if they are receiving all forms. Further, this current role causes some concerns that Department staff are aware of sensitive personal health information when they shouldn't be.
    - A larger oversight role could allow for a more comprehensive reporting to identify trends and outcomes, identify gaps in the system, and inform future service delivery.
    - A cost analysis of expanding the oversight role(s) in the Act would have to be completed before any amendments could be proposed.

- Reviewing short term leave provisions to reduce administrative burden
    - Current short term leave process is administratively burdensome, often requiring multiple passes to allow involuntary patients to leave the facility for short periods of time.
    - The current short term leave provisions were designed to allow leave from the facility for up to 30 days, but do not account for the need for frequent shorter leaves of absence.
    - This issue can be addressed by reviewing the current short term leave provisions and similar leave of absence provisions in other jurisdictions to reduce the administrative burden involved in allowing a patient to leave the facility regularly for short periods of time.

Potential Areas for Amendments

13. Removing ability to apply to the Review Board for a review of a Certificate of Involuntary Assessment
14. Moving the hearing notice period to regulations, decreasing the length of notice that must be provided, and allowing for the notice period to be shortened with consent of all parties
15. Providing clear authority to share personal health information with the Elder/cultural advisor with the consent of the patient or substitute decision maker (if applicable)
16. Clarifying that the Elder/cultural advisor is to be engaged to the extent requested and/or agreed to by the patient or substitute decision maker (if applicable)

NTHSSA

- Removing ability to apply for review of Certificate of Involuntary Assessment
    - Applications can currently be made to the Review Board to cancel any certificate issued. This means that patients admitted under a *Form 3 – Certificate of Involuntary Admission* could potentially be required to apply to the Review Board twice within the span of only a few days if they had applied for their initial Form 2 - *Certificate of Involuntary Assessment* to be cancelled, because a review of this certificate would not result in an automatic

review of their Form 3 - *Certificate of Involuntary Admission.*

- There have been several instances when a patient on a Form 2 – *Certificate of Involuntary Assessment* has applied to the Review Board; however, a hearing cannot be arranged due to the legislated timelines for the review as well as the short duration of the certificate.
- It has been suggested that the ability to apply to the Review Board for a review of a Certificate of Involuntary Assessment be removed as it cannot be reasonably provided.

- Moving hearing notice period to regulations
  - On receiving an application for consideration, a review panel is required to schedule a hearing at the within 14 days and give 7 days written notice of the date, time, place and purpose of the hearing to the parties. We've heard from the Review board that, on multiple occasions, the review panel wanted to schedule hearings earlier and have been

unable to because of this restriction in the legislation. It has been suggested that the 7 days notice requirement be shortened.

- The Department would propose that the most flexible approach to addressing this issue is to move the notice period to the regulations, working with the Review Board and NTHSSA to determine the most appropriate minimum notice period required for all parties to be prepared for a hearing, and adding a provision that allows the notice period to be shortened with consent of all the parties in order to allow hearings to take place as quickly as possible.

- Providing clear authority to share personal health information with the Elder/cultural advisor
  - We've heard from the Review Board that the information being disclosed to the Elder/cultural advisor may be too wide, as the test for disclosure means they basically get every relevant or relied upon record, which could be interpreted to be the whole chart.

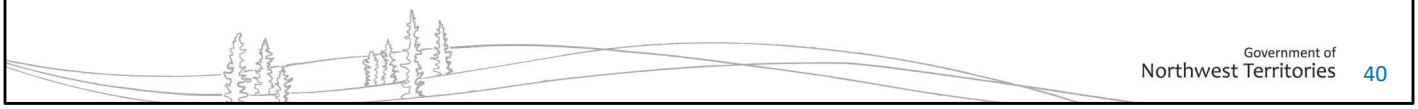
This disclosure may be detrimental to the patient.

- This requires further review and inclusion of a disclosure provision outlining what information may be disclosed, and that consent of the patient always be required.

- Clarifying the role of the Elder/cultural advisor
  - We've heard from the Review Board that clarity is required regarding the role of the Elder/cultural advisor – are they a witness, observer, support person, or amicus (assists court by offering information, expertise, and insight that has a bearing on the issues in the case – typically considered under the court's discretion).
  - The role of the Elder/cultural advisor was left intentionally vague to allow the patient requesting this support to determine what role they would like this person to play in their review. However, this issue could be addressed by expanding on s.68.1 in the Act to

clarify that the Elder/cultural advisor is to be engaged to the extent and for any purpose(s) requested by the patient.

Questions?



Mental Health Act Review Board - Update

The NWT Mental Health Act

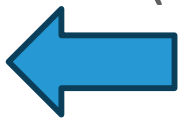
Standing Committee on Social Development Public Briefing

May 8, 2024

Outline

1- Overview of MHARB

a) Who we are (Mental Health Act (MHA) and MHA Review Board)



b) What we do

2- Opportunities for Future Developments in the Mental Health Act

Who we are: Introduction to the Mental Health Act Review Board (MHARB)

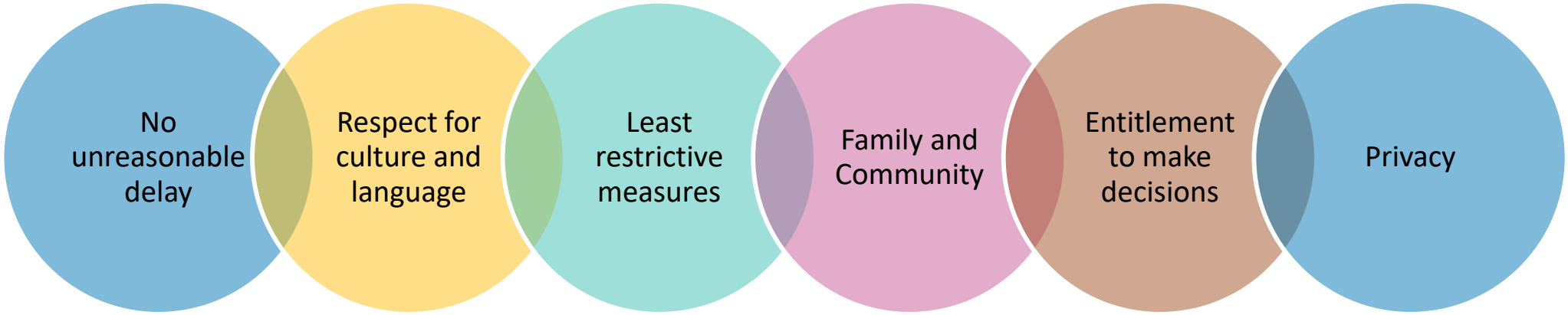
- The Mental Health Act Review Board (MHARB) is created under section 60 of the *Mental Health Act* (MHA)
- MHARB helps protect the rights of people who are held under the *Mental Health Act* (MHA)
- If a patient or someone on their behalf wishes to appeal a decision made by their medical practitioner, they can apply to MHARB
- Currently, there are 12 appointed Board Members

The *Mental Health Act*

What The Mental Health Act Is	***What The Mental Health Is <u>Not</u>***
Only one piece of the overall service continuum for mental health – however, it is still an extremely important tool in the way we care for some of our most vulnerable residents.	Not intended to legislate the continuum of mental health services that exist in communities and other parts of the system that are designed to meet the needs of others with mental health issues.
Designed to meet the needs of those individuals who are acutely ill and whose illness makes them a risk of harm to themselves or others. The legislation is intended to ensure acutely ill patients with this risk get the treatment they need while also having their rights protected.	Not the initial step when a person with a mental health disorder has become a serious risk to themselves or others - it is just one of many initiatives in the NWT to support the mental health of NWT residents.
Provides direction and guidance around who can be admitted to hospital, when the person should be admitted, and how the person should be admitted, while making sure the person's rights are protected.	

The Mental Health Act: How it is Implemented

The Act must be administered and interpreted according to the following principles:



Mental Disorder

“a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life”.

The Mental Health Act: Main Components

- Entry points
- Involuntary Assessment
- Involuntary Admission
- Designated Facilities
- Patient Rights
- Mental Health Act Review Board
- Treatment Decision Certificates and Substitute Decision Makers
- Transfers
- Leave: Short Term Leave and Assisted Community Treatment

Patient Rights

Any person detained under the MHA has the right to:

- Know why the certificate was issued & under what authority
- Make decisions on their own behalf to extent of their capacity
- The right to apply to the Review Board to cancel the certificate
- Consult with and instruct legal counsel in private
- Ongoing Assessment (s. 20) & release if conditions not met
- Respect of their Privacy

Entry Points

There are three ways to be assessed if experiencing a mental health emergency:

(1) RCMP / Peace Officer

(2) Court Order

(3) Health Professional Examination (MD, Psychiatrist, NP, RN, Psychologist)

Entry Points: Health Professional Examination

Voluntary Admission:

a medical practitioner may admit a person to a designated facility as a voluntary patient if they have examined the person and assessed the mental condition of the person and is of the opinion that the person would benefit from in-patient admission and treatment at the facility

Involuntary Admission:

When a person arrives at a health facility, a health professional can also admit a patient as an involuntary patient they have examined the person and have issued a certificate of involuntary assessment of the person

Involuntary Assessment

- Following an examination, a health professional can issue a Certificate of Involuntary Assessment if the health professional is of the opinion that:
  - ❑The person is likely to or has recently caused serious harm to themselves or to another person
  - ❑The person is likely to suffer substantial mental/physical deterioration or serious physical impairment
  - ❑The person has recently threatened to cause such harm
- The person can be held for up to 24 hours in order for the examination (assessment) to be completed

Involuntary Admission

- Allows a designated facility to hold a patient for up to 30 days.
- Doctor completes a psychiatric assessment of the person and issues a Certificate of Involuntary Admission if they believe the person:
  - ❑Suffers from a mental health disorder
  - ❑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.
  - ❑Is not willing or able to be admitted as a voluntary patient
- Process conducted while certificate of involuntary assessment in effect, but for a **different purpose** and by a **different doctor**.
- Can be renewed with a Renewal Certificate for longer periods if necessary.

Treatment Decision Certificates

- As soon as reasonably possible after the patient is admitted to a designated facility, the attending doctor of a patient will determine **whether the patient is mentally competent** to make treatment decisions
- If an attending doctor is of the opinion that a patient is **not mentally competent** to make treatment decisions, doctor shall issue a **Treatment Decision Certificate along with reasons** for the opinion
- Where a Treatment Decision Certificate is issued, the attending doctor or the director of the designated facility where the patient is admitted shall make reasonable inquiries **to find a Substitute Decision Maker** for the patient.

Involuntary Patient Rights

- Know why they are in hospital as an involuntary patient
- Identify a person to be notified of their involuntary admission
- Access to their substitute decision maker*
- Access to visitors during visiting hours*
- To make or receive phone calls*
- To write, send, and receive correspondence*
- Access to correspondence sent to them*
- Not be deprived of any right or privilege enjoyed by others*
- Consent to or refuse treatment, unless a substitute decision maker has been appointed
- A second medical opinion, if they object to being discharged

**These rights may be limited if there is a risk of harm to the patient or another person*

Patient Rights: Health Professional Obligations

- Provide the person/patient with information in a manner and language they understand.
- Allow the person/patient to communicate with a family member if there is a delay in getting them to the hospital.
- Allow the patient to identify someone they would like to be notified of their admission to the hospital.
- Examine the patient regularly to see if they still need to be held involuntarily under the MHA.
- Provide patients with a second medical opinion, if they do not wish to be discharged from hospital.

PLIR0

Outiline

1- Overview of MHARB

a) Who we are ✓

b) What we do ⟵

2- Opportunities for Future Developments in the Mental Health Act

Mental Health Act Review Board

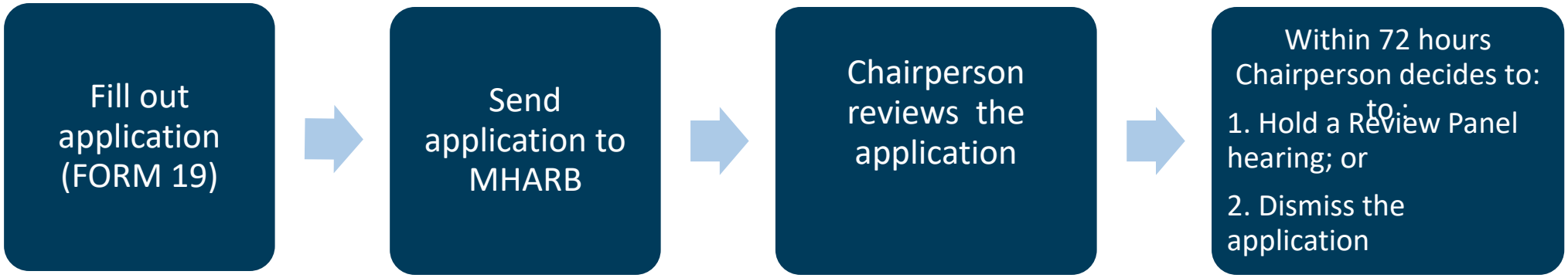
Reasons To Apply:

- Cancel a certificate
- Appoint/ change substitute decision maker
- Remove limits on patient rights

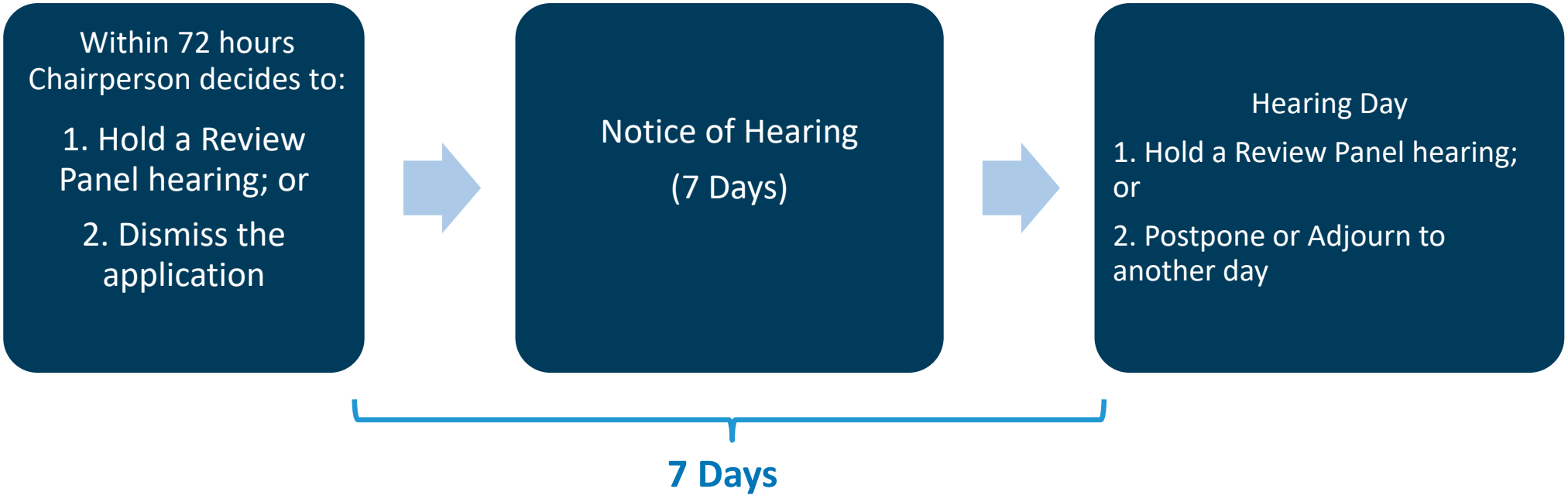
Who Can Apply:

- Patient/person subject to the certificate
- Patient's substitute decision maker
- Patient's legal guardian
- Family member of the patient
- Patient's medical practitioner
- Director of the designated facility
- Public Trustee
- Any other person if the Chairperson gives permission

Mental Health Act Review Board: Application Process



Mental Health Act Review Board: Application Process - continued



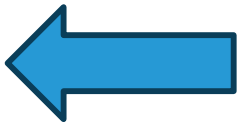
Outline

1- Overview of MHARB

a) Who we are ✓

b) What we do ✓

2- Opportunities for Future Developments in the Mental Health Act



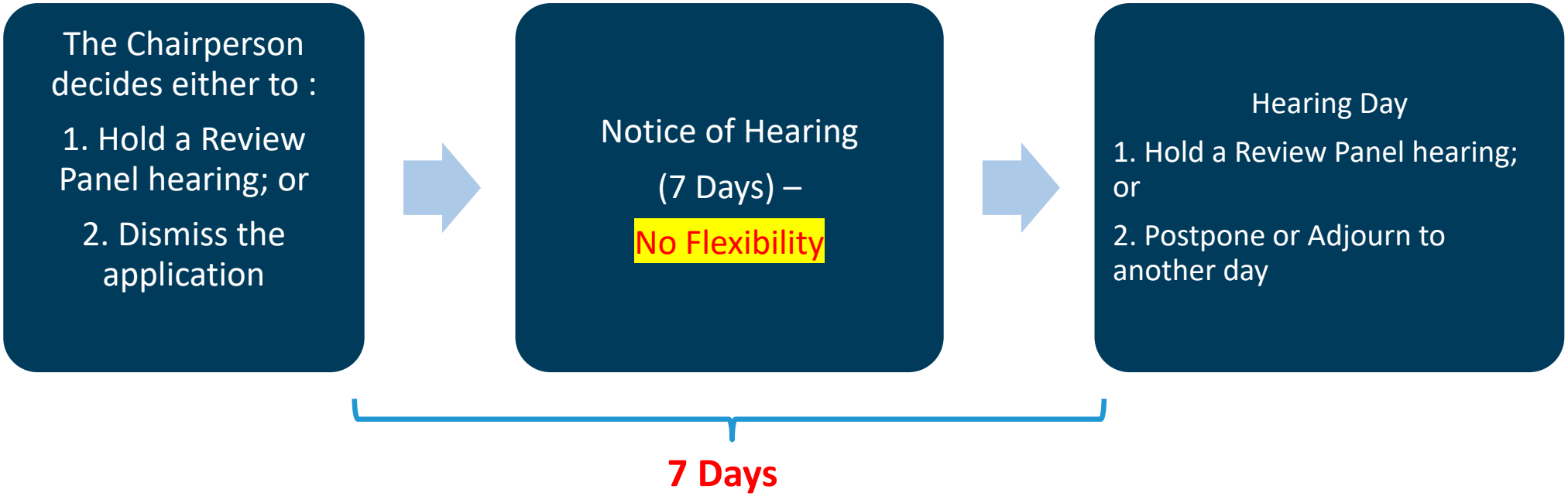
Opportunities for Future Developments in the Mental Health Act

- Ability to waive the notice period for hearings on consent of all parties
- Jurisdiction to review a certificate after its cancellation
- Clarification of standing and role of cultural advisor and powers to disclose information to a cultural advisor

The Mental Health Act: Issue #1: 7-day Notice requirement is very stringent, flexibility is required

- While patient detained (involuntary admission), time is of the essence.
- For most applications, patient wishes to be heard as soon as possible.
- In most cases, the Board could hold a hearing sooner than 7 days from this issuance of a Notice of Hearing.

Mental Health Act Review Board: Application Process - continued



The Mental Health Act: Issue #1: 7-day Notice requirement is very stringent, flexibility is required

70. (1) On receiving an application for consideration, a review panel shall

(a) schedule a hearing at the earliest opportunity, …; and

(b) give seven days written notice of the date, time, place and purpose of the hearing to the parties.

The Mental Health Act: Issue #1: Proposed amendment

70. (1) On receiving an application for consideration, a review panel shall

(a) schedule a hearing at the earliest opportunity, …; and

(b) ~~give seven days~~ on consent of all parties, provide written notice of the date, time, place and purpose of the hearing to the parties.

- Add provision to deal with cases where no consent can be obtained, allowing the panel to set a hearing date and give written notice as set in the regulations.

The Mental Health Act: Issue #2 – Post cancellation file review

- Three out of four certificates for involuntary admission are cancelled within 48 hours of hearing date.
- Currently, there is no authority by MHARB to review a certificate after its cancellation.

The Mental Health Act: Issue #2 – Proposed Amendment: Post cancellation file review

- *Create authority for a MHARB panel, for file review purposes, to obtain a copy of medical records up to the scheduled date of a hearing cancelled due to a certificate being cancelled.*
- *Create ability for the Board to obtain information on re-admissions of an applicant for mental health treatment within 60 days of a cancelled hearing.*

The Mental Health Act: Issue #2 – Proposed Amendment: Post cancellation file review

Why?

1-Post cancellation file review would be for statistical and research purposes only, for MHARB to identify applicant trends and outcomes.

2-Data would be used only for MHARB to report on an annual basis.

3-Privacy of applicants would be maintained by removing any identifiable information and by aggregating data.

The Mental Health Act: Issue # 3 - Role of cultural advisor

- Cultural Advisors can make an important contribution to the patient centered approach and helping the Board discharge conduct hearings and its business in a culturally sensitive and traditional way.
- Currently, the role of cultural advisor is not clearly delineated and the procedure for their standing in a hearing is not set out.

The Mental Health Act: Issue # 3 – Role of cultural advisor

71. (5) On request by a patient, his or her substitute decision maker or the patient's attending medical practitioner, the Review Board shall engage an Elder or other person as a cultural advisor to a review panel.

The Mental Health Act: Issue # 3 – Proposed amendment

71. (5) On request by a patient, his or her substitute decision maker or the patient's attending medical practitioner, the Review Board shall engage an Elder or other person as a cultural advisor to a review panel during the hearing.

- Add provision to clarify that a panel may disclose information to the extent the panel deems necessary for cultural advisor to perform their role.

The Mental Health Act: Proposed Amendments

- Questions and Discussion

APPENDIX B

SUBMISSIONS

From: AP NWT
To: Katie Weaver Charpentier
Subject: Re: 2024-03-07 SCOSD- Feedback for Statutory Review of Mental Health Act- Association of Psychologists of the NWT
Date: May 5, 2024 10:49:53 AM

Hello Katie,
First of all, thanks you to the Standing Committee for involving the APNWT regarding input for review of the Mental Health Act. The APNWT met on April 16, 2024 to discuss the act and provide any feedback we thought was merited. The members involved had experienced only minimal involvement with using the act and there were no major concerns noted from reviewing the Act itself. There was some confusion over the terms Health Professionals and Medical Practitioner which it may help to clarify.

Yours Sincerely
Al Bowerman
APNWT Secretary/Treasurer

On Fri, May 3, 2024 at 9:46 AM Katie Weaver Charpentier <Katie_WeaverCharpentier@ntassembly.ca> wrote:

> Good morning,
>
> I am following up on behalf of the Standing Committee on Social Development of the Northwest Territories Legislative Assembly to ensure you received the attached letter and to check if the Association of Psychologists of the NWT has any interest in providing feedback to the Committee on the Mental Health Act. The deadline for feedback is flexible should you have interest in providing a response.
>
> Thank you and please let me know should you need any additional information.
>
> Mársı | Kinanāskomitin | Thank you | Merci | Hąį' | Quana | Qujannamiik | Quyanainni | Máhsı | Máhsı | Mahsì
>
> Katie Weaver Charpentier
> *Committee Clerk / Greffière des comités*
>
> Northwest Territories Legislative Assembly | Assemblée législative des Territoires du Nord-Ouest
>
> PO Box 1320 | C. P. 1320
>
> Yellowknife NT X1A 2L9

Phone | Tél. : 867-767-9130, ext. | poste 12009

Fax | Téléc. : 867-920-4735

NTASSEMBLY.CA

From: Taylor Maxwell
Sent: Thursday, March 7, 2024 4:11 PM
To: 'info@APNWT.org' <info@APNWT.org>
Subject: 2024-03-07 SCOSD- Feedback for Statutory Review of Mental Health Act- Association of Psychologists of the NWT

Please find attached correspondence addressed to the Association of Psychologists of the Northwest Territories, from Mrs. Jane Weyallon Armstrong, Chair of the Standing Committee on Social Development, regarding Standing Committee Call for Feedback for Statutory Review of *Mental Health Act*

Mársı | Kinanāskomitin | Thank you | Merci | Hąį' | Quana | Qujannamiik | Quyanainni | Máhsı | Máhsı | Mahsì

Taylor Maxwell

Executive Administrative Coordinator |Coordinatateur administrative exécutif

Office of the Clerk | Bureau du greffier

Northwest Territories Legislative Assembly | Assemblée législative des Territoires du Nord-Ouest

P.O. Box 1320 | C. P. 1320
Yellowknife NT X1A 2L9

Phone | Tél. : 867-767-9130, ext. | poste 12010
Fax | Téléc. : 867-873-0432

WWW.NTASSEMBLY.CA

WWW.NTASSEMBLY.CA/FR

Canadian Psychiatric Association
Dedicated to quality care
Association des psychiatres du Canada
Dévouée aux soins de qualité

141 Laurier Avenue West
Suite 701
Ottawa, ON K1P 5J3
Tel: (613) 234-2815
Fax: (613) 234-9857

141, avenue Laurier Ouest
Bureau 701
Ottawa (Ontario) K1P 5J3
tél : (613) 234-2815
téléc : (613) 234-9857

www.cpa-apc.org
cpa@cpa-apc.org

May 21, 2024

SENT BY EMAIL: committees@ntassembly.ca

Mrs. Weyallon Armstrong
Chair, Standing Committee on Social Development
Northwest Territories Legislative Assembly
PO Box 1320
Yellowknife, NT X1A 2L9

Dear Mrs. Armstrong,

RE: Call for Feedback for Statutory Review of Mental Health Act

The Canadian Psychiatric Association (CPA) is pleased to provide its perspective, feedback and suggestions to the Standing Committee on Social Development in relation to its statutory review of the Northwest Territories' Mental Health Act.

The legislative content of mental health acts varies considerably across Canada and the provisions of the Northwest Territories' act fall within the range of options used in other Canadian jurisdictions. How a mental health act operates within a specific jurisdiction also depends on its available facilities and available health human resources.

General Comments

CPA presumes that the inclusion of risk of mental and physical deterioration was, at least in part, to facilitate the introduction of community treatment orders (CTOs), legislative tools that CPA officially supports.

The act has an advance directive provision, which can be overturned if following the patient's express wishes would endanger the physical or mental health or safety of the patient or another person. This is similar to the wording in several other Canadian jurisdictions. It is notably different from Ontario, where an advance directive provision essentially must be followed.

Specific Comments by Section

Section 9.1. A voluntary patient or an involuntary patient who objects to being discharged from a designated facility has the right, prior to discharge, to be examined by a second medical practitioner to determine whether the patient should remain in the facility.

> While unusual, this provision is good from a rights perspective. Many patients are discharged prematurely, and a case can be made for giving families more of a say in the timing of discharge and perhaps an acting substitute decision-maker could be given the same right to ask for a second opinion. The downside is at the system level, where there already are too few psychiatric beds.

Section 10(2) (2) A certificate of involuntary assessment of a person may not be issued under subsection (1) later than 24 hours after the examination to which it relates.

Twenty-four hours seems to be excessively short: in many jurisdictions it is one week. A health professional may conduct an assessment, conclude that a person *may* meet the criteria and want more information before completing a certificate. Attempts to contact a person to obtain collateral information can easily take a few days.

It was unclear from reading the act if assessments using videoconferencing equipment are considered valid. This is likely to be especially important in the Northwest Territories. The pandemic has greatly increased the use of virtual care and CPA suggests that acts should make this explicit. However, this raises the question of whether a telephone assessment or assessment using other modes of communication would suffice.

Section 28 (2) Except where a second medical practitioner is not available, emergency treatment must not be provided under subsection (1) unless a second medical practitioner (a) confirms the incapacity and the need for treatment, in the case of paragraph (1)(a); or (b) confirms the need for treatment, in the case of paragraph (1)(b).

It seems unnecessarily restrictive to require a second medical opinion before administering emergency treatment. In an emergency, even the time required to contact a second physician could result in a bad outcome. The CPA suggests that the committee reconsider this as it is potentially problematic. Alternatively, insert the word "readily" before available.

Section 37(6) 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…*

The use of the word "willing" is very problematic. In Ontario, the wording is "is able to comply." The word "willing" could suggest to clinicians that the person is consenting and that if they do not agree then they are not eligible for a CTO. If this is the intention, then the CTO has very limited function.

Section 51. (1) In this section, "justice" means justice of the peace or territorial judge.
(2) Subject to subsection (3), any person may apply to a justice for an order that an involuntary patient who is subject to an assisted community treatment certificate must undergo an assessment for the purpose of determining whether the certificate should be cancelled under subsection 48(1).
(3) The person applying for an order under subsection (2) must have reasonable grounds to believe that because of a mental disorder, the involuntary patient
(a) 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; or
(b) has recently caused serious harm to himself or herself or to another person, or has threatened or attempted to cause such harm.

This provision, that anyone can apply to a justice of the peace (JP) to have a person on a CTO assessed for the need for admission, is not available in Ontario and CPA is unaware of its availability in other provinces. The less complex and legally onerous route is to go to the physician who is supervising the CTO and explain the concerns. The physician can then decide whether to bring the patient in for an examination under the authority of the CTO. Note that Section 11 indicates that any person can apply to a JP to decide whether a person should have a certificate of involuntary assessment issued i.e., the person does not have to be on a CTO. This is a standard mental health act provision in Canada. When a person is on a CTO there is no need to involve the JP as this may ultimately lead to loss of responsibility for managing the CTO.

Section 12. (1) A peace officer may, without an order issued under subsection 11(6), apprehend a person and convey him or her to a health facility for the purpose of an examination by a health professional to determine whether a certificate of involuntary assessment of the person should be issued, if the peace officer has reasonable grounds to believe that

(a) the person is suffering from a mental disorder;

(b) because of the mental disorder, the person

(i) 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, or*

(ii) has recently caused serious harm to himself or herself or to another person, or has threatened or attempted to cause such harm; […]

> The police do not have the background to determine if a person is going to suffer mental or physical deterioration. Even if they did, this would not constitute an emergency and the officer, or another person, could lay information before a JP. Having to apply to a JP provides more liberty protection for the persons. This is the approach taken in Ontario and CPA recommends that it should be the standard approach.

Somewhat similarly, under section 52 a police officer may, without an order, apprehend a person who is on a CTO and bring the person to a facility for an assessment if the officer believes that:

(b) the patient should be examined by a medical practitioner to determine whether the certificate should be cancelled under subsection 48(1);

(c) the patient is unwilling to undergo or appears not to be mentally competent to consent to an assessment

> Here in the CTO section, there is an implication that police officers will know who is on a CTO. In a small community, this may be true, but CPA has concerns that this legislation might be read as "bringing the police into the team" and actively informing them.

Sections 71 and 72 outline many powers of the review board, clearly indicating that it is an inquisitorial board.

> As patients have mixed interests—liberty and autonomy on one side and treatment and protection from harm on the other—an inquisitorial process is appropriate. Some boards use inappropriate adversarial process. CPA supports the powers of the review board outlined in this section.

The CPA appreciates the opportunity to provide its feedback as part of this statutory review.

Yours sincerely,

Hygiea Casiano, MD, FRCPC
President

Royal Canadian Mounted Police | Gendarmerie Royale du Canada

FEEDBACK

Superintendent Dyson Smith
Criminal Operations Officer
G Division RCMP

May 9th, 2024
Standing Committee on Social Development
Re: Feedback for Review of *NWT Mental Health Act*

Introduction:

Supt. Dyson Smith is the Criminal Operations Officer for the G Division RCMP. He has over 23 years of service, including close to 11 years in total in the north. His experience encompasses 5 Divisions throughout the country, and more recently has fulfilled various Commissioned Officer positions in the NWT since 2018, including the North District Officer, Officer in Charge of Yellowknife Detachment, Assistant Criminal Operations Officer, and now the Criminal Operations Officer.

Mental Health Act Statistics

Row Labels	2021	2022	2023	2024 January-April	Grand Total
Aklavik	57	31	22	10	120
Behchokǫ̀	83	135	154	45	417
Deline	32	22	22	4	80
Fort Good Hope	72	68	58	15	213
Fort Liard	27	63	50	19	159
Fort McPherson	50	70	86	14	220
Fort Providence	51	46	44	21	162
Fort Resolution	42	33	44	9	128
Fort Simpson	78	77	55	18	228
Fort Smith	115	126	77	58	376
Gamètì	5	13	6	5	29
Hay River	145	156	144	46	491
Inuvik	135	173	232	75	615
Lutsel K'e	38	28	27	19	112
Norman Wells	35	22	19	12	88
Paulatuk	17	16	30	5	68
Sachs Harbour	11	15	9	1	36
Tuktoyaktuk	83	128	131	22	364
Tulita	28	35	18	3	84
Ulukhaktok	26	43	53	3	125
Whatì	23	66	51	26	166
Wrigley	11	3	2	1	17
Yellowknife	452	524	518	254	1748
Grand Total	**1616**	**1893**	**1852**	**685**	**6046**

Mental health calls for service require the diversion of a significant amount of police resources. Average call for service is 4 hours which equates to 24,184 hours or 2.7 years of dedicated police resources during this time period.

Strengths:

Section 8(2)/76(1) Patient Rights clearly outlines the rights of a patient when they are apprehended. Universal awareness could mitigate any potential Charter issues especially section 8(2)(a). Section 9(2) is another catch-all to ensure their rights are provided and communicated.

That being said, the act reads that the director of a designated facility shall ensure that an involuntary patient is informed of the rights referred to in subsection (2) at the earliest opportunity after admission. There must be communication of this upon apprehension.

Concerns:

Section 10(2)(2) - potential timing gaps. A certificate of involuntary assessment of a person may not be issued under subsection (1) later than 24 hours after the examination to which it relates. This could become the problem for the police if no involuntary assessment is ordered within 24 hours. This could potentially be an issue in busier communities/nursing stations with minimal or stretched resources. Section 10(3) - Conveyance of the person by a peace officer or other authorized person to a designated facility, but does not identify to whom they are to be delivered. For consideration, there could be a provision where we turn over to a person to take over custody. Other provinces have Institution Safety Officers who take over custody.

“Designated Facilities” – The designated facilities should be identified within the act.

Section 23(1) - The director of a designated facility may, in writing, authorize the transfer of an involuntary patient to another designated facility or to another health facility, if (a) the director is satisfied that the transfer is in the best interests of the patient; and (b) an agreement to admit the patient has been entered into with the receiving facility. It does not specify in this section who is responsible for this transport. It is noted that under section 10(5) a written authorization issued under subsection (1) authorizes conveyance of the involuntary patient by a peace officer or other authorized person to the receiving designated facility, or other health facility and detention and control of the patient for the purpose of conveyance. However, there is no definition of other authorized persons.

Section 24(1) - Transfer out of NWT. This defaults to the police or other authorized person. However, it does not clearly identify who these “authorized persons” are, so it defaults to the police. Section 94 refers to authorized persons, but this too fails to identify who this would be.

Section 35(1) - Short Term Leave. There are no clearly defined roles/responsibilities for who essentially enforces lack of compliance if there is an AWOL. Sections 47(2)(a) and 52(1) discuss this and place the responsibility with the police, whereas other mechanisms, such as health professionals should be the first consideration. The decision to release patients rests with the health professionals, yet the consequences default to the police. Calls of this nature are in addition to the statistics previously referenced.

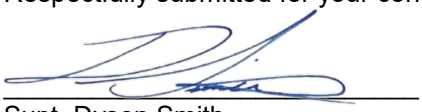
Section 52(1.2) - If it is not possible to convey a person apprehended under subsection (1) directly to a health facility, any temporary detention of the person must be in accordance with the regulations. It is important to note that this was authored without consultation of the police. The default in these circumstances is the incarceration of patients in jail cells, even though they have committed no crime (in most cases), and this is strictly a medical situation. RCMP direction is to not incarcerate these patients, except in exceptional circumstances. It is the position of the RCMP that this section should either be repealed, or reworded to emphasis that this should only occur if there are criminal circumstances associated to a particular situation. There are medical alternatives to control unruly/intoxicated patients to await transport.

Peace Officer Powers and Duties

Section 90.1(b.1) - Shall, in the event of any delay in conveying the person to a designated facility, provide the person with the opportunity to contact a family member, health professional or other person. This is an irrelevant section that only serves to delay or complicate situations. They have a legal right to counsel, which could serve this function. It is counsel’s responsibility to advocate on behalf of the detained person, not the police. This is an unrealistic expectation to place on the police.

Section 90 (d) - Shall remain with the person or arrange for another peace officer to do so until a designated facility or other location, or an authorized person, accepts custody of the person being conveyed. Again, there is no clarification as to an authorized person. Furthermore, there is no clarification as to what the meaning of “accept” is. It is the position of the RCMP that accept means that the patient has been conveyed to a designated facility and that it is up to the facility to safeguard the patient as a duty of care. However, RCMP personnel are often required to remain as the patient is not deemed to be “accepted” until they have been fully assessed. To reiterate, this is a medical situation, and the involvement of the police should end with the conveyance to a designated facility.

Respectfully submitted for your consideration.



Supt. Dyson Smith
Criminal Operations Officer
G Division RCMP

From:	Raymond Pidzamecky
To:	DST_LEG_Committees
Subject:	Material For the Social Development Committee
Date:	June 2, 2024 2:05:59 PM
Attachments:	Offord Study0001 (2016_01_04 17_59_47 UTC).pdf McMaster Study 1998.pdf HOUSING AS A SOCIAL DETERMINANT OF First Nation, Inuit and Metis Health.pdf Submission to Standing Committee on Social Programs.pdf Submission Sept 10 2015.pdf Forsaken Children.pdf Indigenous Culture as Intervention in Treatment and Counselling.pdf A Youth Crisis Has Been Brewing in The North.pdf Just the Facts About Treatment .pdf What Is Eclectic Social Work.pdf Salishan_guide_May04 (2016_01_04 17_59_47 UTC).pdf

Good day. I have attached some previous submissions I made to a previous Social Development Committee. One other item I have attached refers to the Offord Study that occurred in Ontario that determined that 1 out of 5 children has a mental health issue. I would guess those numbers are much higher in the NWT yet there is no trauma/addictions inpatient treatment for children nor is there a Child and Adolescent Psychiatric Unit.

Indigenous persons in the NWT now have access to 45 Indigenous Treatment Centres across Canada. Indigenous Services Canada pays for transportation and the National Native Alcohol and Drug Abuse Program (NNADAP) pays for the treatment:
Substance use treatment centres for First Nations and Inuit (sac-isc.gc.ca)

If you need more information on this treatment model or other resources please let me know. The Indigenous treatment service would theoretically save the GNWT money.

Raymond

Raymond Pidzamecky B.A. B.S.W. M.S.W.
Registered Social Worker
(Ontario [Head Office], Northwest Territories, Nunavut, Alberta)

Ontario Association of Social Workers 2020 recipient of the School Social Work Achievement Award

Mental Health Service Provider First Nations & Inuit Health Branch – Northern Region (Northwest Territories, Nunavut)/Ontario

Therapist/Consultant)

Yellowknife Office:
Arctic Energy Alliance Building: entry via intercom: 2003
5102 51st Street
Yellowknife NT X1A 1S7
Second floor turn right....turn right again

Phone or Text: 905-466-0444
Email:raypidzamecky@gmail.com

Specializing in assessments and counselling: Indian Residential School survivors, trauma response, addictions, depression, children/adolescents, couples, threat/risk assessment, community mobilization.

NOTICE OF CONFIDENTIALITY: I am unable to guarantee confidential email communication due to the nature of the internet. Please be aware that our communication here could be seen by a third party. If you want to share confidential information, let's plan to meet, talk on the phone.

EMAIL REPLY: I will respond to emails within 3 business days, unless an automatic reply lets you know I am away from work.

EMERGENCIES: If you are experiencing an emergency, please call 911.
Alternative Canada Wide Emergency Services:
Canada Suicide Prevention Services: 1-833-456-4566
Crisis Text Line (for youth): text TALK to 686868
Kids Help Phone (ages 20 and under): 1-800-668-6868 (online or phone)
First Nation and Inuit Hope for Wellness: 1-855-242-3310
Canadian Indian Residential Schools Crisis Line: 1-866-925-4419
IRS toll-free #: 1-800-464-8106 (this number includes MMIWG support. There is an option to be directly and immediately connected with a counsellor)
MMIWG crisis Line: 1-844-413-6649

Friday, May 15, 2015

Alfred Moses, Chair
Standing Committee on Social Programs

Dear Mr. Moses,

My name is Raymond Pidzamecky. Thank you for allowing me this opportunity to share my thoughts and experiences. I'm a social worker (M.S.W.) in private practice with over 30 years of experience, including ten years in the Northwest Territories. I have worked with hundreds of residential school survivors and their children and grandchildren through the Health Canada's Indian Residential School Program. I am a member of the Income Assistance Appeal Board, EAP counsellor for GNWT employees and federal employees. A number of projects I've worked on have been recognized by several Ontario school boards, police services and the Ontario Attorney General's office.

I would like to first applaud the committee on the proposed amendments to the *Child and Family Services Act* (Bill 47).

Unfortunately the Act and proposed amendments are in fact unable to address some of the **core issues** at hand. The amendments, act and policies are only as good as the infrastructure, qualified staffing resources and programs available. Respectfully I implore the committee to go beyond its current mandate and examine the state of service delivery that currently exists for children, youth and families in the NWT.

I would also like to say that before we repatriate children back to their home communities, we need to provide treatment to them in the NWT.

There is no shortage of GNWT reports outlining the issues and concerns around children, youth, adults and their families. To name a few:

1. **Working Together Because We Care (Suicide Prevention Regional Forums, 1992)**
   - Community participation in regional forums to come up with recommendations to address high NWT suicide rates
   - Forums held in Rankin Inlet, Baker Lake, Coppermine, Iqaluit, Fort Simpson, Inuvik, Fort Smith & Yellowknife
     Recommended:
   - Training for community caregivers (lay and professional)
   - Promotion of healthy lifestyles;
   - Focus on the problems youth face; and,
   - Better referral, treatment and follow-up for suicidal clients

2. **Working Together for Community Wellness: A Directions Document (1995)**
   - Collaboration between GNWT Departments of Education, Culture & Employment; Health and Social Services; Municipal and Community Affairs; NWT Housing Corporation; Justice; and Intergovernmental and Aboriginal Affairs

- Recommended four areas of change: Prevention, Healing and Treatment Education and Training Interagency Collaboration Community Empowerment

3. **Our Communities, Our Decisions: Final Report of the Minister's Forum on Health and Social Services (1999)**

4. **Mental Health Services in the NWT: A Discussion Document (1999)**
   - Consultation with Health & Social Services Boards (CEO's & clinical staff comprised territorial steering committee) recommended increased integration between MH, addictions & family violence
   - Document described a continuum of mental health services for all populations/age groups.

5. **Alternative Programming Initiative (1999-2000)**
   - Consultation on challenges and alternatives for addictions programming & re-profiling existing buildings/programs
   - Changes with Northern Addictions Services (board moved toward contract with Corrections Canada)
   - Recommendations to address needs of children & youth, women & children, men
   - Women & Children's Healing & Recovery Program initiated (women's trauma treatment, join project with YWCA of Yellowknife & Yellowknife Women's Centre/Centre for Northern Families)
   - Children's Assessment Centre proposed (not completed)
   - Mobile Addictions Treatment (women, youth) pilot projects completed 2000/01
   - Men's healing (not completed)

6. **Toward a Better Tomorrow (2000)**
   - Cabinet released their vision document
   - One of the stated priorities was to build healthy people and communities who could benefit from economic opportunities

7. **Children and Youth Strategy (Draft document) (2000)**
   - Drafted by Children & Family Services, with statistical support from Health Analyst

8. **Mental Health Needs Assessment (2001)**
   - Mental health had been neglected from the Disability Needs Assessment, so a separate contract was established to assess MH needs
   - Focus groups were held in Fort Simpson, Rae-Edzo, Fort Smith, Hay River, Jean Marie River, Inuvik, Deline, and Yellowknife.
   - Results: people saw mental health interconnected with addictions, violence, physical and population health. People requested improved integration and increased range of services.

9. **Working Together for Community Wellness: A Draft Strategy for Addictions, Mental Health and Family Violence (2001)**
   - Adapted from the 1999 Mental Health Discussion Document
   - Used Community Wellness Document as integrated framework

- Extensive public consultation (plain language document mailed out, focus groups and fax-in feedback)
- Feedback supported the proposed directions and priorities:Prevention;
- Services for families and children;Education, training and support for workers;
- Building community capacity to deal with problems; and, a better integrated system.

10. Social Agenda: A Draft for the People of the NWT (2002)

- Territorial working group established to implement recommendations from Social Agenda Conference
- Ten high-level, system recommendations to GNWT social envelope departments

11. State of Emergency: Evaluation of Addictions Services in theNWT (2002)

- Community addictions programs & mobile treatment programs received failing grade.
- Recommendations to begin with building a community based counseling program. Also called for improvements in system coordination, staff training and support

12 DHSS Integrated Service Delivery Model (2002)

- Need for updated and inter-connected core services.
- Chapter 6, ISDM = Mental Health and Addictions Core Services drafted.
- Community Counselling Program implemented (begin 2003)
- Key components of mental health/addictions to be added (children/youth, withdrawal management, crisis services)

There were more reports to follow such as the **MHA Services document draft of May 2004** that outlined the following needs:

Prevention Services
Education about mental health, mental illness, addictions and family violence
Early intervention and support for families
Promoting wellness and positive mental health

Counseling Services
Community Counseling Program (Community Wellness Workers, Mental Health/Addiction Counselor, Clinical Supervisors)

Case Management
Specially trained workers who can reach out to people in distress and high need, to help them connect with the multiple services they need (*Intensive Case Management* and *Assertive Community Treatment*)

Crisis Response/Emergency Services
Flexible support (*Mobile Crisis Units*/Teams work out in the community to support persons in crisis)
Safe alternatives to hospital (*Crisis Stabilization Units*)
Telephone Crisis Response (*Helpline*)
Debriefing and Follow-up support to people after a traumatic crisis (*Critical Incident Stress Management*)

Hospital Based Acute Care/Outpatient (Adults and Children/Youth)

People with serious mental illness will receive hospital care (*In-Patient Psychiatric Unit*) and follow-up support (*Psychiatric Day Treatment Programs)*
People with addictions will receive treatment to withdraw from the substance they are dependent upon (*Withdrawal Management* and *Withdrawal Day Treatment Program*)

Community Treatment (Adult and Child/Youth)
Treatment for people who have mental health AND addictions issues (*Concurrent Disorders Treatment Programs*)
Addiction Programs (e.g. Natsejee K'eh Treatment Center for Substance Abuse)
Mental Health Programs (e.g. post traumatic stress, trauma recovery)

Community Supported Housing Options
A range of housing options that allow people with mental illness to choose their residence and have the level of support they need to live independently (*Support Independent Living Units, Group Homes*)

Consumer Self-Help and Vocational/Education Services
People with similar experiences provide support for one another
Advocacy Programs
Public Education Programs
Supported Employment Programs

Investing in Systems: System Reform Strategies
Policy
Clearly defined policies that support and direct mental health and addictions services
Standards for Community Counselling Program workers
Priorities and order of implementation is clearly defined
Mental Health and Addiction services are coordinated and integrated

So, respectfully I ask this question: How well have we done in meeting the needs of some of our most vulnerable people of the NWT if we use these reports, which are only a sampling, as a measurement tool? Why this is important is because changes to the act will for the most part have little impact on the lives of our most vulnerable sector, children and youth. There first must be a paradigm shift in the way the department works.

Let me give examples from my own experience:

<u>No multisystem model of service delivery</u>

Individually we all want to help our clients. Most workers wear their hearts on their chests. Kudos to them. Unfortuantely it is the very organizations that are established and supported to help people that also restricting its staff from working outside that silo and collaborating with other professionals. That is not unique to the NWT, for it has been the norm for most areas across Canada. Departments talk about collaboration but in fact ultimately protect their silos for fear they will be swallowed up by larger departments. Of course there are other reasons that maintain the silo structure. The research clearly shows that the most effective models for intervention are multisystemic in nature. I encourage the government to create a multi departmental team for children, adolescents and families that includes membership from at least health, social services, education and justice. This team can be used for innovative thinking for service and program development and to intervene in high risk cases.

MST Theoretical Framework

To name a few books: "Serious Emotional Disturbance in Children and Adolescents" Scott W. Henggeler, Sonja K. Schoenwald, Melisa D. Rowland and Phillippe B. Cunningham 2002 and "Multisystemic Therapy for Antisocial Behavior in Children and Adolescents" the same authors 2009.....

From the first book the author's state: "Helping families to change requires considerable support for both the family and the MST practitioner. Regarding the former, MST emphasizes the explicit development of indigenous support systems (e.g. extended family, neighbors, friends, church members) to provide families with the resources and strategies they need to weather times of stress and crisis. Similarly, MST programs surround practitioners with considerable emotional and clinical support (e.g. therapists work in teams with **strong supervisory support** and **ongoing** access to expert consultation) to help achieve favorable outcomes for their clients. **No single therapist,** no matter how talented, can be expected to effectively address the broad range of challenging problems presented by families of children with serious emotional disturbances. Practitioners deserve access to the resources needed to accomplish their families' goals." pg. viii

An example: "If a problem is multidetermined, logic suggests that to optimize the probability of favorable outcomes interventions should have the capacity to address the multiple factors contributing to the problem...Likewise, a broad consensus has been achieved among researchers regarding the variables that influence the development and maintenance of antisocial behavior in children and adolescents (Loeber & |Farrington, 1998). These factors include individual youth characteristics (e.g.,weak verbal skills, favorable attitudes toward anti-social behavior), family functioning (e.g. discipline, affect), **caregiver functioning (e.g. mental health, substance abuse**), peer relations (e.g. rejection, association with deviant peers), school performance, indigenous family supports, and neighborhood characteristics (e.g. criminal subculture). **Hence, to optimize the probability of decreasing antisocial behavior, an intervention should have the capacity to address pertinent risk factors across the youth`s social network (i.e.,family, peers, school, support system).**"

Lack of collaboration between professionals (government, departments, agencies and private sector (private practitioners and business)

There is minimal collaboration between Health and Social Services and counsellors contracted or in private practice such as those employed by Health Canada, Shepell, Human Solutions and Ceridian. Several of us fly into the smaller communities to provide counselling under the criteria developed by Health Canada for Indian Residential School Survivors. Fort Good Hope for example, a community struggling with many issues is no longer directly serviced by counsellors contracted by Health Canada. We tried to use space in the Health Centre and high school but were asked to vacate. Now my colleagues and I fly into communities that have hotel suites so that we can service clients. This necessitates the spending of monies for airfare and accommodations to bring clients to us. Monies that could be better spend on direct community counselling.

The department has not been successful at implementing its mobile team. If it practiced collaboration it could have considered using the counsellors contracted by Health Canada who are already flying into the communities.

For example, I have been servicing the Sahtu region for the last three years and I have never had a referral from any of the Health and Social Services staff except one Mental Health and Addictions Counsellor, Charlotte Hanna from Fort Good Hope. I spoke to my two colleagues who also provide services out of Inuvik and they have had the similar experiences. Why are we not working together? I find this extremely concerning when the Sahtu has had ongoing staffing shortages (down three protection workers in March 2015). I had a 12 year old female client who waited three months to be processed for treatment because of staffing issues. I have been seeing clients in the same building that houses the regional office for Health & Social Services in the Sahtu for the last two years and not one referral has come out of that office to me or my colleagues. I have regularly spoken to management there. Just this week a couple whose child was apprehended 2 years ago informed me that they were never told about how to access Health Canada Indian Residential School Counselling. It was the male partner's probation officer who had referred the couple to me. The Minister of Health & Social Services was made aware of this service at a meeting Norman Yakeleya and I had with him in March 2015. There has since been no overtures made by any of his staff from Health & Social Services to pursue this counselling **opportunity** further.

Unresponsive to Innovation

In 2004 as Director of Youth programs for Appleby College Ontario, I negotiated a cross cultural on the land program for youth with the Gwichen in Fort McPherson. That program ran three consecutive summers. It also ran in Ontario and was presented at the **Native Mental Health Association of Canada 2010 Conference**. I submitted that program to Health & Social Services and got no response.

I also submitted a program outline titled A **Proposal for Integrated Treatment for Aboriginal Youth with Concurrent Disorders in the NWT 2005. No response.**
I submitted a copy of a **parenting work book** that was written out of the work done in Ontario over a 10 year period with parents and was funded in part by the Office of the Attorney General. I thought with the high incidence of child abuse/neglect and the impact of Indian Residential School there may be some interest to try and teach adults how to parent effectively and humanly. I even suggested piloting it in the jails to work with inmates before discharge. No response.

In 2008 I was able to offer Health & Social Services a **1.5 million dollar grant** on behalf of Dr. Leena Augemra and Crime Prevention Canada for a replication study using a world renowned program called SNAP that works with children under the age of 12 years whose behaviours would be chargeable if they were older. I was told by the director at that time it would not work in the NWT because it was a 'southern' program and he declined the offer.

In 2010 I emailed the RCMP, the Chiefs of Behchoko and surrounding areas and the Assistant Deputy Minister for the department of Health & Social Services. I alerted them to the YouTube 'fight' videos being posted from Behchoko. The only response I got was from the RCMP saying that it was a video of adult youth fighting. I pointed out the fact that there were groups of young children in the background watching the fights.

I met with the Chief Public Health Officer in 2014 to address problems with access to prompt medical care through the Primary Care Health Clinic for my Indian Residential School clients from remote communities who were receiving counselling in Yellowknife with myself. In that meeting I had with the Chief Public Health Officer I encouraged him to consider setting up an invitation for health staff, including counsellors, to meet the private therapists in Yellowknife that include social

workers and psychologists. I felt this would lead to better collaboration, cooperation and innovation. This never happened. I presented my concerns about the number of children (as young as 9 years old) and adults abusing marijuana in the communities I was travelling to and asked why there was no campaign to address this like there is for smoking cigarettes. No follow up response to any of this.

I am but one person who provides service to people throughout the NWT. There are many other professionals who have valuable skills and programs to contribute but are not being utilized. I have tried literally dozens of time to make inroads with the Department of Health and Social Services. I feel my information is crucial because I don't believe that your amendments will address the aforementioned issues that are impacting the current service to children, youth and their families. There needs to be a significant paradigm shift in attitude and practice if we are to deliver best practice I the NWT.

Articles I recently wrote:

MST Approach & Caring Communities = Healthy Youth

Many agencies including the courts, police, probation, schools, hospitals and child welfare, struggle with ways to effectively intervene with high risk youth who cycle throughout all of our community based systems.

Many schools and communities are looking for ways to effectively intervene with high risk youth. Youth at risk can present with the symptomology of self-harm, aggression, violence and homicidality. Effective and sustainable intervention solutions that de-escalate high risk youth can best be identified when the process occurs within a multi-systemic approach. Engaging youth, families, multi-agencies and multidisciplinary professionals, we are able to work together and become more effective at assessing youth and developing appropriate intervention and integration plans.

Historically, interventions with youth that have offended, or are a risk to themselves or others, have been determined by individual agencies or professionals. These silo-based unidemensional interventions lack adequate information to properly assess the context and extend of the presenting problem (mental health/substance use, learning issues, sensory issues, and trauma) and thereby resulting in youth cycling repeatedly throughout the systems (repeated visits to emerg and/or admissions to hospital).

Youth, families, multi-agencies and multidisciplinary professionals, are able to work together and become more effective at assessing youth and developing appropriate intervention and integration plans. When all the systems bring their data together to assess/intervene with youth at risk the following occurs:

Coordinated and integrated multi-systemic solutions are established creating a highly effective community based plan where;

An individual person/system/agency is not left alone to manage high risk (cycling) youth.
Both client and service providers begin to work more collaboratively
The least intrusive interventions are utilized
Both short and long term goals/directions are established

This collaborative response uses principles derived from the **Canadian Centre of Threat Assessment and Trauma Response**- bringing everyone that has relevant information about a youth to the same table so that responses are:

- Appropriate
- Collaborative
- Co-ordinated
- Directed
- Effective

Why Are We Failing Youth Mental Health Needs in the Northwest Territories?
May 9, 2015

http://www.myyellowknifenow.com/4897/health-minister-orders-review-of-timothy-hendersons-death/

With all due respect to the Minister of Health and Social Services, none of my colleagues would ever say we are doing enough to help youth in the Northwest Territories. We have numerous problems with our health care system. To name a few: * no child and adolescent psych unit, * no adolescent detox centres, * no adolescent treatment centres, * locum psychiatrists with huge wait lists, * no school based social workers or psychologists, * no collaboration with private practitioners who administer EAP programs and Health Canada's Indian Residential School Program and * uni-dimensional assessments done by Stanton Territorial Hospital in Yellowknife. In my practice I have referred numerous high risk clients to the emerg department at Stanton and provided my clients with letters and in some cases given these letters to their parents to bring. These letters outline the client's presenting condition and my involvement, only never to hear from the hospital. Under the LAW you can in fact 'violate' confidentiality if there is eminent threat or risk. In one recent case I had a 15 year old female who had already been admitted once to Stanton present again with suicidality. Her parents brought my letter to hospital staff. Upon discharge they referred the female to another couselling service that has a wait list. The NWT still 'ships' kids away to the 'south'. In the smaller outlying communities I have 12 year olds abusing drugs and alcohol who have to wait months for treatment because of staffing shortages. It's not because we don't care. There are so many competent and dedicated men and women who try to do their very best for children and families. Still, I have heard some of these same people in the 'back halls' say how frustrated they are with the lack of services for children and youth. How hard it is for children and their families when we don't have adequate labour resources or actual programs to help one of Canada's most imminent demographic groups at risk for threat or harm...our youth in the NWT.

Raymond Pidzamecky M.S.W. RSW
905-466-0444
raypidzamecky@gmail.com

Thursday September 10, 2015

Alfred Moses, Chair
Standing Committee on Social Programs
Public consultations on Bill 55: *Mental Health Act*

Dear Mr. Moses,

My name is Raymond Pidzamecky. Thank you for allowing me this opportunity to share my thoughts and experiences. I'm a social worker (M.S.W.) in private practice with over 30 years of experience, including ten years in the Northwest Territories. I have worked with hundreds of residential school survivors and their children and grandchildren through the Health Canada's Indian Residential School Program. I am a member of the Income Assistance Appeal Board, EAP counsellor for GNWT employees and federal employees. A number of projects I've worked on have been recognized by several Ontario school boards, police services and the Ontario Attorney General's office.

I believe what first needs to happen is to examine the highest levels of leadership/management and ask if we currently have the right people who are able to demonstrate the visionary skills and practical experience required to address the **core issues** at hand.

The GNWT continues to churn out proposal after proposal. Policy papers that eventually die a natural death until the next election or next change in leadership/management. GNWT has failed to keep pace with most of Canada. It has failed to move forward in sustainable and meaningful ways. Who of you will have both the courage and support to change direction?

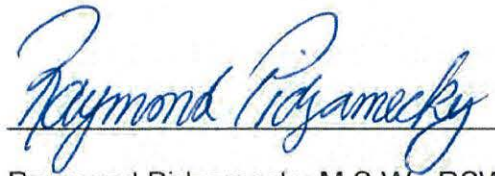
Respectfully here are some of my suggestions:

1. A comprehensive relapse prevention program that is the standardized for all addictions workers across the GNWT (Shepell has one in place)
2. Start keeping follow-up statistics on post treatment clients. The rate of relapse is a clear indication that what we are doing isn't working just as Hay River did not work.
3. Establish school based 'qualified' ***school*** attendance counsellors, psychologists and M.S.W. social workers
4. Put child protection workers in the schools. This has been done by other jurisdictions across Canada.
5. Establish a full time M.S.W. social worker under the department of Health & Social Services assigned to the work out of the Salvation Army centre in Yellowknife
6. A standing committee comprised of both ministries and business to work alongside with agencies to address the homelessness and economic deterioration of the downtown core of Yellowknife. We are losing our economic vitality which is part of a communities overall health.

7. Make a concerted effort to work with the private sector to move the downtown liquor store in Yellowknife to an area that is not most at risk economically.
8. Remove children services (child protection) from Health & Social Services
9. Establish a threat/risk team whose membership with include but not limited to Health, Education and Justice (training is available)
10. Provide training to hospital staff at Stanton to develop multi-systemic assessments. Research has shown that multisystemic assessments not only decreases crisis admissions but are both cost effective and more successful at reducing harm and risk. It allows for monies and staff resources to be allocated to other needs.
11. Design and model the new hospital based on cross cultural practices and traditions that are currently working in other jurisdictions across Canada
12. Enhance child and adolescent services with a dedicated child psychiatrist to start and then followed up with a child an adolescent unit. It must be completely separate from child protection.
13. Develop a mobile team, name to be determined, that works on the street level and is based on models that are successfully operating in cities across Canada. Pilot this program with Health, the RCMP and Social Services for Yellowknife. To run spring 2016 to October 2017. A collaborative multi-systemic team
14. Work with the RCMP to develop a team (officer and mental health counsellor) to be used for predetermined calls for assistance. I wrote a program for the Halton Regional Police that led to their hiring full time M.S.W. social workers.
15. Start running programs that are evidenced based and specifically address children's mental health: Friends for Life, Youth Net and SNAP. I offered a replication of SNAP with money from National Crime Prevention that was turned down.
16. Stop ignoring the crisis in communities around marijuana and alcohol abuse. We need to have open and frank discussions about our tolerance and desensitization to what is becoming the norm. We must begin to address our failure to address the bootlegging and drug trafficking that are becoming the main source of income for small communities.
17. We need to exam how criminal records are restricting employment for many people and thereby leaving them with limited opportunities to move forward in life.

I have many other suggestions that would address service needs better that amending the act.

Thank you for your time.



Raymond Pidzamecky M.S.W. RSW
905-466-0444
raypidzamecky@gmail.com