



The State's Role in Mental Health: Criminal and Civil Mental Health Matters in Canada and Alberta



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Alberta Civil Liberties Research Centre

2025

**The State's Role in Mental Health:
Criminal and Civil Mental Health Matters in Canada and
Alberta**

By the
Alberta Civil Liberties Research Centre

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Acknowledgments



Dedication

This project is dedicated to the memory of Linda McKay-Panos, B.Ed., J.D., LL.M., Executive Director (1992-2024), whose vision, dedication, and contributions were integral to this report.

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The Alberta Civil Liberties Research Centre is supported by a grant from the Alberta Law Foundation.

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I) Introduction

The intersection of mental health and the justice system in Canada has become an increasingly pressing issue. People experiencing mental health challenges are disproportionately affected by state authorities, including law enforcement, healthcare providers, and other institutions. These interactions raise complex legal, ethical, and policy questions, especially when they involve loss of liberty, use of force, or denial of necessary care. The key challenge is balancing public safety with respect for the autonomy, dignity, and rights of individuals living with mental health conditions.

Canada's legal framework adds complexity. The Canadian *Constitution*¹ does not explicitly assign responsibility for health to either the federal or provincial governments. Additionally, the Canadian *Charter of Rights and Freedoms*² (the *Charter*) does not explicitly guarantee a right to health or healthcare. However, both federal and provincial laws acknowledge the importance of access to care, protect against discrimination, and promote equality for individuals with mental health needs. Despite this, gaps remain in ensuring mental health services are safe, accessible, and compliant with rights when state authorities intervene.

International law offers a valuable perspective on these gaps. The right to the highest attainable standard of health, including mental health, is recognized as a fundamental human right. Governments are expected to ensure laws and policies respect autonomy, dignity, equality, and community-based supports, rather than relying primarily on coercive or institutional measures. These international standards highlight the need to align Canada's mental health frameworks with human rights principles, even where these obligations are not directly enforceable in domestic law.

In practice, current systems, including police-led apprehensions, involuntary treatment, and institutional confinement, often fall short of these standards. Police frequently function as first responders in mental health crises, a role that has expanded due to limited community-based supports. Officers must protect the public while addressing complex medical, psychological,

¹ *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (UK), 1982, c 11.

² *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (UK), 1982, c 11.

and social needs, often without specialized training in mental health intervention. This reliance on police can increase the risk of confrontation, use of force, and criminalization of mental health conditions. It also disproportionately affects marginalized populations, including Indigenous peoples, racialized communities, and people experiencing homelessness.

This report focuses on the interaction between provincial mental health laws, police and individuals experiencing mental health crises. By examining provincial legislation, this report considers how legal frameworks shape the rights of people experiencing mental health crises, define police powers and responsibilities, and influence the practical and legal consequences of police-led interventions.

Understanding the interplay between law, policy, and practice reveals how state powers affect real-world outcomes and whether these systems protect civil liberties and human rights. It also provides a foundation for reforms that support community-based, rights-respecting mental health care.

This report begins with an overview of the legal landscape of mental health in Canada, focusing on provincial laws. It then examines how these laws operate in practice, particularly regarding police involvement in mental health crises, critiques of the current system, and reform initiatives. Finally, the report analyzes these frameworks through the lens of the *Charter*, focusing on protections for life, liberty, security, equality, and freedom from arbitrary detention, before offering recommendations aligned with constitutional and international human rights

II) The Right to Health & Mental Health Under International Law

A) The Right to Health as a Fundamental Human Right

The right to the highest attainable standard of health is recognized as a fundamental human right under international human rights law. The preamble of the World Health Organization's (WHO) Constitution defines health as "a state of complete physical, mental and social well-

being and not merely the absence of disease or infirmity.”³ The WHO further affirms that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”⁴

Similarly, Article 25 of the 1948 *Universal Declaration of Human Rights* declares that everyone has the right to a standard of living adequate for their health and well-being, including access to food, clothing, housing, medical care, and necessary social services.⁵

The *International Covenant on Economic, Social and Cultural Rights* (ICESCR), widely regarded as the primary international human rights instrument protecting the right to health, reaffirms this in Article 12, which recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”⁶

As affirmed in the *Vienna Declaration and Programme of Action*, “human rights are interdependent, indivisible and interrelated.”⁷ This means that a violation of the right to health can negatively impact the enjoyment of other rights, such as the rights to work, education, or family life, and, conversely, the denial of these rights can hinder access to health care and well-being.

B) The Right to Mental Health as Part of the Right to Health

As laid out in the *ICESCR*, the right to health goes beyond the simple absence of illness or disability. It encompasses a state of complete mental, physical, and social well-being. But what exactly constitutes mental health?

³ *Constitution of the World Health Organization*, 22 July 1946, 14 UNTS 185 (entered into force 7 April 1948) at 1.

⁴ *Ibid.*

⁵ *Universal Declaration of Human Rights*, GA Res 217 A (III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810 (1948) 71.

⁶ *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

⁷ *Vienna Declaration and Programme of Action*, World Conference on Human Rights, 25 June 1993, UN Doc A/CONF.157/23, art 5.

In their 2023 joint report, the WHO and Office of the United Nations High Commissioner for Human Rights define mental health as “a state of physical, mental, emotional and social well-being, determined by the interaction of the individual with society.”⁸ Alongside physical health, mental health is recognized as an “integral and essential component of the right to health.”⁹

In 2008, the *Convention on the Rights of Persons with Disabilities (CRPD)* entered into force, marking an important recognition of the right to health and the right to mental health.¹⁰ The *CRPD* transformed international human rights standards by affirming the full legal personhood, autonomy, and dignity of individuals with disabilities, including those with mental health conditions. It challenges coercive and paternalistic practices in mental health systems, such as involuntary treatment, forced institutionalization, and the denial of legal capacity. Instead, it promotes a “support paradigm that underlines the duty and importance of rethinking the objective and role of legislation on mental health to promote personhood, autonomy, full participation, and community inclusion.”¹¹

Articles 3, 4, and 29 of the *CRPD* establish foundational principles of dignity, autonomy, and participation, requiring that people with psychosocial disabilities be actively involved in shaping the laws and policies that affect their lives. Article 15 prohibits torture and cruel, inhuman, or degrading treatment, reinforcing protections against involuntary psychiatric interventions, including restraints and forced medication.

⁸ World Health Organization & Office of the United Nations High Commissioner for Human Rights, *Mental Health, Human Rights and Legislation: Guidance and Practice* (Geneva: World Health Organization, 2023) at 9, online: <<https://www.who.int/publications/i/item/9789240080737>> [WHO].

⁹ *Ibid* at 17.

¹⁰ *Convention on the Rights of Persons with Disabilities*, 12 December 2006, 2515 UNTS 3, (entered into force 3 May 2008) [*CRPD*].

¹¹ WHO, *supra* note 8 at 1.

III) Mental Health Rights in Canada

Canada's *Constitution Act*, 1867 does not explicitly assign health as a legislative power to either Parliament or to the provincial legislatures.¹² Similarly, the *Charter* does not guarantee a specific right to health or healthcare.

Nonetheless, federal legislation such as the *Canada Health Act* affirms the importance of equitable access to care.¹³ Its preamble states that “continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians.”¹⁴

Section 3 further establishes that “the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.”¹⁵

However, these guarantees do not fully extend to mental health. As the Canadian Civil Liberties Association notes:

The Canada Health Act does not consider mental health services (unless delivered by a physician and/or in a hospital setting) ‘medically necessary.’ Mental health services are excluded from federal health transfers and therefore are not covered under provincial and territorial health plans. This means that many people have to pay out of pocket to meet their basic mental health needs. Countless others are unable to access services altogether.¹⁶

Mental health has long been acknowledged as a critical aspect of overall well-being, but services outside hospitals or physician offices, such as counselling or therapy, are often uninsured. As the Canadian Mental Health Association explains:

¹² *Constitution Act*, 1867 (UK), 30 & 31 Vict, c 3, reprinted in RSC 1985, Appendix II, No. 5 [*Constitution* 1867].

¹³ *Canada Health Act*, RSC 1985, c C-6.

¹⁴ *Ibid* at Preamble.

¹⁵ *Ibid*, s 3.

¹⁶ Canadian Civil Liberties Association, “The State of Mental Health in Canada” (9 February 2017) online: < <https://ccla.org/get-informed/talk-rights/the-state-of-mental-health-in-canada/> >.

Unless received in a hospital, psychological services must be paid for out-of-pocket or covered by private third-party insurance. This means that weekly visits to psychiatrists or counsellors come at one's own expense. This, despite recognition that health is a fundamental right for all Canadians, with mental health being one such component of one's overall health.¹⁷

While some legal protections exist, they remain limited. The *Charter* guarantees equality and non-discrimination, which extends to people with mental health conditions. Provincial and territorial human rights legislation has contributed meaningfully to advancing mental health rights. However, significant gaps persist.

Canada is also bound by international human rights instruments as described above. However, international obligations are not directly enforceable under Canadian law, unless incorporated into domestic legislation.

The Canadian courts have acknowledged the complexity of health within the constitutional framework. In *Schneider v The Queen*, the Supreme Court observed that “‘health’ is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation.”¹⁸ Similarly, in *Chaoulli v Quebec (Attorney General)*, the Court clarified that “the *Charter* does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*.”¹⁹ This position was reaffirmed by the Alberta Court of Appeal in *Baier v Alberta*.²⁰

While Canada's legal and policy landscape acknowledges the importance of mental health, significant gaps remain in the implementation and enforcement of related rights, particularly when individuals with mental health conditions interact with state authorities, including the police.

¹⁷ Canadian Mental Health Association, “Brief: Mental Health as a Human Right – CMHA's Vision” (10 December 2021), online: < <https://cmha.ca/brochure/brief-mental-health-as-a-human-right-cmhas-vision/> >.

¹⁸ *Schneider v The Queen*, 1982 CanLII 26 (SCC), [1982] 2 SCR 112 at 142.

¹⁹ *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35 (CanLII), [2005] 1 SCR 791 at para 104.

²⁰ *Baier v Alberta*, 2006 ABCA 137 at para 44.

As a State Party to the *CRPD*, as well as other international instruments, Canada is obligated to ensure that its laws, policies, and practices promote the right to the highest attainable standard of physical and mental health. This includes a focus on autonomy, dignity, equality, and access to community-based supports rather than coercive or institutional responses.

However, current frameworks, including police-led apprehensions, involuntary treatment, and institutional confinement, frequently fall short of these international standards. To assess whether Canada's domestic legal systems uphold the civil liberties and human rights of individuals experiencing mental health challenges, the following section will examine provincial mental health legislation, with a particular focus on Alberta's *Mental Health Act* and its 2020 amendments.²¹

IV) Mental Health Act in Alberta

Mental health legislation sets out the legal standards and procedures for the involuntary admission, detention, and treatment of individuals with mental health disorders. While these laws are intended to protect both individuals and the public, they also raise complex questions about individual rights, personal autonomy, and the limits of state power. This section looks at the powers of detention under Alberta's *Mental Health Act* and the definition of "mental disorder" and updates to the criteria for patient certification and community treatment orders. These amendments will be examined in greater detail below.

A) Overview

Alberta's *Mental Health Act* provides the legal structure for the admission, detention, and treatment of individuals with mental health conditions within the province. Sections 2-8 of the *Mental Health Act* set out the criteria and processes for issuing admission and renewal certificates, which permit the involuntary confinement and treatment of individuals considered to be at risk of harming themselves or others. Sections 9.1-9.6 establish provisions for

²¹ *Mental Health Act*, RSA 2000, c M-13 [*Mental Health Act*].

Community Treatment Orders, which allow certain individuals to receive mandated care while living outside of institutional settings.

To protect patient rights, sections 34–43 establish independent review panels tasked with examining decisions related to detention and treatment, thereby offering a formal appeals mechanism. Additionally, sections 44–47 designate the Mental Health Patient Advocate as a resource to help individuals in understanding their legal rights and navigating the mental health care system.

B) Powers of Detention under the *Mental Health Act*

As Erin Nelson notes, Canada’s mental health laws, remain predominantly “focused on involuntary treatment for mental illness, often within an institutional setting.”²² In Alberta, the *Mental Health Act* outlines a standardized process for apprehension, conveyance, and detention of individuals experiencing mental health crises. According to the legislation, these terms refer to “the process of seeking out and taking a person to a designated facility for examination by a qualified health professional.”²³ Once apprehended, the individual must be examined as soon as possible to determine whether they meet the statutory criteria for formal admission.²⁴

There are three common legal pathways for initiating this process:

1. A qualified health professional may issue a Form 1 Admission Certificate (s 2);
2. A Provincial Court judge may issue a Form 8 Warrant (s 10);
3. A peace officer may complete a Form 10 Statement of Peace Officer on Apprehension (s 12).

These mechanisms serve as gatekeeping tools, ensuring that individuals are not detained arbitrarily and that there is a legal and clinical basis for the use of involuntary psychiatric care.

²² Erin Nelson, “Alberta’s Mental Health Review Panels: Accountable, Transparent Adjudication?” (2022) 59:3 Alta LRev 563, online:

< https://www.canlii.org/en/commentary/doc/2022CanLIIDocs1106#!fragment/zoupio-Tocpdf_bk_1/BQCwhgziBcwMYgK4DsDWszlQewE4BUBTADwBdoAvbRABwEtsBaAfX2zhoBMAzZg11TM_AjAEoANMmylCEAlqJCuAJ7QA5KrERCYXAnmKV6zdt0gAynlIAhFQCUAogBI7ANQCCAOQDC9saTB80K_TsIjJAA > at 567 [Nelson].

²³ Alberta, Alberta Health Services, *Guide to Alberta’s Mental Health Act*, (2022 Ed.), at 25 online: < <https://www.albertahealthservices.ca/assets/info/hp/mha/if-hp-mha-guide.pdf> > [AHS Guide].

²⁴ *Mental Health Amendment Act*, 2020, SA 2020, c 15, s 5 [*Amendment Act*].

In addition to these inpatient detention mechanisms, the *Mental Health Act* provides for Community Treatment Orders (CTOs) as an alternative form of compulsory psychiatric care. CTOs allow individuals with a history of repeated hospitalizations or treatment non-compliance to be treated in the community under a legally binding care plan, rather than in a hospital setting. CTOs aim to promote continuity of care, reduce relapse and re-hospitalization, and maintain patient autonomy where possible.²⁵

As Nelson outlines, for a CTO to be granted, two qualified health professionals must certify that the individual suffers from a mental disorder and meets at least one of the following criteria:

In the immediately preceding 3-year period, the person has been a formal patient or been in an approved hospital or detained in a custodial institution and clearly would have met the criteria for detention as a formal patient on two or more occasions totalling at least 30 days; or
In the immediately preceding 3-year period, has been subject to a CTO;
or
Has, while living in the community, shown a pattern of recurrent or repetitive behaviour that indicates that the person is likely to harm himself or others or to suffer substantial mental or physical deterioration or serious physical impairment if he or she does not receive ongoing mental health treatment while living in the community.²⁶

Under the *Mental Health Act*, CTOs generally require the consent of the individual or, if the individual lacks capacity, the consent of a substitute decision-maker.²⁷ Although CTOs do not involve physical confinement, Nelson emphasizes that they still operate within a coercive legal framework.²⁸ While they are less restrictive than hospitalization, they compel compliance with treatment plans under threat of re-admission. In this way, CTOs represent a shift in the nature of coercion—from institutional settings to the individual’s daily life in the community.²⁹

Nelson also acknowledges the potential benefits of CTOs, noting that they can offer a more compassionate alternative to hospitalization for individuals with severe and persistent mental

²⁵ Alberta, Alberta Health Services, *Community Treatment Orders (CTO) Information Sheet*, (MHA & CTO Team, 2020) online: <<https://www.albertahealthservices.ca/assets/info/hp/mha/if-hp-mha-cto-infosheet.pdf>> [AHS CTO].

²⁶ Nelson, *supra* note 22 at 569-70.

²⁷ *Mental Health Act*, *supra* note 21, s 9.1(f)(i).

²⁸ Nelson, *supra* note 22 at 572.

²⁹ *Ibid.*

illness. However, she points out that perceptions of CTOs can vary. While families often express relief that their loved ones are being monitored and receiving consistent care, individuals subject to CTOs may feel stigmatized, constrained, and view the orders as imposed rather than supportive.³⁰

i) Revision to the Definition of “Mental Disorder”

Before the 2020 amendments, the *Mental Health Act* defined “mental disorder” as:

a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs

- (i) judgment,
- (ii) behaviour,
- (iii) capacity to recognize reality, or
- (iv) ability to meet the ordinary demands of life³¹

As noted by Fraser Gordon, this definition did “not adopt psychiatric-diagnostic terms (such as schizophrenia, or bipolar disorder) but rather attends to symptoms a person is suffering from and the potential functional impairment which may ensue from such symptoms.”³²

The 2020 amendments refined the definition of mental disorder, clarifying that the definition “does not include a disorder in which the resulting impairment is persistent and is caused solely by an acquired or congenital irreversible brain injury”.³³

This change narrowed the scope of the definition, excluding individuals with persistent and untreatable impairments, such as certain types of dementia or brain injuries, even if those conditions caused severe dysfunction.

This amendment is significant because the definition of mental disorder acts as the threshold for the application of involuntary detention powers under the *Mental Health Act*. Section 2 of the *Mental Health Act* provides criteria for whether a person may be admitted as a “formal patient” and involuntarily detained, with one criterion being that the person must “suffer from a

³⁰ *Ibid.*

³¹ *Mental Health Act*, *supra* note 21, s 1(1)(g).

³² Fraser Gordon, “The New Definition of a ‘Mental Disorder’ in the Mental Health Amendment Act: A Potential Gap in Care for ‘Persistent’ Mental Disorders?” ABLawg (13 August 2020), online: <<https://ablawg.ca/2020/08/13/the-new-definition-of-a-mental-disorder-in-the-mental-health-amendment-act-a-potential-gap-in-care-for-persistent-mental-disorders/>> [Gordon].

³³ *Amendment Act*, *supra* note 24, s 2(a)(ii).

mental disorder”.³⁴ As Gordon explains, “What constitutes a ‘mental disorder’ is therefore the threshold consideration when determining whether a person is suitable for the involuntary detention provisions under the MHA.”³⁵

The amendment marked a move away from a purely functional approach to mental illness, which previously focused on symptoms and impairment, toward one that also assessed the persistence and treatability of the underlying condition.

Gordon further notes:

This new definition appears to move away from the purely functional definition under the MHA towards something that distinguishes the application of the MHA depending not so much on the nature of the disorder, but rather on whether or not it causes ‘persistent’ impairment.³⁶

The College of Physicians and Surgeons of Alberta emphasized that this change reflects a broader shift toward ensuring that detention is only used when treatment is possible.³⁷ They stated, “the addition of the fourth criterion ensures detention applies only to people who can benefit from psychiatric treatment.”³⁸ In this way, the 2020 amendments adopted key elements of the *JH* decision, reinforcing that detaining individuals who cannot benefit from treatment may be constitutionally problematic.

ii) Criteria for Formal Patient Certification

For a person to be lawfully detained as a “formal patient” under a Form 1 Admission Certificate, certain statutory criteria must be met. Before the 2020 amendments, section 2 of the *Mental Health Act* provided three criteria for when a person could be admitted as a formal patient and involuntarily detained:

(a) suffering from a mental disorder;

³⁴ *Mental Health Act*, *supra* note 21, s 2(a).

³⁵ Gordon, *supra* note 32.

³⁶ *Ibid.*

³⁷ College of Physicians and Surgeons of Alberta, *From Alberta’s Health Advocate: Changes to the Mental Health Act and You* (11 March 2021), online: CPSA <<https://cpsa.ca/news/from-albertas-health-advocate-changes-to-the-mental-health-act-and-you/>>.

³⁸ *Ibid.*

- (b) likely to cause harm to the person or others or to suffering substantial mental or physical deterioration or serious physical impairment; and
- (c) unsuitable for admission to a facility other than as a formal patient.³⁹

The 2020 amendments revised and expanded these criteria, shifting the focus toward treatment potential and risk of harm within a defined timeframe. Under the amended provision, a person could be detained if they:

- (a) are suffering from a mental disorder;
- (b) have the potential to benefit from treatment for the mental disorder;
- (c) are, within a reasonable time, likely to cause harm to others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder; and
- (d) are unsuitable for admission to a facility other than as a formal patient,⁴⁰

These changes narrowed the scope of who can be detained under the *Act*. The addition of the requirement that the individual “has the potential to benefit from treatment” introduces a therapeutic justification into the legal test, one that was previously only implied.

A person becomes a formal patient once they are involuntarily admitted to a designated facility through the issuance of two admission or renewal certificates, both of which must be completed by qualified health professionals. The term qualified health professional was introduced in the 2020 amendments and refers to those authorized to determine whether the individual meets all four statutory criteria outlined in the *Mental Health Act*. This process ensures that detention is not only clinically justified but also legally compliant.⁴¹

Importantly, the *Mental Health Act* does not distinguish between adults and minors in its criteria for involuntary detention. In Alberta, a minor is defined under section 28(1)(ii) of the *Interpretation Act* as “anyone under the age of 18.”⁴² As such, a minor may also be certified as a formal patient, provided they meet the same legal thresholds. This uniform application

³⁹ *Mental Health Act*, *supra* note 21, as it appeared on 29 July 2020.

⁴⁰ *Amendment Act*, *supra* note 24, s 3.

⁴¹ AHS Guide, *supra* note 23 at 18.

⁴² *Interpretation Act*, RSA 2000, c I-8.

underscores the *Mental Health Act*'s emphasis on clinical need and treatment potential, rather than age-based distinctions.⁴³

iii) Community Treatment Orders (CTOs)

CTOs, established under Alberta's *Mental Health Act*, provide a mechanism for delivering compulsory psychiatric care in the community rather than in a hospital setting. As described by Alberta Health Services, a CTO is "a tool to help patients comply with treatment while in the community. Its purpose is to break the cycle of involuntary hospitalization, decompensation, and re-hospitalization."⁴⁴

A CTO includes a legally binding treatment and care plan, which typically outlines prescribed medications, required medical appointments, and engagement with community-based supports such as addiction services or mental health programs. The goal is to help individuals remain stable outside of the hospital while ensuring necessary oversight and treatment compliance.⁴⁵

As Nelson explains, CTOs "confer the power on mental health professionals to impose some form of treatment in the outpatient setting, provided that legislative criteria are met."⁴⁶ CTOs are commonly justified as a less intrusive alternative to hospitalization, allowing for community-based intervention while preserving some aspects of liberty. Nelson further notes, "These orders are also often justified as a less intrusive treatment option when compared to involuntary admission to hospital and treatment as an inpatient."⁴⁷

The 2020 amendments to the *Mental Health Act* introduced several changes to how CTOs are issued, reviewed, and administered, reinforcing their role as a less restrictive alternative to inpatient detention. Notably, the amended legislation permits the issuance of a CTO without a person's consent if:

negative effects to the person, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to

⁴³ AHS Guide, *supra* note 23 at 18.

⁴⁴ AHS CTO, *supra* note 25.

⁴⁵ *Ibid.*

⁴⁶ Nelson, *supra* note 22 at 568.

⁴⁷ *Ibid* at 569.

the mental disorder, or of harm to others, and a CTO is reasonable in the circumstances and would be less restrictive than retaining the person as a formal patient⁴⁸

The amendments also introduced procedural changes. For instance, the required examinations for a CTO renewal (Form 20) must now occur at least seven days apart. Formal patients were also granted new rights, including the ability to apply directly to the Review Panel for an order requiring the issuance of a CTO. Furthermore, unless the patient objects on reasonable grounds, the patient's nearest relative must also be notified and provided with a copy of the issued, amended, or renewed CTO, along with information about the Review Panel and how to contact it.⁴⁹

Together, these amendments expanded access to CTOs while embedding additional safeguards and rights into the process. They reflect a broader legislative shift toward promoting treatment in the least restrictive setting possible, aligning with principles of continuity of care and patient autonomy.

iv) Qualified Health Professionals (QHPs)

The 2020 amendments introduced the term Qualified Health Professional (QHP), establishing a broader and more flexible framework for determining who is authorized to perform key functions under the *Mental Health Act*.⁵⁰

The amendments defined a QHP as:

a physician or nurse practitioner or a person who is registered under section 33(1)(a) of the *Health Professions Act* as a member of a health profession or of a category within a health profession designated by the regulations for the purposes of all or part of this Act.⁵¹

This definition is significant because it both clarifies and expands the range of health professionals who may carry out crucial responsibilities under the *Mental Health Act*. QHPs are

⁴⁸ Alberta, Alberta Health Services, *Mental Health Amendment Act, 2020: Summary of Recent Changes*, (22 February 2021), at 3 online: <https://www.albertahealthservices.ca/assets/info/amh/if-amh-mh-amendment-act-summary-of-recent-changes.pdf>.

⁴⁹ *Ibid.*

⁵⁰ AHS Guide, *supra* note 23 at 9.

⁵¹ *Mental Health Act*, *supra* note 21 at s 1(2)(n.1). See also *Health Professions Act*, RSA 2000, c H-7.

empowered to complete admission and renewal certificates, which classify an individual as a formal patient, thereby authorizing involuntary detention in a designated facility. As noted by the Alberta Health Advocate, “A person who is assessed by qualified health professionals who determine the person meets these criteria, may be held in hospital against their will. This is referred to as being ‘detained’.”⁵²

QHPs are thus central actors in the initial decision-making process that determines whether an individual is subject to the *Mental Health Act*’s most serious restrictions on an individual’s liberty. Their responsibilities also extend beyond hospital-based care. Under the amended framework, QHPs assess eligibility for CTOs, and are responsible for issuing them, including developing and renewing the treatment and care plans required to support individuals receiving involuntary psychiatric care in the community. Alberta Health Services emphasizes that CTOs often begin in psychiatric units within designated facilities, but once a person is discharged, “they may be admitted to a psychiatric facility far away from their home community. In these cases, the person requires a Qualified Health Professional (QHP) who will take on the role of supervising a CTO in their home community.”⁵³

By formally recognizing nurse practitioners and other regulated professionals as QHPs, the amendments have made mental health care more flexible and accessible, particularly in rural or remote areas where psychiatrists may be scarce.

v) The Role of Law Enforcement

Under Alberta’s *Mental Health Act*, peace officers play a significant role in assisting individuals experiencing acute mental health crises by facilitating their transport to designated facilities for examination and possible involuntary admission. This role is typically initiated through either a judicial warrant (Form 8) under section 10 or through a peace officer apprehension (Form 10) under section 12 of the *Mental Health Act*.

⁵² Alberta, Office of Alberta Health Advocates, *Detention, treatment and care while in a mental health facility*, online: < <https://www.alberta.ca/detention-treatment-and-care-while-in-a-mental-health-facility> >.

⁵³ Alberta Health Services, *Community Treatment Orders: Mental Health Act*, online: <<https://www.albertahealthservices.ca/info/Page3556.aspx>>.

Peace officers often become involved “when they observe behaviors that are of concern, when they receive requests for assistance from family or healthcare workers, or complaints from a member of the community.”⁵⁴ Their authority to act without a warrant under section 12 is triggered when they have reasonable and probable grounds to believe that an individual:

- “is suffering from a mental disorder,”
- “is within a reasonable time, likely to cause harm to others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder,” and
- “should be examined in the interests of the person’s own safety or the safety of others.”⁵⁵

Additionally, the peace officer must believe that waiting to obtain a judicial warrant would be dangerous “when imminent risk or extreme behaviours of the individual may justify immediate apprehension and conveyance to a hospital.”⁵⁶

Once apprehended, the individual must be conveyed to a designated facility and examined by a qualified health professional as soon as possible (section 5(1)) to determine whether the criteria for involuntary admission are met.⁵⁷

The 2020 amendments introduced section 12.1, which clarified what happens after this initial examination:

After a person has been conveyed to a secure location under section 10 or 12 and has been assessed and examined, a peace officer shall

- (a) convey the person to the person’s home, the location of apprehension or appropriate accommodations, if no admission certificate is issued after the examination, or
- (b) convey the person to a facility for a further assessment and examination, if an admission certificate has been issued.⁵⁸

⁵⁴ AHS Guide, *supra* note 23 at 30.

⁵⁵ *Ibid* at 32.

⁵⁶ *Ibid* at 30.

⁵⁷ *Mental Health Act*, *supra* note 21, s 5(1).

⁵⁸ *Amendment Act*, *supra* note 24, s 19.

This addition clarified peace officers' obligations after apprehension, ensuring that individuals who do not meet the threshold for involuntary admission are safely returned home, while those requiring further care are appropriately transferred.

V) Comparative Overview of Mental Health Laws Across Canada

In Canada, both the federal and provincial governments play roles in health and health care. However, “the federal government has numerous responsibilities relevant to health, [while] the provinces are responsible for delivering health care to the majority of Canadians.”⁵⁹ This authority stems from the *Constitution Act, 1867*, which grants provinces jurisdiction over property and civil rights and matters of a local or private nature.⁶⁰ As a result, the regulation and delivery of mental health care fall predominantly under provincial authority, resulting in a patchwork of systems across the country.

As Erin Nelson explains, “health and health care are generally considered to be matters within the jurisdiction of the provinces and territories.”⁶¹ As a result, Canada does not have a uniform mental health care system. Rather, there are “multiple, disparate systems across the country” each shaped by provincial legislation and priorities.⁶²

These differences are especially evident when examining how provinces define and manage involuntary treatment detention criteria and community-based mental health interventions. Alberta’s legislation is particularly distinct, allowing for CTOs to be issued without prior hospitalization and, in certain cases, without the individual’s consent.

This section examines how mental health legislation in Saskatchewan, Ontario, British Columbia, and Nova Scotia differ from Alberta’s approach, highlighting key similarities and

⁵⁹ Canada, Library of Parliament, *The Federal Role in Health and Healthcare* by Martha Butler and Marlisa Tiedemann (Ottawa: Publication No. 2011-91-E, 2013) online: <https://lop.parl.ca/sites/PublicWebsite/default/en_CA/ResearchPublications/201191E#ftn1>.

⁶⁰ *Constitution 1867*, *supra* note 12, ss 92(13), 92(16).

⁶¹ Nelson, *supra* note 22 at 565.

⁶² *Ibid.*

points of divergence in the powers of detention and the legal mechanisms for authorizing treatment.

A) Mental Health Services Act in Saskatchewan

Saskatchewan's *Mental Health Services Act (MHSA)* provides the legal framework for the delivery of mental health services in the province, including the admission and treatment of individuals experiencing serious mental illness.⁶³ The overall purpose of the *MHSA* is to ensure access to appropriate treatment for individuals whose mental health conditions impair their decision-making capacity.

Although the *MHSA* includes provisions for involuntary treatment, it emphasizes voluntary care as the preferred approach. Involuntary interventions are permitted only in exceptional circumstances, basically, when individuals are unable to make informed decisions due to mental illness and are at risk of harming themselves or others.⁶⁴

Under Section 24 of the *MHSA*, a physician may initiate involuntary admission by completing a medical certificate if the following conditions are met:

- (a) ... the physician has examined the person named in the certificate within the preceding 72 hours and that, on the basis of the examination and any other pertinent facts regarding the person or the person's condition that have been communicated to the physician, he or she has reasonable grounds to believe that:
 - (i) the person is suffering from a mental disorder as a result of which he or she is in need of treatment or care and supervision that can be provided only in a mental health centre;
 - (ii) as a result of the mental disorder the person is unable to fully understand and to make an informed decision regarding his or her need for treatment or care and supervision; and
 - (iii) as a result of the mental disorder, the person is likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration if he or she is not detained in a mental health centre;
- (b) state the facts on which the physician has formed his or her opinion that the person meets the criteria set out in clause (a);

⁶³ *Mental Health Services Act*, SS 1984-85-86, c M-13.1.

⁶⁴ Saskatchewan, "Personal Rights and The Mental Health Services Act," Saskatchewan Ministry of Health, online: <https://publications.saskatchewan.ca/#/products/85724>.

(c) show the date on which the examination was made; and (d) be signed in the presence of one subscribing witness.

Under section 20 of the *MHSA*, law enforcement may apprehend a person without a warrant. A peace officer may apprehend and transport a person for psychiatric assessment if there are *reasonable grounds to believe that the person is:*

(a) suffering from a mental disorder; and

(b) likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration if he or she is not detained in a mental health centre.

The *MHSA* also authorizes the use of CTOs which permit individuals with serious mental illness to receive treatment while living in the community. A CTO may be issued if the following conditions are met:

- You have a mental disorder which requires treatment and supervision in the community, and you do not need to be in hospital;
- You have been hospitalized in the last two years including the current admission;
- Your mental disorder could make you harm yourself or others, or make your illness get worse if you are not treated;
- The services which you need are available in the community;
- Your mental disorder keeps you from understanding that you need treatment and supervision, so that you cannot make an informed decision; and
- You are able to co-operate with the CTO.⁶⁵

If a second physician concurs, the CTO can be issued for up to six months and renewed for additional six-month periods. The individual is then required to follow the prescribed medical treatments and attend required appointments.

⁶⁵ *Ibid.*

B) Mental Health Act in Ontario

Ontario's *Mental Health Act* (*MHA*) governs the legal framework for psychiatric care in the province.⁶⁶ It sets out the processes for voluntary and involuntary admissions, provides for CTOs, and grants police and judicial authorities specific powers of apprehension. The *MHA* also prescribes patients' rights and includes procedural safeguards.

The *MHA* applies to psychiatric facilities designated by the Minister of Health. A "patient" is defined as "a person who is under observation, care and treatment in a psychiatric facility."⁶⁷ Patients may enter as voluntary, informal or involuntary patients

A voluntary patient is an individual who consents to admission to a psychiatric facility for care, observation, and treatment. Voluntary patients are free to leave the facility at any time, provided they have the capacity to make their own treatment decisions. They may also withdraw consent and refuse treatment.

An informal patient is a person who is incapable of consenting to treatment but admitted with the consent of a substitute decision-maker under section 24 of the *Health Care Consent Act*.⁶⁸ Informal patients are typically minors or adults lacking decision-making capacity.

These categories are distinct from involuntary patients, who are detained under certificates issued under section 20 of the *MHA*. Involuntary admission typically begins with an application for psychiatric assessment, either by a physician using Form 1, or by a justice of the peace under Form 2. Following the assessment, if the statutory criteria are met - namely, that the individual poses a risk of harm to themselves or others, or is likely to experience substantial mental or physical deterioration - a Certificate of Involuntary Admission may be issued.

This certificate authorizes detention for up to 14 days and must be accompanied by a Form 30, which informs the patient of their legal status and rights. Ongoing detention requires renewal through additional certificates, each subject to time limits and procedural safeguards to ensure compliance with the patient's rights under the *MHA*.

⁶⁶ *Mental Health Act*, RSO 1990, c M.7 [ON *Mental Health Act*].

⁶⁷ *Ibid*, s 1(1).

⁶⁸ *Health Care Consent Act*, 1996, SO 1996, c 2, Sch A.

Under Section 20 of the MHA, there are two sets of criteria for issuing or renewing a Certificate of Involuntary Admission: Box A and Box B:

Box A Criteria (Section 20(5))

A physician may issue or renew a certificate if, after examining the patient, they believe:

(a) The patient has a mental disorder that is likely to result in one of the following unless they remain in a psychiatric facility:

- Serious bodily harm to themselves
- Serious bodily harm to others
- Serious physical impairment

(b) The patient is not suitable for voluntary or informal admission.

Box B Criteria (Section 20(1.1))

Alternatively, a certificate may be issued based on a history of mental disorder if the physician determines that the patient:

1. Has a history of treatment for a recurring or ongoing mental disorder that, when untreated, is likely to cause:
 - Serious harm to self or others
 - Substantial mental/physical deterioration or impairment
2. Has shown clinical improvement from past treatment
3. Is currently suffering from the same or a similar disorder
4. Is likely, based on history and current condition, to cause harm or deterioration if untreated
5. Has been found incapable of consenting to treatment, and substitute consent has been obtained
6. Is not suitable for informal or voluntary admission

Box B is designed for "revolving door" patients—those with a known treatment history who relapse and become at risk when not treated.⁶⁹

The *MHA* allows any person to appear before a justice of the peace and swear evidence justifying an involuntary psychiatric assessment. If satisfied, the justice may issue an order for examination, directing the person to be taken to a hospital.⁷⁰

Without a court order, police may detain and transport a person to a physician if there are reasonable and probable grounds to believe that the person:

⁶⁹ Katharine Byrick & Barbara Walker-Renshaw, "A Practical Guide to Mental Health and the Law in Ontario" (2023) at 3-11, Ontario Hospital Association, online: <<https://www.oha.com/Legislative%20and%20Legal%20Issues%20Documents1/A%20Practical%20Guide%20to%20Mental%20Health%20and%20the%20Law%2C%20Fourth%20Edition%2C%202023.pdf>> at 3-11.

⁷⁰ ON *Mental Health Act*, *supra* note 69, s 16(1).

- a) is acting in a disorderly manner;
 - b) has threatened or attempted... to cause bodily harm to himself or herself or another person;
 - c) has behaved violently... or caused another person to fear bodily harm;
 - d) has shown a lack of competence to care for himself or herself;
- and in addition, the police officer has reasonable cause to believe that the person is apparently suffering from mental disorder that likely will result in serious bodily harm or physical impairment, and that it would be dangerous to delay taking action.⁷¹

CTOs were introduced in Ontario in 2000 to address the cycle of repeated hospitalizations among individuals with serious mental illnesses. Section 33.1(4) lays out the criteria that must be met for a CTO order, which include:

A physician may issue or renew a community treatment order under this section if,

- (a) during the previous three-year period, the person,
 - (i) has been a patient in a psychiatric facility on two or more separate occasions or for a cumulative period of 30 days or more during that three-year period, or
 - (ii) has been the subject of a previous community treatment order under this section;
- (b) the person or his or her substitute decision-maker, the physician who is considering issuing or renewing the community treatment order and any other health practitioner or person involved in the person's treatment or care and supervision have developed a community treatment plan for the person;
- (c) within the 72-hour period before entering into the community treatment plan, the physician has examined the person and is of the opinion, based on the examination and any other relevant facts communicated to the physician, that,
 - (i) the person is suffering from mental disorder such that he or she needs continuing treatment or care and continuing supervision while living in the community,
 - (ii) the person meets the criteria for the completion of an application for psychiatric assessment under subsection 15 (1) or (1.1) where the person is not currently a patient in a psychiatric facility,

⁷¹ *Ibid*, s 17(1).

- (iii) if the person does not receive continuing treatment or care and continuing supervision while living in the community, he or she is likely, because of mental disorder, to cause serious bodily harm to himself or herself or to another person or to suffer substantial mental or physical deterioration of the person or serious physical impairment of the person,
- (iv) the person is able to comply with the community treatment plan contained in the community treatment order, and
- (v) the treatment or care and supervision required under the terms of the community treatment order are available in the community;
- (d) the physician has consulted with the health practitioners or other persons proposed to be named in the community treatment plan;
- (e) subject to subsection (5), the physician is satisfied that the person subject to the order and his or her substitute decision-maker, if any, have consulted with a rights adviser and have been advised of their legal rights; and
- (f) the person or his or her substitute decision-maker consents to the community treatment plan in accordance with the rules for consent under the Health Care Consent Act, 1996. The CTO must be based on a structured treatment plan and is subject to renewal and review. It cannot be issued without the consent of the individual or their substitute decision-maker.

The *MHA* outlines the conditions for involuntary admission and community treatment while ensuring procedural protections, such as notice, legal counsel, and appeal rights, to maintain a balance between public safety and personal autonomy.

C) Mental Health Act in British Columbia

British Columbia's *Mental Health Act* governs both voluntary and involuntary psychiatric treatment in the province.⁷² Like other provincial mental health laws, it emphasizes voluntary care where possible. However, the *Mental Health Act* also provides a broad framework for involuntary detention and treatment without consent in situations where an individual's mental disorder poses a risk of harm or significant deterioration.

⁷² *Mental Health Act*, RSBC 1996, c 288 [BC *Mental Health Act*].

Under the *Mental Health Act*, a person with a mental disorder is defined as “a person who has a disorder of the mind that requires treatment and seriously impairs the person's ability (a) to react appropriately to the person's environment, or (b) to associate with others”.⁷³

Voluntary patients are those who admit themselves to a designated facility and provide consent for treatment. A person may be admitted involuntarily if a physician or nurse practitioner has examined them and finds they meet the criteria set out in the statute.

The relevant criteria are outlined in section 22 of the *Mental Health Act*:

- (3) Each medical certificate under this section must be completed by a physician or nurse practitioner who has examined the person to be admitted, or the patient admitted, under subsection (1) and must set out:
 - (a) a statement by the physician or nurse practitioner that they
 - (i) have examined the person or patient on the date or dates set out, and
 - (ii) are of the opinion that the person or patient is a person with a mental disorder,
 - (b) the reasons in summary form for the opinion, and
 - (c) a statement, separate from that under paragraph (a), by the physician or nurse practitioner that they are of the opinion that the person
 - (i) requires treatment in or through a designated facility,
 - (ii) requires care, supervision and control in or through a designated facility to prevent the person's or patient's substantial mental or physical deterioration or for the protection of the person or patient or the protection of others, and
 - (iii) cannot suitably be admitted as a voluntary patient.

Once two valid certificates are completed, the patient may be detained for up to one month. The detention can be renewed: first for one additional month, then for three months, and thereafter in six-month increments, as permitted under section 24.

British Columbia employs a deemed consent model, where individuals detained involuntarily may be treated without their express consent. Under section 31, the facility director may authorize treatment that is in the patient's best interest.

⁷³ *Ibid*, s 1.

This model has faced constitutional scrutiny, especially when compared to provinces like Ontario, which rely on substitute decision-makers and explicit consent frameworks for treatment authorization.

The *Mental Health Act* grants police officers significant powers to intervene in psychiatric emergencies. Under section 28:

(1) A peace officer may apprehend and immediately take a person to a physician for examination if the officer has reasonable grounds to believe the person is
(a) acting in a manner likely to endanger themselves or others, and
(b) appears to be suffering from a mental disorder.

This provision enables officers to act swiftly in crises where waiting for medical or judicial authorization could result in harm. Following apprehension, a physician must examine the individual and may initiate involuntary admission by completing a medical certificate under section 22 if the statutory criteria are met.

While the *Mental Health Act* allows for involuntary treatment without consent, it includes procedural protections to safeguard patient rights. Upon admission, patients must be notified of their legal status and rights, typically using Form 13. Involuntarily detained patients may apply for review by the Mental Health Review Board, established under section 25.1. This independent body has the authority to determine whether the criteria for continued detention are still met.

D) Nova Scotia *Involuntary Psychiatric Treatment Act*

Nova Scotia's *Involuntary Psychiatric Treatment Act (IPTA)* establishes the legal authority for the involuntary psychiatric assessment, admission, and treatment of individuals within the province.⁷⁴ The *IPTA* emphasizes a patient-centred approach grounded in both domestic and international human rights standards, including the United Nations *Convention on the Rights of Persons with Disabilities (CRPD)*.

⁷⁴ *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42 [*Involuntary Psychiatric Treatment Act*].

Section 14 of the *IPTA* outlines the authority of peace officers to intervene without prior judicial authorization in psychiatric emergencies:

A peace officer may take a person into custody and take the person forthwith to a place for a medical examination by a physician if the peace officer has reasonable and probable grounds to believe that

the person apparently has a mental disorder;
the person will not consent to undergo medical examination;
it is not feasible in the circumstances to make application to a judge for an order for a medical examination pursuant to Section 13;
and

the person,

as a result of the mental disorder, is threatening or attempting to cause serious harm to himself or herself or has recently done so, has recently caused serious harm to himself or herself, is seriously harming or is threatening serious harm towards another person or has recently done so,

as a result of the mental disorder, will suffer serious physical impairment or serious mental deterioration, or both, or

is committing or about to commit a criminal offence.

The individual may then be detained for up to 24 hours for psychiatric assessment. If certified as meeting the criteria under the *IPTA*, a psychiatrist must develop a treatment plan. The patient may be detained for further treatment, subject to periodic review.

Under the *IPTA*, individuals may be involuntarily detained if they meet the following criteria:

(1) A member of the treatment staff of a psychiatric facility may detain and, where necessary, restrain a voluntary patient requesting to be discharged if the staff member believes on reasonable grounds that the patient

(a) has a mental disorder;

(b) because of the mental disorder, is likely to cause serious harm to himself or herself or to another person or to suffer serious mental or physical deterioration if the patient leaves the psychiatric facility; and

(c) needs to have a medical examination conducted by a physician.⁷⁵

If these criteria are met, the individual will receive a psychiatric assessment. Should they also meet the conditions outlined in section 17, they may be admitted as an involuntary patient. A key criterion is that, due to their mental disorder, the patient lacks the capacity to make decisions regarding admission and treatment.⁷⁶

The *IPTA* also authorizes the issuance of CTOs, which permit the delivery of psychiatric treatment in a community setting as an alternative to involuntary hospitalization.⁷⁷ CTOs require the approval from a psychiatrist and the consent from a substitute decision maker. They are subject to ongoing review by the Involuntary Psychiatric Treatment Review Board (Review Board).

The Patient Rights Advisory Service must be notified upon any involuntary admission or issuance of a CTO. This body provides independent assistance to patients and substitute decision makers, including representation before the Review Board.⁷⁸

Notably, the *IPTA* explicitly requires that proceedings and decisions under the *IPTA* comply with Canada's international obligations under the *CRPD*. The inclusion of *CRPD* references in the statute and associated forms, such as Form 2 (Involuntary Psychiatric Assessment Certificate), Form 4 (Admission Certificate), and Form 9 (CTO), distinguishes Nova Scotia's legislative approach. While other Canadian jurisdictions may reference the *Charter* or general human rights principles, explicit mention of *CRPD* obligations remains rare.

Nova Scotia has also introduced Bill 475, the *Mental Health Services Improvement Act*, which proposes a broader mental health rights framework. This Bill aims to improve access to timely, evidence-based, and person-centred services.⁷⁹ Though still in the legislative process

⁷⁵ *Ibid*, s 7(1).

⁷⁶ *Ibid*, s 17(e).

⁷⁷ *Ibid*, s 47.

⁷⁸ The Involuntary Psychiatric Treatment Review Board is a quasi-judicial tribunal comprised of a lawyer, a psychiatrist, and a layperson, is empowered to review admissions, treatment orders, and substitute decision maker decisions.

⁷⁹ Bill 475, *Mental Health Services Improvement Act*, 1st Sess, 64th Leg, Nova Scotia, 2024 (first reading 10 September 2024).

and not yet in force, it reflects growing interest in enhancing the quality and accessibility of mental health care.

Together, the *IPTA* and proposed reforms situate Nova Scotia at the forefront of human rights-oriented mental health law in Canada, with strong procedural safeguards and recognition of international standards.

VI) Police, Mental Health, and Public Safety

A) The Role of Police under Provincial Mental Health Laws

Under various provincial mental health acts, police and peace officers may apprehend and detain a person without a warrant if they have reasonable grounds to believe the individual is suffering from a mental disorder, poses a risk of harm to themselves or others, and that waiting to obtain a warrant would be dangerous.⁸⁰ Warrantless apprehensions⁸¹ also occur, for example, when a person subject to committal leaves a facility without being released⁸² or when a patient violates a community treatment order.⁸³

While some provincial mental health acts explicitly authorize the use of force in apprehensions,⁸⁴ section 25 of the *Criminal Code* also applies.⁸⁵ It authorizes police to use force in the lawful execution of their duties, provided it is necessary, proportionate to the perceived threat, and assessed from the perspective of a reasonable officer in the moment, not in hindsight.⁸⁶

⁸⁰ See e.g. *Mental Health Act*, *supra* note 21 at s 12; *Mental Health Services Act*, *supra* note 66 at s 20; ON *Mental Health Act*, *supra* note 69 at s 17; BC *Mental Health Act*, *supra* note 75 at s 28; *Involuntary Psychiatric Treatment Act*, *supra* note 77 at s 14.

⁸¹ Robert Diab & Jolene Sanderson, “Reasonable Apprehension Under Mental Health Law” (2022) 48:1 Queen's LJ, 1 at 6 [Diab & Sanderson].

⁸² ON *Mental Health Act*, *supra* note 69 s 28(1).

⁸³ *Mental Health Act*, *supra* note 21 s 12(1)(b).

⁸⁴ See e.g. *Mental Health Care and Treatment Act*, SNL 2006, c M-9.1, s 21(1)(a).

⁸⁵ *Criminal Code*, RSC 1985, c C-46.

⁸⁶ Canada, Royal Canadian Mounted Police, 2023 Police Intervention Options Report, online: <<https://rcmp.ca/en/corporate-information/publications-and-manuals/2023-police-intervention-options-report>> [2023 Police intervention Options Report].

These provisions cast law enforcement not only as agents of public safety, but as first responders within the mental health system. While this dual role aims to protect both the individual and the broader community, it has produced troubling consequences for people living with mental illness, particularly those who are already vulnerable or marginalized.

Police are frequently the first point of contact in mental health emergencies, despite often lacking the specialized training necessary to de-escalate psychiatric crises. This gap can heighten the risk of confrontation and, in some cases, result in the use of force or detention practices that compound trauma and lead to further criminalization. Racialized individuals, Indigenous peoples, and people experiencing homelessness are disproportionately affected, raising systemic concerns about equity, dignity, and human rights in the administration of mental health legislation.

Building on the analysis of provincial mental health laws, this section examines instances of police interactions with individuals experiencing mental health crises and critically assesses their impact on those subjected to apprehension and detention. Drawing on legislation, case law, media reporting, and scholarly commentary, it considers the implications of police-led mental health interventions and identifies structural reforms necessary to better safeguard the rights and well-being of those in crisis.

B) Case studies in Alberta and Across Canada

Encounters between police and individuals experiencing mental health crises have become an area of concern in public safety and health policy. As noted in the RCMP's 2021 *Police Intervention Options Report*, police officers are often the first responders in such situations.⁸⁷ In 2023, the RCMP reported that incidents involving the *Mental Health Act* were the second most common reason for police intervention, accounting for 11% of cases.⁸⁸ While police officers are not medical professionals and cannot diagnose mental illness, their role in interactions with individuals experiencing mental health crises is critical. Officers must be equipped with the knowledge and skills to recognize signs of psychological distress and respond appropriately.

⁸⁷ *Ibid.*

⁸⁸ 2023 Police intervention Options Report, *supra* note 86.

As discussed, under section 25 of the *Criminal Code*, police are authorized to use force in the lawful execution of their duties, provided they act on reasonable grounds. However, when these standards are not met, or when interactions escalate unnecessarily, the consequences for individuals in crisis can be severe, even fatal.

A CBC News investigation revealed that since 2000, over 460 Canadians have died during police interactions, with approximately 70% of those individuals affected by mental health issues or substance abuse.⁸⁹ This trend has nearly doubled over the past two decades, highlighting systemic gaps in mental health resources, stigma, and policing practices. While some police services have implemented specialized crisis intervention teams and de-escalation training, many incidents continue to result in tragic outcomes.

The following case studies highlight the complex realities of law enforcement encounters with individuals in mental health crises and underscore the need for more effective and informed policing practices.

i) Alberta

Edmonton 2000-2017:

Between 2000 and 2017, 23 people died during interactions with the Edmonton Police Service.⁹⁰ Of these, 21 were experiencing mental illness, disability, substance use issues, or a combination of these. One such case involved Trevor Proudman, a 32-year-old man with Prader-Willi syndrome, a rare genetic condition that affects behaviour and physical health. In 2014, after causing a disturbance at a medical clinic, Proudman was handcuffed and left alone in the back of a police van. When officers returned 23 minutes later, he was unresponsive and later died in hospital. His death was ruled to be due to positional asphyxia.

Despite the circumstances, an internal police investigation cleared the officers involved. Proudman's mother and brother publicly called out for more compassionate and better-

⁸⁹ Katie Nicholson & Jacques Marcoux, "Most Canadians killed in police encounters since 2000 had mental health or substance abuse issues", *CBC News* (4 April 2018), online: <<https://www.cbc.ca/news/canada/calgary/death-calgary-in-custody-asirt-mental-health-crisis-1.5523444>>.

⁹⁰ Josee St-Onge, "Most people killed in encounters with Edmonton police have mental health problems", *CBC News* (5 April 2018), online: <<https://www.cbc.ca/news/canada/edmonton/most-people-killed-in-encounters-with-edmonton-police-have-mental-health-problems-1.4603170>>.

informed responses to people with cognitive disabilities. Keith Spencer, a retired University of Alberta criminologist, echoed this suggestion of a new model of policing.

Spencer emphasized that while more police training is important, officers shouldn't be expected to fill the role of social workers. To reduce risk, he recommended that mental health professionals be present during police interactions involving people in crisis, acting as intermediaries between individuals and officers.

Proudman's death reflects a broader pattern of fatal police encounters with individuals facing complex mental health needs, a pattern that continues across other jurisdictions in Alberta.

Calgary 2020:

A similar incident occurred in Calgary in April 2020, when police responded to a 911 call involving a man experiencing a psychotic episode related to schizophrenia.⁹¹

Paramedics waited for police backup due to safety concerns. Upon arrival, the man who was laying face down, was helped to his feet but then made a sudden forward movement toward a paramedic. A police officer took him to the ground and restrained him in a semi-face-down position until a second officer arrived. The man was then handcuffed, placed in the recovery position after vomiting, and transported to the hospital, where he was pronounced dead.

The Alberta Serious Incident Response Team (ASIRT) investigated the incident and cleared the officers of wrongdoing, concluding that no excessive force was used. The initial autopsy cited “excited delirium” as the cause of death, though this term is medically contentious. After consultation, the cause was revised to “complications of schizophrenia and struggle during police restraint.”⁹²

A 2022 investigative article by *The Canadian Press* highlights the national consequences of relying on police to handle mental health crises across.⁹³ The report focused on Anthony

⁹¹ ASIRT clears police in death of Calgary man during mental health call, *CBC News* (7 July 2023), online: <<https://www.cbc.ca/news/canada/calgary/asirt-calgary-police-1.6900853>>.

⁹² *Ibid.*

⁹³ Bill Graveland, "Police forces across Canada need help to deal with people in mental health crises", *The Canadian Press* (9 May 2022) online: <<https://www.nationalobserver.com/2022/05/09/news/police-forces-canada-people-mental-health-crises>>.

Heffernan, a 27-year-old man recovering from addiction, who was fatally shot by police in a Calgary hotel room. Officers were responding to reports of erratic behavior and shot Heffernan four times after he allegedly failed to comply with commands. His parents later questioned the approach, asking, “What would have happened if a mental-health professional had been there?”⁹⁴

The case underscored a broader systemic issue. As the article notes, “75 per cent of police-involved civilian fatalities in Canada involved a person experiencing a mental-health crisis or who was under the influence of a substance.”⁹⁵ Although the use of force is statistically rare, its frequent application in mental health calls raises serious concerns about the appropriateness of law enforcement as first responders in these situations.

ii) Across Canada

Violent police interactions with individuals experiencing mental health crises are not confined to Alberta. Incidents across the country underscore the need for reform in how policing systems handle these complex and high-risk situations.

Since 2018, Saint John, New Brunswick, has seen a 40% increase in mental health-related 911 calls, placing growing pressure on police to respond appropriately.⁹⁶ The urgency for systemic change was amplified by two tragic incidents in 2020: the deaths of Chantel Moore⁹⁷ and Rodney Levi⁹⁸, both fatally shot by police during wellness checks. These cases prompted coroners’ inquests and led to strong recommendations for enhanced police training and the broader deployment of mobile crisis intervention teams that include mental health professionals.

⁹⁴ *Ibid.*

⁹⁵ *Ibid.*

⁹⁶ Rachel Cave, “Saint John police use less force when mental health workers come along to crisis calls”, *CBC News* (8 August 2023) online: <<https://www.cbc.ca/news/canada/new-brunswick/saint-john-police-less-force-mental-health-1.6928142>>.

⁹⁷ Shane Magee, “New Brunswick police officer who fatally shot Chantel Moore won’t be charged”, *CBC News* (7 June 2021) online: <<https://www.cbc.ca/news/canada/new-brunswick/chantel-moore-no-charges-officer-shooting-police-1.6056025>>.

⁹⁸ Shane Magee, “Lawsuit alleges RCMP failures in shooting death of Rodney Levi”, *CBC News* (4 May 2023) online: <<https://www.cbc.ca/news/canada/new-brunswick/rodney-levi-rcmp-lawsuit-1.6832205>>.

In the wake of these events, research led by University of New Brunswick professor Mary Ann Campbell examined over 300 crisis calls. Her findings showed that when police were accompanied by a clinician, such as a nurse or social worker, use of force declined, fewer individuals were taken to the hospital involuntarily, and community resources were utilized more effectively.

The study also found that individuals were less likely to be held in custody when a clinician was present, freeing up police resources and improving access to care. These findings have contributed to specialized training for Saint John officers in crisis recognition and de-escalation, training now being expanded across New Brunswick. This shift reflects a growing recognition that law enforcement alone cannot safely or effectively manage mental health crises and that integrated, trauma-informed approaches are necessary to protect both individuals and officers.

In British Columbia, similar concerns were raised following the 2022 death of a suicidal Indigenous man during an RCMP standoff in Williams Lake.⁹⁹ The police response involved tear gas, drone surveillance, and tactical entry. Although the Independent Investigations Office (IIO) cleared the officers of criminal wrongdoing, the case highlighted significant concerns about how police interact with Indigenous communities and individuals experiencing mental health crises.

The IIO report acknowledged the longstanding systemic discrimination faced by Indigenous peoples in Canadian policing, noting disproportionate arrest and incarceration rates. Indigenous leaders, including Williams Lake First Nation Chief Willie Sellars, expressed frustration over the lack of accountability and called for fundamental changes in RCMP engagement within Indigenous territories.

The investigation also raised questions about current police tactics in mental health crisis calls, particularly the use of militarized approaches. Experts have repeatedly emphasized that such tactics may escalate rather than defuse these situations. The IIO forwarded

⁹⁹ Courtney Dickson, “Watchdog suggests review of how RCMP interact with Indigenous people, mental health calls”, *CBC News* (21 July 2025) online:< <https://www.cbc.ca/news/canada/british-columbia/iio-report-williams-lake-death-rcmp-indigenous-people-mental-health-review-crcc-1.7588718>>.

recommendations to the Civilian Review and Complaints Commission to reassess RCMP protocols and training, with an emphasis on de-escalation, cultural safety, and the involvement of mental health professionals.

In another case in 2024, Toronto police shot Tylor Coore, a 32-year-old Afro-Indigenous man living with schizophrenia, during a mental health crisis.¹⁰⁰ Police were responding to reports of a man with a knife. Coore survived the shooting but required multiple surgeries and was later charged with assault and weapons offences. The Special Investigations Unit cleared the officer involved of criminal wrongdoing.¹⁰¹

Coore's mother, Cheryl Maxie, publicly questioned the use of firearms in a mental health crisis, stating: "You know that there's other ways of dealing with people with mental health." She added: "He needs help, he needs love, he needs community."¹⁰²

Advocates, including harm reduction worker Mskwaasin Agnew, echoed her concerns, arguing that police are not equipped to handle these calls safely and that public resources should be redirected toward health and social services. As Agnew put it: "How many people have to die to understand that we need more funding for mental health care?"

C) Critiques of Current Police-led Responses

Policing remains the default response to mental health crises across Canada, despite growing evidence that this approach is harmful, ineffective, and disproportionately impacts Black, Indigenous, and marginalized individuals. Critics, including legal scholars, civil liberties advocates, and mental health organizations, argue that police are not equipped to provide appropriate care. Coercive interventions such as the use of force, arrests, and involuntary hospitalization often escalate rather than resolve them. These critiques call for a shift toward

¹⁰⁰ Abby O'Brien, "Man shot by Toronto police was in mental health crisis, family says", *CTV News* (31 July 2024) online: <<https://www.ctvnews.ca/toronto/article/man-shot-by-toronto-police-was-in-mental-health-crisis-family-says>> [O'Brien].

¹⁰¹ Muriel Draaisma, "Police watchdog clears Toronto officer in shooting of man in Cabbagetown", *CBC News* (6 November 2024) online: <<https://www.cbc.ca/news/canada/toronto/special-investigations-unit-shooting-cabbagetown-1.7376215>>.

¹⁰² O'Brien, *supra* note 100.

non-police, community-led, and rights-based crisis response models that prioritize care, de-escalation, and the dignity of those in distress.

i) Canadian Mental Health Association

The Canadian Mental Health Association (CMHA) has raised serious concerns about the continued reliance on police to respond to mental health crises, particularly in light of the numerous fatalities involving individuals experiencing psychiatric distress. The CMHA emphasizes that “mental illness is not a crime” and urges decision-makers to recognize that health emergencies require a healthcare response, not law enforcement response.¹⁰³ These incidents, the CMHA asserts, reflect a long-standing failure to invest in mental health services, resulting in police being used as first responders in situations for which they are neither trained nor suited.¹⁰⁴ The organization underscores the disproportionate risks faced by Black and Indigenous individuals, whose interactions with police are often shaped by systemic racism and colonial legacies.¹⁰⁵

While the CMHA acknowledges that some individuals report compassionate and effective police intervention, many others experience stigma, harm, or trauma, further undermining trust in public institutions.¹⁰⁶ The CMHA calls on governments to invest in community-led mental health infrastructure, expand peer and clinician-led crisis response teams, and ensure that the voices of people with lived experience are central to policy development.¹⁰⁷

ii) Canadian Civil Liberties Association

The Canadian Civil Liberties Association’s report, *Rethinking Community Safety: A Step Forward for Toronto*, highlights the disproportionately high involvement of police in responding to mental health crises, despite a lack of evidence that this approach is appropriate or effective.¹⁰⁸ According to the report, Toronto police respond to over 30,000 mental health-

¹⁰³ Canadian Mental Health Association, “Statement on Police and Wellness Checks”, (25 August 2020) online: < <https://cmha.ca/brochure/statement-on-police-and-wellness-checks/>>.

¹⁰⁴ *Ibid.*

¹⁰⁵ *Ibid.*

¹⁰⁶ *Ibid.*

¹⁰⁷ *Ibid.*

¹⁰⁸ Canadian Civil Liberties Association, “Rethinking Community Safety: A Step Forward for Toronto” (Toronto: CCLA, 2021), online: < <https://ccla.org/wp-content/uploads/2021/07/Rethinking-Community-Safety-A-Step-Forward-For-Toronto-Full-Report-12.pdf> >.

related calls annually, representing about 3% of total service calls. However, these calls account for 11% of all use-of-force incidents, a rate significantly higher than that for robberies or cases involving suspects wanted on charges.¹⁰⁹ Alarming, 40% of conducted energy weapon (Taser) deployments are used on individuals in a mental health crisis.

The report notes that this overreliance on police is not only ineffective but harmful, particularly for racialized and Indigenous individuals, who face compounded risks due to systemic inequities. A policing model that emphasizes control and force is fundamentally ill-suited to the needs of individuals in crisis, who typically respond better to de-escalation, time, and supportive engagement. As the report states: "Criminalizing mental health conditions is a fundamental problem, made worse by the impact policing has had on the community".¹¹⁰

These findings align with recommendations from coroners' inquests and mental health organizations, which advocate for non-police, community-based professionals to respond to mental health emergencies. As the report underscores, the over policing in these situations not only endangers vulnerable individuals but also reflects a broader failure to provide humane, health-based responses to mental illness.

iii) **Challenging Involuntary Treatment and Confinement in Canada Through the *CRPD***

Rozinskis and Rourke critically examine Canada's mental health legislation through the lens of the *CRPD*, arguing that forced psychiatric interventions, including involuntary detention, undermine the dignity and rights of individuals with psychosocial disabilities.¹¹¹ They highlight articles 12 and 14 of the *CRPD*, which affirm the universal legal capacity and liberty for persons with disabilities, and describe involuntary detention as a routine violation of these rights under current Canadian mental health regimes.

The authors underscore that involuntary psychiatric interventions are frequently justified through broad legal mechanisms, including police-led apprehension and transportation to

¹⁰⁹ *Ibid* at 10.

¹¹⁰ *Ibid*.

¹¹¹ Russell Rozinskis & Chloe Rourke, "Challenging Involuntary Treatment and Confinement in Canada Through the United Nations Convention on the Rights of Persons with Disabilities" (2024) 18:3 *Studies in Social Justice* 418 at 419–20.

treatment facilities under provincial mental health laws. They observe that these practices are deeply embedded in legal frameworks, despite being at odds with *CRPD* standards.

Through interviews with disability rights activists and survivors, the authors highlight how police involvement in involuntary detention exemplifies a coercive paradigm that denies individuals legal capacity and reinforces state control over their lives. They argue that such practices continue due to entrenched legal norms and institutional values that have persisted even after Canada ratified the *CRPD*. They contend that deinstitutionalization has shifted coercive practices into community settings, where police still play a central role in enforcing psychiatric detentions.

Ultimately, the article calls for a paradigm shift toward non-coercive, supports-based approaches that uphold dignity and autonomy, and for legislative reform to align Canada's mental health laws with the *CRPD*. This entails significantly reducing or eliminating police-driven involuntary detention and replacing it with rights-based, health-centred alternatives.

iv) **Mental Health Care and Policy (In)justice in Ontario: Making Intersections Visible**

In *Mental Health Care and Policy (In)justice in Ontario: Making Intersections Visible*, Cohen, Morrow, and Rawson critically examine the Ontario government's *Roadmap to Wellness*, highlighting how the continued reliance on police in mental health crisis responses entrenches systemic injustices.¹¹² The authors argue that coercive mechanisms, including **involuntary detention, apprehension, and treatment**, are not isolated tools but embedded features of the province's broader mental health policy and practice landscape.

The article critiques the use of police as first responders in mental health crises, particularly when **policing intersects with race, poverty, and Indigeneity**. Marginalized individuals, the authors contend, are more likely to be subjected to surveillance, force, and institutionalization, outcomes rooted in broader structures of exclusion and criminalization.

Drawing from recent community mobilization efforts in Toronto, the article highlights how grassroots advocacy has pushed for **non-police crisis response models**. These alternative

¹¹² Abraham J Cohen, Marina Morrow & Edward Rawson, "Mental Health Care and Policy (In)justice in Ontario: Making Intersections Visible" (2024) 18:3 *Studies in Social Justice* 461.

systems seek to prioritize care and de-escalation, resisting the logic of criminalization embedded in the current mental health framework. Such shifts reflect an effort to reduce the **trauma and harm associated with police-led interventions** - especially in cases involving racialized individuals and those with histories of institutional violence.

The authors argue that meaningful mental health policy reform must involve **a decoupling of care from law enforcement**. This includes recognizing the social determinants of mental health, and a commitment to equity-informed, rights-based approaches that center lived experience and community knowledge.

D) Reform Initiatives

Police responses to mental health crises across Canada have undergone significant reform, reflecting a growing consensus that enforcement-led approaches alone are inadequate. Many jurisdictions are now adopting co-responder or civilian-led models that embed mental health expertise into crisis intervention. Alberta has implemented and scaled several of these programs, while other provinces have developed comparable and, in some cases, more civilian-focused models.

i) Calgary’s Community Mobile Crisis Response, 911/211 Co-location Project & PACT

In 2022, Calgary began shifting from traditional enforcement-led interventions to more tailored, community-centred responses to mental health and related crises. The Community Mobile Crisis Response (CMCR) pilot, was initiated in October 2022 by the Alex Community Health Centre in collaboration with the City of Calgary, Calgary Police Service, and Distress Centre Calgary.¹¹³

The pilot aimed to divert non-emergency mental health, addiction, and social crisis calls away from frontline police to specialized crisis teams, helping to prevent escalation and reduce the risk of violent confrontations. The pilot emphasized a “person-centred, trauma-informed, equity-based approach to crisis response” for individuals experiencing non-emergency

¹¹³ City of Calgary, “The Alex selected to deliver the Community Mobile Crisis Response Pilot Program” (11 October 2022) *The City of Calgary Newsroom*, online: <<https://newsroom.calgary.ca/the-alex-selected-to-deliver-the-community-mobile-crisis-response-pilot-program>>.

behavioural or mental health crises and substance use disorders, provided there is no immediate safety risk.¹¹⁴

CMCR teams, consisting of a healthcare worker and a peer support worker, supported by a plainclothes police officer during the initial phase, were first deployed in District 4 in February 2023, then expanded to District 5 in March 2023. Dispatched via 911 or 211, these teams provided trauma-informed care, ongoing case management, and follow-up supports aimed at preventing repeat crises.

Robyn Romano, CEO at Distress Centre Calgary emphasized:

Experiencing a mental health or addictions related crisis is an urgent and distressing situation, but it often does not require a 911 or police response, and instead a community response, [...] Ensuring people are easily connected with the hundreds of different social agencies and programs throughout our city, including The Alex, helps to improve outcomes and mitigates crises from escalating.¹¹⁵

Early reports showed promising outcomes. By the end of 2023, CMCR had expanded citywide and responded to over 180 calls, providing follow-up support in approximately 70% of cases.¹¹⁶ However, in October 2024, the Calgary Herald reported that the program had failed to gain traction¹¹⁷, having only received 240 calls by April 2024 despite its citywide availability.

Joy Bowen-Eyre, the CEO of The Alex Community Health Centre, noted that the lack of work wasn't due to a lack of demand for mental health assistance, rather, "people just don't know where to turn or how to navigate that when there is a crisis".¹¹⁸

¹¹⁴ *Ibid.*

¹¹⁵ City of Calgary, "A Better Crisis Response System in Calgary" (13 April 2023) *The City of Calgary Newsroom*, online:< <https://newsroom.calgary.ca/a-better-crisis-response-system-in-calgary> >.

¹¹⁶ Darren Krause, "The Alex's Community Mobile Crisis Response expands to citywide coverage", *LiveWire Calgary* (22 December 2023) online:<<https://livewirecalgary.com/2023/12/22/the-alex-community-mobile-crisis-response-expands-to-citywide-coverage>>.

¹¹⁷ Bill Kaufman, "Police-social agency pilot project targeting mental health issues falls short", *Calgary Herald* (11 October 2024) online:< <https://calgaryherald.com/news/local-news/police-social-agency-mental-health-pilot-effort-falls-short>> [Kaufman].

¹¹⁸ *Ibid.*

Despite the limited number of calls, Bowen-Eyre emphasized the program's effectiveness. The teams successfully directed 240 callers to 1,842 referral points across various social service agencies. She described the outcomes as "really, really effective — when they did connect, it was magical."¹¹⁹

In addition to the CMCR, Calgary launched another pilot project to address mental health: the 911/211 Co-location Project. Led by Calgary 911 and the Distress Centre Calgary, the initiative began in February 2021 to divert non-life-threatening and non-criminal calls from 911 to 211.¹²⁰ In August 2022, the program expanded to include a pilot allowing 211 to dispatch Calgary Alpha House Society's Human-centred Engagement and Liaison Partnership (HELP) teams instead of the Calgary Police Service for non-threatening individuals. That year, 1,662 calls were diverted from police response to intervention by HELP team intervention, an average of over 300 calls per month.

Since 2009, the Police and Crisis Team (PACT) has operated as a collaborative initiative between Alberta Health Services and the Calgary Police Service.¹²¹ PACT pairs specially trained officers with medical professionals to respond to individuals involved with the law who are experiencing mental health, addiction, or psychosocial challenges and may pose a risk to themselves or others.

The primary goal of PACT is to divert such individuals from hospital emergency departments and the criminal justice system, promoting more appropriate and supportive interventions.¹²² In 2021, the program was expanded both in staffing and operational hours, increasing coverage from 18 to 22 hours per day.¹²³ As of 2021, PACT has assisted more than 5,100 people since the program first launched in 2009.¹²⁴

¹¹⁹ *Ibid.*

¹²⁰ City of Calgary, "Calgary's Mental Health Addiction Strategy and Action Plan: Five Year Evaluation" (2023) online:<<https://www.calgary.ca/content/dam/www/programs-services/social-programs-and-services/mental-health-and-addiction-strategy/mental-health-addiction-strategy-evaluation-report.pdf>> at 18.

¹²¹ Calgary Police Service, "Vulnerable persons in Calgary" online: <<https://www.calgary.ca/cps/community-programs-and-resources/vulnerable-persons/vulnerable-persons.html>>.

¹²² Kaufman, *supra* note 117.

¹²³ Dave Dormer, "Calgary Police and Crisis Team partnership expands staff, hours", *CTV News* (24 June 2021) online:< <https://www.ctvnews.ca/calgary/article/calgary-police-and-crisis-team-partnership-expands-staff-hours/#:~:text=By%20Dave%20Dormer,and%20mental%20health%20distress%2C'%20says>>.

¹²⁴ *Ibid.*

ii) Additional Canadian Reform Initiatives

Across Canada, a range of initiatives have emerged to improve responses to mental health crises, reflecting a shift toward more integrated and health-focused approaches.

In British Columbia, the Car 87 program, a partnership between the Vancouver Police Department and Vancouver Coastal Health, pairs a plain-clothes police officer with a psychiatric nurse to jointly respond to crisis calls.¹²⁵ These teams combine law enforcement authority with clinical expertise, enabling on-site assessment, de-escalation, and connection to community resources. The program aims to reduce the need for police patrol response and unnecessary hospital admissions, while connecting individuals in crisis to the necessary services in their community.¹²⁶

In 2022, British Columbia committed \$10 million for new and existing Peer Assisted Care Teams (PACTs).¹²⁷ These are “civilian-led, community-based team[s] that respond to mental health crisis calls” and are composed of trained peer support workers and mental health clinicians. Typically operating without police involvement, PACTs provide a culturally informed, non-coercive alternative for individuals in distress.¹²⁸

Toronto has implemented one of the most prominent fully civilian-led crisis intervention models with the launch of the Toronto Community Crisis Service (TCCS) in 2022.¹²⁹ Partnering with five organizations, TCCS dispatches mobile teams composed of crisis workers and peer support staff to respond to certain 911 calls without police attendance. In its first year, the TCCS resolved 78 per cent of calls without requiring police involvement.¹³⁰ By late 2024, TCCS had expanded city-wide with twelve mobile units and 100 crisis workers. The city describes the service as “model of mental health and addiction crisis response that is

¹²⁵ Vancouver Police Department, “Mental Health Initiatives” online: <<https://vpd.ca/policies-strategies/mental-health-initiatives>>.

¹²⁶ *Ibid.*

¹²⁷ Government of British Columbia, “New team will help people in mental-health, substance-use crisis in the Comox Valley” (7 July 2023) online: <<https://news.gov.bc.ca/releases/2023MMHA0050-001104>>.

¹²⁸ Canadian Mental Health Association, “Commitment to more Peer Assisted Care Teams (PACT) in BC” (British Columbia Division) online: <<https://bc.cmha.ca/news/commitment-to-more-peer-assisted-care-teams-pact-in-bc>>.

¹²⁹ City of Toronto, “Toronto Community Crisis Service” online: <<https://www.toronto.ca/community-people/public-safety-alerts/community-safety-wellbeing-programs/toronto-community-crisis-service>>.

¹³⁰ City council votes unanimously to expand community crisis service across Toronto, *CBC News* (9 November 2023) online: <<https://www.cbc.ca/news/canada/toronto/community-crisis-toronto-citywide-1.7023744>>.

community-based, client-centred and trauma-informed.”¹³¹ Although police are not members of the TCCS team, they may still attend calls if there is a risk of violence and can also refer calls to TCCS.¹³² This model highlights the potential for entirely non-police responses in large, diverse urban centres.

Collectively, these initiatives illustrate a national trend toward integrating mental health expertise into crisis response systems, reducing reliance on enforcement, and prioritizing diversion and connection to appropriate community-based supports.

VII) *Charter Rights Analysis*

Canadian mental health legislation grants police and other state actors broad powers to apprehend, transport, and detain individuals for psychiatric assessment. As outlined above, these powers may be exercised without a warrant where there are reasonable grounds to believe a person is experiencing a mental disorder and poses a risk of harm. They also extend to situations such as breaches of committal or community treatment orders. These expansive apprehension powers provide the context in which they engage the *Charter*, raising complex constitutional questions.

The landmark case of *JH v Alberta (Minister of Justice and Solicitor General)* challenged the constitutionality of key aspects of the *Alberta Mental Health Act* and its detention powers.¹³³ In particular, this case examined the *Charter* implications of the *Alberta Mental Health Act* in relation to sections 7, 9, and 10(b) of the *Charter*.

Section 7 protects life, liberty, and security of the person; section 9 guards against arbitrary detention; and section 10 ensures the right to be informed promptly of the reasons for detention and to retain counsel without delay. While the Supreme Court has clarified these rights in

¹³¹ Toronto's non-police crisis response service expands citywide, *CBC News* (26 September 2024) online:<<https://www.cbc.ca/news/canada/toronto/toronto-community-crisis-service-fourth-emergency-service-1.7335208>..

¹³² *Ibid.*

¹³³ *JH v Alberta (Minister of Justice and Solicitor General)*, 2020 ABCA 317 [*JH CA*].

criminal contexts, such as in *R v Sinclair*¹³⁴ and *R v Swain*¹³⁵, their application to involuntary psychiatric apprehensions remains contested. Scholars and legal commentators note that individuals detained under mental health statutes often experience de facto arrests without receiving the same informational or legal protections, creating potential *Charter* vulnerabilities.¹³⁶ This constitutional tension is particularly visible when police act as first responders to mental health crises, blurring the line between therapeutic intervention and law enforcement. This dynamic raises concerns about whether current practices meet constitutional standards of necessity, proportionality, and fairness.

Further, because police have the authority to detain individuals whom they reasonably and on probable grounds suspect meet the legal criteria for detention, persons with mental illness or disabilities may be at risk of having their section 15 equality rights infringed. They may also be vulnerable to prejudice and stereotypes when interacting with state authorities or police under this legislation.

A) JH v Alberta (Minister of Justice and Solicitor General)

The case of *JH v Alberta* involves a constitutional challenge to several provisions of Alberta's *Mental Health Act*, following the involuntary detention and treatment of *JH*, an Indigenous man and member of a First Nation in British Columbia. In 2014, *JH* was hospitalized at Foothills Medical Centre in Calgary for a knee infection.

After physically recovering and requesting discharge, he was instead detained under the *Mental Health Act* through a Form 1 admission certificate, citing an alleged risk of self-harm and alcohol relapse. Form 1 certificates permit for one month of involuntary detention. Despite a psychiatrist's opinion that *JH* did not require psychiatric treatment, his detention was repeatedly renewed through Form 2 certificates, resulting in nine months of involuntary confinement and forced administration of antipsychotic medication.¹³⁷

¹³⁴ *R v Sinclair*, 2010 SCC 35, [2010] 2 SCR 310.

¹³⁵ *R v Swain*, [1991] 1 SCR 933, 1991 CanLII 104 (SCC) [*Swain*].

¹³⁶ Ruby Dhand & Kerri Joffe, "Involuntary Detention and Involuntary Treatment Through the Lens of Sections 7 and 15 of the Canadian Charter of Rights and Freedoms" (2020) 43:3 Man LJ 207 [Dhand & Joffe].

¹³⁷ *JH CA*, *supra* note 133 at paras 10-13.

Four months into his detention, *JH* began challenging his certification. After an unsuccessful review by the Review Panel, he appealed to the Alberta Court of Queen’s Bench (now the Court of King’s Bench), alleging violations of his *Charter* rights under sections 7, 9, and 10. In a 2015 decision, Justice Eidsvik found that Alberta Health Services had failed to meet the legal criteria for his detention and cancelled admission certificates.¹³⁸

In 2019, the case returned to the Alberta Court of Queen’s Bench to address the broader constitutional issues, specifically whether *JH*’s *Charter* rights were breached and whether certain provisions of the *Mental Health Act* were themselves unconstitutional.¹³⁹ The court ruled that key provisions related to detention and review under the *Mental Health Act*, including sections 2, 4(1), 4(2), 8(1), 8(3), 38(1) and 41(1), were overbroad and procedurally unfair, and therefore violated the *Charter*. These provisions were declared unconstitutional, with the Court suspending the declaration of invalidity for 12 months to allow Alberta time to amend the legislation. Alberta appealed the decision.

The Alberta Court of Appeal upheld most of the trial judge’s findings, confirming that the detention and review provisions were overbroad and violated section 7 of the *Charter*. The Court emphasized that the *Mental Health Act* permitted deprivations of liberty without tailoring the extent or duration of detention to the individual’s circumstances. It noted that the review mechanism allowed only a binary outcome (renewal or cancellation of certificates) with no ability to adjust the level of restraint, making the *Act* a “blunt instrument [that] will foreseeably overshoot the Act’s protective goals in some cases”.¹⁴⁰

The Court also found that the vague definitions of “mental disorder” and “harm” led to inappropriate and unjustified detention, including individuals with conditions such as “learning or developmental disorders, brain injuries and cognitive impairment”.¹⁴¹

Moreover, the criteria for certification did not require a causal connection between the mental disorder and the risk of harm, where the Court noted that under the *Mental Health Act* “there is no requirement that the risk of harm or deterioration *result from* the substantial mental

¹³⁸ *JH v Alberta Health Services*, 2015 ABQB 316.

¹³⁹ *JH v Alberta Health Services*, 2019 ABQB 540 at para 237.

¹⁴⁰ *JH CA*, *supra* note 133 at para 88.

¹⁴¹ *Ibid* at para 90.

disorder.”¹⁴² As the Court noted, “if the potential harm is not connected to the mental disorder, then one cannot expect that treating the disorder will reduce the potential for harm.”¹⁴³

Regarding procedural fairness, the Court held that the *Mental Health Act* failed to ensure that patients were given adequate and timely information, effective access to their medical records, and meaningful representation during review processes. While the *Mental Health Act* guaranteed a right to representation, it did not ensure that patients would actually have someone present to advocate for them. As the Court stated: “the Act provides a right to representation, but it does not ensure representation. The difference is significant”.¹⁴⁴

Although the Court overturned the trial judge’s finding on a violation of section 10(a), it upheld the findings of breaches under sections 7, 9, and 10(b) of the *Charter*. The relevant provisions of the *Mental Health Act* were declared of no force or effect.¹⁴⁵

Following this decision, the Government of Alberta acknowledged the need for legislative reform. Although the province was appealing the ruling at the time, it simultaneously committed to updating the law. In 2020, it introduced *Bill 17: Mental Health Amendment Act* to address the constitutional issues identified by the Court.¹⁴⁶

In particular, the legislature sought to amend provisions related to involuntary detention and the “treatment for persons suffering from mental disorders that are untreatable, and [...] refocus, and perhaps narrow, these provisions upon persons who are suffering from severe mental illness that are capable of being resolved by treatment.”¹⁴⁷ Then-Health Minister Tyler Shandro emphasized that the amendments were not only necessary to comply with the *JH* decision but also were “the right thing to do” to improve patient rights and system accountability.¹⁴⁸

¹⁴² *Ibid* at para 91.

¹⁴³ *Ibid*.

¹⁴⁴ *Ibid* at para 121.

¹⁴⁵ *Ibid* at paras 133-135.

¹⁴⁶ *Amendment Act*, *supra* note 24.

¹⁴⁷ Gordon, *supra* note 32.

¹⁴⁸ ‘Right thing to do’: Alberta introduces Mental Health Act changes to protect patients’ rights, *CBC News* (4 June 2020) online: <<https://www.cbc.ca/news/canada/edmonton/right-thing-to-do-alberta-introduces-mental-health-act-changes-to-protect-patients-rights-1.5598782>>.

Bill 17 introduced significant amendments to Alberta's *Mental Health Act* to improve patient rights and align with *Charter* obligations. Key changes included narrowing the definition of "mental disorder," revising criteria for involuntary detention, recognizing nurse practitioners as Qualified Health Professionals, changes to administering Community Treatment Orders without consent, and police powers.

B) Section 7: Life, Liberty, and Security

i) Overview of Section 7 Rights

Section 7 of the *Charter* guarantees everyone the 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".

To determine whether a violation of section 7 has occurred, courts apply a two-step test: 1) whether the individual's right to life, liberty, or security of the person has been interfered with; and 2), if so, whether that interference is consistent with the principles of fundamental justice.

The right to life protects the basic right to be alive and has traditionally been considered paramount among *Charter* rights. Liberty safeguards an individual's freedom to make personal choices and to move without physical restraint. The right to liberty can be violated when the government interferes with a person's physical freedom or their ability to make personal decisions.¹⁴⁹

The right to security of the person encompasses protection of bodily integrity and health, extending beyond physical to serious psychological harm that can be objectively demonstrated. Security of the person also encompasses a person's right to control their own body, engaging when the government interferes with a person's control over their own body or mental well-being.¹⁵⁰

The principles of fundamental justice establish the legal standards that must be met for any interference with section 7 rights to be constitutionally valid. These principles include both

¹⁴⁹ *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519 at 10, 104 DLR (4th) 342.

¹⁵⁰ *R v Morgentaler*, [1988] 1 SCR 30 at 56.

procedural fairness and substantive justice, which prohibit laws that are arbitrary, overbroad, or grossly disproportionate. Together, they ensure that government actions impacting life, liberty, or security are fair, rational, and proportionate.

ii) Impact of Mental Health Legislation on Section 7

Provincial mental health laws engage section 7 of the *Charter* in multiple ways. These statutes authorize involuntary treatment and often limit or remove the ability of detained individuals to consent to or refuse medical care. For example, as discussed, in British Columbia, the *Mental Health Act* operates under a deemed consent model, where a person who is involuntarily detained is “deemed to consent to any treatment that is authorized by the director of the facility.”¹⁵¹ This approach significantly infringes on section 7 rights by undermining the detained individual’s ability to make informed decisions about psychiatric treatment. As Dhand and Joffe note, “stripping an involuntarily detained person of their right to medical self-determination plainly interferes with their liberty and fundamental personal decisions.”¹⁵² Additionally, it infringes on the right to security of the person by denying patients control over decisions affecting their physical and psychological integrity.¹⁵³

Similarly, police powers to detain individuals under provincial mental health laws for psychiatric assessment constitute a profound form of state interference with personal autonomy and psychological integrity, both fundamental elements of the right to security of the person under section 7. These detentions can occur without prior judicial authorization, relying instead on the subjective judgment of police officers. Officers are granted broad discretion to apprehend individuals they believe are experiencing a mental disorder and who may pose a risk to themselves or others. This wide latitude in decision-making raises serious concerns about the potential for arbitrary detention, where individuals may be deprived of their liberty and subjected to psychiatric evaluation without sufficient safeguards or oversight. The psychological impact of involuntary detention amplifies the infringement on security of the person, underscoring the need for clear standards and procedural protections to ensure such interventions are justified, proportionate, and respectful of individual rights.

¹⁵¹ Dhand & Joffe, *supra* note 136 at 223; See BC *Mental Health Act*, *supra* note 75 s 31(1).

¹⁵² Dhand & Joffe, *supra* note 136 at 227.

¹⁵³ *Ibid* at 229.

C) Section 9: Freedom from Arbitrary Detention

i) Understanding Arbitrary Detention

Under section 9 of the *Charter*, everyone is guaranteed “the right not to be arbitrarily detained or imprisoned.” This protection applies to any significant interference with an individual’s liberty through physical, legal, or psychological restraint. To constitute a detention, there must be some element of “physical or psychological restraint by the state.”¹⁵⁴

In *R v Grant*, the Supreme Court of Canada defined detention as “a suspension of the individual’s liberty interest by a significant physical or psychological restraint.”¹⁵⁵ The Supreme Court of Canada has identified three types of detention,¹⁵⁶ including:

- Physical detention: where a person is physically restrained;
- Legal detention: where a person would face legal consequences “for failing to comply with a police officer’s demands”;¹⁵⁷ and
- Psychological detention: where a person has either a legal obligation to follow a police request or order, or if a reasonable person in those circumstances would feel that they had no choice but to comply.¹⁵⁸

A detention is considered arbitrary if “there are no criteria, express or implied, that govern its exercise”.¹⁵⁹ Drawing from the three-part test in *R. v Collins*¹⁶⁰ (originally developed under section 8), the Court in *Grant* held that detention will be arbitrary if:

1. It is not authorized by law;
 2. The law authorizing it is itself arbitrary; or
 3. The manner in which the detention is carried out is arbitrary.
- Any unlawful detention is, by definition, arbitrary.¹⁶¹

This structure was reaffirmed in *R v Le*¹⁶², where the Court emphasized that for a detention to be non-arbitrary, it must meet all three criteria: “authorized by law; the authorizing law itself

¹⁵⁴ Government of Canada, “Section 9 – Arbitrary Detention” online: <<https://www.justice.gc.ca/eng/csj-sjc/rfc-dlc/ccrf-cedl/check/art9.html>> [Section 9-Arbitrary Detention].

¹⁵⁵ *R v Grant*, 2009 SCC 32 at para 44. [Grant].

¹⁵⁶ Alberta Civil Liberties Research Centre “Access to Justice and the Police”, online: <<https://www.aclrc.com/issues/police/accessing-justice-and-the-police>>.

¹⁵⁷ *Ibid.*

¹⁵⁸ *Grant*, *supra* note 155 at para 44.

¹⁵⁹ *R v Hufsky*, 1988 CanLII 72 (SCC), [1988] 1 SCR 621.

¹⁶⁰ *R v Collins*, 1987 CanLII 84 (SCC), [1987] 1 SCR 265.

¹⁶¹ Section 9-Arbitrary Detention, *supra* note 154; *Grant*, *supra* note 155 at 54-56.

¹⁶² *R v Le*, 2019 SCC 34.

must not be arbitrary; and, the manner in which the detention is carried out must be reasonable”.¹⁶³

The addition of the third requirement that detention be carried out in a reasonable manner is significant, particularly when assessing section 9 rights in the context of police-led mental health apprehensions under mental health legislation, such as Alberta’s *Mental Health Act*.

ii) Application to Mental Health Apprehensions

Section 9 of the *Charter* is most often discussed in the context of criminal investigations; however, its protections against arbitrary detention also apply to non-criminal state actions, including police apprehensions under mental health legislation. Such apprehensions, though often motivated by safety and welfare concerns, involve a significant deprivation of liberty and therefore must meet the constitutional requirements.

Detention under mental health laws differs from criminal detention in that it is framed in therapeutic rather than punitive terms. As Diab and Sanderson explain, “Provincial mental health acts in Canada codify police powers not to arrest but to apprehend or take a person to a health facility where, in general terms, the person appears to suffer from a mental disorder and poses a danger to themselves or others.”¹⁶⁴

Diab and Sanderson also note that these statutes provide “limited guidance on the scope of these powers, giving rise to questions about the use of force or restraint, privacy, and the right to counsel, among others.”¹⁶⁵

Alberta’s *Mental Health Act* simply provides that the peace officer must make note of the grounds they formed their belief in the need to apprehend the individual.¹⁶⁶

In addition to a lack of guidance on how police are to conduct a reasonable apprehension, there is also a lack of oversight. Police conduct in mental health apprehensions is seldom subject to review in courts. Rather, once a person has been remitted to a hospital, a provincial

¹⁶³ *Ibid* at para 124.

¹⁶⁴ Diab & Sanderson, *supra* note 81 at 2.

¹⁶⁵ *Ibid*.

¹⁶⁶ *Mental Health Act*, *supra* note 21 s 12(3).

review board will determine whether that person should remain in custody. However, this review does not examine how the apprehension was carried out or whether police had appropriate grounds to initiate it.¹⁶⁷

The Supreme Court's decision in *R v Le* is relevant in this context. As discussed earlier, *Le* reinforced the requirement that “the manner in which the detention is carried out must be reasonable.” Diab and Sanderson argue that this principle must apply equally to mental health apprehensions. It is no longer sufficient for police to simply have legal authority under mental health legislation; they must also exercise that authority in a reasonable manner.

Provincial mental health laws, including Alberta's *Mental Health Act*, permit warrantless apprehensions in several contexts. Peace officers may detain and transport individuals to designated facilities when they have reasonable grounds to believe that the individual appears to be experiencing a mental disorder, is posing a threat of harm to themselves or others, and that delaying obtaining a warrant would create a danger. Additional powers exist for apprehending individuals who are subject to committal leaves a facility without authorization, as well as cases where an individual fails to comply with the terms of a community treatment order, as seen in section 12(1)(b)(ii) of the Alberta *Mental Health Act*.

While these powers may be necessary for public safety and patient care, they also carry a heightened risk of arbitrary or unjustified detention—especially given the stigma associated with mental illness and the risk of misinterpreting psychiatric behaviours. These concerns are intensified when police exercise discretion inconsistently, or in the presence of systemic bias, inadequate training, or when dealing with racialized and marginalized individuals.

D) Section 15(1): Equality Rights

I) Principles of Equality Rights under Section 15

Section 15(1) of the *Charter* guarantees that all individuals are:

equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular,

¹⁶⁷ Diab & Sanderson, *supra* note 81 at 3.

without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

These nine characteristics, known as enumerated grounds, reflect personal and immutable traits. Laws that discriminate based on these grounds violate section 15. However, the list is not exhaustive. Other prohibited bases of discrimination, referred to as analogous grounds, are also covered under section 15.

It is important to note that a violation of section 15 is not limited to intentional discrimination. Legislation or government actions that appear neutral on their face but produce adverse effects, resulting in the exclusion or disadvantage of certain groups, may also constitute a violation.

Section 15(2) permits the government to implement programs aimed at benefiting disadvantaged groups. Such programs are not deemed discriminatory under the *Charter* because their purpose is to address and reduce existing inequalities.

To determine whether a government action or legislation violates section 15 of the *Charter*, courts will apply the two-part test based on the Supreme Court decisions in *R v Kapp*¹⁶⁸, *Withler v Canada (Attorney General)*¹⁶⁹ and *Quebec (Attorney General) v A.*¹⁷⁰ The test will analyze whether: “(1) the law creates a distinction based on an enumerated or analogous ground; and (2) whether the distinction creates a disadvantage by perpetuating prejudice or stereotyping”.¹⁷¹

The court will then consider whether the law or program qualifies as an ameliorative initiative under section 15(2). To be protected under this provision, the government must demonstrate a clear correlation between the program and the disadvantage suffered by the target group, show that the declared purpose is genuine, and establish that the distinction generally serves or advances the program’s ameliorative goal.¹⁷²

¹⁶⁸ *R v Kapp*, 2008 SCC 41 [*Kapp*].

¹⁶⁹ *Withler v Canada (Attorney General)*, 2011 SCC 12.

¹⁷⁰ *Quebec (Attorney General) v A.*, 2013 SCC 5.

¹⁷¹ *Kapp*, *supra* note 168 at para 17.

¹⁷² *Alberta (Aboriginal Affairs and Northern Development) v Cunningham*, 2011 SCC 37 (CanLII), [2011] 2 SCR 670 at paras 44-45.

iii) Mental Health Legislation and Equality Concerns

In the context of mental health legislation, section 15 of the *Charter* is particularly relevant to the provisions and impacts related to involuntary detention. Involuntary detention has been described as “the most significant deprivation of liberty without judicial process that is sanctioned by our society.”¹⁷³ This practice raises serious concerns under section 15, which guarantees equality rights, as mental health legislation often targets individuals labelled with mental disabilities for involuntary detention and treatment.¹⁷⁴ This differential treatment singles out a particular group based on an enumerated ground (mental disability), perpetuating prejudice and stereotyping. The Supreme Court has recognized that people with mental disabilities are vulnerable to such harms, stating that “[t]here is no question but that the mentally ill in our society have suffered from historical disadvantage, have been negatively stereotyped and are generally subject to social prejudice.”¹⁷⁵

As Dhand and Joffe note, mental health laws across Canada establish inconsistent standards for determining capacity to consent to medical treatment and offer varying degrees of access to decision-making supports. As a result, individuals who are involuntarily detained may be denied their right to medical self-determination solely because of their mental disability.¹⁷⁶ These provisions, they argue, “reinforce the negative stereotype that having a mental disability necessarily means that a person cannot make decisions about their health care treatment.”¹⁷⁷

This stereotype has long been held, not only in medical fields, but in society at large. The Supreme Court explained:

The tendency to conflate mental illness with lack of capacity, which occurs to an even greater extent when involuntary commitment is involved, has deep historical roots, and even though changes have occurred in the law over the past twenty years, attitudes and beliefs have been slow to change. For this reason it is particularly important that

¹⁷³ Dhand & Joffe, *supra* note 139 at 208, citing Raj Anand, “Involuntary Civil Commitment in Ontario: The Need to Curtail the Abuses in Psychiatry” (1979) 57:2 Can Bar Rev 250 at 251.

¹⁷⁴ *Ibid* at 209.

¹⁷⁵ Swain, *supra* note 135.

¹⁷⁶ Dhand & Joffe, *supra* note 136 at 244-5.

¹⁷⁷ *Ibid* at 245.

autonomy and self-determination be given priority when assessing individuals in this group.¹⁷⁸

By including provisions that reinforce stereotypes about people with mental disabilities being incapable of making decisions about their own healthcare, provincial mental health legislation can “treat involuntarily detained persons with mental disabilities as entitled to less equality, autonomy, and dignity, with respect to their health care decisions, than persons who are not involuntarily detained.”¹⁷⁹

The application of section 15 in the mental health context highlights critical concerns about equality and autonomy. Canadian mental health laws, by singling out individuals with mental disabilities for involuntary detention and treatment, risk perpetuating harmful stereotypes and systemic disadvantage. Ensuring respect for the dignity and decision-making rights of these individuals is essential to uphold the *Charter*’s commitment to substantive equality and to challenge the deep-rooted biases embedded in both law and society.

¹⁷⁸ *Starson v Swayze*, 2003 SCC 32 at para 77.

¹⁷⁹ Dhand & Joffe, *supra* note 136 at 245-6.

VIII) Recommendations

The Alberta Civil Liberties Research Centre recommends the following:

1. Alberta's *Mental Health Act* should be fully aligned with international human rights standards, including articles 12 and 14 of the Convention *on the Rights of Persons with Disabilities*.
2. Involuntary detention and treatment should be permitted only in narrowly defined, rights-consistent circumstances, and only after less-restrictive, voluntary options have been exhausted.
3. Individuals subject to detention must be promptly informed of the reasons for their detention, their rights, and their ability to access immediate legal advice.
4. All detention decisions should be subject to timely, independent review, with meaningful rights of appeal.
5. Police should not be the primary enforcers of mental health apprehension orders except where there is imminent risk of harm.
6. Persons with lived experience of mental illness should be meaningfully involved in developing legislative amendments and related mental health policies.
7. Non-police, community-led mental health intervention teams should be expanded to ensure 24/7 availability across the province.
8. Non-violent mental health-related 911 calls should be diverted to health or community services rather than police.
9. First responders, including police, should receive comprehensive and ongoing training in crisis de-escalation, trauma-informed care, and disability rights.
10. An independent civilian oversight body should monitor and publicly report on police interactions with individuals experiencing mental health crises.

11. Mental health crisis responses should be integrated with housing, addiction treatment, income support, and other community resources to address the social determinants of mental health.

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