

The Alberta Mental Health Act 2010 and Revolving Door Syndrome: Control, Care, and Identity in Making Up People

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Abstract

In this paper I describe dividing practices in making up a specific medical-legal category—the revolving door patient—to identify, label, and direct the actions of particular people living with mental illness. The revolving door patient, was a category that had been spoken of for some time, but became a formal legal subject with the introduction of the Alberta Mental Health Act 2010 and Community Treatment Orders (CTO). I demonstrate how a rationale of control over unpredictable and dangerous individuals was primary in creating this new category, and that the characterization of the revolving door patient required a disciplinary technology to reduce danger. I argue that the CTO is a medical-legal technology that solves the problem of governing a subject in order to produce a patient that manages mental illness. I conclude by reflecting on how the narrative of the revolving door patient, and of mental illness more broadly, has implications for personal identity and tensions between care and control.

Résumé

Dans cet article, je décris comment des 'pratiques divisées' ont créé une catégorie spécifique médico-légale - le « revolving door patient » - afin d'identifier, d'étiqueter et de contrôler les comportements de certains individus vivants avec une maladie mentale. Le « revolving door patient », une catégorie dont on avait parlé depuis un certain temps, est devenu un sujet juridique formel par l'introduction de la loi de la santé mentale de l'Alberta 2010 et de l'Ordre de Traitement Communautaire (OCT). Je démontre comment une logique de contrôle sur les individus imprévisibles et dangereux eu un rôle prépondérant lors de la création de cette catégorie et que la caractérisation du « revolving door patient », entant que telle, a nécessité une technologie disciplinaire pour réduire le danger social. Je soutiens que le OTC est une technologie médico-légale qui résout le problème de contrôle d'un sujet en produisant un patient qui gère une maladie mentale. Je conclus en démontrant de quelle façon le « revolving door patient », et la maladie mentale en général, a des répercussions sur l'identité personnelle et produisent des tensions entre les soins et le contrôle.

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as the reminder that “the stakes are low”. A Canadian Institutes of Health Research Frederick Banting and Charles Best Canada Graduate Scholarship funded the research upon which this paper is based.

Introduction

On February 28, 2004 a series of unfortunate events led to the deaths of Jim Galloway, an officer of the Royal Canadian Mounted Police, and Martin Ostopovich, a man who had been diagnosed with schizophrenia and was experiencing distress. In what follows I demonstrate that the deaths of Ostopovich and Galloway, together with a concern for the uncertainty surrounding mental illness and the dangers it implies, came to drive the process of creating new mental health law in Alberta. The result was the introduction of Community Treatment Orders (CTOs) and expanded involuntary committal criteria for the purpose of managing a particular type of person diagnosed with mental illness.

Past research has argued that CTOs are coercive, that this coercion originates from a particular environment where limited resources are available, and access to services is thereby allocated by mandating a patient to receive treatment (Mfoafo-M'Carthy and Williams, 2010). Everett (2001) has also argued that “doing good” to protect society from dangerous individuals has been marshaled as a rationalization for introducing CTOs. I argue that while a lack of resources for people diagnosed with mental illness is a problem, it is not the source of the CTO's coercion. Rather, coercion was identified as a necessary solution to the problem defined in the characterization of a particular subject—a person diagnosed with mental illness that is dangerous and unpredictable and who can gain access to mental health services, but habitually refuses to do so due to a lack of insight into what is best for the subject's self. This subcategory of person diagnosed with mental illness is known as the revolving door patient. I argue that the CTO is a medical-legal technology that solves the problem of the revolving door patient by producing a patient that manages mental illness. It is the articulation and formalization of the revolving door patient that I describe in this paper. I do so by examining media and public hearing documents from the process that created the *Alberta Mental Health Act 2010*.

The *Alberta Mental Health Act 2010* (AMHA) introduced new criteria for involuntary committal.

These criteria characterize the person that would be subject to CTOs and distinguish between types of people diagnosed with mental illness *and* who could also be identified as having particular histories and behaviours. To apply a CTO two physicians, one of whom is a psychiatrist must determine that a person is “suffering from a mental disorder” and be of the opinion that *one or more* of the following three conditions are met:

1. Within the immediately preceding 3-year period the person has on two or more occasions, or for a total of at least 30 days i) been a formal patient at a facility; and/or ii) been in an approved hospital or been detained in a custodial institution, where it is evident that he/she would have met the criteria to be detained as a formal patient;
2. the person has within the preceding 3-year period been subject to a CTO; or
3. the person has, while living in the community, exhibited a pattern of recurrent or repetitive behaviour that indicates that the person is likely to cause harm to him/herself or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community.

(Alberta Health Services, 2010:80)

If at least one of these conditions has been met the two physicians must then separately conclude within 72 hours that *all of* the following conditions also apply:

1. the person is likely to cause harm to themselves or others, or to suffer substantial mental or physical deterioration or serious physical impairment if they do not receive continuing treatment or care while living in the community;
2. the treatment or care the person requires exists in the community, is available to the person and will be provided to the person, and;
3. the person must be able to comply with the treatment or care requirements in the CTO.

(Alberta Health Services, 2010:80)

These criteria identify a particular type of subject, one that is diagnosed with mental illness, but who is also characterized by a history of difficulty with medical treatment. These characteristics were the product of years of claims-making activities that eventually led to this subject's articulation in the law.

A CTO is a physician's order that commits an individual to treatment in a community, rather than confining the person in a hospital. The CTO articulates a specific type of person for which it is designed, a specific medical treatment plan to be followed by a patient, and that the patient be monitored to ensure the treatment is followed. As of January 1, 2010, all Canadian jurisdictions other than New Brunswick and the territories had adopted similar legislation. In this paper I examine the process of introducing CTOs into the AMHA. My intent is not an analysis of the CTO, though explaining some of its details are necessary for the discussion. Instead, I pay specific attention to how introducing the CTO into Alberta law articulated a new subject that would be monitored in their own homes and communities, rather than within the confines of hospitals and similar institutions.

I describe how the work that went into promoting and introducing the CTO constitutes what Foucault has called "dividing practices" that separate people into different categories. Such practices divide a subject "inside himself" or from others. Dividing practices make objectified categories to identify the subject as a distinct object to be governed in particular ways. Examples include "the mad and the sane, the sick and the healthy, the criminals and 'the good boys'" (Foucault, 1994:326). A subject is the product of processes that categorize a person and determines particular characteristics of that category. As Foucault puts it: "There are two meanings of the word 'subject': subject to someone *else by control and dependence* [emphasis added], and tied to his own identity by a conscience or self-knowledge." (Foucault, 1994: 331). To be clear, this paper is concerned with a process that would place particular people under the control and dependence of others. In what follows I demonstrate that the revolving

door patient is characterized by an unpredictable mental state that implies potential danger to self and others. As the discussion proceeds I also articulate how a rationale of “doing good” by caring for people who are suffering is also tied up with the a necessity to control. These rationales articulate the revolving door patient's mental state as something that can be altered through caring treatment that can only be made possible by coercion.

The CTO classifies a subcategory of person diagnosed with mental illness, a particular type of “revolving door patient”, one that is irresponsible and a poor decision maker that must be guided, watched, and medically treated. By demonstrating how a category of person was identified and elaborated through such claims making this paper makes a contribution to studies of governance and to studies of what Hacking (1999) has called “making up people”. That is, to document and describe how a particular kind of person, “ways to be persons... conditions of personhood” (p.163) came to exist, informally through mental health advocacy, and formally in the AMHA. Hacking has described several examples of particular types of people that have been made up. For example, the disease called perversion and its corresponding person—the pervert—were inventions of the nineteenth century, prior to that no one could have been a pervert, and no one had perversion or needed to be cured of it. However, Hacking is clear that these are not categories that were out there waiting to be discovered by science or bureaucrats. These kinds of people came into being as they were articulated and invented. Perhaps one of the most important points about making up people is that “Who we are is not only what we did, do and will do but also what we might have done and may do” (Hacking, 1999:165). Once we have made a new category and identify people by it, much of how we treat them and how they will have to live will be changed, it also creates new conditions that shape possibilities for everyone.

This paper also contributes to broader studies related to the construction of social problems (Parnaby, 2003; Crabbe, 2003; Groves, Siu, and Ho, 2014) and the problem of how attempts to care for others

sometimes also involve coercion (Han, 2012; Stevenson, 2014). For example, Parnaby's (2003) study of media surrounding “squeegee kids” articulated them as a problem, disassociated them from the larger homeless population, and identified the solution in law and order. Closer to the project at hand, Stevenson (2014) has researched government suicide prevention efforts among Inuit in the Canadian arctic that simultaneously demand Inuit survival while presuming their failure. For example, suicide prevention programs for Inuit youth articulate them as a problem by reminding the very people they aim at helping that they have suicidal tendencies. This poses issues for the youth who internalize the suicidal identity, but are faced with trying to constitute themselves differently. Frank (2016) has also been concerned with the ways in which institutionalized and public narratives shape the ways in which people bring their own identities into being. As such this paper is also concerned with the ways in which public and institutional discourses have implications for how people think and live.

Method

I approached this paper as a process of putting together a history of the present that is concerned with the description of procedures, practices, institutions, knowledge, and their effects on relations between people (Carabine 1995). I conducted my research entirely through document analysis. I followed typical practices of discourse analysis in reading through my data iteratively, developing themes, understanding context by looking at history related to the topic, identified categories and objects used in discourse, and compared counter discourses (Carabine, 1995). In doing so I demonstrate the process of constructing the revolving door syndrome patient as a social problem (Spector and Kitsuse, 2001).

To begin analysis I first taped sheets paper across the wall in my office and wrote the dates and names of all of Alberta's mental health related legislation across the paper in chronological order to create a time line of legislation. For the media search I searched *Canadian Newstand*, which includes all of the

content present in the Canadian Business & Current Affairs (CBCA) databases; CBCA Current Events which includes Canadian media titles focusing on current events; the *Globe & Mail* Database; and *Factiva*. From this search I collected all references using specific search terms, without date restrictions, and saved them to a folder in RefWorks. Search terms included: community treatment order, involuntary community committal, involuntary treatment, mental health act, mental illness admission, mental illness treatment, mental illness committal criteria, mental illness, mental health policy. My first round of searches included the word “Alberta” in order to target sources specific to the case of interest, then I completed a second round of searches without Alberta included. When I completed the media search and eliminated duplicates I had a total of 2,775 news articles.

In order to systematically approach my reading of the articles I organized them into separate folders on my computer according to region (e.g., Alberta or Canada) and topic (e.g., CTO or other Mandatory Treatment). I then read through the articles in reverse chronological order and added these to the time line to create a picture of changes in legislation, mental health advocacy, the rights of people living with mental illness, and other events of interest to the project. I took notes and copied excerpts of particular articles of interest and organized them in a Microsoft Word Document in chronological order. As I read through the media I eliminated articles that were erroneous as well as additional duplicates that I had not previously eliminated using Refworks automated duplicate deletion tool. The remaining total of articles was 1,153. After reading through each folder of news media and constructing the initial draft of the timeline, I re-read the media around particular times to clarify the events that occurred and particular details, as well as to clarify if I had missed any articles that would shed further light on what had occurred. By constructing this time line I was able to understand history of legislative and public responses to people diagnosed with mental illness over time, clarify the ways in which they were characterized, and how such characterizations were responded to.

In addition to the time line and media analysis my primary sources for analysis regarding processes to introduce the CTO and AMHA were transcripts, meeting minutes, attached reports and submissions from members of the public that were prepared for meetings of Alberta's Standing Committee on Community Services (SCCS) as well as documents related to the public inquiry into the deaths of Martin Ostopovich and Jim Galloway. The meetings of the SCCS were held through July and October of 2007, with a day of public hearings held on October 1, 2007. The meetings and hearings dealt with potential amendments to the Alberta Mental Health Act. I acquired the majority of documents online from the Alberta Queen's Printer, or the Alberta Legislature Library; some were provided by a clerk of the library on a compact disc, and via email. I also organized these documents in folders on my computer.

As I proceeded with my reading of government and related documents, I often found additional documentation that I needed to track down and include for consideration in the project. For example, the Alberta Health Services *Guide to the Mental Health Act and Community Treatment Order Legislation*, released in February 2011 was useful in clarifying my knowledge of how the AMHA is supposed to be used as it was designed for physicians and other professionals to better understand how the legislation was intended to direct action. For example the *Guide* describes specific practices, "In practice, many physicians routinely seek a second physician's opinion of the formal patient's competence to make treatment decisions at the time of issuing the certificate of incompetence" (Alberta Health Services, 2010:65).

Once I had completed an initial reading of all of the sources I had acquired, I created an Nvivo file and imported the documents into the program. Nvivo is a qualitative data analysis tool, that helps researchers organized and sort textual information as well as do some basic quantitative analysis. I used the program to help organize extracts from my documentation. Once I created a new project file in

Nvivo I began to manually extract pieces of the documents and sort them into themes related to how people diagnosed with mental illness were characterized, people's concerns, what organizations and individuals were involved in claims making activity, as well as justifications and rationales for particular actions. In this manner I was able to more effectively understand perceptions and activity related to changes in the AMHA and with regard to people diagnosed with mental illness. While much of the materials I consulted provided me with contextual and historical understanding of the AMHA, the SCCS consultations and public inquiry report serve as the primary materials for the discussion herein. The documents I have used as data and also have cited in this paper appear in Appendix A, those that I used as data but have not cited in this paper are illustrated in Appendix B, I do not include uncited media in the appendix as it would be impractical to list all of those sources here.

In the discussion that follows I make use of extracts from the media or other documentation that capture overarching sentiment as articulated in claims making activities. I also rely upon many extracts from appearances made by a psychiatrist, Dr. Patrick White, who was particularly influential in the proceedings that created the Alberta Mental Health Act. Dr. White appeared at every major event involving the AMHA changes, he gave testimony at Judge Ayotte's inquiry into Ostopovich's death, he spoke at the public hearings regarding potential changes to the AMHA, and he served as the Chair of the steering committee for the Minister of Health and Wellness on the matter (SCCS, 2007a). Dr. White's perspective was echoed cautiously by the Canadian Mental Health Association (CMHA, 2007), emphatically by the Schizophrenia Society of Alberta (Schizophrenia Society of Alberta, 2007), and other influential Albertans and organizations also shared his views. While alternative portrayals of people diagnosed with mental illness and other concerns regarding any potential changes were raised, these were not effective—some of the most compelling individuals who spoke against the changes based on their own negative experiences with medications and their treatment by the mental health

system were discredited as anti-psychiatry protesters and scientologists (SCCS, 2007b:53)—nor were they the majority perspective that was heard at the public hearings.

A brief history of the revolving door patient

With deinstitutionalization of people diagnosed with mental illness in the 1960s through 1980s, the revolving door patient as a concept began to have salience and travel through the media and into legislation. The motivations for deinstitutionalization were largely economic (Scull, 1977), but the process involved much rhetoric regarding benefits of community treatment (Wasylenki, 2001; Greenland and Hoffman, 2001). The community was imagined to be a place where people could live and access treatment through local general hospitals, allowing them to build social relationships, and perhaps work and be productive. Soon it became clear that many of the people that had been released were not being helped through the new community based model, and they were getting caught in a “revolving door”. These revolving door patients were regularly moving in and out of hospitals where they would receive brief treatment, be released onto the streets and soon return into homelessness and illness (Greenland and Hoffman, 2001; Gray, Shone and O’Reilly, 2012). Critics of “decarceration” have argued that the notion of community treatment is little more than a slogan without substantive content (Scull, 1977). The argument is that because people diagnosed with mental illness could be regarded as “sick” rather than merely “deviant” we should not incarcerate them as a form of punishment. Instead, advocates have argued for their control as a form of “‘treatment’ for their own good” (Scull, 1977: 124). More recently, medication of patients in the community has been characterized as a form of “chemical incarceration” whereby the effects of pharmaceutical treatments alienate individuals from themselves and others by sedating those who use them thereby trapping them in their own bodies and making them less problematic to live with (Fabris, 2011).

To address concerns with the effects of deinstitutionalization there was a shift during the 1980's to increase community supports. Care was planned to be integrated across locations at hospitals, day programs, and supported housing (Wasylenki, 2001). The Ontario Medical Association, the Ontario Psychiatric Association (McKague, 1987), and Friends of Schizophrenics (Star, 1986) began work to do away with the right of the people diagnosed with mental illness to refuse treatment. The right to refuse treatment also received growing attention in the media which promoted greater control over people diagnosed with mental illness. Headlines articulated the problem, “Homeless: should mentally ill get ‘freedom to self-destruct?’” (Orwen, 1987) and “Snared in revolving door system, schizophrenics find peace in death” (Picard, 1988). Violent incidents committed by homeless and “mentally ill” individuals continued to garner considerable media attention into the 1990's.

In 1992, Calgary newspapers reported the case of a man who was held for treatment but refused medication—his mental state deteriorated—he then beat two women with a baseball bat. One psychiatrist commented, “mentally ill people are being forced to break the law to get the treatment they need” (Lunman, 1992: B1). Similar stories made the news in Ontario, where an inquest was underway into the rape and murder of a young boy by a man who was “certified under the *Mental Health Act* as an involuntary patient, he was diagnosed as a homosexual, psychopathic, sadistic pedophile...” (Hudson, 1992: A6). In another article a representative of the Friends of Schizophrenics criticized the notion that “rights are paramount and care and treatment are secondary” (Hines, 1992: A7). The right to refuse treatment allowed the revolving door patient to deteriorate, to break laws, and only then treatment was assured. Need for access to services without having to break the law has continued to be a concern for law enforcement officers, families of people diagnosed with mental illness, the public, and health-care workers.

Deinstitutionalization was promoted using a logic that people diagnosed with mental illness ought to have the ability to live beyond the walls of hospitals and to accept or refuse treatment just as people living with any other illness can do. As we shall see, as people began to recognize that deinstitutionalization posed new problems, the solutions created a tension between two concerns. First, a concern with care that would require effective supports and services for people in the community who are suffering from mental illness—a system already in place for people diagnosed with other illnesses. The second, a concern with control over danger which recognized that mental illness is somehow different and that sometimes people should not be free to refuse treatment when such refusal leads to self-destruction. There was growing recognition in Alberta and across Canada that more control over people diagnosed with mental illness was needed, particularly in instances where people were being temporarily treated with medication and later deteriorating into unpredictable states of mind. The public and medical professionals began to recognize the revolving door patient as a problem, but it had not yet been articulated in official legislation.

By the year 2000 public concern and advocacy had resulted in a nationwide trend to introduce new legislation that allowed for CTOs and similar measures. Alberta made no attempt to adopt such legislation until a series of high profile deaths involving men diagnosed with schizophrenia who had regularly refused treatment (Barrett, 2004). The Royal Canadian Mounted Police (RCMP) responded to a call regarding Martin Ostopovich, who was known to have suffered with psychosis and later discovered to have stopped taking his medication. Events shortly after the RCMP's arrival at Ostopovich's home led to his death, and the death of RCMP officer Jim Galloway. Alberta's *Fatality Inquiries Act* (Alberta Justice, 2011a) requires that any deaths due to use of force by police be investigated through an official inquiry. In Alberta, inquiries are conducted by a provincial court judge to determine the identity of the dead person(s), date, time, and circumstances of death. At the conclusion of an inquiry, the presiding judge may make recommendations to prevent future death

(Alberta Justice, 2011b). The inquiry into the deaths of Galloway and Ostopovich by Judge Peter Ayotte ended in 2006 and offered a number of recommendations. The one of concern to us here is that CTOs should be introduced into the AMHA (Cormier, 2006). Ayotte's inquiry articulated the prevalence of revolving door syndrome among Alberta's population and detailed the danger that such a sub-population posed to themselves, the police, and the public. The report from Ayotte's inquiry often generalized people diagnosed with mental illness as one homogeneous category facing similar problems—and particularly incapacity for self-control. As the following discussion progresses I demonstrate how these generalizations became refined to articulate a specific subpopulation as particularly problematic and in need of special attention, care, and control.

Identifying the subject's characteristics

At roughly one o'clock in the afternoon on Saturday February 28, 2004 in the town of Spruce Grove Alberta, one of Martin Ostopovich's neighbours noticed a bullet hole in the side of his vehicle and called the RCMP to investigate. The call began a cascading series of events that ended with Jim Galloway and Martin Ostopovich's deaths (Ayotte, 2006). Judge Ayotte's inquiry report presents Ostopovich through a police interview with neighbours and Ostopovich's wife. Mrs. Ostopovich had told police when they arrived at her house that her husband had spent two weeks in a mental hospital, that he had been diagnosed as “paranoid delusional”, but was not taking his medications. The report further describes Ostopovich as an individual with a history of mental illness that involved “extreme antipathy toward police”, that he was extremely paranoid, that he believed everyone was against him, and that he could not be reasoned with. The danger of the revolving door patient starts to take form in this description of Ostopovich.

Ostopovich's death was considered an exemplar of a broader problem faced by families of people living with mental illness. Ayotte's report highlights the testimony of Dr. Patrick White. In his

testimony Dr. White claimed that 34% of those who live in the Edmonton (the capital of Alberta) area meet the criteria for mental illness and of that number 50% will have, “some major emotional event in their lifetime.” (Ayotte, 2006: 14). Dr. White’s testimony continued:

The number of psychiatric consults done at the Royal Alexandra Hospital [a hospital in Edmonton Alberta] last year was 4000... The suicide rate in young males, suicide rate in male children, has quadrupled in 25 years... Thirty-four percent of Edmonton adults meet the criteria for psychiatric illness. Twenty percent have substance abuse disorders... And each psychiatrist in this region has invariably one or two young people psychotic, aggressive and addicted to crystal meth at this very point in time.
(Ayotte, 2006: 14-15).

Dr. White presents Alberta in the midst of a spiralling problem, a situation where a system is strained to supply much needed services to a growing number of individuals suffering with mental health and addiction problems. In the midst of the numbers and percentages is the characterization of individuals living with such problems who are described as suicidal, aggressive, psychotic, and addicted to crystal meth. Here Dr. White articulates what David Altheide (2002) calls a problem frame, which is a “secular alternative to the morality play” (p.47) and includes a narrative structure, moral meanings, specific time and place, unambiguous content, a focus on disorder, and cultural resonance. The problem frame is structured to create fear (Altheide, 2002). At the outset the report characterizes people diagnosed with mental illness as unpredictable and dangerous, articulates them as problematic, and that the legal and health systems need to adapt to better control such individuals.

During Judge Ayotte's inquiry Constable Paul White¹, an Emergency Response Team (ERT) sniper with the RCMP, was asked whether he was aware of any special attempt to deal with Martin Ostopovich's mental problems. He replied:

All that I can say is that we deal with schizophrenic people on a daily basis and we have no idea what to do with them. The system will not deal with them. If they are a threat to themselves or others or suicidal, we take them to a doctor. If they change their mind and tell the doctor they are not suicidal, they're released out that door and it's a situation... (Ayotte, 2006: 17).

1 Yes, two people who gave testimony had the same surname. Such coincidences happen.

While his statements are well intended and he clearly wishes for more effective services, the Constable's statement buttresses those made by Dr. White. Making the claim that the ERT team deals with "schizophrenic people on a daily basis", contributes to the notion of Alberta suffering a crisis in relation to mental illness. The Constable clarifies that his work with people diagnosed with schizophrenia consists of two components. The first is that the patient with schizophrenia does not know what is best for the patient's own wellbeing. The second is that due to this lack of self-awareness people with schizophrenia still have the freedom to refuse treatment. Constable White's testimony emphasizes a need to gain control. He presents a subject that has limited decision making capacity—a disposition to make decisions that do not accord with what more rational others perceive to be best—and therefore has too many rights. The point is that "poor" decision makers should have fewer rights than "good" decision makers, they must be controlled. We might also reframe the statement in relation to a concern for access to treatment, but this does not do away with the problem that requires control over people making poor decisions. The second part of the problem is that the mental health system is under strain. In this instance the strain is caused by these poor decision makers with too many rights that allow them to ignore what is best for their own health and the safety of others. The poor decision makers are straining the limited resources of the health system, the ERT team has to deal with them "on a daily basis". Again, we might construe Constable White's statement as a matter of requiring better services, but the issue of controlling people who refuse such services is at the heart of the problem he addresses in his testimony. While the revolving door patient is not explicitly mentioned in Constable White's testimony the pattern of being in and out of services is indicated, the patient is released "and it's a situation."

Ayotte's report returned to the case of Ostopovich with a reminder that he was released against medical advice and provided medications to "reduce the risk" of danger, medications which he stopped taking. The report recognized patients that are non-compliant with doctor's orders—usually drug regimes—as

particularly problematic (Ayotte, 2006:19) which Ayotte emphasized by returning to the testimony of Dr. White:

There's a minority of patients within the system who are seriously mentally ill and who have a long history of non-compliance with treatment. They will come into hospital, be certified or come in voluntarily, leave hospital. (They) probably have limited insight into the fact that they're sick and they stop taking their medication. Back into hospital, treated, stabilized. Back out; back in again. *The revolving door syndrome*. (Ayotte, 2006: 19, my emphasis).

Here the subject is diagnosed with revolving door syndrome. The subject is characterized by resistance to treatment, lacks insight into its own condition, and poses a potential risk to self and society. Dr. White describes that a patient with limited insight is the likely candidate for revolving door syndrome. The patient is not aware of a problem, and so ceases to follow a treatment regime which results in the individual's return to hospital. It is noteworthy that White's description does not preclude patients who do have insight from the potential to become a revolving door patient. Because mental illness waxes and wanes, and the effects of medications may also change over time, a person who has insight into their illness one day may not have insight a day, a week, or a month into the future. Moreover, because the context presented by Dr. White is one where a health care system is severely strained for resources the amount of resources required must be identified in order for the revolving door subject to become something the health care system not only recognizes but acts upon. So while White previously emphasized the prevalence of mental illness, here he emphasizes that those with revolving door syndrome are a minority of patients, therefore, a minority of a minority of the total population. In addition, by regarding a problematic group of people as a "minority" it seems more reasonable to infringe on the group's rights. The rationale can be stated as "there are not many to whom we are doing this, these sanctions are not going to be used on everyone, or as often as one might worry about". The subject of governance described thus far exists in relation to a system of scarce resources and limited capacity, but is also a cause of that strain.

People diagnosed with mental illness who are identified as having revolving door syndrome are characterized as a minority of a minority, a potential harm to self or others, poor decision makers, and lacking insight to take control over their minds and bodies. This definition articulates outside control and monitoring of the patient's mental condition as a necessity to ensure the patient's safety and the safety of others. The characterization of the subject outlined in the Ayotte report compels a particular form of intervention to deal with the subject, new criteria for committal and new interventions in the community to ensure that treatment is followed correctly. Below I demonstrate how the same subject would be further articulated in the debates of the Standing Committee on Community Services which was tasked with recommending amendments to the *Alberta Mental Health Act* based on the Ayotte report and public hearings.

Unofficial category to legal category

My brief review of news media accounts demonstrated that the notion of revolving door syndrome, and danger it represents, had an unofficial status that identified a problem. During the Ostopovich fatality inquiry the informal social category of the revolving door patient became recognized in legal proceedings as a problem requiring intervention. The lack of personal insight, resistance, lack of control over the self, and potential harm to self or others that characterize revolving door syndrome also became the focus of discussion at the meetings of Alberta's Standing Committee on Community Services (SCCS). In what follows I show how the public hearings and meetings of the SCCS further described the revolving door patient and led to its official recognition in law as the subject of the AMHA.

More than a dozen men and women composed the SCCS and their staff of clerks, researchers, and legal counsel, and they would draw upon other expertise when needed. From mid-summer to early Fall of 2007 the SCCS held several preliminary meetings to discuss the background of Bill 31—the *Alberta*

Mental Health Amendment Act—the question of CTOs, and how to go about holding public hearings. The public hearings ultimately involved 16 presentations and 49 submissions from different citizens and representatives of mental health advocacy organizations (SCCS, 2011b). Advocates for people diagnosed with mental illness regarded the hearings as an opportunity to stress the importance of guaranteeing services and supports for individuals and families facing dire and miserable circumstances (SCCS, 2007d; SCCS, 2007e; SCCS, 2007f). The Canadian Mental Health Association, for example, shared the story of a young woman who lied to her doctors by telling them that she had plans to commit suicide because she believed it was the only way she would be able to receive the attention and treatment she needed (SCCS, 2007e). The Schizophrenia Society of Canada was also afraid that the criteria for involuntary committal—that someone be likely to cause harm to self or others—was stigmatizing in that it would contribute to the notion that individuals diagnosed with mental illness are dangerous and would not allow people to access a CTO in the absence of meeting this harm criterion (SCCS, 2007e). Though they also indicated that CTOs might not work for everyone advocates generally regarded changes to the AMHA as means to ensure access to care. Unfortunately, the new AMHA did not improve access to services for the majority of people diagnosed with mental illness, nor did it increase services available across the province. Rather it focused on a very specific category of unpredictable person in order to prevent danger. CTOs were implemented in such a way that they could not be used unless services and supports already existed in a patient's community.

Among the first presentations heard by the SCCS was that of Dr. White, who had also provided testimony at Judge Ayotte's fatality inquiry. In his presentation Dr. White clarified what he had said in his testimony to Judge Ayotte and attempted to frame his prior statements more clearly in terms of the deterioration of people living with mental illness in need of care. One of the proposed amendments to the AMHA was to change one of the criteria used to involuntarily commit a person to a hospital. Referred to below as criteria 2, but commonly known as the dangerousness criterion, it stated that a

person be “in a condition presenting or likely to present a danger to himself or others” (Government of Alberta, 1988). The proposed change was to move from the dangerousness criterion to a harm criterion by changing the wording: “the person is likely to cause harm to self or others or suffer substantial mental deterioration or physical deterioration or serious physical impairment” (Government of Alberta, 2010; Alberta Health Services, 2011: 80). Speaking to the SCCS Dr. White identified the revolving door cycle and articulated the problematic situation of people diagnosed with mental illness in Alberta as he had when he testified to Judge Ayotte, he then argued:

Criteria 2, where we’re talking about the issue of deterioration: we’re fully in favour. We no longer have to wait for the patients to become dangerous. Waiting for them to become dangerous is actually a very dangerous exercise because it predicates the fact that you can only intervene when you feel harm is about to occur to an individual or others. We’ve been in situations where harm, unfortunately, belatedly has occurred. If we can intervene sooner, when we feel the patient is deteriorating both psychologically and physically, we get the patient into hospital quicker. (SCCS, 2007f: 49).

Here Dr. White’s statement clarifies that including deterioration allows for earlier intervention and is believed to result in better prognosis and this seems to express a rationale of care. However, the justification for such intervention is in terms of preventing harm to self or others, preventing the subject from realizing its potential as a dangerous individual. Dr. White’s explanation of criteria 2 is that it allows intervention to deal with the unpredictable and uncertain aspect of the mental health subject, the subject capable of unpredictably deteriorating to a dangerous state. The use of mental deterioration and physical impairment in the AMHA are references to the fact that the subject is at least potentially dangerous. The purpose of specifying an individual who is likely to experience deterioration is to intervene at a time before the patient becomes explicitly dangerous. The subject proposed for the AMHA was one that always has the potential to be dangerous. The concern to intervene for the sake of the patient’s well-being is motivated by concern to control a dangerous individual. While there were many more presentations to the SCCS, the concern for control and danger was the engine for legislative change and was considered the mechanism toward care.

The SCCS provided a final review of their findings wherein they suggested amendments to the AMHA.

The review stated that there are three categories of individuals that may be subject to a CTO:

The first category would be those who have been a formal patient or in an approved hospital or a custodial institution who satisfy the admission criteria for formal patients...

The second category of persons who are eligible would be someone who has been subject to a CTO within the immediately preceding three-year period.

The third category of individual who would be eligible would be someone who in the opinion of two health professionals exhibits a pattern of recurrent and repetitive behaviour suggesting that he or she may be likely to cause harm to him- or herself or others or that the person will suffer substantial mental or physical impairment if he or she does not receive treatment and care while living in the community (SCCS, 2007g: 158).

All three categories pertain to the person diagnosed with mental illness. Each category articulates the characteristics of revolving door syndrome. The first category—the formal patient—meets the criteria of being a potential harm to self or others, or at risk of mental deterioration or physical impairment.

The formal patient has also been identified as repeatedly accessing mental health services, deteriorating, and returning for further mental health treatment, clearly a revolving door patient. The second category refers to a person who has fit the third category in the past. And the third category is more clearly articulated as the patient characterized thus far: dangerous, lacking insight, in and out of services. The fact that the individual conceptualized in these categories may be likely to cause harm to self indicates the person is dangerous to self or others. Experiencing substantial mental deterioration indicates that the person is becoming dangerous and will be likely to cause harm to self or others, and referring to substantial physical impairment indicates that harm has already occurred. The three categories of people potentially subject to a CTO are really one dangerous subject that can be apprehended at various points in time.

It is worthwhile at this point to make note of two other aspects of the CTO. First, a potential subject of a CTO has the right to choose to be placed on one or to refuse. However, the choice is between accepting the CTO or to be placed in hospital. The choice offered to patients is a forced choice.

Freedom to choose in the absence of a formalized system of coercive consequences is nonexistent,

there is no option to walk away and tell the system “thank you, but this is not for me, I'll look at other options or do my own thing”. Further, in making the choice to undertake the CTO the patient is also accepting the categorization that validates the CTO, accepting an official identity of being unpredictable, making poor decisions, with a potential to become dangerous. The CTO will require them to be under surveillance, to follow a treatment plan, and meet other conditions. Second, a CTO cannot be issued unless the required services are accessible in the patient's community. Requiring services in the community remains informed by a need for supervision and control of the patient. The CTO cannot function effectively without such services. The requirement that services exist in the community is as much a matter of ensuring the patient is cared for as it is to ensure efficacy of the CTO as a technology of governance. The remaining alternative is hospitalization with or without consent. The unpredictable subject must be controlled. What I have described thus far fits well with notions of subjectification and governance in that they are matters of making people “subject to someone else by control and dependence and tied to his [sic] own identity by a conscience or self-knowledge” (Foucault, 1994:331) and “...the legitimately constituted forms of political or economic subjection...destined to act upon the possibilities of action of other people” (Foucault, 1994:341).

The process of formalizing a particular kind of mental health patient as a new subject in the *Mental Health Act 2010* is the consequence of a process involving concern over uncertainty as to the stability of a particular subgroup of the “mentally ill”. The final version of the *Mental Health Act, 2010* contains the recommendations of the SCCS (Government of Alberta, 2010; Orr, Watson, Aggy-King Smith, 2012), which were consistent with the subject outlined in the final report of Judge Ayotte and described in popular news media for many years. Through these processes people diagnosed with mental illness were occasionally characterized as a group of people at risk of deterioration and dangerousness, but the revolving door patient came to be a specific type of person diagnosed with mental illness—a subpopulation—of particular concern. While the revolving door patient had been referred to for some

time, its description through the SCCS hearing and articulation in the law made it a subject that could be acted upon, monitored, and governed. The recommendations of the SCCS were informed by the need for control over undisciplined and dangerous individuals. Rather than merely offer increased funding for mental health services or new forms of care, the CTO offers more opportunities to monitor and direct the activities of the revolving door patient. The imperative is to reduce danger through application of medication and ongoing surveillance. The revolving door patient is forced to choose between commitment to an institution or being monitored in a community. Choosing life in the community means developing insight, self-knowledge regarding one's mental status, and the adoption of particular practices to hold one back from becoming unpredictable. The subject of mental health governance is thereby made docile, predictable, less dangerous.

Discussion and conclusion

In Alberta, the deaths of Ostopovich and Galloway instigated changes to mental health legislation that grew out of concern to ensure care, but also to control danger. Shortly after deinstitutionalization the media began to report on people diagnosed with mental illness living in the streets and committing violent acts as a growing problem. Eventually, a subpopulation of people characterized as dangerous, unpredictable, and unable to understand their own consciousness were identified as a strain on the health system. These problematic individuals were in and out of services as they repeatedly refused treatment, entered emergency care, were released, then entered care again, were released, and so on. The CTO was legalized as the mechanism to solve the revolving door problem. While the CTO offers freedom in the sense of allowing the subject of the AMHA to live beyond the walls of an institution, the rationale of danger and control requires the subject to be supervised, to be medicated, to report regularly for health related check ups to ensure the person has not deteriorated and has not lost insight, become resistant or unreasonable.

As described herein, the revolving door patient is defined by behaviour attributed to unpredictable mental states and made responsible for its unpredictable character. Yet revolving door syndrome is not a necessity. Fabris (2011) has argued an approach to complicated mental states that does not refute suffering, or that some people can benefit from medications or other treatments to help them manage their lives. Instead, his personal experience and his research into other's experiences in relation to CTO's and traditional medical treatment lead him to argue that we can do things differently. Fabris argues that our categorizations and treatments of “madness” are inadequate and dominate people living with those experiences in unsatisfactory ways—alienating them from themselves, their families, and communities. He has also argued that our society needs to create space for “mad identity” and “mad experience” that is free from interference by people outside of that experience. He proposes practices that allow communities to support people, allow them to live with, and go through their “mad” experiences in safe, comfortable environments. People diagnosed with mental illness incorporate their experiences with the medical system, their diagnoses, and categorizations in their diagnostic labels, into their identities, and these subsequently relate to how they choose to live (Martin, 2006; Schneider, 2007, Carpenter-Song, 2009). There are lessons here for how we think and act in relation to diagnostic labels and behaviours.

Citing Paul Riceour, Arthur Frank (2013) argues that we bring our identities into being through the process of telling our life stories. The subject is not known or articulated at the beginning of the narrative. Frank also notes that “the responsibility for narrative identity is directly expressed in illness stories” and that chronic illness poses the question of whether one can be ill successfully (p.62). Considering cancer patients Frank (2016) asks “what kinds of stories are available to people, through which they can make sense of their experience being the person whom illness turns them into?” (p.14). Frank finds that cancer patients have had three broad narratives from which to draw, a medical-institutional narrative, a personal illness-experience narrative, and an in-between narrative promoted

through popular media such as the pink ribbon campaign. Considering the media history and medical-legal narratives of mental illness and revolving door syndrome I have shared in this paper, the narrative options for people diagnosed with mental illness are not very appealing. The concern with narrative options is at the core of what Fabris (2011) is trying to convey, he wants spaces for people diagnosed with mental illness to create their own narratives and be allowed to incorporate those into their identity without having that written off as a part of their illness, as mere anti-psychiatry rhetoric, or being otherwise discounted.

Frank (2002) has also described the fact that “the cancer patient as a generic entity does not exist. There are only persons who are different to start with, having different experiences according to the contingencies of their diseases”, his point being that “care begins when difference is recognized” (2002: 45). Care requires engaging people with regard to their individual illness-experiences, taking the time to recognize their individuality. Treatment, however, finds a middle ground between efficiency and care by creating an illusion that “begins with a recipe made up of key words referring to psychological states, that tells treatment providers what behavior to expect” (p.45). Following the narrative of the revolving door patient, it seems to be that the AMHA was not about care after all, but about treatment. In defining the revolving door patient as a legally actionable category, expected behaviors were defined, and solutions were proposed. That is to say, in making up the revolving door patient the possibilities for how this subject might be cared for, rather than merely treated, were reduced. The work of making the revolving door patient and the AMHA itself articulate a subject who is dangerous, unpredictable, a strain on the health care system, and who must be controlled in order to ensure treatment. Care may always have some tension with control, but appears to exist within an altogether different articulation of people and their relationships.

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