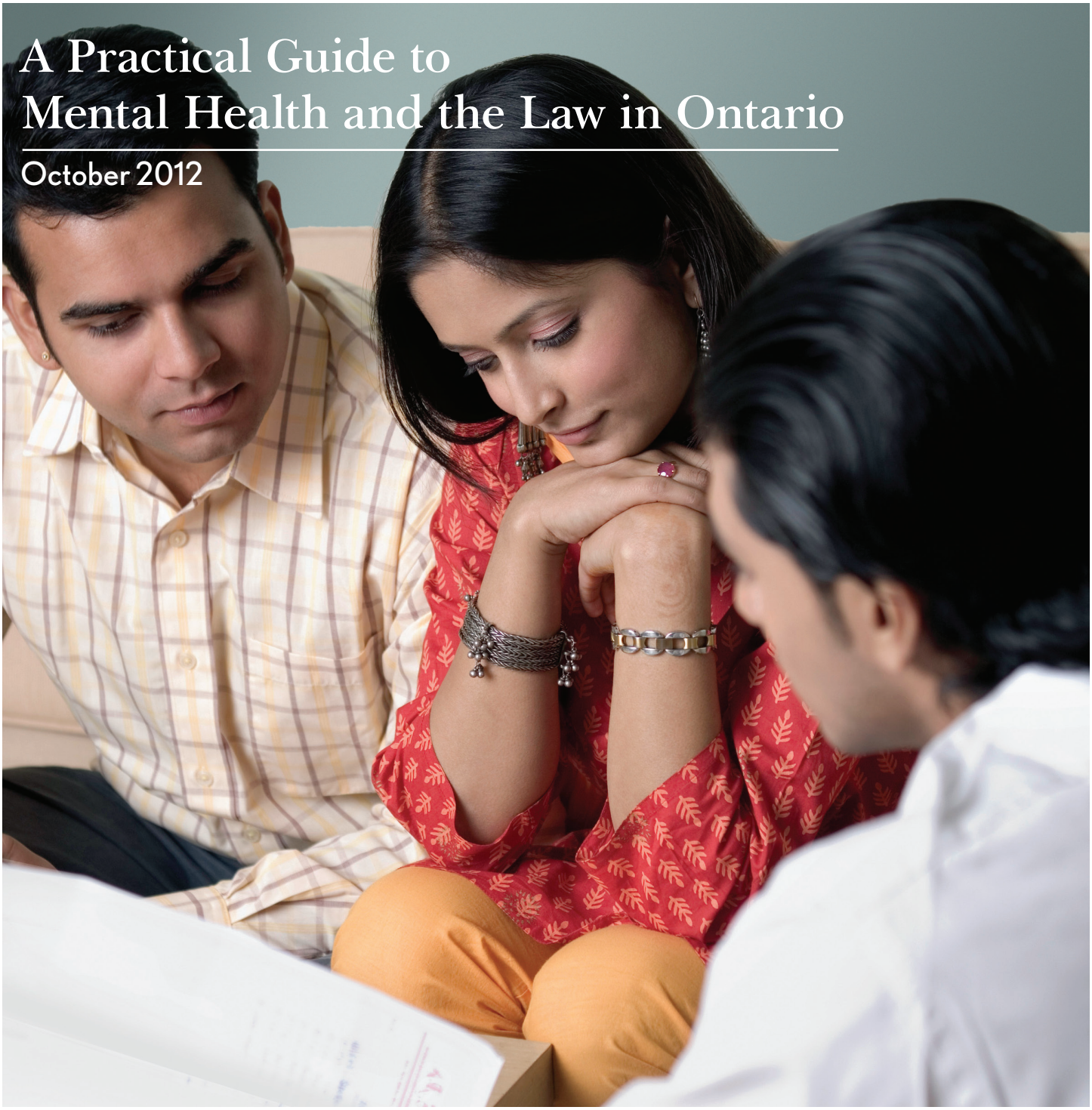
# A Practical Guide to Mental Health and the Law in Ontario

October 2012



ONTARIO HOSPITAL ASSOCIATION

# Foreword

The legislative and regulatory environment governing mental health in Ontario has evolved significantly in recent years. Health care practitioners, from both Schedule 1 and Non-Schedule 1 facilities are consistently faced with new and unique challenges in caring for patients with mental illness.

In 2009, the Ontario Hospital Association (OHA) released *A Practical Guide to Mental Health and the Law in Ontario Toolkit* (Toolkit) to assist health care providers in complying with the legislative provisions and legal principles governing the delivery of mental health services in Ontario. Then in October 2010, the OHA provided a legislative update to highlight the significant legislative changes impacting hospitals that provide mental health and addiction services.

Since that time, there have been a number of legislative changes impacting the provision of mental health services. As such, the OHA is pleased to offer an update to the Toolkit to ensure that health care practitioners have the most current and up-to-date resource to assist in caring for their patients in a mental health context.

People living with mental illness have unique needs and quite often several issues are at play. Understanding a patient's privacy, seeking rights advice, and ascertaining capacity, among others, makes mental illness and the law an increasingly complex area. We hope that you find this Toolkit useful, and that it will help Ontario hospitals and other health care providers build on the progress we have made in understanding the complex legal environment in which mental health care is provided.

Pat Campbell

President and Chief Executive Officer

Ontario Hospital Association

# Disclaimer

This Toolkit was prepared by Borden Ladner Gervais LLP for the ownership and use of the Ontario Hospital Association (OHA). This Toolkit is intended to provide health care providers with a general understanding of mental health law issues and with an overview of the legislation that governs the provision of mental health care in Ontario. It is also written from the perspective of legal counsel who regularly assist health care providers and institutions in mental health law matters.

The materials in this Toolkit are for general information. The Toolkit reflects the interpretations and recommendations regarded as valid at the time that it was published based on available information. The Toolkit is not intended as, nor should it be construed as, legal or professional advice or opinion.

Hospitals concerned about the applicability of mental health legislation to their activities are advised to seek legal or professional advice. The OHA will not be held responsible or liable for any harm, damage, or other losses resulting from reliance of the use or misuse of the general information contained in this Toolkit.



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As part of her appellate practice in both ORB and CCB matters, Barbara was co-counsel for an intervenor in the Supreme Court of Canada decision, *Starson v. Swayze*, which considered the legal test for capacity to consent to treatment in psychiatric care under Ontario's *Health Care Consent Act*. She has represented health care organizations and their staff in matters dealing with issues relating to mental health care, including ones that have involved constitutional challenges to mental health legislation. She also regularly advises psychiatric facilities on policy matters related to mental health care.

Barbara is author of the Chapter on Mental Health Law in the *Canadian Health Law Practice Manual*, published by Lexis Nexis.

# Acknowledgements


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Chapter 1

# Overview of Legislation Relevant to Mental Health Care in Ontario

## 1. Introduction

We are fortunate to be writing this Toolkit at a time when mental illness is receiving much needed attention in Ontario and across Canada.

In March 2007, the federal government appointed Senator Michael Kirby to chair the Mental Health Commission of Canada and charged the Commission with the task of developing a national strategy for setting priorities and coordinating services in mental health care. In May 2012, the Commission released a long awaited national mental health strategy: "Changing Directions, Changing Lives: A Mental Health Strategy for Canada.[1]"

Mental health care is regulated by both provincial and federal legislation. Generally, under Canada's Constitution, health is a provincial matter, while the criminal law is a federal concern. The ways in which these two levels of governmental power overlap creates tension as the criteria for the involuntary admission under the civil law of the province differs from the law governing the detention and eventual release into the community of the mentally disordered criminal offender. At the same time, the civil and forensic regimes look to the province's mental health care system to support the needs of mentally ill persons that each regime strives to address.

**In any given year, one in five people in Canada experiences a mental health problem or illness, with a cost to the economy of well in excess of $50-billion.**

*Mental Health Commission of Canada. (2012). Changing Directions, Changing Lives: The Mental Health Strategy for Canada, p. 8*

The intersection of law and medicine is never far below the surface when a patient and the health care team are discussing options for treatment. Ontario's law of consent to treatment, for example, has been designed to apply universally to all types of treatment in a wide variety of settings. Regardless of whether the setting is an out-patient clinic or a specialized psychiatric facility, there are special considerations in the mental health care context that we will address in this Toolkit. As one author has pointed out:

> *The treatment of psychiatric patients raises legal issues that ordinarily do not arise in the treatment of other illnesses. The fact that patients are often detained against their will places a high priority on the protection of individual rights within the treatment facility. Consequently, administrators and health professionals who work in the mental health field must be as sensitive to legal issues as they are to medical issues. Decisions about treatment of psychiatric patients will often receive a high degree of scrutiny from tribunals or boards charged under the provincial legislation with the review of such decisions. For courts and tribunals, the question whether treatment is authorized by law may eclipse any question about the quality of the treatment administered and whether or not it was effective. This is because courts and tribunals are concerned with process issues. If the process is inadequate, there is likely to be negative comments on the health care providers and institution regardless of the outcome for the patient*[2]

1 Strategy can be found at http://strategy.mentalhealthcommission.ca/pdf/strategy-images-en.pdf.

2 John J. Morris and Cynthia D. Clarke, *Law for Canadian Health Care Administrators*, 2nd ed., (LexisNexis, 2011), pp.151-152.

In Ontario, mental health care practitioners must be familiar with the legislation that governs treatment decisions and involuntary hospitalization. There are a multitude of procedural requirements and rights that apply when patients are incapable of making treatment decisions for themselves and where patients require admission to a psychiatric facility, whether on a voluntary, informal or involuntary basis.

The goal of this Toolkit is to provide health care providers and administrators with an overview of the legislative scheme governing mental health care in Ontario that is sufficiently detailed to use as a desk top resource. In this 2012 edition, we have updated the Toolkit to reflect noteworthy developments in Ontario's mental health law since the first edition was released in March 2009.

## 2. Historical Development and Context

On January 26, 1850, Ontario's first Provincial Lunatic Asylum opened its doors on the location of what is now known as the Queen Street Site of the Centre for Addiction and Mental Health. Upper Canada, which later became Ontario, was a colony of the United Kingdom, and so had imported the approach set out in the *County Asylums Act*, a statute passed by the British House of Commons in the year 1813, which provided for the establishment of institutions for care of the mentally ill.[3] Following the opening of Ontario's first Asylum, other provincial public mental hospitals were opened to provide treatment and custody for the seriously mentally ill. For many years, Ontario's *Mental Hospitals Act* governed such facilities.

The courts reviewed admission and discharge decisions into designated mental hospitals until 1933, when the legislation changed to allow for any two physicians to authorize the admission of a mentally ill person, with no involvement of the judicial system. The legislation did not provide for the review of the committal decision unless the patient brought a writ of habeas corpus to the Court for the purpose of challenging the lawfulness of the detention and seeking a court order requiring the patient to be released.[4]

In the early 1960s, with the introduction of new medications for treating mental illness, it became possible to reduce or control symptoms to the extent that patients could be discharged into the community to settings such as Homes for Special Care, or as out-patients monitored by acute care, hospital based psychiatric teams.[5] The introduction of universal health insurance in Ontario in 1972, for example, resulted in a "four fold increase in the utilization of psychiatric services."[6]

**Since the 1960s, a number of other developments have had a significant impact on the mental health system in Ontario.**

3 Michael Bay, "1933-2003: Lessons from 70 Years of Experience with Mental Health, Capacity and Consent Legislation in Ontario", Health Law in Canada, April 2004, Vol. 24, No. 3, pp. 36 – 43, at p. 36.

4 *Ibid.*

5 Dan Newman, M.P.P. and Parliamentary Assistant to the Minister of Health, "Mental Health 2000 and Beyond: Strengthening Ontario's Mental Health System: A Report on the Consultative Review of Mental Health Reform in the Province of Ontario", June 1998.

6 *Ibid.*

Another significant development was the amendment in 1968 of the *Mental Health Act* ("MHA"), which provided for the admissions of persons to a psychiatric hospital based on criteria of "dangerousness", and where the person required hospitalization "in the interests of his/her own safety or the safety of others". The MHA also established a tribunal that could review the committal, if the patient requested.[7]

In 1978, the MHA was amended to include criteria for involuntary admission where the person was suffering from a mental disorder and was at risk of "imminent and serious physical impairment of the person." Although the "imminent" criteria only applied to the physical impairment of the patient, the view that it also applied to the dangerousness criteria was widely held and persists today, even after the removal of the word "imminent" from the legislation when it underwent further reform in the year 2000. As government publications have noted, "the 'imminent' requirement often prevented people who were deteriorating from getting the treatment they needed at an earlier stage."[8]

In the 1990s, the MHA was again amended to protect patients' legal rights by requiring that rights advice be delivered to patients in certain circumstances and by imposing obligations on hospital administrators to ensure that procedures associated with involuntary admissions were followed.[9]

Up until the 1990s, treatment decisions were not the subject of legislation. Treatment of incompetent persons was based on the directions of the family, or, on the clinical opinion of the treating physician.[10] The Crown had the ultimate responsibility for the treatment of incompetent adults as there were no principles in the common law that provided for an individual substitute decision maker to have priority over the Crown. In fact, health practitioners could be liable to patients for the common law tort of battery, if they treated incompetent adults without court authorized consent.[11]

Consent to treatment legislation, which was introduced in the 1990s, represented a significant shift away from global findings of incompetency to a more nuanced approach to capacity that recognized that capacity could fluctuate with respect to both time and treatment. The legislation began as the *Consent to Treatment Act* in 1992, and later evolved into the *Health Care Consent Act* ("HCCA").[12]

The law set out in the HCCA essentially codifies the common law requirement that health care practitioners obtain capable, informed and voluntary consent prior to proceeding with treatment. The HCCA rules on consent to treatment are applicable universally in all health care settings, and therefore, apply to mentally ill patients in psychiatric facilities. Further, the HCCA establishes that patients may challenge findings of incapacity by applying to the provincial Consent and Capacity Board ("CCB") for a review of the finding. If the CCB confirms the health care provider's finding of incapacity, the patient has a right of further review or appeal to the courts.[13]

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7 MHA amendments, S.O. 1967, c. 51, s. 8, and Michael Bay, *supra* note 3.

8 "Mental Health: Bill 68 (Mental Health Legislative Reform), 2000"; Ontario Ministry of Health and Long Term Care web site; http://www.health.gov.on.ca/english/public/pub/mental/imminent.html; accessed on May 29 2012.

9 Michael Bay, *supra* note 3 at p. 38.

10 *Enquiry on Mental Competency: Final Report, Chairman:* Professor David Weisstub, 1990, at p. 306.

11 John J. Morris, "Substitute Decision Makers: Who has Authority to make the Decisions?" conference paper, June 6, 1996, citing Re Eve, [1986] 2 S.C.R. 388; at pp. 1 2.

12 *Health Care Consent Act,* S.O. 1996, c. 2, Sch. A., [HCCA].

13 A more detailed discussion of the law relating to consent to treatment and the jurisdiction of the Consent and Capacity Board, including practical issues related to appearing before the Board, is set out in Chapters 2 and 5 respectively.

The issue of capacity to manage property arises regularly in the provision of mental health care, particularly upon admission to a psychiatric facility. For many years, Ontario had a *Mental Incompetency Act*,[14] which provided for a global finding of mental incompetency, based on evidence that a person was suffering from either developmental delay or brain injury or a mental disorder of such a nature that the person required care and supervision for his or her protection. Once such a global finding had been made, the *Mental Incompetency Act* called for the establishment of a "committee" that would oversee the person's property. This Act was eventually repealed in 1995.

The *Substitute Decisions Act* ("SDA") came into force in 1992. It provides the procedure by which a person's capacity to manage property or to make personal care decisions may be assessed. It also provides the criteria that must be met in order for the Public Guardian and Trustee ("PGT") or someone else to become a person's guardian, in the event that the person is found incapable. Further, it sets out the legal framework for granting power to an "attorney" of the person's choosing, in the event of his or her incapacity to manage property or to make personal care decisions.

Following the provincial government's 1998 review of Ontario's mental health related legislation,[15] amendments were made to the MHA to address the "revolving door syndrome". This "syndrome" saw a patient admitted to a hospital in crisis, treated under substitute consent until the crisis passed, and then discharged to the community where insufficient out-patient resources lead to the patient's eventual non compliance, deterioration and return to hospital for a further involuntary admission. The amendments included a new ground for civil commitment: substantial mental or physical deterioration that would likely arise if the person were not treated. This ground is now known as the "Box B" criteria and may be used as the basis for a preliminary "Form 1" application for psychiatric assessment, as well as an involuntary admission.

Notably, the year 2000 amendments to the MHA also established Community Treatment Orders ("CTOs"), which provide a structure for the treatment of persons with mental illness in the community, rather than in a psychiatric facility, if certain criteria are met.[16]

The legislative scheme governing the provision of mental health care in Ontario continued to evolve with the introduction in 2004 of the *Personal Health Information Protection Act* ("PHIPA"). This legislation sets out comprehensive rules for the collection, use and disclosure of personal health information in a manner that provides for the consistent protection of confidentiality of personal health information, while also facilitating the effective provision of health care. PHIPA, in large measure, replaced and amended some of the specific provisions that governed clinical psychiatric records in prior versions of the MHA. However, there remain notable exceptions that allow the "privacy" provisions of the MHA to take precedence over the provisions of PHIPA.[17]

14 R.S.O. 1990, Chapter M.9, repealed on April 3, 1995.

15 Dan Newman, *supra* note 5.

16 We discuss the *Mental Health Act*, and the law governing psychiatric patient admissions, including voluntary, informal and involuntary admissions, as well as community treatment orders in Chapter 3. For a discussion of the amendments which led to Community Treatment Orders, see: http://www.health.gov.on.ca/english/public/pub/mental/treatment_order.html; accessed on May 29, 2012.

17 Privacy of personal health information in mental health care is discussed in Chapter 7 in greater detail.

The two administrative tribunals that most frequently hear matters concerning the rights of mentally ill persons are the Consent and Capacity Board (CCB) and the Ontario Review Board ("ORB"). The CCB has jurisdiction to hear matters under a number of Ontario statutes: The HCCA, the MHA, the SDA, the PHIPA, and more recently, the *Mandatory Blood Testing Act,* 2006[18]. Because health care providers are frequently called up on to appear before the CCB to defend findings of incapacity to consent to treatment, as well as involuntary admissions and admission to long term care, we have devoted Chapter 5 to hearings before the CCB.

The ORB is an administrative tribunal established pursuant to Part XX.I of the Criminal Code to have jurisdiction over criminally accused persons who have been found unfit to stand trial or who have been found not criminally responsible on account of mental disorder. Prior to 1992, criminally accused persons had available to them the common law defence of insanity, which was recognized in Section 16 of the Criminal Code. Other provisions of the *Criminal Code* allowed those found unfit to stand trial or found not guilty by reason of insanity to be automatically detained in custody at the discretion of the Lieutenant-Governor of the province. Following the enactment of the *Canadian Charter of Rights and Freedoms*[19], those provisions of the *Criminal Code* were challenged and found by the Supreme Court of Canada to be unconstitutional, leading to the reform which gave rise to the current system under Part XX.I.[20] We will address ORB hearings within Chapter 6, which deals with the forensic psychiatric system and mentally disordered offender.

# 3. Key Legislation

## The *Mental Health Act*

The MHA sets out the criteria for voluntary, informal and involuntary admissions to specially designated psychiatric facilities, as well as for the management of psychiatric out-patients under CTOs. The statute also requires the assessment of psychiatric patients' capacity to manage property following their admission to a psychiatric facility. The statute protects the rights of psychiatric patients by requiring that patients receive formal rights advice in certain circumstances and providing for the review of informal and involuntary admissions, capacity to manage property and CTOs before the CCB.

## The *Health Care Consent Act*

This legislation sets out rules for determining capacity in three key areas: treatment decisions; admission to care facilities; and personal assistance services. It also provides rules for obtaining informed, voluntary consent from either the capable patient or his or her substitute decision maker ("SDM"); and provides for the review of findings of incapacity by a provincial administrative tribunal, the CCB. The HCCA sets out who may take on the SDM role, and by what principles SDMs should be guided in making treatment decisions. Other provisions of the HCCA provide when treatment may be administered in emergency situations and if and when treatment may be commenced pending the resolution of an appeal of an incapacity finding.

18 *Mandatory Blood Testing Act* 2006, S.O. 2006, C. 26.
19 Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 ("the Charter").
20 The case which considered and decided the constitutionality of the former regime was *R. v. Swain*, [1991] 1 S.C.R. 933.

## The *Substitute Decisions Act*

This statute provides the legal framework for granting a power of attorney for personal care or property, which allows capable individuals to appoint someone to act on their behalf during a period of incapacity. As well, the statute sets out the procedure for an individual to apply to the Court to be appointed as a guardian where a person has not completed a power of attorney, or where someone wishes to challenge the validity of a particular power of attorney. This is an important piece of "companion" legislation to both the MHA and the HCCA.

## The *Personal Health Information Protection Act*

This legislation, enacted in 2004, governs the collection, use and disclosure of personal health information. It is essential for health care providers to understand how the unique demands of providing mental health care affect the interpretation of the health information custodian's obligations under PHIPA, and to understand the circumstances in which the MHA takes precedence over the terms of PHIPA, to allow for the collection, use and disclosure of personal health information without consent.

## Part XX.I of the *Criminal Code of Canada*

Since 1992, this section of the Criminal Code has governed the assessment, detention and release of persons who have come into contact with the criminal justice system as a result of mental disorder, and who have been found either unfit to stand trial or, not criminally responsible on account of mental disorder. The detention, treatment and supervision of criminally accused, forensic psychiatric patients in specially designated psychiatric facilities is a sub-speciality of mental health law with which mental health care providers should have some familiarity, regardless of whether they work for one of Ontario's forensic facilities.

**In summary, the key pieces of legislation that mental health care practitioners and administrators need to know are:**

- The *Mental Health Act*
- The *Health Care Consent Act*
- The *Substitute Decisions Act*
- The *Personal Health Information Protection Act*
- Part XX.I of the *Criminal Code of Canada*

# Chapter 2 Consent to Treatment

## 1. Introduction

The focus of this chapter is consent issues for patients with mental illness. This requires consideration of the principles and provisions of the HCCA which applies to all areas of health care in the Province of Ontario.

A fundamental principle of health care in Ontario is that treatment shall not be provided without consent. If a patient is capable, then that patient will decide whether to consent to, or refuse, the proposed treatment. If a patient is not capable, then a SDM will be asked to make the decision on their behalf.[21]

**Appendix "A" provides a decision tree to assist in working through some of these issues.**

The stated purposes of the HCCA include the following:

(a) To provide rules with respect to consent to treatment that apply consistently in all settings;

(b) To facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;

(c) To enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by,

  (i) Allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,

  (ii) Allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to a care facility or personal assistance services, and

  (iii) Requiring that wishes with respect to treatment, admission to a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to;

(d) To promote communication and understanding between health practitioners and their patients or clients;

(e) To ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service; and

(f) To permit intervention by the PGT only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to a care facility or personal assistance services.[22]

21 HCCA, *supra* note 12, s. 10.
22 *Ibid.*, s. 1.

The evolution of this legislation is summarized in the Introduction to this Toolkit.

**This Chapter will focus on the treatment section, or Part II, of the HCCA, and its impact on the provision of treatment for mental illness in the hospital and out-patient settings.**

## What is "Treatment"?

The definition of "treatment", and related terms, are set out in the definitions section of the HCCA:

"**treatment**" is "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan". The definition of treatment specifically states that it does not include:

1. the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the SDA of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,
2. the assessment or examination of a person to determine the general nature of the person's condition,
3. the taking of a person's health history,
4. the communication of an assessment or diagnosis,
5. the admission of a person to a hospital or other facility,
6. a personal assistance service,
7. a treatment that in the circumstances poses little or no risk of harm to the person,
8. anything prescribed by the regulations as not constituting treatment.[23]

A "**course of treatment**" is a "series or sequence of similar treatments administered to a person over a period of time for a particular health problem".[24]

A "**plan of treatment**" is "a plan that:

1. Is developed by one or more health practitioners;
2. Deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition; and
3. Provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition".[25]

23 *Ibid.*, s. 2.
24 *Ibid.*
25 *Ibid.*, s.13.

Where a plan of treatment is proposed, one health care provider is able to represent others involved in the plan for the purposes of proposing the treatment, assessing capacity and seeking the informed consent of the capable patient or SDM of an incapable patient.[26]

A "**community treatment plan**" is "a plan that is required as part of a community treatment order"[27] and will be discussed in Chapter 3.

An individual's capacity, or incapacity, is always considered with respect to the proposed treatment for which consent is being sought. An individual can be capable with respect to some treatments, and incapable with respect to others.[28] Capacity can fluctuate, and an individual may be capable with respect to a proposed treatment at one time, and incapable at another.[29] If an individual becomes capable with respect to a treatment that is being provided pursuant to substitute consent, then that person's decision to continue with, or discontinue, the treatment will supersede the substitute consent.[30]

In a review of a person's capacity to consent to treatment, one of the first questions to be asked is "**what is the proposed treatment**". As a health care provider seeking consent to treatment, it is important to be clear on what is being proposed to the patient, or their SDM.

Necessary and "**ancillary treatment**" will be covered by substitute consent when it is required as part of the treatment for which the substitute consent is given. This will be the case even if the person is capable with respect to the necessary and ancillary treatment.[31] Some examples of "ancillary" treatment issues include the use of restraints for the purpose of administering medication by injection pursuant to substitute consent[32] and diagnostic testing, or testing for the purpose of monitoring a condition or treatment.

# 2. Determining Capacity to Consent to Treatment

## The Test for Capacity

The test for capacity is set out in subsection 4(1) of the HCCA and provides that:

> **A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.** [33]

26 *Ibid.*
27 *Ibid.*
28 *Ibid.*, s. 15(1).
29 *Ibid.*, s. 15(2).
30 *Ibid.*, s. 16.
31 *Ibid.*, s. 23.
32 *T. (S.M.) v Abouelnasr*, 2008 CarswellOnt 1915 (Ont. S.C.J.).
33 HCCA, *supra* note 12, s. 4(1).

Based on the statute, an evaluation of capacity involves a "two-part test" with consideration of the following:

A capable person:

(a) Is able to understand the information relevant to making a decision about the proposed treatment; and

(b) Is able to appreciate the reasonably foreseeable consequences of their decision.

A person may be found incapable if he or she does meet one part of the test, or both.

There is a presumption of capacity with respect to treatment and absent "reasonable grounds", a health care practitioner can assume that a person is capable.[34]

Capacity can fluctuate – it is not static, and must be considered at various points in time and in relation to different issues and/or proposed treatments. A health care provider who becomes involved with an incapable person can rely upon previously documented evaluations and assessment of capacity, however, the health care provider should review capacity as appropriate during his or her clinical interactions with a patient.

## PART A:
### *Is the person able to understand the information that is relevant to making a decision about the treatment?*

In the leading decision or consent to treatment, *Starson v. Swayze*[35], the Supreme Court of Canada commented on the first part of the test as follows:

> ***The person must be capable of intellectually processing the information as it applies to his or her treatment, including its potential benefits and drawbacks.*** *Two types of information would seem to be relevant: first, information about the proposed treatment; and second, information as to how that treatment may affect the patient's particular situation. Information relevant to the treatment decision includes the person's symptoms and how the proposed treatment may affect those symptoms. (emphasis added)*[36]

Individuals who are not capable as defined by this first part of the test often have a cognitive condition that impedes their ability to retain and or process the information. Communication barriers[37] should not be an impediment to a person's ability to process relevant information. When seeking consent from an individual who has difficultly communicating, all reasonable steps should be taken to facilitate their discussion with their health care providers for the purpose of assessing capacity and seeking consent.

34 *Ibid*, s. 4(2)(3).
35 *Starson v Swayze*, 2003 SCC 32, [2003] 1 S.C.R. 722, 225 D.L.R. (4th) 385.
36 *Ibid*, para. 16.
37 Examples of communication barriers include language barriers, a person being deaf or a person being unable to speak. Possible solutions to remove these communication barriers may include the use of interpreters, communication through "hand squeezing" or "blinking" as well as writing, typing and other forms of communication.

## PART B:
### *Is the person able to appreciate the reasonably foreseeable consequences of a decision or lack of decision?*

The second component of the test is that the person be "able to appreciate the reasonably foreseeable consequences of a decision or lack of decision". In considering the second part of the test, in *Starson v. Swayze*, the Supreme Court of Canada commented that:

> ***The patient must be able to acknowledge his or her symptoms in order to be able to understand the information relevant to a treatment decision.*** *Agreement with a medical professional's diagnosis per se, or with the "label" used to characterize the set of symptoms, is not, however, required.*[38] *(emphasis added)*

The appreciation test has been characterized as more stringent than a mere understanding test. In the Starson decision, Justice Major commented that:

> *While a patient need not agree with a particular diagnosis, if it is demonstrated that he has a mental "condition", the patient must be able to acknowledge the possibility that he is affected by that condition…As a result, a patient is not required to describe his mental condition as an "illness", or to otherwise characterize the condition in negative terms…**Nonetheless, if the patient's condition results in him being unable to recognize that he is affected by its manifestations, he will be unable to apply the relevant information to his circumstances, and unable to appreciate the consequences of his decision.***[39] *(emphasis added)*

This is the more complicated part of the test, and is often the main issue at CCB hearings. A patient will not be able to "appreciate the reasonably foreseeable consequences of a decision" if he/she cannot apply the information relevant to making the decision to his or her own situation.

In making a determination of a person's ability to appreciate the consequences of a decision, or lack of decision, in respect of treatment there must be tangible evidence of understanding consistent with and beyond mere verbalization of an understanding. The second part of the test for capacity will not be met where it is demonstrated that the person is unable to apply the information about the proposed treatment to his/her own situation.[40]

#### Examples of Incapacity Under this Part of the Test

A patient diagnosed with schizophrenia is able to understand the information about the illness, and that it can affect some people, but does not believe that he has that illness, in spite of a two year history of symptoms consistent with schizophrenia, hospitalization and treatment.

A patient diagnosed with anorexia nervosa is able to understand and intelligently discuss the nature and consequences of the illness and readily acknowledges that people have to eat or that they may die. In spite of this, the patient is not able to eat and maintains that she will be fine.

38 *Starson, supra* note 35, para 16.
39 *Ibid.*, at para. 79.
40 *Khan v. St. Thomas Psychiatric Hospital* (1992), 7 O.R. (3d) 303 (C.A.) at pp. 314 5; *Tran v. Ginsberg*, 2011 ONSC 927 at pp. 34 and 38.

## Adolescents and Children

Health care practitioners often ask if there is an "age of consent". The short answer is no. The presumption of capacity applies to all persons, regardless of age.

Age can, and should, be taken into account by a health care practitioner when considering whether there are "reasonable grounds" to depart from the presumption of capacity and when assessing capacity. If the patient is a baby, this concept is overwhelmingly obvious. Presumably, the health care provider does not waste more than a second's thought on who to go to for informed consent to treatment. As the child matures, this thought process should deepen.[41] While the patient's age will become decreasingly determinative, it need not be ignored completely.[42]

There is a requirement for formal rights advice to be given to any patient in a psychiatric facility who has been found incapable with respect to treatment if they are 14 years of age or older.[43]

Otherwise, health practitioners are simply expected to follow their professional guidelines with respect to the provision of information about the consequences of a finding of incapacity, which recognize that the communication should take into account the particular circumstances of the situation, which presumably would include the patient's age / maturity.

In the case of a reasonably intelligent adolescent, however, the health care practitioner would likely be expected to advise the young person that they are not considered to be capable of making this particular treatment decision, and that a SDM [i.e., usually the parent] will be making decisions about their care. It would also be expected that this young person would be provided with an explanation of the right to apply to the CCB for a review of the finding of incapacity. There is no age restriction involved in making an application to the CCB.

## Geriatric Patients

For elderly people, the same presumption of capacity applies. The difficulty is that, with older patient populations, capacity can be affected by a myriad of health care conditions that develop as a result of the aging process. Geriatric patients can have significant mental health issues that need to be recognized and addressed.

Capacity in this patient population needs to be carefully and routinely evaluated. Capacity can fluctuate and at times may depend on the stability of an underlying condition.

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41 The term "mature minor" is really just a short form of describing a young adolescent who has been judged to have the capacity to make the particular decision under discussion, despite the past practice of generally regarding all children under the age of 16 to be under their parents' control when it came to medical decision making. In *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181 – The Supreme Court of Canada found that the child's views with respect to his or her health care decisions become increasingly determinative depending on his or her maturity. However, the more serious the nature of the decision and the more severe its potential impact on life or health, the greater the degree of scrutiny required to determine whether the child in fact has capacity to make the given decision or not. If, after a careful analysis of the young person's ability to exercise mature and independent judgment, the court is persuaded that the necessary level of maturity exists, the young person's views ought to be respected.

42 Please see comments above re: the 2009 decision of the SCC. Support for this view is also found in the decisions of Madame Justice Janet Wilson, (*T.H. v. Children's Aid Society of Metropolitan Toronto, et. al* (Unreported, January 5, 1996, Ont Ct (Gen. Div.)), in which a 13-year old Jehovah's Witness appealed from a Provincial Court finding that she was a child in need of protection. The girl was refusing a life preserving blood transfusion, and her mother insisted that the girl alone make that decision. It was confirmed that the law does not recognize a specific age of consent. Rather, it holds that capacity or lack of capacity is a function of a number of factors including the maturity of the individual and the complexity of the decision to be made.

43 Section 15 of R.R.O. 1990 Reg. 741, to the *Mental Health Act*.

### Example of Incapacity Under this Part of the Test

A patient with dementia may lose her capacity to make certain decisions as her condition worsens. She may well retain the ability to make lower level decisions regarding her care and treatment, or aspects of her discharge plan.

This patient population needs to be carefully evaluated so that they are given the opportunity to make decisions for themselves to the extent it is appropriate, but at the same time monitored closely so that a SDM can make decisions when necessary.

## Consequences of a Finding of Incapacity

Under the MHA, patients admitted to a psychiatric facility must be given "notice" of findings of incapacity.[44] A "Form 33" Notice is given to a psychiatric patient who has been found incapable of consenting to treatment.[45]

Members of regulated health professions are also subject to practice guidelines from their respective Colleges.[46] These guidelines generally require health care practitioners to consider capacity and explain findings of incapacity to their patients. Each regulated health professional should be familiar with their professional obligations as set out for their discipline.

The "next steps" on the part of the health care provider will be to determine who the appropriate SDM is for the incapable person, and to seek their informed consent for the proposed treatment.

# 3. Substitute Decision Makers

When a person is incapable, a health care provider proposing treatment will look to their SDM to make decisions on their behalf.

## Identifying an Appropriate Substitute Decision Maker

There is a "hierarchy" for determining who may give substitute consent on behalf of an incapable person.

The following is a reproduction of the hierarchy from the legislation:

1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.

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44 The requirement for rights advice to be given to a person who is admitted to a psychiatric facility who is 14 years of age or older on a finding of incapacity with respect to treatment is set out in s. 15 of R.R.O. 1990 Reg. 741, to the *Mental Health Act*.

45 Rights Advice to psychiatric patients and Form 33s are discussed in Chapter 3.

46 The College of Physicians and Surgeons of Ontario – Policies, online: The College of Physicians and Surgeons of Ontario, <http://www.cpso.on.ca>, The College of Nurses of Ontario –Standards and Guidelines, online: The College of Nurses of Ontario, <http://www.cno.org>.

3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent to the treatment.
4. The incapable person's spouse or partner.
5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.
6. A parent of the incapable person who has only a right of access.
7. A brother or sister of the incapable person.
8. Any other relative of the incapable person.[47]

Generally, the highest-ranking person in the "hierarchy" is entitled to make decisions on behalf of the incapable person. An SDM who is lower in priority may give or refuse consent if they believe that a higher ranking SDM would not object to him or her making the decision as long as the higher ranking SDM is not guardian, attorney for personal care or CCB representative.[48]

In addition to being the "highest ranking" on the list, in order to be a SDM there are additional criteria, all of which must be met.[49] These criteria include:

1. The proposed SDM must be capable with respect to the treatment. The 'test" for capacity for a SDM is the test set out in section 4 of the HCCA and which is discussed in detail above.
2. The proposed SDM must be at least 16 years old, unless he or she is the incapable person's parent.
3. The proposed SDM must not be prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf.
4. The proposed SDM must be available.
5. The proposed SDM must be willing to assume the responsibility of giving or refusing consent.

**A possible SDM is "available" if "it is possible, within a time that is reasonable in the circumstances, to communicate with the person and obtain a consent or refusal". If an SDM is out of the country for an extended period of time, and is not available as required by the health care providers, they will not meet the criteria to make decisions for the incapable person. (subsection 21(11) of the HCCA).**

47 HCCA, *supra* note 12, s. 20(1).
48 *Ibid.*, s. 20(4).
49 *Ibid.*, s. 20(2).

The following is a more detailed commentary of the various rankings within the hierarchy.

### 1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.

A "guardian of the person" is someone who has a Court Order for guardianship. The application process to be appointed as a guardian is set out in the SDA.[50] When appointing a guardian, the court must specify the functions over which the guardian has decision making power. This can be limited in time or by any conditions the court wishes to impose.[51] Full guardianship may be ordered when the individual is fully incapable of all functions.[52] In all other cases, the court will award a partial guardianship outlining the exact role of the guardian.[53] Where the guardian has authority to give or refuse consent to the proposed treatment, the guardian will be the SDM for the incapable person, as there is no higher ranking option.

**Examples of Situations in which a Guardianship Application may be made:**

- Equally ranked SDMs disagree on a proposed treatment and one (or more) is seeking to be appointed so as to be in a position of higher rank in the determination of who is the SDM.
- A close friend of the patient applies to be appointed if the patient does not have any family.

The court will only appoint someone to this role if it is satisfied that there is no other alternative action which does not require the person to be found incapable and which is less restrictive on the person's decision making rights.[54] The court will also consider whether the proposed guardian is the incapable person's guardian for property under a continuing power of attorney; the incapable person's wishes, if they can be ascertained; and the closeness of the relationship between the applicant and the incapable person.[55]

The court will not appoint a person who is paid to provide health care, social, training or other support services unless this person is also a family member or there is no other suitable and available person.[56]

**Where the SDM for an incapable person is a guardian of the person, it is strongly recommended that a copy of the Court Order be placed in the incapable person's chart.**

50 *Substitute Decisions Act,* S.O. 1992, c.30, ss.55 – 65, [SDA]. These sections in Part II of the SDA cover applications for Guardianship of the Person.
51 *Ibid.*, ss. 58(1)(2).
52 *Ibid.*, s. 59(1). The test for determining capacity to consent to "personal care" is in s. 45 of the SDA.
53 *Ibid.*, ss. 58(3) and 60.
54 *Ibid.*, s. 55 (2).
55 *Ibid.*, s. 57 (3).
56 *Ibid.*, s. 57 (1). Unless the person is also the Guardian of Property, Power of Attorney for Personal care or Continuing Power of Attorney, as per s. 57(2).

### 2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.

A "Power of Attorney for Personal Care" is a document completed in accordance with the legal requirements set out in the SDA.[57] The test for capacity to grant a power of attorney for personal care is not the same as the test for capacity to consent to treatment. A person is capable of granting a power of attorney if:

(a) The person can understand whether the proposed attorney has a genuine concern for their welfare; and

(b) The person can appreciate that the attorney may need to make decisions regarding personal care on his or her behalf.[58]

To be valid, the power of attorney document must be signed in front of two witnesses, and the witnesses must also sign the document.[59]

The attorney may have authority to make treatment decisions if the patient has been determined not to be capable under the HCCA.[60] Provisions may be included in a power of attorney which restrict the attorney from making any decisions until it has been formally determined that the grantor is not capable and may outline the method to be used and factors to be considered to make this determination.[61]

Several provisions which may be included in the power of attorney are considered to have such significant consequences for the grantor that additional requirements must be met before these provisions are valid. These provisions include:

(a) Authorizing the reasonable use of force to:
  (i) Determine if the patient is incapable;
  (ii) Confirm if the patient is incapable of personal care when there is a condition that no decisions may be made by the attorney until this is confirmed; or
  (iii) Obtain an assessment for any reason the patient outlines in the power of attorney;

(b) Authorizing the reasonable use of force to admit and/or detain the patient in the place where the patient is receiving care or treatment;

(c) Waiving the patient's right to a review by the CCB of a finding of incapacity by a health practitioner or an evaluator.[62]

57 *Ibid.*, ss. 46 – 54. These sections cover Powers of Attorney for Personal Care.
58 *Ibid.*, s. 47.
59 *Ibid.* There is a list of individuals who are excluded from acting as a witness to a power of attorney (s. 10(2) SDA), which includes the attorney, or the attorney's spouse/partner; the grantor's spouse/partner; a child of the grantor or a person whom the grantor has demonstrated a settled intention to treat as his or her child; a person whose property is under guardianship or who has a guardian of the person; and a person who is less than eighteen years old.
60 *Ibid.*, ss. 49(1)(2).
61 *Ibid.*, ss. 49(1)(b), (2)(3).
62 *Ibid.*, s. 50(2).

In order to make these provisions effective the power of attorney must include:

(a) A statement from the grantor, on the prescribed form, indicating that within 30 days after executing the power of attorney the grantor understood its effect; and

(b) A statement from an assessor, on the prescribed form, dated within 30 days after the power of attorney was executed, indicating that at the time of the assessment the grantor was capable of personal care, he or she understood the effect of the document and the facts upon which the assessor's opinion is based.[63]

A court has the power to validate any power of attorney that is otherwise ineffective.[64]

**Where the SDM for an incapable person is a power of attorney for personal care, it is recommended that a copy of the power of attorney document be placed in the incapable person's chart.**

### 3. The incapable person's representative appointed by the CCB under section 33, if the representative has authority to give or refuse consent to the treatment.

The procedure and process for an application to the CCB to be appointed as a "representative" is set out in section 33 of the HCCA. This type of application can be brought by an incapable person, for the appointment of someone to make decisions for them, or by another person who wants to make decisions for the incapable person.[65] If the incapable person has a court appointed guardian or a power of attorney for personal care with the authority to give or refuse consent to the proposed treatment they do not have the right to apply to the CCB for a representative.[66]

Treatment cannot be commenced while an application for the appointment of a representative is pending.[67]

**Where the SDM for an incapable person is a representative appointed by the CCB, it is recommended that a copy of the Order of the CCB be placed in the incapable person's chart.**

63 *Ibid.*, s. 50(1).
64 *Ibid.*, s. 48(4).
65 HCCA, *supra* note 12, s. 33(1)(2).
66 *Ibid.*, s. 33(3).
67 *Ibid.*, ss. 18(2)(3).

### 4. The incapable person's spouse or partner.

Unless two people are living separate and apart as a result of a breakdown in their relationship[68], they are considered to be "spouses" if:

(a) they are married to each other; or

(b) they are living in a conjugal relationship outside marriage and,

(i) have cohabited for at least one year,

(ii) are together the parents of a child, or

(iii) have together entered into a cohabitation agreement under section 53 of the *Family Law Act*, 1996.[69]

A "partner" is "either of two persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives".[70] The definition of "spouse" in the HCCA includes same sex partners.

### 5. A child or parent of the incapable person, or a Children's Aid Society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent.

**This paragraph does not include a parent who has only a right of access. If a Children's Aid Society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.**

If there is more than one child of the incapable person, all children rank equally as substitute decision makers.

A "child" is not defined in the HCCA. A "child" includes any child of their natural parents, whether born within or outside marriage and any child who has been formally adopted.[71] There is also a "presumption of paternity" in a variety of circumstances.[72]

68 *Ibid.*, s. 20 (8).
69 *Ibid.*, s. 20 (7).
70 *Ibid.*, s. 20 (9)(b).
71 *Children's Law Reform Act*, R.S.O. 1990, C.12, s. 1 [CLRA].
72 *Ibid,* s. 8(1). These circumstances include: when the person is married to the mother of the child at the time of the birth; the person was married to the mother of the child by a marriage that was terminated by death or judgment of nullity within 300 days before the birth of the child or by divorce where the decree nisi was granted within 300 days before the birth of the child; when the person marries the mother of the child after the birth of the child and acknowledges that he is the natural father, when the person was cohabiting with the mother of the child in a relationship of some permanence at the time of the birth of the child or the child is born within 300 days after they ceased to cohabit; the person has certified the child's birth, as the child's father, under the *Vital Statistics Act* or a similar Act in another jurisdiction in Canada; and when the person has been found or recognized in his lifetime by a court of competent jurisdiction in Canada to be the father of the child.

### 6. A parent of the incapable person who has only a right of access.

When dealing with parents who are making decisions for their incapable children, the highest ranking parent is the one who has custody. If both parents have custody (i.e., living together or through a joint custody agreement following a marital separation), both are equally entitled to make decisions.

As indicated by the numbering above, where the parents are separated and one has custody and the other access, the custodial parent is a higher ranked substitute decision maker.

**In situations in which there is an apparent dispute between parents of an incapable person, and there are issues of custody, access or Children's Aid Society involvement, it is recommended that a copy of the applicable court order be obtained for the chart.**

### 7. A brother or sister of the incapable person.

If there is more than one sibling of the incapable person, they all rank equally as substitute decision makers.

### 8. Any other relative of the incapable person.

A "relative" under this section is someone "related by blood marriage or adoption" to the incapable person.[73]

## The Role of the Public Guardian and Trustee

If there is not a SDM available, then the PGT shall make the decision to give or refuse treatment on behalf of the incapable person.[74] This is often referred to as the PGT acting as the "SDM of last resort". One of the steps taken by the PGT will be to try to locate a SDM who meets the criteria in s. 20 of the HCCA. For more information on the role of the PGT, please refer to their website at www.attorneygeneral.jus.gov.on.ca/english/family/pgt.

## Managing Conflict Between SDMs

If SDMs, with equal authority to make the decision and meeting all the requirements, disagree on whether to give or to refuse consent, then the PGT shall make the decision for them.[75]

### Example of Conflict Between Equally Ranked SDMs

- An incapable patient is receiving treatment based on substitute consent provided by her four children. A new treatment is recommended, and only three of the four children consent.
- The majority does not "rule" in this situation. If the equally ranked SDMs cannot agree on a proposed treatment, then the PGT will be approached to make the decision on behalf of the incapable person.

73 HCCA, *supra* note 12, s. 20(10).
74 *Ibid.*, s.20(5).
75 *Ibid.*, s.20(6).

# 4. Principles that Guide the Substitute's Decision Making on Behalf of an Incapable Person

A SDM, on behalf of an incapable person, is required to make decisions in accordance with the principles for substitute decision-making set out in the HCCA.[76] In 1997, the Ontario Superior Court commented:

> *It is mental capacity and not wisdom that is the subject of the SDA and the HCCA. The right knowingly to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The State has no business meddling with either. The dignity of the individual is at stake.*[77]

While a capable person can make "unwise" decisions on their own behalf, a SDM must be guided by the principles in the legislation.

## Prior Capable Wish

A SDM who:

> knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age... shall give or refuse consent in accordance with the wish.[78]

This is generally referred to as a "prior capable wish". The key issues are determining the wish – and in particular whether it was expressed while the patient was capable and that it is applicable to the circumstances. As long as these criteria are all met, the wish should be followed with very limited exceptions.[79]

In considering the significance of a "prior capable wish", the Court has commented that:

> *While the Board in a proper case may make a finding as to prior capable wishes that differs from the view of prior capable wishes expressed by the SDM, once the Board has found what the prior capable wishes are, it does not have a general discretion to override those wishes. That is not only, or primarily, a matter of interpretation of the statute, although it is that: it is also a matter of constitutional law. The whole of the Consent and Capacity Board should have this point brought home to it.*
>
> *With respect to prior capable wishes, there is a small amount of "wiggle room" for the Board in connection with whether the prior capable wishes are "applicable in the circumstances", but that should be approached with care and restraint because of the constitutional dimension. It is not a discretion.*[80]

This is illustrative of the significant degree of defence that should be given the decision of a SDM who is acting in accordance with a prior capable wish.

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76 *Ibid.*, s.21.
77 Koch (Re) (1997), 35 O.R. (3d) 71 (S.C.) at para. 17.
78 HCCA, *supra* note 12, s. 21(1).
79 *Conway v Jacques* (2002), 59 O.R. (3d) 737, 214 D.L.R. (4th) 67, 2002 CarswellOnt 1920 (C.A.).
80 L. (L.) v. T. (I.), 1998 CarswellOnt 4097 (Gen. Div) at 30 – 31.

Both a SDM and a health care practitioner proposing a particular treatment can apply to the CCB for "directions" to clarify a possible prior capable wish, or to depart from a prior capable wish.[81]

## "Best Interests"

In situations in which there is no "prior capable wish", or if it is impossible to comply with the wish, then the SDM is required to act in the incapable person's "best interests".[82] In determining what the incapable person's best interests are, a SDM is to consider:

1. The values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
2. Any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and
3. The following factors:

    (a) Whether the treatment is likely to
        (i) Improve the incapable person's condition or well-being;
        (ii) Prevent the incapable person's condition or well-being from deteriorating; or
        (iii) Reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
    (b) Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
    (c) Whether the benefit of the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
    (d) Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

The application of the "best interests" to a specific case will be considered in the context of the proposed treatment for a specific patient, taking into account the available information and options.

## Other Obligations of a Substitute Decision Maker

SDMs who are court appointed guardians or powers of attorney have legislated duties.[83]

These "duties" include:

(a) Explaining their role to the incapable patient;
(b) Encouraging the patient's participation in the decision making process;
(c) Fostering the independence of the incapable patient;
(d) Encouraging regular contact with family and friends;

81 HCCA, *supra* note 12, ss. 35 and 36. A Form E is an Application to the Board for Permission to Depart from Wishes.
82 *Ibid.*, s.21(2).
83 SDA, *supra* note 50, ss. 66 and 67.

(e) Consenting to the least intrusive and restrictive action available in the circumstances;

(f) Refusing consent to confinement or monitoring devices unless there is a risk of harm to others or to permit greater freedom for the patient; and

(g) Only giving consent to electric shock treatment if in accordance with the HCCA.

While these are not "binding" responsibilities of other substitute decision makers, these duties provide a guide to assist other substitute decision makers in fulfilling their obligations to an incapable person on whose behalf they are making decisions.

## Limits on Substitute Decision Making

While a SDM can consent to an incapable person's admission to a hospital or other facility for the purpose of receiving the proposed treatment,[84] there are limitations on the ability of a SDM to consent to admission to a psychiatric facility for this purpose. This is addressed in more detail in Chapter 3.

Subject to limitations in the appointment, a guardian of the person or power of attorney for personal care is generally able to make decisions on all issues that impact the well-being of the incapable person for whom they are making decisions.

## Decisions Not Being Made in Accordance with these Principles

If a SDM is not making decisions in accordance with the principles for substitute decision making, a health practitioner may bring a "Form G" application to the CCB.[85] The purpose of this application is to determine whether a SDM is complying with the principles for making decisions on behalf of an incapable person.[86] These applications (Form G) do not result in the substitute being "removed" from their decision making position, but rather in the CCB directing the SDM in a particular situation, with reference to the obligations of the SDM.

If the SDM does not comply with the direction of the CCB within the time set out in the CCB's decision, the SDM "shall be deemed not to meet the requirements" for being a SDM.[87] In this situation, the health care provider may seek substitute consent from the next appropriate person who meets the criteria in subsection 20(1) of the HCCA.

84 HCCA, *supra* note 12, s. 24.
85 *Ibid.*, s.37.
86 *Ibid.*, s.37(1).
87 *Ibid.*, s.37(6).

# 5. What is a Valid Consent?

For a consent to be legally "valid", it must relate to the treatment, be "informed", be given voluntarily and not be obtained through misrepresentation or fraud.[88]

For a consent to be "informed" the capable person, or SDM for incapable person, must have received "the information ... that a reasonable person in the same circumstances would require in order to make a decision about the treatment". This "information" should include the nature of the treatment, the expected benefits of the treatment, the material risks of the treatment, the material side effects of the treatment, alternative courses of action, and the likely consequences of not having the treatment. Consent to a proposed treatment may be express or implied. Consent to a proposed treatment can be withdrawn by a capable patient, or by a SDM for an incapable patient.[89]

Documentation is important on consent issues. The charting is not, in and of itself, proof of informed consent but it is evidence that a discussion took place with the patient. Documentation of the details of a consent discussion support the health care providers when there is a challenge to the sufficiency of the consent provided by a SDM.

There is further discussion on documentation and charting in Chapter 8.

What steps members of various regulated health professions should take when dealing with consent issues are also addressed by the various Colleges. Members of a regulated health profession should be aware of the policies and guidelines from their respective College on this issue.

# 6. Consent and Capacity Principles in Mental Health Care: Other Considerations

## Emergency Treatment without Consent

An "emergency" is a situation in which the person for whom a treatment is being proposed is considered to be at risk of sustaining serious bodily harm if the treatment is not administered promptly, or if they are experiencing severe suffering.[90]

Treatment can be administered to a capable person without consent in an "emergency" situation in which there is a communication barrier (due to language or disability) and a reasonable, practical means of communication cannot be found without there being a delay that will prolong the apparent suffering of the person or put that individual at risk of sustaining serious bodily harm, and there is no reason for the health care provider proposing the treatment to believe that the person does not want the treatment.[91]

88 *Ibid.*, s.11(1).
89 *Ibid.*, s.14.
90 *Ibid.*, s.25(1).
91 *Ibid.*, s.25(3).

Treatment can be administered to an incapable person without consent in an "emergency" situation in which the time required to seek the appropriate substitute consent will prolong the apparent suffering of the person or put that individual at risk of sustaining serious bodily harm.[92]

A health care provider is also permitted to perform an examination to determine whether there is an emergency, on either an incapable or a capable person, in which there is a communication barrier and there are the same concerns about a delay as set out above.[93]

The ability to provide "emergency" treatment to a capable patient is subject to the health practitioner being aware of a "prior capable wish" to the contrary. [94] For an incapable patient, if the situation is an "emergency" and the SDM is not adhering to the principles for substitute decision making, then the health practitioner can proceed with the treatment without consent.[95]

If treatment is provided without consent in an "emergency" situation, this treatment continues "only for so long as is reasonably necessary" to obtain a consent from a SDM for an incapable person[96], or until the person regains capacity and is able to make their own decision.[97] In either scenario, the opinion of the health care practitioner as to why treatment was given under this section must be documented in the clinical record.[98]

## Assessments of Financial Capacity

As reviewed in Chapter 3, physicians are obliged to examine the capacity of a "psychiatric patient"[99] to manage property.[100] The test for capacity to manage property is similar to that for capacity to consent to treatment.[101]

For individuals who are not "psychiatric patients", concerns with respect to capacity to manage property may be addressed through the procedure and process set out in the Part I of the SDA.[102]

## Consent Issues in Community Treatment Orders (CTO)

For a discussion of the consent issues relevant specifically to CTOs, please see the section on CTOs in Chapter 3.

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92 *Ibid.*, s. 25(2). The role of a prior capable wish in the emergency treatment of an unconscious patient was considered in *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.). The Court found that a physician who administered a blood transfusion to a Jehovah's Witness patient was liable for damages when the physician was aware prior to ordering the treatment that there was card on which the patient had expressly indicated that she did not want to receive blood products, in the event of an emergency.

93 *Ibid.*, s.25(4).

94 *Ibid.*, s.26.

95 *Ibid.*, s.27.

96 *Ibid.*, s.25(6).

97 *Ibid.*, s.25(9).

98 *Ibid.*, s.25(5).

99 Please see Chapter 3, for discussion of what constitutes a psychiatric patient.

100 *Mental Health Act*, R.S.O. 1990, c. M. 7, ss. 54 and 57, [MHA].

101 SDA, *supra* note 50, s.6.

102 The Office of the Public Guardian and Trustee, which is part of the Ministry of the Attorney General, may in some circumstances assume the role of guardian of property, in cases where the criteria set out in the SDA are met. More information on the PGT's role in managing property on behalf of incapable persons is available online at http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/ (accessed on September 14, 2012).

# 7. Applications for Review of Findings of Incapacity to Consent to Treatment

An individual who has been found incapable of consenting to a proposed treatment can apply to the CCB for a review of that finding.[103] On their review, the CCB may either confirm that the person is incapable with respect to the proposed treatment or find that the person is capable, and substitute their finding for that of the health care provider.[104]

There are a few restrictions on applications to review findings of incapacity to consent to treatment. A person whose SDM is a Guardian of the Person with the authority to give or refuse consent on their behalf or a Power of Attorney for Personal Care pursuant to a Power of Attorney document that specifically waives the person's right to bring an application for a review of capacity,[105] may not bring an Application to the CCB to review their capacity.[106]

If the health care provider proposing treatment is aware that the person intends to apply to the CCB for a review of a finding of incapacity with respect to that treatment, then treatment should not be commenced until:

(a) 48 hours have elapsed since the health practitioner was first informed of the intended application to the CCB without an application being made;

(b) The application to the CCB has been withdrawn;

(c) The CCB has rendered a decision in the matter, if none of the parties to the application before the CCB has informed the health practitioner that he or she intends to appeal the CCB's decision; or

(d) If a party to the application before the CCB has informed the health practitioner that he or she intends to appeal the CCB's decision,

(i) Until the period for commencing the appeal has elapsed without an appeal being commenced, or

(ii) Until the appeal of the CCB's decision has been finally disposed of.[107]

The exception to the above is that treatment can be given in accordance with the provisions for emergency treatment as discussed in this Chapter.[108]

103 HCCA, *supra* note 12, s. 32(1).
104 *Ibid.*, s. 32(4).
105 SDA, *supra* note 50, s.50(1).
106 HCCA, *supra* note 12, s.32(2).
107 *Ibid.*, s.18(1)(3).
108 *Ibid.*, s.18(4).

### Calculating Time from "Final Disposition"

Example: A patient applies for a hearing to review a finding that he is incapable of consenting to treatment. The hearing is held on January 4th and the CCB determined on January 5th that the patient was not capable of consenting to the proposed treatment. The patient appealed that decision and the appeal was heard by the Court and dismissed on June 15th. On September 20th, the patient applied to the CCB for a further review of his capacity. The patient's condition and situation were essentially unchanged from January 10th. Can this patient's application to the CCB for a review of his capacity proceed?

Answer: The HCCA restricts repeated applications to review a finding of incapacity. A person cannot make a new application to review a finding of incapacity with respect to the same or similar treatment within six months after the final disposition of the earlier application, unless the Board gives leave in advance. In deciding whether to grant leave, the Board must be satisfied that there has been a material change in circumstances. In this example, the person's appeal of the CCB decision was heard and dismissed on June 15th. That is the final disposition date, as it is the date on which the appealed finding of incapacity was finally confirmed or finally disposed of. September 20th falls well before the six month time period that would expire on December 15th, and because the patient's condition and situation are essentially unchanged, there is no material change in circumstances that would warrant the Board exercising its discretion to hear the application sooner than six months from the "final disposition" of the prior review. In this example, the patient's application could not proceed until after December 15th.

There is a restriction on repeated applications: If a finding of incapacity is "confirmed", a further application cannot be made unless six months have elapsed since the "final disposition" of a previous application.[109] This is not six months from the last hearing, but from the time of a "final decision", which includes an appeal. If there has been a "material change in circumstances that justifies reconsideration of a person's capacity" by the CCB, the CCB may grant "leave", or permission, for an application.[110]

There is a further discussion of applications to the CCB in Chapter 5 of this Toolkit. A complete list of the types of applications that can be made to the CCB is set out in Appendix "C".

109 *Ibid.*, s.32(5).
110 *Ibid.*, s.32(6).

Chapter 3

# Assessment and Hospitalization Under the *Mental Health Act*

## 1. Introduction

The MHA provides the legal framework for the admission into specially designated psychiatric facilities of persons suffering from a mental disorder.[111] The term "mental disorder" is defined broadly in Ontario's MHA to mean "any disease or disability of the mind".[112]

Under the MHA, "psychiatric facility" is a defined term meaning a facility "for the observation, care and treatment of persons suffering from mental disorder, and designated as such by the Minister". The list of psychiatric facilities and their designations is maintained on the Ontario Ministry of Health's website at: http://www.health.gov.on.ca/english/public/contact/psych/designated.html

The MHA provides psychiatric facilities with the power to lawfully detain persons who have been found upon examination by a physician to meet certain prescribed criteria. Although the language of the legislation suggests that this power applies to all psychiatric facilities, the General Regulation enacted under the MHA provides that certain psychiatric facilities are not required to provide in-patient services (i.e., non-Schedule 1 facilities) and are therefore "exempt from the application" of Parts II and III of the MHA. Parts II and III provide for the involuntary admission of patients under Forms 3 and 4, for example.[113]

**There are no court decisions that have commented on what "exempt from the application of Parts II and III" means exactly, but on a plain reading, it is generally taken by non-Schedule 1 psychiatric facilities to mean that, as there is no obligation to provide in-patient psychiatric care, the authority and obligations set out in Parts II and III do not apply to those facilities.**

The authority to detain persons who are suffering from a mental disorder against their will, for the purpose of care and treatment in a psychiatric facility, is an extraordinary power. The MHA balances the liberty and autonomy interests of persons suffering from mental disorder with society's interest in protecting persons who, due to mental disorder, are at risk of harm to themselves or others or, who are at risk of substantial physical and mental deterioration. In order to ensure that the liberty interests of persons with mental disorder are protected, the MHA provides for certain procedural safeguards to ensure that decisions to involuntarily admit patients to psychiatric facilities are reviewed. Further, a patient is entitled to apply to an independent administrative tribunal, the CCB, for review of whether the patient has met the criteria for an involuntary admission, as set out in the MHA.

111 Formerly in Ontario, several provincially-run psychiatric hospitals were governed according to the provisions of the *Mental Hospitals Act*, R.R.O. 1990, c. M.8, which was repealed in December 2009. Currently, all hospitals that provide in-patient and out-patient psychiatric care as "psychiatric facilities" are operated as public hospitals, under the *Public Hospitals Act*, R.S.O. C.P. 40 ("**PHA**") and also designated as psychiatric facilities by the Minister of Health, according to section 80.2 of the *Mental Health Act*, R.S.O. 1990, c. M.7.

112 MHA, *supra* note 100, s. 1.

113 General Regulation, R.R.O. 1990, Reg. 741, s. 7 [Regulation]. We discuss non-Schedule 1 psychiatric facilities in further detail in Chapter 4 of this text.

The Officer in Charge ("OIC") is defined by the MHA as the "officer who is responsible for the administration and management of a psychiatric facility".[114] Most psychiatric facilities have policies that cover the duties of the OIC, and who may act on his or her behalf to fulfill the prescribed duties. The duties of the OIC are discussed in greater detail later in this chapter.

## 2. Who is a "Patient" under the *Mental Health Act*?

The provisions of the MHA apply only to patients in a psychiatric facility. The term "patient" has a precise legal definition in the MHA: "a person who is under observation, care and treatment in a psychiatric facility."

Such a patient may be admitted to a psychiatric facility in one of the following ways:

(a) **Voluntary patient –** A person who has agreed to be admitted to the psychiatric facility for care, observation and treatment;

(b) **Informal patient –** A person who has been admitted pursuant to a substitute decision maker's consent under section 24 of the HCCA;

(c) **Involuntary patient** (Form 3 or 4) – A person who has been assessed by a psychiatrist and found to meet certain criteria set out in section 20 of the MHA, following which the person is admitted as an involuntary patient; or

(d) **Patients admitted under court order** (Form 6 or 8), according to sections 21 to 25 of the MHA.

"**Out-patient"** is also a defined term, and means a person who is "registered in a psychiatric facility for observation or treatment or both, but who is not admitted as a patient and is not the subject of an application for assessment" (section 1, MHA).

A patient's status under the MHA can change throughout the course of a hospital admission. For example, a patient who has been involuntarily admitted may experience an improvement in his or her condition such that he/she no longer meets the criteria for an involuntary admission, even though the authorized period of detention has not expired. In that case, the attending physician may authorize the continuation of the patient's admission as a voluntary or informal patient, by executing the approved form (Form 5, subsection 20(7), MHA).

Moving in the other direction, a voluntary or informal psychiatric patient's condition may change such that he or she is no longer suitable for continuation as a voluntary or informal patient. In that case, the attending psychiatrist must assess the patient to determine whether he or she meets the criteria for an involuntary admission. If so, the attending physician must complete and file a certificate of involuntary admission with the OIC of the psychiatric facility.[115]

114 MHA, *supra* note 100, s. 1.
115 MHA, *supra* note 100, s. 19.

Where a person is being assessed for admission to a psychiatric facility as the subject of either a Form 1 (application by a physician for assessment), Form 2 (order for examination issued by a justice of the peace) or Form 13 (order to admit a person coming into Ontario issued by an authorized delegate of the Minister of Health), the person is not considered a "patient" within the meaning of the MHA until they have been formally admitted to a psychiatric facility by the attending physician.[116]

Psychiatric facilities are designated as such by the Minister of Health and the designation applies to the whole facility, not just the ward designated as the in-patient psychiatric unit. Consequently, a person who is being treated for a medical condition on a medical ward of a hospital may become a psychiatric patient due to the patient's need for psychiatric treatment, even though he or she is on the medical ward.

Whether a person is, or is not, a patient in a psychiatric facility, and what type of patient he or she is, will have significant ramifications for the person's rights under the MHA. For example, once admitted to a psychiatric facility and regardless of the psychiatric patient's status as voluntary, informal or involuntary, the MHA requires a physician to examine the person to determine whether he or she is capable with respect to managing his or her property (section 54). We discuss assessments of capacity to manage property in greater detail below.

## Voluntary Patients

The meaning of "voluntary patient" is not set out expressly in the definition section of the MHA. The Ontario Court, in an appeal of a CCB decision, has stated that in order for a person to be a voluntary psychiatric patient, the person must be in a position to exercise his or her own free will and must have made a capable decision to consent to voluntary status as a psychiatric patient.[117]

Patients can either be admitted voluntarily for treatment or, having been admitted involuntarily, may have their status changed to voluntary when their condition improves. In both cases, there will be a discussion with the patient about the voluntary admission or change of status. Particularly where the patient's status changes after admission, it is prudent practice to document the discussion with the patient in his or her record of personal health information.

Patients admitted on a voluntary basis to a psychiatric facility are free to leave the facility if they choose, even against medical advice. At that point, if the departure from the psychiatric facility is considered inadvisable by the treatment team, it will fall to the attending physician to assess whether or not the patient meets the criteria for an involuntary admission.

116 *See R. v. Webers*, [1994] O.J. No. 2767 (Ont. Ct. Gen. Div.), which held that an involuntary patient does not include a person who is being detained in hospital for assessment under a Form 1 application. Therefore, the Form 1 subject is not a psychiatric patient under the MHA.

117 *Daugherty v. Stall* (2002), 48 E.T.R. (2d) 8, 2002 CarswellOnt 4163 (S.C.J.).

The MHA provides that admission may be refused where the "immediate needs in the case of the proposed patient are such that hospitalization is not urgent or necessary".[118] Similarly, the MHA is clear that a patient "shall be discharged" when he or she is no longer in need of the observation, care and treatment provided in a psychiatric facility.[119] The admission or discharge decision remains dependent on the clinical judgment of a physician. Since psychiatric facilities are also public hospitals, they are governed by the *Public Hospitals Act* ("PHA") and the regulations enacted under that statute. Under the PHA, no person shall be admitted to a hospital as a patient except on the order or under the authority of a physician who is a member of the medical staff.[120]

The admission or discharge assessment has been an area of legal scrutiny in medical negligence cases where patients have been assessed and found not to need admission, either voluntarily or involuntarily, and who have subsequently become involved in an adverse event in the community.

In that context, if following discharge, or admission refusal, the person subsequently harms him or herself, or another person, the admission and/or discharge assessment will be looked at closely.[121] Under subsection 34(1) of the MHA, "a patient shall be discharged from a psychiatric facility, when he or she is no longer in need of the observation, care and treatment provided therein". Determining whether a patient requires the kind of observation, care and treatment afforded by an in-patient admission to a psychiatric facility, is a matter of clinical judgment.

Generally, in order to meet the standard of care, mental health care professionals must exercise reasonable care and skill and take into consideration all relevant factors in arriving at a clinical judgment regarding admission or discharge decisions. [122] The law recognizes that psychiatry is an inexact science, in part because it is dependent on what patients are willing to disclose about their thoughts and feelings.

However, accepted standards of care require that all reasonable steps be taken to reduce the risk of harm. That said, not all persons who arrive on the doorstep of a psychiatric facility must be admitted.

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118 MHA, *supra* note 100, s. 11.

119 *Ibid.*, s. 34.1.

120 *Hospital Management Regulation*, R.R.O 1990, Reg 965, s. 11(1)(a). This regulation also provides for the admission of patients under the orders of certain specialties not generally applicable to the mental health care context: oral and maxillofacial surgeons, midwives or on the joint order of a dentist and physician.

121 See for example: *Ahmed v. Stefaniu* (2006) 216.O.A.C. 323 (C.A.); J had been an involuntary patient pursuant to the *Mental Health Act* at a Sch. 1 psychiatric facility. He was released when the physician responsible for his care made the decision to change his status from an involuntary patient to a voluntary patient on December 5, 1996. Several weeks later, in January 1997, J. murdered his sister, K. Her husband, Ahmed, commenced an action on his own behalf and on behalf of his two daughters against the physician for medical malpractice. At the conclusion of a jury trial, the physician was found to be negligent in that she failed to meet the standard of care of a psychiatrist practicing in a general in-patient psychiatric unit in a community hospital, when she made the decision to change Johannes' status under the Mental Health Act to that of a voluntary patient. The physician's appeal of the trial decision was dismissed.

122 *Haines v. Bellissimo* (1977), 18 O.R. (2d) 177 (H.C.J.), at 190 – 191, cited in Richard D. Schneider, *Annotated Ontario Mental Health Statutes*, 4th ed. (Toronto: Irwin Law, 2007) at 7.

## Informal Patients

An "informal patient" is defined in the MHA to mean "a person who is a patient in a psychiatric facility, having been admitted with the consent of another person under section 24 of the HCCA". That provision applies to persons who have been found incapable with respect to treatment and provides his or her substitute decision maker with the authority to consent to the incapable person's admission to a hospital or other facility for the purpose of the treatment, including the admission to a psychiatric facility. However, if the person is 16 years of age or older, and objects to being admitted to a psychiatric facility for treatment of a mental disorder, then consent to the admission may be given only by the person's guardian of the person or attorney for personal care, and only if the guardian or attorney has been granted the express authority to do so in the respective authorizing documents.

In practice, the informal admission process is used mostly for persons under the age of 16. Incapable adolescents who are 12 years of age or older, but less than 16, who have been admitted as informal patients, have the right to apply to the CCB to determine whether they need observation, care and treatment in a psychiatric facility.[123] Incapable persons who are older than 16 have the right to object to or refuse an informal admission to a psychiatric facility, as noted above. The patient may demonstrate their objection to being admitted informally by attempting to elope or by statements that he or she wants to go home. A recent decision of the CCB held that patients should be informed of the SDM's decision to admit them informally, so that they may exercise their right to object to the admission if they wish to do so, and further, this discussion should be noted in the patient's chart.[124]

Where the informal patient is objecting to being in hospital or where he or she requires restraint or detention on a regular basis to safely manage their mental condition, his or her attending physician should consider whether the patient meets the criteria for involuntary admission, which includes a finding that the patient is not suitable for admission or continuation as an informal or voluntary patient.[125]

123 MHA, *supra* note 100, s. 13 (Form 25). Such applications may be made every three months by the patient. There is a "deemed" application every six months (s. 13(2).

124 In *Re* C.A. (CCB, TO-12-0752 and TO-12-0810), the Board rescinded a fourth certificate of involuntary admission (Form 4) for a patient who had been initially admitted informally. The Board considered the circumstances leading up to the physician's decision to change the patient's status from informal to involuntary, due to the patient's ongoing need for restraint. The Board held that the patient was not properly admitted as an informal patient, since she was over the age of 16 and the evidence demonstrated that she objected to being admitted to a psychiatric facility. Relying on the decision of *Daugherty v. Stall*, *supra* note 117, the Board stated that the patient should have been informed expressly of her informal admission, so that she could exercise her right to object if she wished to do so. The Board commented that there was no notice to CA of her status as an informal patient and no indication in the chart as to whether her status was communicated to her, nor her response, if any. Ultimately, the Board rescinded the fourth certificate of renewal, since the patient was neither an informal nor a voluntary patient at the time the physician changed her status to involuntary, pursuant to section 19 of the MHA.

125 MHA, *supra* note 100., ss. 20(1.1)(f), 20(5)(b). See also s. 14 of the MHA which provides that "nothing in this Act authorizes a psychiatric facility to detain or to restrain an informal or voluntary patient." Many CCB decisions have interpreted section 14 as a prohibition on the restraint of informal or voluntary patients, necessitating the treatment of a psychiatric patient on an involuntary basis where ongoing use of restraint is necessary: see for example, Re W (2006 Carswell Ont 9390) at paras 44 and 45.

# 3. Form 1: Criteria for Application for Psychiatric Assessment

In most cases, the path to an involuntary admission begins with an Application for Psychiatric Assessment ("Form 1"). The physician who makes such an application need not be a psychiatrist, however, the physician must have personally examined the person within the past seven days prior to issuing the certificate.[126] In addition to his or her own observations, the physician is entitled to rely on the reports of others about the person, but the physician must distinguish between the two and document accordingly. There is no requirement that the examination take place in hospital. In practice, such examinations often take place in emergency departments.

The statutory authority for a Form 1 assessment is found in section 15 of the MHA. There are two sets of criteria, which have come to be known as Box A and Box B criteria, since that is how they are set out on the approved Form 1.

### "Box A"

Box A is known as the "serious harm test" and is derived from the language of subsection 15(1):

15.(1) Where a physician examines a person and has reasonable cause to believe that the person,

(a) Has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) Has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; **or**

(c) Has shown or is showing a lack of competence to care for himself or herself,

**and**, if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) Serious bodily harm to the person;

(e) Serious bodily harm to another person; or

(f) Serious physical impairment of the person,

the physician may make application in the prescribed form for a psychiatric assessment of the person. R.S.O. 1990, c. M.7, s. 15(1); 2000, c. 9, s. 3(1).

We have emphasized the use of the conjunctive "**or**" in the criteria to show that not all of the "behaviour" criteria that are set out in a, b and c must be met. Rather, the physician need only find that one of the criteria is met in that portion of the test. The use of the conjunctive "**and**" indicates that, in addition to one of the a, b, or c, the physician must be of the opinion that person is suffering from a mental disorder such that it is likely to result in one of the types of harm set out in d, e, or f. Again, the physician need not find that all of the harms will arise. One is sufficient to ground the involuntary admission.

126 *Ibid.*, s. 15(2).

### "Box B"

The Box B criteria were added to the MHA as amendments in 2000 to provide the authority to involuntarily admit persons who suffered from recurrent mental disorders that have responded to treatment in the past. Like Box A criteria, the Box B criteria require the physician to have personally examined the person, and formed a reasonable belief that the person:

(a) Has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person; **and**

(b) Has shown clinical improvement as a result of the treatment;

**and** if in addition the physician is of the opinion that the person,

(c) Is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(d) Given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment; **and**

(e) Is incapable, within the meaning of the *Health Care Consent Act*, 1996, of consenting to his or her treatment in a psychiatric facility **and** the consent of his or her substitute decision-maker has been obtained,

the physician may make application in the prescribed form for a psychiatric assessment of the person.[127]

We have emphasized the conjunctive "**and**" throughout this section to emphasize that, unlike Box A, all of the criteria set out in Box B must be met in order to justify the application for a Form 1 psychiatric assessment in these circumstances.

A Form 1 takes effect on the date that it is signed by the physician, and that must be within seven days of the physician's last examination of the person who is subject of the application.[128] Once signed, the Form 1 is effective for seven days and provides authority for any person to take the person to a psychiatric facility where he or she may be detained, restrained, observed and examined for no more than 72 hours.[129]

There is no right to apply to the CCB for a review of whether the criteria for the issuance of the Form 1 have been met. That said, some CCB decisions have held that, although a CCB cannot be called upon to review a Form 1 per se, significant deficiencies in the Form 1 may be grounds to declare the Form 3 invalid. For example, if the Form 1 is clearly deficient on its face, in that it was completed in a manner that was not in compliance with the MHA, the CCB may exercise its discretion to rescind the subsequent Form 3.

The MHA imposes an obligation on the attending physician of the person who is subject of a Form 1 assessment to provide the person with written notice that sets out the reason for the detention and the fact that the person has the right to retain and instruct counsel without delay.[130] This written notice is typically given in a Form 42, although that Form is no longer statutorily required and was revoked in 1995.

127 *Ibid.*, s. 20(1.1).
128 *Ibid.*, s. 15(4).
129 *Ibid.*, s. 15(5).
130 *Ibid.*, ss.38.1(1) 38.1(2).

Courts and CCB panels have held that where a patient has not been provided with a Form 42, or other written notice of their decision, the statutory requirements of the MHA have not been met and the person's detention is therefore unlawful.[131]

Given that a patient may challenge the validity of the Form 1, if the written notice is not delivered to the patient, it is prudent practice to ensure that the date and time notice is delivered to the patient is noted by the physician on the Form 1, in the space provided for that purpose. Many hospitals also retain a copy of the notice that was delivered to the patient and file it with the Form 1 on the clinical chart. Most hospitals continue to use the Form 42 to provide notice.[132]

# 4. Other Routes to Assess Persons at Risk of Harm

## Form 2

In addition to a physician's application for psychiatric assessment (Form 1), any person can appear before a justice of the peace and provide sworn information that there is a person within the jurisdiction of the justice, who meets either the Box A or Box B criteria outlined above. After considering that information, the justice of the peace may issue an order in the prescribed form for the examination of the person by a physician.[133]

This section gives rise to a "Form 2" application. It is sometimes used by concerned family members but may also be resorted to by other persons who have come into contact with a person, who they believe requires mental health care. The General Regulation enacted under the MHA states that for the purposes of this type of order, the "information on oath" that is brought before the justice of the peace may be oral or written information, and may include documents and other materials relevant to the justice's determination as to whether the criteria are met.[134]

The Form 2 order is directed to the police in the same locality where the justice has jurisdiction and provides authority to the police to take the person named in the order into custody "forthwith" to an "appropriate place" where the person may be detained for examination by a physician.[135] For the purposes of this section and also section 17 discussed below, the place to which people are most often taken is a hospital emergency department.[136] However, the MHA terminology of "appropriate place" confers discretion to have the person examined in a physician's office, or other facility, if need be. It is common for the physician's Form 2 examination to result in a Form 1 application for psychiatric assessment.

131 *R. v. Webers*, [1994] O.J. No. 2767 (Ont. Ct. Gen Div.); followed in S.S.R. (Re), 2008 CanLII 15889 (Ont. C.C.B.).

132 See for example, *C.B. v. Sawadsky*, [2005] O.J. No. 3682 (S.C.J.) [*Sawadsky*]. In this decision, the court considered a patient's claim that she had been unlawfully detained due to the physician's alleged failure to provide her with a Form 42, after he executed a Form 1. In that case, the physician had not noted on the Form 1 that the Form 42 had been delivered, nor was there a copy of the Form 42 on the chart. The trial judge ultimately accepted the physician's evidence that he had delivered the Form 42, as it was his normal practice to do so. The court preferred the physician's evidence over that of the plaintiff, who had alleged that the Form 42 had never been delivered.

133 MHA, *supra* note 100, s. 16(1).

134 Regulation, *supra* note113, s.7.1.

135 MHA, *supra* note 100, ss. 16(2) 16(3).

136 *Ibid.*, s.18.

## Police Apprehension

Section 17 of the MHA provides police officers with authority, under certain circumstances, to take a person to an appropriate place for examination by a physician, where it would be "dangerous" to proceed to obtain a Form 2. In other words, the police officer may apprehend a person, without a Form or order, if the circumstances set out in section 17 are met. Section 17 provides that the police officer must have reasonable and probable grounds to believe that a person is acting or has acted in a "disorderly manner" and that the person meets the Box A criteria discussed above.[137]

Where a police officer takes a person in custody to a place for the purpose of a psychiatric assessment under the authority of the MHA, the police officer must remain at the facility and retain custody of the person until the facility takes custody of him or her.[138] Pursuant to the MHA's General Regulation, a decision by the facility to take custody of the person must be made as soon as is "reasonably possible". The Regulation also contemplates consultation between the police or person who has taken custody of the person, and the staff of the psychiatric facility who are responsible for making the decision as to whether the facility will take custody of the person; and requires the staff to promptly inform the police when the decision is made.

## "Forthwith"

Section 18 of the MHA requires that where a physician is conducting an examination under section 16 (Form 2) or section 17 (police action) the examination "shall be conducted forthwith after receipt of the person at the place of examination".[139] The question of what is meant by "forthwith" often arises. In a recent decision, the Ontario Superior Court considered whether an examination conducted by a physician pursuant to a Form 2 was conducted "forthwith" when the physician completed the examination some two and a half hours after the person had been brought to the hospital by police.[140] The judge held that "it is difficult to determine precisely when an examination is conducted forthwith". In the circumstances of the case – a busy emergency room during the SARS outbreak where reasonable efforts were made to prioritize persons brought in under the MHA – the trial judge held that the patient had been examined forthwith.[141] We take that to mean in more general terms that "forthwith" means as soon as is reasonably possible.[142]

137 See Box A discussion above at text following footnote 117. Note that section 17 does not allow the police to rely on Box B criteria.

138 MHA, *supra* note 100, s. 33 and *supra* note 107, s. 7.2.

139 *Ibid.*, s. 18.

140 *Sawadsky, supra* note 132 at paras. 41–42.

141 *Ibid.*

142 Police officers have expressed frustration at waiting times in busy emergency rooms, where there is a delay in medical staff availability to examine a person brought in on a Form 2 or under section 17, prior to determining whether or not the person will become the subject of a Form 1 application for psychiatric assessment and consequently, detained in custody at the facility. Police officers are required to maintain custody of the person until that time, under section 33 of the MHA, as noted above. Hospitals may have practices and procedures to help facilitate communication between police and staff on this issue, as required by s. 7.2 of the General Regulation under the MHA, supra note 100.

## Patients Admitted or Assessed under Court Order (Sections 21 – 22)

Patients may also be taken to a psychiatric facility by judge's order in certain circumstances. For example, where a person appears before a judge charged with or convicted of an offence, and the judge has reason to believe that the person suffers from a mental disorder, the judge may order the person to attend a psychiatric facility for examination.[143] The order is issued as a Form 6. Or, if the person is already in custody and appears before a judge charged with an offence, and the judge has reason to believe the person suffers from a mental disorder, the judge may order that the person be admitted as a patient to a psychiatric facility for a period of not more than two months.[144] That order may be issued as a Form 8.

When relying on either section 21 (out of custody accused) or section 22 (in custody accused), the judge must confirm with the "senior physician" of the psychiatric facility – defined as the physician responsible for clinical services in the psychiatric facility, otherwise known as the Psychiatrist in Chief – that the services of the psychiatric facility are available to the person named in the order.[145] Also, in each of these circumstances, the "senior physician" in the facility has the responsibility of writing a report to the judge as to the mental condition of the person ordered examined or admitted.

# 5. Form 3: Criteria for Involuntary Admissions under the *Mental Health Act*

The criteria for Involuntary Admission are set out in subsection 20(5) (Box A) and subsection 20(1.1) (Box B). These criteria are also set out on the face of the Form 3. The attending physician[146] must have observed and examined the person who is either the subject of an application for assessment under section 15 (Form 1), or the subject of an order under section 32 (Form 13 Order to admit a person coming into Ontario), in order to make one of the following three decisions:

(a) To release the person from the psychiatric facility if the attending physician is of the opinion that the person is not in need of the treatment provided in a psychiatric facility;

(b) To admit the person as an informal or voluntary patient if the attending physician is of the opinion that the person is suffering from mental disorder of such a nature or quality that the person is in need of the treatment provided in a psychiatric facility and suitable for admission as an informal or voluntary patient; or

(c) To admit the person as an involuntary patient by completing and filing with the Officer in Charge a certificate of involuntary admission if the attending physician is of the opinion that the conditions set out in the subsection 20(1.1) or 20(5) are met.[147]

The attending physician may also change the status of an informal or voluntary patient to that of an involuntary patient if the "Box A" or "Box B" criteria, discussed below are met.[148]

143 MHA, *supra* note 100.
144 *Ibid.*, s. 22(1).
145 *Ibid*, s.23.
146 *Ibid.*, s. 1 – "attending physician" means a "physician to whom responsibility for the observation, care and treatment of a patient has been assigned".
147 *Ibid.*, s. 22(1).
148 *Ibid.*, s. 19.

## Box A Criteria (Subsection 20(5), MHA)

The physician, under **Box A criteria**, is required to admit the patient on an involuntary basis if he or she forms the opinion that:

(a) The patient is suffering from mental disorder of a nature or quality that likely will result in,

(i) Serious bodily harm to the patient,

(ii) Serious bodily harm to another person**, *or***

(iii) Serious physical impairment of the patient, unless the patient remains in the custody of a psychiatric facility; **and**

(b) The patient is not suitable for admission or continuation as an informal or voluntary patient.[149]

Essentially, the criteria require that the symptoms of the mental disorder from which the person is suffering are such that there is a likelihood that serious bodily harm will result either to the patient or to another person, or that the patient will experience serious physical impairment, unless the patient is detained in a psychiatric facility. The CCB, in matters where the patient has challenged their involuntary admission under this criteria, has emphasized that "likelihood" means probability and that a mere "possibility is not sufficient".[150]

The term "serious bodily harm" is not defined in the MHA. CCB panels have interpreted this phrase on various occasions. For example, several panels have defined serious bodily harm as that which is "more than merely trifling".[151] This definition echoes the Criminal Code definition of bodily harm: "any hurt or injury that interferes with the health or comfort of a person that is more than merely transient or trifling."[152]

In the criminal law context, the Supreme Court of Canada has defined "serious bodily harm" to mean "any hurt or injury, whether physical or psychological, that interferes in a substantial way with the physical or psychological integrity, health or well-being of the complainant".[153] At least one CCB panel has adopted the Supreme Court of Canada's definition of serious bodily harm as fitting for the criteria for involuntary admission, including the fact that serious psychological harm may amount to serious bodily harm.[154]

In considering whether the criteria for involuntary admission is made out at the time of the hearing, evidence of past harm to the patient or to other persons may be relevant. Examples of past harm, inflicted while the patient was suffering from a mental disorder, that the CCB has found to constitute "serious bodily harm" include throwing a cosmetic jar at a nurse resulting in the nurse's nose being broken,[155] or assaulting a stranger when the stranger refused to provide a cigarette.[156] However, the criteria is whether serious bodily harm is likely to occur in the future if the person is not involuntarily admitted. It is arguable that this does not necessarily require evidence of past actual harm.

149 *Ibid.*, s. 20(5).
150 See *Re W.J.K.*, 2007 CanLII 32896 (Ont. C.C.B.).
151 See for example, *Re A.B.*, 2003 CanLII 54969 (Ont. C.C.B.); citing *Dayday v. MacEwan* (1987), 62 O.R. (2nd) 588 (Ont. DW.Ct.)
152 *Criminal Code of Canada*, R.S.C., 1985, c. C 46 [CC], s. 2.
153 *R. v. McCraw*, [1991] 3 S.C.R. 72 at 81.
154 *Re J.S.*, 2004 CanLII 46818 (Ont. C.C.B.).
155 *Re A*, 2005 CanLII 12686 (Ont. C.C.B.).
156 *Re J.H.*, 2007 CanLII 49468 (Ont. C.C.B.).

In terms of the third criteria, "serious physical impairment", one panel of the CCB has interpreted that term as follows:

> **Serious physical impairment refers to unintentional harm to the patient that includes the outcome of a range of potential risky activities that the patient would likely undertake. These risky activities must occur as a result of the mental disorder and arise after discharge. The range of risky activities that could result in serious physical impairment to the patient might include the outcome of failing to take medication where such conduct is predictable and physically harmful. Socially inappropriate conduct that would create hostility and violence in others towards the patient might also be connected with the mental disorder and create serious physical impairment through fights or other unreasonably risky behaviour.**[157]

As noted in the first chapter of this Toolkit, the MHA historically required that the risk of serious physical impairment be "imminent"; however, the amendments that were introduced in 2000 removed the "imminent" requirement. Although the MHA does not spell out a required time period within which the harms set out in the Box A criteria must take place, the harm must be expected to occur within some reasonable time after the discharge so as to be connected to the illness and the risks that would arise from lack of hospitalization of the patient.

## Box B Criteria (Subsection 20(1.1), MHA)

The alternate grounds for an involuntary admission, set out in subsection 20(1.1), were added to the MHA in 2000, with a view to facilitating intervention and hospitalization for persons with recurrent mental illness. The attending physician must examine the patient and form a clinical opinion that all of the following six criteria are met:

(a) The patient has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in:

- Serious bodily harm to the patient; or
- Serious bodily harm to another person; or
- Substantial mental or physical deterioration of the patient; or
- Serious physical impairment of the patient;

(b) The patient has shown clinical improvement as a result of the treatment;

(c) The patient is apparently suffering from the same mental disorder as the one for which he or she previously received treatment, or, from a mental disorder that is similar to the previous one;

(d) Given the patient's history of mental disorder and current mental or physical condition, the patient is likely to:

- Cause serious bodily harm to himself or herself; or
- Cause serious bodily harm to another person; or
- Suffer substantial mental or physical deterioration; or
- Suffer serious physical impairment;

157 *Re M.T.*, 2004 CanLII 56536 (Ont. C.C.B.).

(e) The patient has been found incapable, within the meaning of the *Health Care Consent Act*, 1996, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained; and

(f) The patient is not suitable for admission or continuation as an informal or voluntary patient.

The Form 3 Box B states that all criteria within the Box must be met. These criteria correspond to items "a" through "e" above, which are taken from subsection 20(1.1) of the MHA. The foundational criteria for Box B is set out in subsection 20(1.1), that is, that the patient has previously received treatment for a mental disorder of an ongoing or recurring nature that, when not treated, will likely result in certain harms, but has shown clinical improvement when treated. This initial language makes clear that the Box B criteria are meant to be invoked for the "revolving" door patient who has responded to treatment for a mental disorder in the past and who poses a risk of harm when not treated.

**There are two other criteria which must also be met and are incorporated at the outset of the Form 3 – that the physician personally examines the patient and that the physician is of the opinion that the patient cannot be managed in the facility as an informal or voluntary patient.**

In terms of the type of harms that will likely result from the patient's untreated mental disorder, we have discussed serious bodily harm and serious physical impairment above in relation to Box A criteria. How have CCBs interpreted "substantial" mental or physical deterioration? Many panels of the CCB have considered "substantial" to have its plain dictionary meaning, that is, "considerable, consequential, ample, significant".[158] Where the attending physician has found that the patient is likely to suffer substantial mental deterioration if not detained in a psychiatric facility, the CCB has accepted evidence of non-compliance with treatment while in the community, leading to a re-emergence of symptoms of a mental disorder that disrupt the person's ability to function in the community. For example, in one case before the CCB, the patient had become non-compliant with treatment in the community and had started to exhibit grandiose behaviours and signs of thought disorder; the CCB accepted that the patient was at risk of substantial mental deterioration. The patient was also at risk of physical deterioration as she suffered from a number of medical conditions, such as diabetes and hypertension, which would worsen when her mental disorder interfered with her ability to manage treatment of those physical conditions.[159]

In another case, the CCB did not accept the attending physician's conclusion, without evidence of this having happened in the past that the re-emergence of symptoms of the patient's chronic paranoid schizophrenia would lead to substantial physical deterioration of the patient, once discharged and living in the community. In part, the CCB relied on evidence that the patient was part of a large family, with siblings who lived within close proximity and who would intervene to prevent physical deterioration. However, the CCB accepted that the patient would suffer substantial mental deterioration if not in the custody of psychiatric facility and so confirmed the certificate on that ground.[160]

158 *See Re* C.P., 2003 CanLII 15613 (Ont. C.C.B.).

159 *Re K.S.*, 2008 CanLII 32289 (Ont. C.C.B.); see also Re D.M., 2011 CanLII 70531, where the CCB found that there was evidence that the patient would suffer both substantial physical deterioration and serious phyician impairment if not admitted as an involuntary patient. DM suffered from both schizophrenia and end stage Huntington's disease, a neurological condition that affected the patient's mental and physical status.

160 *Re Ms. R.*, 2008 CanLII 28422 (Ont. C.C.B.).

## What is the difference between substantial physical deterioration and serious physical impairment?

In cases before the CCB that have considered both criteria, it appears that the CCB considers that deterioration implies a process of decline that becomes more serious as time goes on; whereas impairment suggests harm where the cause is more temporally finite – injuries, for example, that arise as a result of a physical assault linked to the patient's mental disorder.[161] For instance, serious physical impairment could arise out of medication non-compliance, which results in socially inappropriate conduct that creates hostility and violence in others towards the patient, leading to fights and other unreasonably risky behaviours.[162] Wandering in traffic might be another example.[163] At the same time, medication non-compliance can also lead to substantial mental or physical deterioration, the symptoms of which increase in significance over time.

It is clear from the CCB decisions that the impairment or deterioration must be linked to the mental disorder. It is often a matter of judgment and argument whether physical harm is characterized as serious physical impairment or substantial physical or mental deterioration. The results experienced by the patient could potentially meet any one or all three of the criteria. In one case recently before the CCB, the patient suffered from alcoholic amnestic disorder and psychogenic polydipsia. Unless closely supervised, the patient would consume excessive amounts of fluid which would lead to electrolyte imbalance and serious cardiac problems. The patient also suffered from high blood pressure and diabetes, and could not remember to take medications for these illnesses. In this case, the CCB confirmed the certificate on the ground that the patient would likely suffer serious physical impairment if not detained in a psychiatric facility.[164] However, it is arguable that this patient's outcomes might also have satisfied the criteria of substantial physical or mental deterioration.

## Box A Versus Box B: What's the difference?

The essential differences between Box A and Box B criteria is the latter's requirements that:

- The patient must have a history of having suffered from a mental disorder that, in turn, has responded to treatment in the past; and
- That patient is currently incapable with respect to the treatment, for which substitute consent has been obtained.

Box A does not have the two bulleted requirements listed above. Instead, Box A focuses on risk of serious bodily harm or serious physical impairment if the patient does not remain in the custody of a psychiatric facility. Box B criteria, added in 2000 to the MHA, signals a shift towards treatment as a basis for involuntary admission. Prior to the 2000 amendments, the focus of the involuntary admission criteria was on preventing harm to the self or others that arises from untreated or treatment refractory mental disorder.

161 *See Re J.J.*, 2005 CanLII 57872 (Ont. C.C.B.).
162 *Re M.T.*, 2004 CanLII 56536 (Ont. C.C.B.).
163 *Re K.S.*, *supra* note 159.
164 *Re R.K.*, 2008 CanLII 8769 (Ont. C.C.B.).

While Box B also has harm elements, the criteria of additional substantial mental or physical deterioration shows that it is directed towards the "revolving door" patient who has been successfully treated for mental disorder in the past, but who has currently fallen away from treatment, and is therefore at risk of various adverse events which could be prevented or ameliorated by hospitalization and treatment.

The attending physician will be unable to choose Box B grounds for the patient he or she is seeing for the first time, where there has been no prior treatment or where the history is not well known or where there has not yet been time to assess whether the patient is capable with respect to treatment. In these circumstances, the physician who wishes to rely on Box B criteria will have to obtain more historical information, consider performing a capacity assessment and obtaining substitute consent. Otherwise, only the Box A criteria or a voluntary admission would be available as grounds for an admission.

## Procedural Aspects of Involuntary Admission

Regardless of the criteria under which a patient is involuntarily admitted, the physician's decision to involuntarily admit a patient triggers certain further events designed to safeguard the patient's liberty interests and ensure that the involuntary admission is in compliance with the MHA. For example, it is essential that the physician, who completes the Form 1 assessment leading to a Form 3, is a different physician than the one who applied for the Form 1 assessment. This builds in a second medical opinion, as it were, into the process. Further, the attending physician must file the certificate with the OIC, and the OIC or his or her delegate, must review the certificate for compliance with the MHA.[165]

Certificates of involuntary admission are time limited, but may be renewed, provided that the patient still meets the criteria for involuntary admission at the time of renewal. The criteria relied on at the time of a renewal depend on the patient's condition at that time; they do not have to be same criteria as when the patient was first admitted.

The first certificate of involuntary admission is statutorily limited to two weeks duration; the first certificate of renewal is similarly limited to one additional month; the second certificate is limited to two additional months; and a third or subsequent certificate of renewal is limited to three additional months. Just as with the first certificate of involuntary admission, all certificates of renewal must be filed with, and reviewed by the OIC.[166]

The patient has the right to apply to the CCB for a review of whether the criteria for issuing or renewing the certificate of involuntary admission are met. Even if the patient chooses not to apply to the CCB, the MHA provides that the fourth certificate of renewal must be reviewed by the CCB, and every fourth certificate of renewal thereafter.[167]

165 MHA, *supra* note 100, s. 20(8).
166 *Ibid.*, s. 20(4).
167 *Ibid.*, s. 39(4).

If the period of detention on the certificate has expired, the involuntary patient who was the subject of the expired certificate is deemed to be an informal or voluntary patient.[168] If prior to the expiry of the certificate, the patient's condition has improved such that the criteria of involuntary admission are no longer met, the patient may be continued as an informal or voluntary patient upon the completion of a certificate of continuation by the attending physician.[169] The attending physician should discuss the prospect of becoming a voluntary patient with the patient, and document the discussion indicating the patient's willingness to remain at the facility on a voluntary basis in the patient's chart.

## Applications for Transfer of an Involuntary Admission from one hospital to another (Form 19)[170]

In 2010, the MHA was amended to provide the CCB with jurisdiction to conduct "transfer hearings", which consider applications for the transfer of an involuntary patient from one psychiatric facility to another. Subsection 39.2(1) of the MHA provides that:

> "An involuntary patient, any person on his or her behalf or the Officer in Charge of the psychiatric facility where the patient is currently detained may apply to the Board in the approved form [Form 19] to determine whether the patient should be transferred to another psychiatric facility named in the application".

A Form 19 application may be brought when a physician is issuing the fourth certificate of renewal (six and a half months after the first certificate of involuntary admission was issued according to the statutory timelines set out in s. 20(4) of the MHA), and then at every fourth renewal certificate after that (MHA, s. 39.2(2)). Since certificates of renewal last for three months by the time the fourth certificate of renewal is issued, these provisions allow for a first transfer application to be made after six and half months of an involuntary admission (at the time of the fourth certificate of renewal) and then every 12 months thereafter.

After the first application for transfer is finally disposed of, the second may be made sooner than 12 months later, but only if the CCB is satisfied that there has been a material change in circumstances that justifies a reconsideration of the patient's transfer. The same "material change in circumstances" criteria governs whether the CCB will hear a patient's application for review of a finding of incapacity with respect to the same or similar treatment sooner than six months after the final disposition of an earlier application (*Health Care Consent Act*, s. 32 (5) and (6)).

168 *Ibid.*, s. 20(6).
169 *Ibid.*, s. 20(7).
170 An earlier version of this section was first published by the OHA in "Legislative Changes Impacting Mental Health and Addictions Services: An Update", October 2010. We are also acknowledging Nyranne Martin and Kendra Naidoo for their article, "Consent and Capacity Board Transfer Hearings: What Can Psychiatric Faciilities Expect?" (OBA newsletter, *Health Matters*, Vol. 20, No. 1 December 2010) ("Martin and Naidoo").

As set out in subsection 39.2(6) of the MHA, the parties to the hearing are the patient who is the subject of the transfer application, the Officer in Charge of the current facility where the patient is involuntarily detained and the Officer in Charge of the proposed receiving facility (the facility named in the application). The Minister of Health and Long-Term Care is entitled to notice of the application and to be heard at the hearing; the Minister may also apply for party status at the hearing.[171] It has become a practice of the CCB to convene a pre-hearing conference where a Form 19 application has been made, in order to set a date for the hearing and to canvas the likely issues and position of the parties in advance.

All of the parties to the hearing have an opportunity to present evidence that mitigate in favour of, or against, the proposed transfer. Similar to hearings where the Board reviews an involuntary admission or a CTO, the CCB hearing a transfer application applies the balance of probabilities to the clinical and other evidence presented in determining whether the factors to be considered (items (a) through (f) below) tip the balance towards a transfer or to maintaining the patient's status quo at the current facility.

If the patient does not object to the proposed transfer, the Board may order the patient transferred to the psychiatric facility named in the application. In determining whether to grant a transfer, under subsection 39.2(1) of the MHA, the CCB is required to consider certain criteria, namely whether:

(a) the psychiatric facility named in the application is able to provide for the person's care and treatment;

*In transfer application cases, the CCB has considered whether the potential receiving facility offers the particular type of care and treatment required by the patient. For example, where a patient requires a highly secure setting, the CCB will consider whether the potential receiving facility can provide the required level of security.*[172] *The CCB has not considered bed availability at this stage of the hearing, preferring instead to take bed availability into account when addressing the timing of the transfer, if it is ultimately granted.*[173]

(b) the psychiatric facility named in the application is able to safely manage any risk the patient poses to the patient or another person;

*The CCB will consider the risks posed by the patient and whether the receiving facility is equipped to manage these risks.*[174]

171 MHA, *supra* note 100, ss. 39.2(5), 39.2(7) and 39.2(8).

172 *Re G.B.*, 2012, PE-11-4847 (ON CCB). In this case, the patient, G.B., requested a transfer from a secure facility to a less secure facility. G.B. gave evidence at the hearing and admitted that he did not have any concrete information about the less secure facility, but believed that it was a "better place" than his current facility. At the time of the hearing, the patient was untreated and had recently assaulted a co-patient. The more secure facility had a secure perimeter within which patients could walk, whereas the evidence demonstrated that at the less secure facility, the patient would likely be confined to a five bed unit for intense observation and treatment. The Board determined that the less secure facility could not provide for the patient's care and treatment as it lacked a maximum secure unit. The Board considered other factors as well, and ultimately, the patient's application was denied.

173 Martin and Naidoo, *supra* note 170, citing *Re A.H.*, 2010 CanLII 51099 (ON CCB), and *Re G.J., infra* note 174>.

174 See, for example, *Re G.J.*, 2010 CanLII 47505 (ON CCB), where the CCB considered a patient's application to be transferred from a highly secure setting to a less secure setting, so he could be closer to his family and girlfriend. Given the patient's history of assaultive behaviour, it was anticipated that he would spend a significant period of time in locked seclusion if he were he transferred to a less secure facility. The current, highly secure facility had a higher staff to patient ratio and was better able to deal with aggressive behaviour. A similar conclusion was reached in *Re. G.B., supra* note 172.

(c) the transfer is in the patient's best interests;

*The CCB will consider all of the factors that would advance the patient's interests and will balance competing interests, some of which may be better addressed at the current facility, while others may be better addressed at the potential receiving facility. Examples of such interests include: access to family and support networks and the likelihood that access will actually increase or decrease at a new facility, the facility which provides the best access to specialized treatment, or programming specific to the patient's needs; active therapeutic engagement with current hospital staff as compared to the effect of new therapeutic relationships at the potential receiving hospital.*[175]

(d) the transfer is likely to improve the patient's condition or well being;

*Evidence of the patient's clinical condition will be considered, including how well the patient adapts to change and whether the transfer would likely precipitate a setback or improvement in the patient's mental condition. Often evidence on this factor will be similar to evidence considered under item c above.*[176]

(e) the transfer is likely to foster the patient's reintegration into the community; and

*This factor also requires a comparative analysis as to which facility is more likely to offer the patient opportunities to reintegrate into the community, based on, for example, evidence relating to accessibility to community placement services and supports.*[177] *The CCB will consider the patient's readiness for community reintegration in deciding how heavily to weigh this factor.*[178]

(f) an attempt has been made to transfer the patient under section 29 (a transfer on the consent of the officers in charge of each facility)

*This factor is most likely to be considered where the application for transfer is brought by the Officer in Charge of the current facility. The CCB will want to hear evidence of what efforts have been made to effect a transfer on a voluntary basis, pursuant to section 29 of the MHA.*

In preparing for a transfer hearing, based on the reported decisions so far, psychiatric facilities should marshal detailed evidence on the first two factors above, which could be summarized as the patient's treatment and care needs, and risk management needs (factors (a) and (b) respectively above). That said, no one factor will be determinative. Rather the CCB will weigh the evidence as a whole, taking all of the factors into consideration. Consequently, psychiatric facilities preparing for transfer hearings will need to consider the clinical, operational and other evidence that speaks to each factor the CCB is mandated to consider at the transfer hearing, regardless of who brings the application.

If the CCB were to grant the application and order the patient transferred, the CCB may specify a period of time within which the transfer must be made. The receiving hospital is required to admit the patient within the specified period of time.[179] However, if a transfer order is appealed, a party to the appeal may make a motion to the Court to have the transfer ordered stayed pending the appeal.[180]

175 *Re S.R.*, 2011 CanLII 32706 (ON CCB).
176 *Ibid.* See also *Re S.W.*, 2010 CanLII 80303 (ON CCB).
177 *Re S.W., supra* note 176.
178 *Re G.B., supra* 172.
179 *Ibid.*, s. 39.2(12).
180 *Ibid.*, s. 48(13).

# 6. Leaves of Absence

The MHA provides for the attending physician, or the OIC (upon the advice of the attending physician) to place a patient on a leave of absence from the psychiatric facility for a designated period of not more than three months.[181] The OIC may specify terms and conditions with which both the attending physician and patient must comply during the leave of absence.[182]

These provisions may be used as a way to assist in the transition from in-patient to out-patient status. The leaves of absence may begin with day passes, and proceed to overnight or weekend passes until the patient is ready for discharge. In appropriate cases, some health care providers use leaves of absences as a less structured alternative to a community treatment order.

## Absences without Authorization

If an involuntary patient or patient who is otherwise detained in the psychiatric facility (i.e., the forensic patient subject to detention under an ORB disposition), is absent from the facility without permission, the OIC may issue an order for the return of the patient to the facility.[183] The order is authority for a police officer, or any other person to whom it is issued, to apprehend the patient and return him or her either to the psychiatric facility from which the patient left; or to the facility nearest to where the patient was apprehended. This order is a Form 9 and is valid for one month after the absence becomes known to the OIC.[184]

If the person has not been returned to the psychiatric facility within one month after the absence became known, the patient is deemed to be discharged, unless the patient was subject to detention in the psychiatric facility under legislation or authority other than the MHA. For example, a mentally disordered offender who is detained at the psychiatric facility under a disposition of the ORB would not be deemed discharged from the facility, but is still subject to the ORB's disposition.

# 7. Community Treatment Orders

CTOs came into effect in Ontario on December 1, 2000, as part of the amendments to the MHA designed to deal with the "revolving door" patient. CTOs were introduced to facilitate the supervision of treatment in the community of persons who had experienced two or more admissions to a psychiatric facility or for a cumulative period of 30 days during the prior three-year period.

As set out in the legislation itself, the purpose of CTOs is to get patients out of hospital and into the community where they may be provided with community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility.[185] The legislation goes on to provide that CTOs are directed at developing a comprehensive community treatment plan for the person who, "as a result of his or her serious mental disorder" experiences the following pattern:

181 MHA, *supra* note 100, ss. 27(1)-27(2).
182 *Ibid.*, s. 27(3).
183 *Ibid.*, s. 28.
184 *Ibid.*
185 MHA, *supra* note 100, s. 33.1(3).

*The person is admitted to a psychiatric facility where his or her condition is usually stabilized; after being released from the facility, the person often stops the treatment or care and supervision; the person's condition changes and as a result the person must be re-admitted to a psychiatric facility.*[186]

## Criteria for Issuing a CTO

A physician may issue a CTO with respect to a person provided that the reason is consistent with the purposes set out in subsection 33.1(3) and provided that the criteria set out in subsection 33.1(4) are met. The criteria for issuing a CTO are as follows:

(a) During the previous three-year period, the person has either been a patient in a psychiatric facility on two or more occasions or for a cumulative period of 30 days **or** more during that time; or, during the previous three years, the person has been the subject of a previous CTO;

(b) A community treatment plan ("CTP") has been developed for the person by the physician who is considering issuing or renewing the CTO, with input from the person or his or her SDM, and from any other health practitioner, or person involved in the person's treatment, or care and supervision;

(c) The physician has examined the person in the 72 hours prior to entering into the CTP, and the physician has formed 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 completion of a Form 1 application for psychiatric assessment on either Box A or Box B criteria; if the person is not currently a patient in a psychiatric facility,

(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 to suffer serious physical impairment of the person,

(iv) The person is able to comply with the CTP contained in the CTO, **and**

(v) The treatment or care and supervision required under the terms of the CTO are available in the community;

(d) The physician has consulted with the health practitioners or other persons proposed to be named in the CTP;

(e) The physician is satisfied that the person subject to the CTO and his or her SDM if any, have consulted with a rights adviser and have been advised of their legal rights, except where the person subject to the CTO refuses to consult with a rights adviser and the rights adviser so informing the physician; and

(f) The person or his or her SDM, if any, consents to the CTP in accordance with the rules for consent under the HCCA.

186 *Ibid.*

Note that under criterion (e), in order for the CTO to be valid, the issuing physician had to be satisfied that the person and his or her SDM had consulted with a rights adviser and been advised of their legal rights. This particular criterion may be waived if the person subject to the CTO refuses to consult with a rights adviser, and the rights adviser so informs the physician. Under the 2010 amendments to the MHA, this exception was preserved and two other exceptions were added:

- if, on the renewal of a CTO, the SDM for the person is the Public Guardian and Trustee (PGT), rights advice need not be provided to the PGT; and
- if a rights adviser has made best efforts[187] to locate the person subject to the CTO and the person cannot be located, then rights advice need not be provided. (MHA subsection 33.1 (5))

In the circumstances prescribed by all of the exceptions, if the issuing physician is kept informed by the rights adviser, the CTO may be issued or renewed, provided that all of the other criteria are met

If all the criteria are met, the physician may issue a CTO in respect of the person. The CTO is issued in a Form 45, which must be attached to the CTP. The contents of the CTO are specified in the legislation and reflected on the Form 45. To be valid, the CTO must indicate:

- The date on which the physician performed the examination which formed the basis of the opinion required in (c) above;
- The facts on which the physician formed the opinion;
- A description of the CTP; **and**
- An undertaking by the person who is subject to the CTO or an undertaking by the SDM, to use best efforts to ensure that the person will comply generally with the CTP, particularly with the requirements to attend appointments with the physician who issued or renewed the CTO or with any other health practitioner or person named in the CTP, at the times and places as scheduled.

Similar to the Form 1 application, a person who is being considered for, or who is subject to a CTO, and the SDM, if any, have a right to retain and instruct counsel, and to be informed of that right.[188] The issuing physician must provide the person with a Notice of Intention to Issue or Renew a CTO (Form 49). The Form 49 also contains a notice to the patient that they have the right to retain and instruct counsel and to receive rights advice.

## When do CTOs Expire?

Generally, a CTO expires six months after it is made, unless it is renewed or terminated early, at the person's or SDM's request, in which case the physician who issued or renewed the order shall review the person's condition to see if he or she is able to continue to live in the community without the CTO.[189]

187 On the new "best efforts" exception, the Psychiatric Patient Advocates Office created a policy for rights advisers as to what would constitute "best efforts in locating persons subject to CTO for rights advice." For example, the policy requires rights advisers to make multiple phone calls to the known contact numbers for the person at different times of the day, and further, the rights adviser must contact the CTO coordinator to ascertain whether there are alternative routes of contact for the person. Given other requirements of the policy, it is possible that "best efforts" to locate the person may take between two to four weeks of attempted contact. We have not been able to locate any CCB decisions that have reviewed this policy in the context of an application for review of a CTO's validity.

188 *Ibid.*, s. 33.1(8).

189 *Ibid.*, ss. 33.1(11), 33.2.

Prior to the 2010 amendments to the MHA, a CTO may also have been terminated where the person who is subject to the CTO failed to comply with the order. In cases of non-compliance, the issuing physician could issue an Order for Examination (Form 47), which provides authority for the person's apprehension by the police and his or her return to the issuing physician for examination.

The former CTO provisions could be interpreted to mean that the return of the patient under an Order of Examination automatically terminated the CTO, which required the physician to issue another CTO "from scratch". CCB policy in the past stated that a CTO was not automatically terminated when an order for examination was issued. The 2010 amendments to the MHA to clarify this situation and provides that a CTO is not terminated by the issuance of an Order for Examination (MHA, section 33.3(1.1)).

Practically speaking, this amendment reduces the administrative burden on the issuing physician, as it continues the CTO that was in place at the time the Order for Examination was issued, such that it remains in effect until it expires or is renewed on the original six month time frame. This in turn can assist with maintaining the patient's community tenure without interrupting the services that are already in place under the continuing CTO.

The remaining ground for early termination of a CTO is withdrawal of consent. As noted above, item (f), the criteria for issuing the CTO in the first place require that the CTP be consented to by the patient or his or her SDM, in accordance with the principles governing consent to treatment in the HCCA. It is a foundational principle in consent and capacity law that consent to treatment may be withdrawn at any time. Thus, the person or the SDM may withdraw their consent to the CTP at any time, but must provide the physician who issued or renewed the order with notice of intention to withdraw the consent.[190] Upon receipt of the notice of intention, the physician is required to review the person's condition within 72 hours to determine whether the person is able to live in the community without being subject to the CTO.[191] If the person refuses to submit to the examination, the physician may issue an order for examination, provided that the physician has reasonable cause to believe that the person is suffering from a mental disorder such that he or she needs continuing treatment or care and continuing supervision while living in the community.

## CCB Review of CTOs

Similar to an involuntary admission, the person who is the subject of a CTO has the right to apply to the CCB to review whether or not the criteria for issuing or renewing the CTO are met as at the time of the hearing.[192] Persons subject to a CTO are entitled to apply to the CCB when the CTO is issued and when it is renewed. If the person chooses not to apply for a review, there is an automatic, mandatory review of the CTO by the CCB when it is renewed for the second time and upon every second renewal after that.[193] The issuing physician has an obligation to notify the CCB upon the second renewal. The patient does not have the right to waive that review.[194]

The CCB reasons for decisions in matters where CTOs have been challenged demonstrate that the CCB will methodically analyze whether there is evidence to support each criterion which is a condition precedent to the issuance of the CTO.

190 *Ibid.*, s. 33.4.
191 *Ibid.*, s. 33.4(2).
192 *Ibid.*, ss. 39.1(1), 39.1(6).
193 *Ibid.*, s. 39.1(3).
194 *Ibid.*, s. 39.1(5).

In a January 2011 decision, the CCB revoked a CTO, where the physician was unable to satisfy the requirement that he had examined the patient within the 72-hour period before entering into the community treatment plan. The evidence demonstrated that the physician had examined the patient at 1:30 p.m. on December 17, 2010, and the community treatment plan was entered into at 3:00 p.m. on December 20, 2010: 1.5 hours outside of the 72-hour period prescribed by s. 33.1(4)(c). The CCB ruled that time requirement must be strictly construed; it had no discretion to "ignore a statutory requirement" on the basis that the requirement had almost been met.[195]

In a June 2008 decision, the CCB upheld the eighth CTO with respect to the same patient. The CCB found that the patient suffered from and has been treated for paranoid schizophrenia for several years, with a lengthy history of non-compliance with medications that resulted in multiple hospitalizations over the years. In particular, the patient did not believe that she suffered from any mental illness at all. Given her history, the CCB confirmed the CTO, ruling that there was evidence to support all the criteria, and in particular, to support the issuing physician's clinical opinion that the patient was likely to suffer substantial mental deterioration if she were to live in the community without continuing supervision of her treatment.[196]

## 8. Assessment of Capacity to Manage Property

The right to manage one's own property is considered a fundamental right of autonomous individuals that can only be removed by operation of law. Usually, this happens according to the provisions of the *Substitute Decisions Act* ("SDA"),[197] which may result in an order of a judge, after a finding of incapacity by an assessor, or where the person has provided for the management of his or her property during a period of incapacity by granting a Power of Attorney for Property.[198]

For persons who are patients in a psychiatric facility, the MHA requires that a physician must conduct a capacity assessment with regard to a patient's ability to manage his or her property, "forthwith upon the patient's admission to a psychiatric facility".[199] The mandatory language of the MHA indicates that the patient lacks the right to object to the assessment

A recent amendment to the MHA provides that where the physician has reasonable grounds to believe that a psychiatric patient has a continuing power of attorney with respect to the management of the patient's property, or the patient's property is under guardianship under the SDA,[200] the physician has no authority or obligation to complete a financial capacity assessment as provided for in subsection 54(1) of the MHA.

Where a physician determines that the patient is not capable of managing property, the physician is required to issue a certificate of incapacity (Form 21), and also to note the determination, with reasons, in the patient's record.[201] The OIC is required to transmit the certificate of incapacity to the PGT. Where there are circumstances such that the PGT should immediately assume management of the person's

195 *Re P*, 2011, CCB File Nos: OT-10-3804 and OT 10-3805 (ON CCB).
196 *Re E.D.*, 2008 CanLII 34346 (Ont. C.C.B.).
197 SDA, *supra* note 50.
198 *Re A.*, 2002 CanLII 6475 (Ont. C.C.B.).
199 MHA, *supra* note 100, s.54(1).
200 *Ibid.*, s. 54(6).
201 *Ibid*, ss. 54(3)-54(4).

property, the Officer in Charge is required to notify the PGT as quickly as possible. If the OIC is absent, this duty of notification falls to the attending physician.[202] Further, the OIC has a duty to transmit "forthwith" a financial statement in the approved form to the PGT (Form 22).

If the patient's capacity improves with treatment, the attending physician may, after examining the patient, cancel the certificate, in which case the OIC is required to transmit a notice of cancellation to the PGT, using Form 23.

As the patient is approaching discharge from the psychiatric facility, the attending physician is required to examine him or her to determine whether the patient continues to be incapable, or has regained capacity, with respect to managing property. This examination must take place within 21 days of discharge and, if the physician determines that the patient is not capable, the physician shall issue a notice of continuance in a Form 24, which the OIC must transmit to PGT.[203]

Patients have the right to challenge the attending physician's finding that he or she is incapable with respect to property by applying to the CCB. When a patient applies to the CCB for such a review, the physician bears the burden of proving that the patient is incapable. The statutory criteria for capacity to manage property is set out in section 6 of the SDA: "A person is incapable of managing property if the person is not able to understand information that is relevant to making a decision in the management of his or her property, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."[204] While there is no one test that is always applied with respect to incapacity to manage property, many CCB decisions consider a list of six factors when deciding whether to uphold a physician's finding that the patient is incapable with respect to property management.

### Those Factors Are:

a) Does the patient suffer from active symptoms of mental disorder, such as delusions or hallucinations, which will likely materially affect the patient's understanding and management of finances in a material and detrimental way?

b) Is the patient oriented to time, place and person?

c) Is the patient's memory sufficiently intact so as to allow the patient to keep track of financial matters and decisions?

d) Is the patient's calculating ability sufficient in the circumstances?

e) Does the patient suffer specific thought process deficits that give rise to the conclusion that deficits in financial judgments exist?

f) Does the patient possess or have the capacity to learn the skills necessary to make the sort of decisions required in an estate of the size, nature and complexity that he or she possesses?[205]

202 *Ibid.*, s. 54(5).
203 *Ibid.*, s. 57.
204 *See Re R.H.*, 2007 CanLII 42448 (Ont. C.C.B.).
205 *See Re J.T.*, 2008 CanLII 5623 (Ont. C.C.B.).

# 9. Patients Admitted to Hospital for Medical Reasons Following Which Psychiatric Issues Emerge

Challenges to findings of incapacity to manage property may also arise in cases where the patient was admitted for medical reasons to an acute care hospital and psychiatric issues became apparent subsequent to the medical admission. When psychiatrists are asked to consult on such cases, it will often be appropriate to merely provide the consultation, without the patient becoming a "psychiatric patient" under the MHA. The patient remains a "medical patient" with a psychiatric consult.

Where the patient's psychiatric condition requires the patient to remain in hospital after the medical problems have been resolved, or where the psychiatric condition becomes a substantial reason for admission, it may be necessary to consider whether the patient should be "admitted" as a psychiatric patient, as opposed to simply continuing as a medical patient with a psychiatric consult. In this case, the patient's category of admission – voluntary, informal or involuntary – will need to be considered.[206] It is only when the medical patient also becomes a psychiatric patient that the obligation to conduct an assessment of the patient's capacity to manage property is triggered.

In cases where patients have challenged a physician's finding that they are incapable with respect to managing property, the CCB and Superior Court have held that it is not enough to consider that a person is a voluntary psychiatric patient, simply because the person is in a public hospital, which is also designated as a psychiatric facility, and is being treated for various conditions, including mental health conditions.[207]

If the medical patient requiring psychiatric treatment is incapable with respect to the psychiatric treatment, the SDM may be approached to obtain consent for the treatment and also for an "informal" admission for the purpose of administering the treatment, under section 24 of the HCCA. In this way, the patient would be admitted as an informal patient, and the financial capacity assessment requirement in section 54 of the MHA would be triggered. If the SDM declines to admit the patient, or there is no substitute willing or able to act, and the condition of the patient warrants detention in the hospital, then the patient should be subject to a Form 1 assessment, followed by a Form 3 Certificate of Involuntary Admission. As this patient was not previously a voluntary psychiatric patient, the process must start at the beginning with a Form 1 assessment.

The situation of the medical patient who subsequently becomes a psychiatric patient should be distinguished from cases where a person has attended at the hospital for the sole purpose of seeking psychiatric treatment and indicated his or her willingness to be admitted for psychiatric treatment. In that case, it is reasonable for the attending physician to imply or infer the patient's consent to a voluntary admission as a psychiatric patient.

Finally, in some circumstances, consulting psychiatrists may be asked to conduct a financial capacity assessment by concerned family members. The CCB has made clear, however, that a consulting psychiatrist or attending physician has no authority under the MHA to conduct such an assessment unless the patient is one of the four categories of patients recognized in the MHA. Consequently, it would be more appropriate for concerned family members, if there is no continuing power of attorney with respect to property, to make arrangements for an independent assessment under the SDA.

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206 Consent must be obtained for voluntary or informal admissions and the MHA procedural requirements for involuntary admissions followed, as outlined above.

207 *Daugherty v. Stall*, 2002 CanLII 2657 (ON S.C.), at paras. 21-23.

# 10. Duties of the "Officer in Charge"

Section 1 of the MHA defines "OIC" as "the officer who is responsible for the administration and management of a psychiatric facility".

The MHA imposes various duties on the OIC or his or her delegate, which has been alluded to throughout this chapter. Many hospitals have policies that address the duties of the OIC and who may act as his or her delegate in what circumstances. It is important to ensure that duties are delegated appropriately and in a manner that complies with the MHA. Psychiatric facilities should therefore consider the nature of each OIC responsibility and how it can be effectively carried out.

The chart below outlines the various duties of the OIC, for ease of reference.

| MHA Section | General Area | Duty of the Officer in Charge ("OIC") |
|---|---|---|
| s. 19 | Involuntary Admission Filing | Receipt of certificate of involuntary admission by the OIC or delegate; filed by the attending physician who changes the status of an informal or voluntary patient to involuntary. |
| s. 20(1)(c) | Involuntary Admission Filing | Receipt of certificate of involuntary admission (Form 3) by the OIC or delegate, to be filed by the attending physician who has completed a Form 3 assessment. |
| s. 20(3) | Form 1 Expiry Release of Patient | When 72 hours has elapsed from the initiation of a Form 1 (or a Form 13), the OIC is required to release the person, unless the attending physician has already acted on the Form 1 (or 13) assessment by releasing the person, or admitting the person as either a voluntary, informal or involuntary patient. In the last case, the physician must have filed the Form 3 with the OIC. |
| s.20(4)(b)(iii) Reg. 741, section 9 | Renewal Involuntary Admission | Receipt of the certificates of renewal (Form 4) at the mandated intervals. The OIC or his or her delegate shall complete and transmit to the CCB a notice in Form 17 of the filing of a fourth certificate of renewal or sequent fourth certificate of renewal respecting a patient. |
| s. 20(8) | Involuntary Admission Review for Compliance with MHA | Following the filing of a certificate of involuntary admission or renewal (Form 3 or 4), the OIC or his or her delegate shall review the certification documents to ensure they have been completed in compliance with the MHA, and if not, the OIC shall inform the attending physician and unless the person is re-examined and released or admitted in accordance with section 20, the OIC shall release the person. |

| MHA Section | General Area | Duty of the Officer in Charge (OIC) |
|---|---|---|
| s. 26 | Withholding Communications To and From Patients | Where the OIC or delegate has reasonable cause to believe that the contents of a communication written by, or sent to, a patient meets certain criteria (see Ch. 7); the OIC or delegate may open and examine the contents of the communication and if the contents meet the criteria, may withhold it from delivery, unless the communication appears to be sent to or by, a lawyer, a member of the CCB, an elected member of the legislature, or the Ombudsman of Ontario. |
| s. 27 | Leave of Absence | The OIC may, upon the advice of the attending physician, place a patient on a leave of absence from the psychiatric facility for a designated period of not more than three months, and prescribe terms and conditions for the leave. |
| s. 28 | Unauthorized Absence | Where a person who is subject to detention (i.e., under the MHA or *Criminal Code*) is absent without leave from a psychiatric facility, the OIC may issue an order to a police officer or any other person for the return of the person to the psychiatric facility where he or she was detained, or to the psychiatric facility nearest to the place where the person is apprehended. |
| Reg. 741, section 8 | Unauthorized Absence Form 9 | Under the MHA regulations, as soon as the OIC becomes aware of the unauthorized absence, the OIC or his or her delegate, is required to issue a Form 9 and notify the appropriate law enforcement authorities "forthwith". Similarly, the OIC shall notify the authorities "forthwith" when the patient has returned, or the patient has not returned and the order has expired. |
| s. 29 | Inter Facility Patient Transfer | The OIC, upon the advice of the attending physician, may transfer a patient to another psychiatric facility, if otherwise permitted by law and subject to arrangements being made with the OIC of the potential receiving facility. The OIC is also a necessary party to Form 19 transfer applications under s. 39.2. |
| s. 30 | Transfer to Public Hospital | Upon the advice of the attending physician, the OIC or his or her delegate, may transfer the patient to a public hospital for treatment that cannot be provided in the psychiatric facility. |
| s. 33.1(10) | Community Treatment Orders | The physician who issues or renews a CTO must ensure that a copy of the order, together with the community treatment plan, is given to the OIC, where applicable. |

| MHA Section | General Area | Duty of the Officer in Charge ("OIC") |
|---|---|---|
| s. 35(2) | Personal Health Information ("PHI") Exceptions to PHIPA | The OIC or his or her delegate, may collect, use and disclose PHI about a patient, with or without the patient's consent, for the purposes of:<br>• Examining, assessing, observing or detaining the patient in accordance with the MHA or;<br>• Complying with Part XX.I of the *Criminal Code*, or an order or disposition made under that Part.[208] |
| s. 35 | Mandatory Disclosures as Set Out in MHA | The OIC, or his or her delegate, has a mandatory obligation to disclose a patient's record of PHI in certain circumstances:<br>• To the CCB in relation to a proceeding before the CCB regarding the patient;<br>• To a person who is entitled to have access to the record under section 83 of the SDA;[209]<br>• Pursuant to a summons, order, direction, notice or similar requirement in respect of matter that may be in issue in a court of competent jurisdiction or under any Act, except where the attending physician states in writing that he or she is of the opinion that the disclosure is likely to result in harm to the treatment or recovery of the patient or is likely to result in injury to the mental condition of a third person, or bodily harm to a third person. |
| s. 35 | PHI Permissive Disclosures as Set Out in MHA | The OIC or his or her delegate may disclose PHI to:<br>• A physician who is considering issuing or renewing, or who has issued or renewed, a CTO;<br>• A physician appointed to act as a substitute of the CTO's issuing physician;<br>• Where requested by the issuing physician or a person named in the CTP, to another person named in a person's CPT; and<br>• A prescribed person who is providing advocacy services to patients in prescribed circumstances, i.e., a rights adviser. |

208 Where this section conflicts with the provisions of the *Personal Health Information Protection Act, the Mental Health Act* prevails: section 34.1, MHA. See Chapter 7 for further discussion.

209 Section 83 of the *Substitute Decisions Act* permits the PGT to have access to the clinical record for the purpose of an investigation into whether a person is experiencing serious adverse effects as a result of being incapable with respect to property or personal care.

| MHA Section | General Area | Duty of the Officer in Charge (OIC) |
|---|---|---|
| s. 38(6) | Informal Patient Who is a Minor | The OIC, or his or her delegate, must promptly give an informal patient who is between the ages of 12 and 16 written notice of their entitlement to a hearing before the CCB. |
| s. 48(12) | Involuntary Admissions Under Appeal | The OIC, or his or her delegate, receives a statement in writing from the attending physician that a patient who has appealed a decision of the CCB confirming his involuntary status, continues to meet the criteria, at the time period that would have applied for the renewal of the certificate. |
| s. 50 | Communication with Consent and Capacity Board | If a patient or another person on the patient's behalf, provides to the OIC an application to the CCB under the MHA or any other Act, the OIC, or his or her delegate, must transmit the application promptly to the CCB. |
| ss. 54 - 58 | Incapacity to Manage Property | Under this section, where a physician has determined that a patient is incapable with respect to managing his or her property, the OIC, or his or her delegate, has certain obligations:<br>• To transmit the Form 21, certificate of incapacity, to the PGT;<br>• To notify the PGT if there are circumstances requiring the PGT to immediately assume management of the person's property;<br>• To transmit a Form 22, financial statement, to the PGT;<br>• To transmit the Form 23, notice of cancellation, to the PGT;<br>• To transmit the Form 24, notice of continuation, to the PGT prior to discharge; and<br>• To transmit notice of the incapable patient's discharge to the PGT. |
| Reg. 741<br>Section 7.2 | Transfer of Custody from Police to Psychiatric Facility | When a person is taken to the psychiatric facility pursuant to a Form 2 or, under the police power of apprehension (s. 17, MHA), the OIC, or his or her delegate, must ensure that a decision is made as soon as possible as to whether the facility will take custody of the person. |

# 11. Rights Advice

While the MHA is recognized as remedial legislation aimed at facilitating the care and treatment of persons for whom mental disorder has put them at risk in a number of ways, it is still legislation that has the effect of removing or compromising rights which are considered fundamental in a free and democratic society.[210] Consequently, the MHA provides for the **mandatory delivery of rights advice in the following situations:**

- The attending physician has determined that a person meets the criteria for involuntary admission and has issued a certificate of involuntary admission, or a certificate of renewal, in respect of that person; or has determined that a voluntary or informal patient meets the criteria for an involuntary admission and changes the patient's status to that of an involuntary patient (Form 3 or Form 4);[211]
- An adolescent who is 12 years of age or older but less than 16 years of age is admitted as an informal patient and has the right to apply to the CCB for a review of his or her status (every three months)
(Form 27);[212]
- The attending physician has determined that a patient over the age of 14 in a psychiatric facility is incapable with respect to psychiatric treatment (Form 33);[213]
- The OIC, or his or her delegate, has determined that a patient who is over the age of 14 is incapable with respect to the collection, use of disclosure of his or her personal health information (Form 33 ),[214] unless certain exceptions apply;[215]
- The attending physician has determined that the patient is incapable with respect to managing his or her property, including finances, and has issued a certificate of incapacity to manage property (Form 21), or a certificate of continuation (Form 24);[216] and
- A physician is considering issuing or renewing a CTO (Form 49).[217]

When one of the above situations occurs, the attending physician is required by the MHA to notify the rights adviser, who will make arrangements to promptly see the patient. Patients, and their SDMs, who are entitled to receive rights advice are also entitled to refuse it. Where this happens, the rights adviser must provide confirmation of the refusal to the physician.

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210 *Re A., supra* note 155 at 6.
211 MHA, *supra* note 100, ss. 38(1), 38(3).
212 *Ibid.*, ss. 38(6)-38(7).
213 *Regulation, supra* note 113, s. 15.
214 *Regulation, supra* note 113, s. 15.1.
215 *Regulation, supra* note 113, s. 15.1(5) – if the person has a guardian of the person or property, under the *Substitute Decisions Act, 1992*, who has authority to do so on the person's behalf; or the person as an attorney under a Power of Attorney for personal care, that waives the person's right to apply to the CCB to review a determination of incapacity in this respect; the person is in a coma, is unconscious or otherwise unable to communicate, despite reasonable efforts to understand the person; or the attending physician determines there is an emergency.
216 MHA, *supra* note 100, s. 59(2).
217 *Ibid.*, s. 33.1(4)(e); see also *Regulation, supra* note 113, s. 14.3 (in this case, both the patient and the substitute decision maker, if any, must be provided with rights advice see discussion above under section of this chapter discussing CTOs).

Under the General Regulation of the MHA, only certain persons may be designated to perform the functions of a rights adviser. The person must be knowledgeable about the legislation and the rights of the patient to apply to the CCB under the MHA, and also under the other relevant legislation – the HCCA and the PHIPA. The rights adviser must also be knowledgeable about the CCB, and about how to obtain legal services and have the necessary communications skills to function effectively as a rights adviser. Finally, the person must obtain certification that he or she has successfully completed a Ministry-approved training course for rights advisers.[218] In many Ontario hospitals, members of the Psychiatric Patient Advocate Office (PPAO) provide rights advice.[219]

Rights advisers are deemed to have met their obligations under the MHA and the General Regulation if they have done their best to explain the matter at issue in a manner that addresses the special needs of the person whose rights are in issue, even if the person ultimately does not understand the explanation.[220] The rights adviser is required to confirm that rights advice has been given by completing and filing a Form 50.[221]

Up until recently, where rights advice was provided by a member of the PPAO, the practice of the PPAO was to comply with the strict requirements of the MHA regulations and provide notice to the attending physician of the patient's intention to apply to the CCB only with regard to findings of incapacity with respect to psychiatric treatment. Beginning September 1, 2008, the PPAO will make a note in Part 1 of the Form 50 as to whether the patient has decided to apply to the CCB for a hearing regarding other types of available review in respect of an involuntary or informal admission, and capacity with regard to decisions involving property management or personal health information.

218 *Regulation, supra* note 113, s. 14.2.
219 For more information on this organization, see http://www.ppao.gov.on.ca.
220 *Regulation, supra* note 113, s. 16(1).
221 *Regulation, supra* note 113, s. 16(2).

Chapter 4

# Issues for Non-Schedule 1 Psychiatric Facilities and Community Hospitals

## 1. Detention at Non-Schedule 1 Psychiatric Facilities and Community Hospitals

The purpose of this section is to review the "detention" of patients in non-Schedule 1 psychiatric facilities and community hospitals. For hospitals that are not designated as Schedule 1, or that are not "psychiatric facilities," there are different challenges that arise when dealing with patients with mental illness, and in particular when these patients need to be detained.[222]

The related issue of "restraint" is addressed in more detail in Chapter 8.

### Sources of Authority that Hospitals have to Detain Patients at Risk of Harm to Themselves or Others

Generally, there are three sources of lawful authority under which a person may be detained in a hospital: the statutory authority provided to psychiatric facilities which is set out in the MHA; the statutory authority provided in the HCCA to a SDM, who may authorize the admission to hospital of an incapable person on whose behalf the substitute is consenting to treatment; and the common law.

### Under the *Mental Health Act*

The authority to detain patients in psychiatric facilities has been reviewed in detail in Chapter 3. Although the language of the MHA suggests that the powers of detention apply to all psychiatric facilities, those that are not required to provide in-patient services (i.e., non-Schedule 1 facilities) are "exempt from the application" of the parts of the MHA that provide psychiatric facilities with the authority to involuntarily detain patients.[223]

Public hospitals that are not designated psychiatric facilities do not have the authority to detain a person under the MHA.

A physician at a non-Schedule 1 psychiatric facility or a community hospital who has assessed a patient and is of the opinion that the person meets the criteria for a psychiatric assessment as set out in section 15 of the MHA can issue a Form 1.[224] Issues with respect to the transfer of patients on a Form 1 will be addressed later in this chapter.

222 Please see Chapter 3, for discussion of what constitutes a "psychiatric facility" and a 'Schedule 1 psychiatric facility" under the MHA.

223 *Regulation, supra* note 113, s. 7.

224 For a detailed discussion of a Form 1, please see Chapter 3.

## Under the *Health Care Consent Act*

Non-Schedule 1 psychiatric facilities and community hospitals may admit a patient who is incapable with respect to treatment where the admission is consented to by the patient's SDM if section 24 of the HCCA applies. This section of the HCCA provides that:

1. Subject to subsection (2), a SDM who consents to a treatment on an incapable person's behalf may consent to the incapable person's admission to a hospital or psychiatric facility or to another health facility prescribed by the regulations, for the purpose of the treatment;
2. If the incapable person is 16 years of age or older and objects to being admitted to a psychiatric facility for treatment of a mental disorder, consent to his or her admission may be given only by,
   a) his or her guardian of the person, if the guardian has authority to consent to the admission; or
   b) his or her attorney for personal care, if the power of attorney contains a provision authorizing the attorney to use force that is necessary and reasonable in the circumstances to admit the incapable person to the psychiatric facility and the provision is effective under subsection 50(1) of the *Substitute Decisions Act, 1992*.[225]

This allows a lawfully designated SDM who is consenting to a treatment on behalf of an incapable patient to also consent to the patient's admission for the purposes of the specific treatment. The SDM can consent to the admission over the patient's objection, unless the admission is for treatment of a mental illness in a psychiatric facility and the patient is over 16 years of age. The SDM's authority in these circumstances therefore includes detention or restraint as necessary for the admission and treatment.

The application of this section to the admission of a person to a psychiatric facility is discussed in more detail in Chapter 3.

## Common Law Duty

There is a common law duty of a health care provider "to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others". This is the language of section 7 of the HCCA that expressly continues the common law duty.

Caregivers have a common law duty to restrain or confine in emergency circumstances. Depending on the level of concern or risk presented by a particular patient, the common law duty is likely invoked in many situations with patients on "Form 1". The statutory criterion for Form 1 considers the same sorts of concerns as this common law duty.[226]

It is often suggested that the common law duty is confined in time to the immediate emergency and that it cannot be extended indefinitely. Depending on the circumstances, it may be that the emergency continues so long as the patient continues to meet the required level of risk to self or others. For example, nursing staff can act on the common law power and restrain a patient in an emergency, pending a physician assessment.

225 HCCA, *supra* note 12, s. 24.
226 For a detailed discussion of a Form 1, please see Chapter 3.

Please see below for a discussion of detention at a non-Schedule 1 psychiatric facility or community hospital while awaiting transfer to a Schedule 1 psychiatric facility.

## 2. Transferring Patients to a Schedule 1 Psychiatric Facility

When a patient is detained or restrained for reasons of a mental disorder at a non-Schedule 1 psychiatric facility or community hospital, it is recommended that they be transferred to a Schedule 1 psychiatric facility.

### Transferring Patients "Forthwith"

A Form 1 is an application by a physician for psychiatric assessment of a person who has been examined by that physician and found to likely be suffering from a mental disorder and meeting one or more of the criteria set out on the Form. The Form may be acted upon at any time during the seven-day period following its completion by the physician; however, once a person acts upon the authority of the Form to take the person into custody, then the transfer to a psychiatric facility needs to take place "forthwith".[227]

**Generally, case law interpreting provisions of the MHA that require an action to be completed "forthwith" suggests this means "as soon as reasonably possible".**

There are no hard and fast rules to determine what is meant by "as soon as reasonably possible". What a reviewing court will find "reasonable" will derive from its examination of all of the circumstances of the transfer in a particular case. Consequently, it will be important for the hospital and medical staff to document the efforts made to transfer the person, the care provided pending transfer and the ongoing monitoring and assessment of the patient to determine that he or she still meets the criteria for the Form 1 application, and therefore for transfer to a psychiatric facility.

The time of acceptance by the receiving facility should also be noted in the chart, as well as the efforts made to transfer as soon as reasonably possible thereafter, again depending on whether the patient still meets the criteria for a Form 1 assessment. The documentation of these steps will be important to determining whether indeed the person was transferred as soon as reasonably possible, or "forthwith".

### Detention While Awaiting Transfer

Where circumstances require the detention of a person pending transfer to a Schedule 1 psychiatric facility, non-Schedule 1 psychiatric facilities and community hospitals may look to the common law duty to detain patients where immediate action is necessary to restrain or confine the person in order to prevent serious bodily harm to the patient or others. In certain, prescribed cases, non-Schedule 1 psychiatric facilities may look to the HCCA authority to admit patients informally.

227 MHA, *supra* note 100, s. 15(5).

It can also be argued that, where a timely and appropriate transfer of a Form 1 patient to a Schedule 1 facility is not possible, and where the psychiatric facility does in fact have an in-patient mental health unit, a patient's rights are arguably better respected if he or she is detained at the non-Schedule 1 facility, and provided with both written notice of the detention with a Form 3 and rights advice,[228] including the right to counsel and the ability to challenge the detention with the usual review mechanisms.

This is a difficult area in which the risks must be balanced between detaining or discharging a patient. Non-Schedule 1 psychiatric facilities and community hospitals are advised to seek specific legal advice if they are in this situation.

## Patient Transfers to Schedule 1 Facilities

Non-emergent transfers of patients are an issue in all areas of health care. Those working to facilitate transfers of patients from non-Schedule 1 facilities to a Schedule 1 facility for assessment need to consider the appropriate mode of transportation for these patients. The security of the patient and others must be considered when determining the appropriate mode of transportation.

**The courts may find liability where the harm suffered by the patient was reasonably foreseeable by the defendants in the circumstances of the case and could have been avoided through a different mode of transport.**

The physician who completed the Form 1 should make a clinical assessment as to how the individual can be safely transferred given his or her physical and mental condition. The physician's determination of the appropriate mode of patient transport, as well as the basis for this decision, should be documented in the clinical record. Similarly, any psychiatric patient who requires transfer to another facility, whether for psychiatric or medical care, should be assessed to determine the appropriate mode of transport given that patient's condition.

If there is a delay in transporting the patient, a clinical assessment should be undertaken once again when the patient is actually set to be transferred. If a patient is harmed and/or harms someone else in the course of being transferred in a non-Emergency Medical Services vehicle, the decision to use such a transfer may be the subject of some legal scrutiny. Consequently, the decision-making process for the transfer should be documented, including an account of the particular condition and presentation of the patient being transferred, in order to manage the risks associated with patient transfers.

228 Please note that not all facilities currently have access to "Rights Advisers".

Chapter 5

# Consent and Capacity Board Hearings

## 1. Introduction to the CCB and its Role

The CCB is an independent provincial tribunal that has been established to provide "fair and accessible adjudication of consent and capacity issues, balancing the rights of vulnerable individuals with public safety."[229]

The CCB holds hearings under the HCCA, MHA, PHIPA and SDA. A complete list of the types of applications that may be made to the CCB can be found on the CCB website at http://www.ccboard.on.ca/scripts/english/forms/index.asp. Appendix "C" sets out the applications that may be made to the CCB under the HCCA and MHA.

The most common types of hearings in which health care providers in mental health may be involved are those relating to capacity to consent to treatment (Form A), capacity to manage property (Form 18) and involuntary admission (Form 16). The other types of applications to the CCB may arise, however the three noted above are by far the most prevalent for health care providers in mental health.[230]

### The Statutory Framework

When an application is received, the CCB will convene a hearing within seven days to review the issue.[231] On the consent of the parties, this time line can be extended.[232]

**Reasons for decisions of the CCB are available in a searchable database supported by the Canadian Legal Information Institute ("Can LII") at http://www.canlii.org/en/on/onccb/index.html.**

At the hearing, a "panel" of the CCB will hear the evidence relevant to the application. The "panel" will be comprised of 1, 3 or 5 members of the CCB.[233] If it is a single member, it will be a senior lawyer member of the CCB.[234] A three-member panel will include a senior lawyer member, a psychiatrist and a community member. A five-member panel will include the members who would sit on three-member panel, with an additional two members who may be "in training".

229 Consent and Capacity Board Website, online: Ontario – Consent and Capacity Board, www.ccboard.on.ca

230 According to the CCB's 2009-2012 annual report, 56% of hearings in that period related to involuntary admission, with 23% for treatment capacity review and 9% related to CTOs. http://www.ccboard.on.ca/english/publications/documents/annualreport20092010.pdf.

231 HCCA, *supra* note 12, s. 75 (1)(2).

232 *Ibid.*, s. 75(2).

233 *Ibid.*, s. 73(1).

234 *Ibid.*, s. 73(2). A single panel member hearing an application under the *Mandatory Blood Testing Act* may have different qualifications.

Following a hearing, the CCB will render a decision within one day.[235] The "decision" is a concise statement of the result, with no reasons. Any party can request written reasons for the decision within 30 days of the decision. The written reasons are to be provided within two business days of the request.[236]

## CCB Rules of Practice

As an administrative tribunal, the CCB can establish Rules of Practice and Policy Guidelines to govern its practice.[237] The purpose of these Rules is:

> ... to provide a just, fair, accessible and understandable process for parties to proceedings before the Board. The Rules attempt to facilitate access to the Board; to promote respectful hearings; to promote consistency of process; to make proceedings less adversarial, where appropriate; to make proceedings as cost effective as possible for all those involved in Board proceedings and for the Board by ensuring the efficiency and timeliness of proceedings; to avoid unnecessary length and delay of proceedings; and to assist the Board in fulfilling its statutory mandate of delivering a just and fair determination of the matters which come before it.[238]

For a copy these Rules, please refer to CCB's web site at http://www.ccboard.on.ca/scripts/english/legal/rulesofpractice.asp.

## CCB Policy Guidelines[239]

The CCB has established "Policy Guidelines" with the stated purpose to:

> …identify guiding principles for adjudicating and managing care. While not binding on Board members, these Policies provide guidance to Board members and to the personnel supporting adjudicative functions with regard to the procedures that should be followed in particular situations before the Board.[240]

**Copies of these policies may be found on the CCB website at http://www.ccboard.on.ca/scripts/english/legal/policyguidelines.asp**

- **Policy Guideline No. 1** - Right to Apply When Certificate of Involuntary Status or Renewal is Renewed before the Board Renders a Decision.[241]

  This applies when an application has been made to the CCB for a review of involuntary status, and the hearing has yet to be held or there has been a hearing and the decision has not been delivered. If, in these circumstances, a Form 4 is completed with respect to the same patient, this states that the new form will not give rise to a further hearing.

235 *Ibid.*, s. 75(3).
236 *Ibid.*, s. 75(4).
237 *Statutory Powers Procedure Act*, R.S.O. 1990, c.S.22, [SPPA].
238 CCB Rules of Practice, Rule 1.1, online: Ontario – Consent and Capacity Board, <http://www.ccboard.on.ca/scripts/english/legal/rulesofpractice.asp>.
239 In the 2009 edition of this Toolkit, there was reference to a Policy #3 – Effect of a Form 47 (Order for Examination) on a CTO. This is no longer in effect.
240 http://www.ccboard.on.ca/scripts/english/legal/policyguidelines.asp.
241 *Ibid.* This policy is effective from September 1, 2007.

- **Policy Guideline No. 2** - Ordering Counsel Where the Subject of an Application Does Not Have Legal Representation.[242]

  This is limited to situations in which the subject of the hearing, typically the patient, is unrepresented. It does not take into consideration when the health care provider or other parties may require representation. This sets out the process the CCB plans to follow when the person who is the subject of the hearing does not have counsel.

- **Policy Guideline No. 3** - Disclosure of An Applicant's Personal Information For Hearings Under the *Mandatory Blood Testing Act,* 2006.[243]

  This outlines the procedure and rationale for disclosing part of the information included in an Applicant Report when conducting a hearing under the *Mandatory Blood Testing Act, 2006.*

- **Policy Guideline No. 4** - Policy for Handling Documents Sent to the CCB by Parties / Counsel in Advance of a Hearing.[244]

  This outlines rules with respect to documents sent to the CCB in advance of a hearing. Panel members will only look at the materials in advance of the hearing in certain circumstances:

  1) Where all parties have consented;
  2) Where one or more panel members will be participating by teleconference or video-conference;
  3) Where the hearing will take place in writing;
  4) Where a Board member or panel has previously ordered the sharing of the document(s); and
  5) In any other case where the Registrar of the Board is of the opinion that the sharing of the document(s) with panel members before the hearing will promote the just and expeditious disposition of the proceeding.

  In all other cases, copies should just be brought to the hearing and distributed at the outset.

If questions arise about the interpretation of these polices, or their application, consideration should be given to obtaining legal advice.

## Parties to Hearing and Appointment of Counsel

The "parties", or required participants to an application, are set out in the legislation.[245] An overview of the usual parties to these applications is included in Appendix "C".

The CCB has the discretion of adding other parties as it sees fit. This is usually done on a motion by the person seeking to be added as a party to the application. The factors to be considered and process to be followed by the CCB in considering a motion with respect to whether someone should be specified as a party to an application are set out in Rule 5 of the CCB's Rules of Practice.[246]

242 *Ibid.* This policy is effective from September 1, 2007. In *Re: A.F.,* 2010 CanLII 77954 (ON CCB), the patient wanted to proceed without counsel and, after following the process set out in this policy the decision was made to proceed with the hearing.
243 *Ibid.* This Policy Guideline is effective from December 15, 2010.
244 *Ibid.* This Policy Guideline is effective from December 5, 2011.
245 For example – for applications relating to consent to treatment see s. 32(3) of the HCCA and for applications relating to admission to a psychiatric facility see s. 41 of the MHA.
246 *Supra* note 238, Rule 5.

There is no legal requirement for parties to be represented by legal counsel. As discussed above, there is a policy guideline for the CCB (policy guideline # 2) to be involved in appointing counsel for the person who is the subject of the hearing. This may involve the PGT, or the Children's Lawyer where the subject of the hearing is a minor.

**Most health care organizations in Ontario will have formal or informal polices/ practices to assist health care providers in accessing legal counsel.[247]**

A patient may request, or deny, the assistance of counsel. The CCB is likely to grant a "reasonable" request for an adjournment of a hearing based on a patient request for counsel.[248] What is "reasonable" will be determined on the facts of a particular situation.

It is recommended that legal counsel be consulted if there is a contentious issue, or if patient's counsel indicates an intention to raise technical or legal arguments. Often, legal counsel can assist in preparation for the hearing, but may not be required for the hearing itself.

It is open to a heath care provider to request an adjournment at the outset, or in the course of, a hearing, for the purpose of consulting with counsel. A health care practitioner faced with a legal issue or other situation in the course of a hearing with which they are not comfortable should request an opportunity to consult with legal counsel. This request should be made "on the record" for the proceeding. The CCB may be reluctant to grant an adjournment request when the consultation or advice could have been sought prior to the commencement of the hearing, however it is anticipated that a decision will be made on the particular circumstances of a situation.

## The Burden of Proof on Health Care Providers

The person who made the finding that is the subject of the hearing has the burden of proof. The standard of proof on applications dealing with consent issues is a "balance of probabilities", which is also referred to as the civil standard of proof.[249]

The standard of proof is an "enhanced balance of probabilities" when issues of involuntary admission are being considered. This has been described as "something more than the simple enhanced balance of probabilities required in civil litigation, but much less than proof beyond a reasonable doubt, as required by criminal law".[250]

The onus is on the party making the finding to present clear and compelling evidence that supports the finding.[251] There is no obligation on the patient to prove anything.

247 The internal and external resources available to health care practitioners dealing with issues relating to and before the CCB vary as between health care organizations throughout Ontario and may include internal legal counsel, risk management staff, individuals within the organization with experience and expertise in dealing with these issues and access to external counsel. Physicians may also wish to contact the Canadian Medical Protective Association.

248 The right of a patient to decline the offered assistance of appointed counsel and to request counsel of choice, or in the alternative to be self-represented before the CCB is discussed in *Gligorevic v. McMaster,* 2012 ONCA 115.

249 Starson, *supra* note 35.

250 *M (Re)*, 2005 CanLII 56677 (Ont. C.C.B.).

251 *Starson, supra* note 35.

The "usual" party on a application before the CCB is the health care practitioner who made the finding that is the subject of the review. The physician who is most responsible for the patient's care at the time of the hearing is often the most appropriate "party" to the hearing. The physician may present information from other prior evaluations, from a review of the chart, from collateral sources, and from his or her own examination of the patient. The physician may determine that another individual, including a health care provider, should also attend and give their own evidence on an issue to which the physician cannot speak directly.[252]

Bringing witnesses to a Board hearing is discussed further below.

# 2. Preparation for Hearings

The "preparation" for a CCB hearing begins well before an application is made, or notice is received that an application has been made. **Documentation of clinical interactions and information, as well as legible charting, are very important to support any subsequent proceedings or hearings.** It is also important to understand the workings of the CCB, as well as the rules, policies and practices that will impact its review of any application.

## Notice of a Hearing

Once a health care provider becomes aware that an application has been made to the CCB[253] steps should be taken to ensure that the necessary forms are complete and available. These forms are the underpinning of the finding to be reviewed, and a preliminary issue will be whether the procedural processes, as required in the legislation, were followed.

It is recommended that the health care practitioner contact counsel for the patient, if appointed, and inquire if there are any preliminary or procedural issues to be addressed. If there are preliminary or procedural issues, the health care practitioner should consider whether these can be resolved with counsel and if not, prepare to argue the issue at the outset of the hearing. The health care practitioner may also want to consider seeking legal advice to review the issue being raised.

Health care practitioners should also provide patient's counsel with copies of any documents to be relied upon, prior to the hearing, including the clinical summary. This communication in advance of the hearing may assist with identifying any preliminary or substantive issues that may require consultation with a lawyer, or an adjournment.

252 In *Re J.W.*, 2010 CanLII 33086 (ON CCB) the Board was asked to determine the appropriate "respondent" on an application to review a finding of incapacity with respect to admission to a care facility. Several health care providers were involved with the evaluation of the patient over a period of time. The Board concluded that the MRP was the most appropriate respondent as he had coordinated the assessment and ultimately took responsibility for the finding of incapacity. The MRP had relied on other members of the multi-disciplinary team for the evaluation of capacity. The other members of the team would have had the option of being added as respondents, and did given evidence at the hearing.

253 When a patient is provided with Rights Advice and a Form 50 is completed, the Rights Adviser will note on the form if they are aware an application has been made to the CCB. In the event that there is not a "spot" on the form to check when an application is made, the Rights Adviser should make a handwritten note on the Form, advising of an application.

**Copies of documents to be submitted at the hearing should be prepared in advance of the hearing – one copy for each CCB member (when in doubt, assume that there will be three) and a copy for the patient or counsel. It is a good idea to have one extra copy for good measure. If the patient (or counsel in situations in which the patient is represented) agrees, copies of the documents can be provided to the CCB members prior to the commencement of the hearing. Practically, this would be in the 30 minutes preceding the commencement of the hearing, as the CCB does not receive materials for review in advance of the hearing date.**

When preparing for the presentation of evidence at a hearing, review the legal tests that are to be addressed. If uncertain about the tests, or how they apply to the facts of a particular case, it is better to seek legal advice or support prior to the commencement of the hearing.

Finally, a health care practitioner presenting without the assistance of counsel at a hearing, will want to spend time preparing opening comments, questions for other witnesses and a closing argument.

If the person making the application to the CCB decides not to proceed with the hearing this should be communicated to the CCB, in writing. The preferred form for this communication is the CCB's "Notice of Withdrawal".[254]

## The Use of Clinical Summaries and Documentation from the Chart

It is recommended that a clinical summary be prepared for use at a hearing. **A clinical summary outlines the issue(s) before the CCB and the applicable legal test(s), as well as the facts and opinions that the health care practitioner is relying on to support the finding**. These summaries streamline the issues for the CCB and assist the health care practitioner in preparing his or her evidence. The clinical summary should form part of the record for the hearing, and can be referenced by the CCB in preparing any reasons for decision.

Clinical summaries should always be written in a manner that best addresses the facts and evidence of a particular case. A clinical summary should not function as a substitute for providing the CCB with copies of relevant extracts from the patient's chart. Filing these key clinical records as exhibits at a hearing is important. These materials may include clinical notes and records from previous attendances and admissions that document the patient's clinical history, consultation reports and notes from other health care practitioners involved with the patient, as well as significant progress reports from other members of a multi-disciplinary team. While the CCB does not need to be provided with a complete copy of the patient's chart, copies of relevant documents can supplement the clinical summary and assist with the presentation to the CCB. The documents that are marked as exhibits become documentary evidence and part of the record.

The CCB has prepared Summary Templates to assist health care practitioners preparing for a hearing and these can be found at: http://www.ccboard.on.ca/scripts/english/publications/ccbtemplates.asp

254 This may be found on the CCB website at http://www.ccboard.on.ca/scripts/english/forms/index.asp#now. The use of this form is not mandatory.

### Identification of Possible Witnesses

In preparing for a CCB hearing, a health care provider should also consider whether it is appropriate, in the circumstances of the particular hearing, to call "witnesses". A witness may be a service provider, another member of the health care team family member of the patient, a friend, or someone who is involved with the patient in the community. If other members of the health care team, family members or anyone else is going to be asked to give evidence at the hearing, make sure they are aware of the date, time and location.

**Contact the CCB directly to get more information about obtaining a summons for a possible witness.**

Generally, possible witnesses who have been involved with the patient will be prepared to attend voluntarily at the hearing. If for some reason a potential witness is not prepared to attend voluntarily, then a "summons" can be requested from the CCB. Rule 27.1 of the CCB's Rules of Practice confirms that this is possible.

## 3. CCB Hearings

The hearing will open with introductory comments from the CCB Chair, and an overview of the process. The patient is usually present, as they are usually the subject of the hearing, but in some cases they may choose not to attend. If the patient is not in attendance, the CCB will likely enquire as to why they are not present.

A patient who is the subject of an application to the CCB may be represented by counsel. If the patient does not have counsel, the CCB will likely enquire as to whether the patient would like to have counsel present, and in some cases may appoint counsel.

The CCB will usually ask if there are any procedural or jurisdictional issues to be raised. If yes, these will often be addressed and resolved on a "preliminary" basis. If evidence is required to address these issues, they may be dealt with later in the hearing process.

Once the substantive part of the hearing is to begin, the health care practitioner, or the person who made the finding that is the subject matter of the hearing, will be asked to present. If a clinical summary has been prepared, the presentation can focus on key information that is relevant to the finding, and the presentation of supporting documentation. **Remember to have any supporting documents marked as "exhibits".** Rather than just reading from or referring to relevant documents, provide the CCB with copies and make sure to ask that they be "marked as exhibits" so as to form part of the official record.

### Example

During a hearing to determine whether a patient was capable with respect to a proposed treatment, the attending physician referred extensively to a seven-page discharge summary prepared a year earlier at the conclusion of a four month admission for the same patient. The physician did not have copies of the summary for the CCB, and it was not marked as an exhibit at the hearing.

The discharge summary will not form part of the record of the proceedings. The only references will be those read in and therefore reproduced on the transcript.

The CCB will not have a copy to refer to in making its decision. On any appeal, the Court also will not have a copy of this document. It is quite likely that this document would provide additional support for the case.

Following the presentation of the evidence, there will be cross-examination by the other parties or their counsel. Following the cross-examination, the members of the CCB may ask questions. If this occurs, the parties will be provided an opportunity to comment or ask questions in response to the CCB.

After the health care practitioner testifies, he or she may call other witnesses. The patient, or patient's counsel where present, then has an opportunity to present evidence. If there are any other parties to the hearing, they may present evidence as well.

The questioning process will continue until the evidence of all parties has been presented. Following the presentation of evidence, there will be "closing submissions". This is an opportunity for summary argument, based on the evidence presented at the hearing. This is an opportunity for the party with the burden of proof to emphasize why their finding is supported in the application of the facts of the particular case to the law.

The CCB has posted "mock hearings" on their website at http://www.ccboard.on.ca/scripts/ english/ publications/mockhearings.asp which provide an example of the hearing process.

## Dealing with "Technical Issues" Before the CCB

The following are some examples of technical issues that have been raised before the CCB:

- Failure to file a copy of the Form 42 (Notice to Person of Form 1 completion) in the chart;
- Form 1 and Form 3 completed by the same physician;
- Form 3 or Form 4 completed just outside of the statutory time period (for example, 73 hours after completion of the Form 1);
- Errors in the completion of the forms (for example, boxes missed, descriptions indecipherable or too brief);
- Improper (or absent) OIC review of Forms 3 and 4; and
- Incomplete (or absent) notes of consent or other discussions.

If a technical issue is raised **before** the hearing, the party who has raised the issue, such as the patient's lawyer, may be asked to fully explain the issue, preferably in writing. If time permits, the health care provider can consult counsel in advance of the hearing. If possible, a solution may be negotiated or an agreement reached as to what will be argued.

If a technical issue is raised for the **first time at the hearing**, the health care practitioner can object to lack of notice and, if he or she is unprepared to deal with the issue "then and there", may request an adjournment to consult counsel.

If a health care provider wants to deal with such an issue, without legal representation, it will be important to carefully read the sections of the applicable Act that the patient's counsel is arguing about, to confirm that the legislation says what he or she is actually arguing. Ask the patient's counsel if he or she is aware of any cases before the CCB that consider the issue, either for or against their position. Counsel has a duty to bring both favourable and unfavourable decisions to the attention of the CCB.

If a health care practitioner "loses" a hearing on technical grounds, without there having been a consideration of the substantive issue on the application, then the health care practitioner should consider re-doing the finding. For example, if a Form 3 or 4 is declared invalid on technical grounds a Form 1 can be completed if the patient still meets the criteria.

### Example

A patient argued that the Form 3 was improperly completed, and therefore the subsequent Form 4 was invalid.

*T.S. v. O'Dea,* [2004] O.J. No. 36

In her decision, Madam Justice Greer commented that:

"..., *In the Matter of P.L.H.*, the Board addresses the Forms used under the HCCA. There at p.16, the Board agreed with an earlier finding in *In the Matter of M.S.*, where the Chair stated that it is the Board's view of the law when a Form 1 expires, the law does not contemplate that its expiry means 'the person must be turned loose even though he or she might cause harm to himself or others serious bodily harm.' The Board in *P.L.H.*, supra, said this reasoning also applies if an improper form is mistakenly used. It said, '**as long as hospital staff are human, mistakes will be made.'** This reasoning applies to the Appeal before me and the issue of the Form 3." (emphasis added)

# 4. After the Hearing

As indicated at the beginning of this Chapter, the CCB is required to deliver a "decision" within one day of the hearing.[255] If one of the parties is not content with the outcome, they may consider an appeal.

## Rights of Appeal

A party before the CCB has a statutory right of appeal to the Superior Court of Justice from the CCB's decisions on questions of law or fact or both.[256]

Legal counsel is required for appeals, and should be consulted on receipt of a Notice of Appeal. Depending on the nature of the appeal, steps may need to be taken urgently. It is prudent to have counsel involved at the outset.

A health care practitioner who would like to appeal a decision of the CCB should seek immediate legal advice. An appeal must be "taken" within seven days of the decision, and depending on the nature of the application that was before the CCB, there may be other considerations.

## The Practical Aspects of an Appeal

A health care practitioner who is served with a Notice of Appeal from a decision of the CCB should contact the appropriate risk management representative or their organization's designated resource for accessing legal counsel. It is strongly recommended that legal counsel be obtained with respect to an appeal.

When the CCB receives a Notice of Appeal that has been issued by the Ontario Superior Court, it will prepare a "Record of Appeal", containing copies of the materials filed with the CCB, and arrange for a transcript of the hearing to be prepared. When these materials are ready, copies will be delivered to the parties and filed with the Court. These materials will form the basis for the appeal, and additional materials cannot be relied upon without "leave", or permission of the Court.

## Impact of Appeal on Treatment

As discussed in Chapter 2, treatment is not to be commenced pending an application to the CCB or an appeal to the Superior Court.[257] If a treatment was in place prior to the commencement of the appeal, it can continue, but a "new" treatment cannot start. The process of getting an appeal heard by the Superior Court can take time, and the practices for getting a hearing of an appeal from a decision of the CCB varies in different regions of Ontario. The Court of Appeal commented in *Conway v. Jacques:*

> *Finally, I must express my concern regarding the unacceptable delay flowing from the protracted nature of these proceedings. Over five years have passed since Dr. Jacques first raised the issue of the patient's psychiatric treatment with SDM. I urge all concerned to do what is required to have the issue of the patient's treatment resolved as soon as possible.*[258]

255 HCCA, *supra* note 12, s. 75(3).
256 HCCA, *supra* note 12, s. 80(1).
257 HCCA, *supra* note 12, s. 18(3)(d); please see Chapter 2.
258 *Conway v. Jacques* (2002, 59 O.R. (3d) 737, 214 D.L.R. (4th) 67, 2002 CarswellOnt 1920 (C.A.) at 41.

It is possible for patients to wait for a considerable time in hospital before receiving treatment for their mental illness, due to the nature of the appeal process.

**Hospitals should have a policy or plan to deal with situations in which a patient appeals from a decision of the CCB**, particularly when the appeal relates to treatment.[259] While there is a timeline for appeals in the HCCA, this is rarely followed. The consequences of delay in moving appeals forward, particularly with respect to treatment can be significant and may include considerable delays in the commencement of treatment that result in the patient's prolonged detention[260] and / or limit the treatment options available to subsequent health care providers.[261]

It is possible to bring a motion to the Court for an Order allowing for treatment pending an appeal.[262] It is also possible for steps to be taken to expedite an appeal to the Superior Court. These are both issues that can be discussed with legal counsel, and whether either is a feasible option will depend on the circumstances of a particular case.

### Treatment Pending Appeal

Example: A psychiatric patient has a long standing history of diabetes, for which he is insulin-dependent. The patient has developed hypertension and it is proposed that he receive medication to treat this condition. When the patient's capacity is assessed, it is determined that he is incapable of making decisions with respect to the proposed treatment as well as with respect to the treatment for his diabetes. The patient appeals to the CCB for a review of this finding and the CCB finds that the patient is not capable of consenting to either treatment. The patient then commences an appeal to the Superior Court.

Upon notice of the patient's intention to apply to the CCB for a review of the finding, the physician must take reasonable steps to ensure that the treatment for hypertension is not commenced. The treatment for the diabetes, which was commenced prior to the appeal, can continue pending the appeal. This "status quo" will remain in place until the final disposition of the appeal, subject to there being an "emergency".

Finally, a health care practitioner who has treatment "on hold" for a patient pending an appeal will need to consider the emergency treatment provisions of the HCCA, in the event that this type of treatment becomes clinically necessary. For more detail on the emergency treatment provisions, please see Chapter 2.

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259 In *Szeman v. Legault*, 2010 ONSC at para. 42, the Court commented that: It is inconsistent with the legislation and the findings of the Supreme Court of Canada, to delay an appellant's attendance at court to have the appeal heard in an expeditious manner. I accept Ms. Roy's submission that the hospital has addressed this issue and that if a similar situation occurs in the future that the hospital or the physician's counsel will contact the Trial Coordinator and arrange for a convenient date for a court appearance forthwith. The process of dealing with an appeal from a decision of the CCB may vary, depending on how these appeals are managed in the various regions of the province.

260 This was discussed in the decision of Brown J. in *Cavalier v. Ramshaw*, 2010 ONSC 5402 at para 5.

261 In *K.M. v. Shammi*, 2012 ONSC 1102, the appellant (patient) was discharged from hospital prior to the appeal being resolved. When she was subsequently readmitted to another facility, treatment could not be commenced due to the outstanding appeal. The appeal was subsequently determined by the Court to be moot.

262 *Starson, supra* note 35.

## Impact on Involuntary Status

The CCB will either confirm that the patient meets the criteria for involuntary admission or rescind a Certificate of Involuntary Admission, or a Certificate of Renewal, following a hearing.

If the CCB **confirms** that the patient met the criteria for involuntary admission at the time of the hearing and the patient appeals this decision, the Certificate of Involuntary Admission continues in effect until:

(a) The certificate is confirmed or rescinded by the court;

(b) The certificate is rescinded by the attending physician;

(c) 48 hours after notice is given to the attending physician that the party appealing has withdrawn the appeal; or

(d) The attending physician confirms under subsection 48(12) that the patient does not meet the criteria set out in subsection 20(1.1) or (5).[263]

During the period in which the certificate is continued pending the appeal, "the attending physician shall examine the patient at the intervals that would have applied under section 20 and shall complete and file with the Officer in Charge a statement in writing as to whether or not the patient meets the criteria set out in subsection 20(1.1) or (5)".[264] This requirement for reassessment of the patient confirms that there is ongoing evaluation of whether the criteria for involuntary admission continue to be met, although the patient is not entitled to further review of their status by the CCB.

If the CCB rescinds the Certificate of Involuntary Admission, or Renewal, the physician may wish to consider an appeal. Where an appeal is "taken"[265] from a decision of the CCB, a Certificate of Involuntary Admission, or Renewal, is extended for three days.[266] During this time, a motion may be brought seeking an Order from the Superior Court extending the effectiveness of the Certificate beyond the three day period.[267] The criteria that must be met for this extension, as well as the process and options available to the Court, are set out in section 48 of the MHA. Due to the nature of these motions to the Court, legal counsel is strongly recommended.

263 MHA, *supra* note 100, s. 48(11).
264 *Ibid.*, s. 48(12).
265 The wording of s. 48(5) of the MHA suggest that a Notice of Appeal must be served and filed with the Court for this extension to be triggered. Practically, it is not often possible to do this on the same day that the decision is received. It is important to have legal counsel review the situation immediately, where there is consideration of an appeal or possible appeal of a Board finding with respect to involuntary admission. At a minimum, notice should be provided to the patient, and legal counsel if acting, of a physician's intention to appeal a CCB decision rescinding a Certificate of Involuntary Admission.
266 MHA, *supra*, note 100, s. 48(5).
267 *Ibid.*, s. 48(6).

Chapter 6

# Forensic Psychiatric Patients and the Criminal Law

## 1. Introduction and Historical Developments

In her introduction to the leading Supreme Court of Canada decision on the criminal justice regime that governs the mentally disordered offender, *Winko v. British Columbia (Forensic Psychiatric Institute)*, Madam Justice McLachlin wrote:

> *In every society there are those who commit criminal acts because of mental illness. The criminal law must find a way to deal with these people fairly, while protecting the public against further harms. The task is not an easy one.*[268]

Indeed, some authors suggest that "the reason the very first mental health legislation was established in Ontario [almost 170] years ago was that the legal/judicial/correctional system could not cope with the problems of the mentally ill".[269] The criminal justice system has attempted for many years to address the needs of the mentally ill who, due to their illness, have behaved in ways that bring them into contact with law enforcement agencies, the criminal courts and "forensic" psychiatric facilities.[270]

However, as the Mental Health Commission of Canada in its report "Changing Directions, Changing Lives" has reminded us:

> The vast majority of people living with mental health problems and illnesses are not involved with the criminal justice system. In fact, they are more likely to be victims of violence than perpetrators. Nevertheless, they are over-represented in the criminal justice system; that is, there is a much higher proportion of people living with mental health problems and illnesses in the criminal justice system than in the general population. The reasons for this over-representation are complex. Clearly, people are involved in the criminal justice system because of criminal behaviour. However, lack of access to appropriate services, treatments and supports have also had a powerful influence on this situation. This over-representation has increased as the process of de-institutionalization of people with living with mental health problems and illnesses, coupled with inadequate re-investment in community based services, has unfolded. Estimates suggest that rates of serious mental health problems among federal offenders upon admission have increased by 60 to 70 percent since 1997.[271]

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268 *R. v. Winko*, [1999] 2 S.C.R. 625 at para. 1, McLachlin J. (as she then was) [Winko].

269 John E. Gray et al, *Canadian Mental Health Law and Policy*, 2d ed. (Markham, Ont.: LexisNexis Canada, 2008) at 411; citing J.C. Deadman & B.F. Hoffman. "Civil Rights and Responsibilities: Problems in the Mental Health Act" (1987), Ont. Med. R. (November/December) at 4-5. Deadman and Hoffman stated that the first mental health legislation appeared in Ontario "148 years ago" as at the time of their writing in 1987.

270 The term "forensic" means "of or relating to courts of law" and in this context, describes a hospital that has been designated by the provincial Minister of Health as a place for the custody, treatment or assessment of mentally disordered offenders pursuant to the provisions of Part XX.1 of the *Criminal Code*.

271 Mental Health Commission of Canada. (2012). *Changing Directions, ChangingLlives: The mental health strategy for Canada*. Calgary, AB; p. 48.

In 1992, there was significant legislative reform following a decision of the Supreme Court of Canada, *R. v. Swain*.[272] In the *Swain* case, the Supreme Court held that the provisions of the *Criminal Code* dealing with those found unfit to stand trial or found not guilty by reason of insanity were unconstitutional, as they violated the accused's *Charter* guaranteed rights to procedural fairness and to be free from arbitrary detention, as guaranteed by the *Charter of Rights and Freedoms*.

In response to the Swain decision, Parliament enacted Part XX.I (Mental Disorder) of the *Criminal Code*, a new regime for dealing with the mentally disordered accused. Justice McLachlin (as she then was) reviewed the purpose of the new regime in the Winko decision as follows:

> *Part XX.I reflected an entirely new approach to the problem of the mentally ill offender, based on a growing appreciation that treating mentally ill offenders like other offenders failed to address properly the interests of either the offenders or the public. The mentally ill offender who is imprisoned and denied treatment is ill-served by being punished for an offence for which he or she should not in fairness be held morally responsible. At the same time, the public facing the unconditional release of the untreated mentally ill offender was equally ill-served. To achieve the twin goals of fair treatment and public safety, a new approach was required.*[273]

Following the enactment of Part XX.I of the *Criminal Code*, Review Boards were established in each province and territory. Accused persons come before the Review Board pursuant to the authority set out in the mental disorder provisions contained in Part XX.I, in sections 672.1 through 672.95, which provide for:

- Orders for an accused's mental condition to be assessed, in certain circumstances;
- Orders for the treatment of an accused who has been found unfit to stand trial, if certain criteria are met;
- Dispositions and orders in relation to the accused who has been found not criminally responsible on account of mental disorder (NCRMD) or unfit to stand trial (Unfit);
- The establishment of provincial Review Boards to make or review dispositions concerning any NCRMD or Unfit accused; and
- The membership, jurisdiction and procedure of the Review Board in making or reviewing dispositions or assessment orders.

This section of the Toolkit provides an overview of these subject areas, featuring recent developments in the case law and will be most useful to people who work in forensic psychiatric facilities. However, as other mental health professionals may be called up to testify in court, or before the Ontario Review Board, when their patients come into contact with the criminal justice system, an understanding of this area of mental health law may be useful to all mental health practitioners. There are many detailed and useful resources on this area of law, cited in the footnotes to this Chapter for further reading.

272 *R. v. Swain*, [1991] 1 S,C,R, 933 [Swain].
273 *Winko, supra* note 268 at para. 20.

# 2. When Mental Disorder is an Issue: Assessment Orders

## Types of Assessments

When an accused charged with a criminal offence appears before the court, the court may order an assessment of the mental condition of the accused, if it has "reasonable grounds to believe" that such evidence is necessary to determine:

(a) Whether the accused is unfit to stand to trial;

(b) Whether the accused was, at the time of the commission of the alleged offence, suffering from a mental disorder so as to be exempt from criminal responsibility;

(c) Where the accused is a female person charged with an offence relating to the death of her newly born child, whether the mind of the accused was disturbed at the time of the alleged offence;

(d) The appropriate disposition to be made, where a verdict of NCRMD or Unfit to stand trial has been reached; or

(e) Whether a stay of proceedings should be ordered, in certain circumstances, where an accused has been found unfit to stand trial.[274]

The court may order an assessment at any stage of proceedings against the accused of its own motion, on application of the accused, or on application of the Crown, the latter being subject to certain limitations.[275]

What would allow the court to form "a reasonable belief" that an assessment of the mental condition of the accused is necessary? Commentators have suggested that reports of the accused's behaviour or the accused's actual observed behaviour in the court room indicative of active mental illness could be sufficient basis for a "reasonable belief" on which to order an assessment of fitness to stand trial.[276]

Where the accused is fit to stand trial,[277] the court's ability to order an assessment of criminal responsibility will be limited at the outset of the trial by whether the accused has put his or her mental condition in issue by raising the NCRMD defence. Once the court has found that the evidence establishes that the accused has committed the offence in question, the Crown may make an application to have the issue of criminal responsibility determined.

In 1991, the Supreme Court of Canada held that a common law rule that allowed the Crown prosecutor to enter evidence of the accused's insanity, where the accused did not intend to enter a defence of insanity, violated the accused's right to control his or her own defence, and thus violated section 7 of the *Charter*.[278] As a result, the Supreme Court articulated a new common law rule to conform with the *Charter*, which

274 CC, *supra* note 152, s. 672.11.

275 *Ibid.*, s. 672.12.

276 Richard D. Schneider, *Annotated Ontario Mental Health Statutes*, 4th ed. (Toronto: Irwin Law, 2007) at 431. Schneider's text includes a very helpful chart setting out the various circumstances in which a judge may order Assessments pp. 431-432.

277 See Section 3 of this chapter for a more detailed discussion of fitness to stand trial.

278 *Swain, supra* note 272.

allowed the Crown to raise independently the issue of insanity only after the trier of fact had concluded that the accused was otherwise guilty of the offence charged. This principle continues to apply to the NCRMD regime currently in force and is recognized by the limitations on the Crown's ability to raise the issue that are articulated in Part XX.I.[279]

Once an accused has been found unfit to stand trial or NCRMD,[280] the Review Board may only order an assessment of the accused on its motion, or on the application of the Crown or the accused, where the Board has reasonable grounds to believe that such evidence is necessary to:

(a) Make a recommendation to the court under subsection 672.851(1);[281] or

(b) Make a disposition under section 672.54 in one of the following circumstances:

(i) No assessment report on the mental condition of the accused is available,

(ii) No assessment of the mental condition of the accused has been conducted in the last twelve months, or

(iii) The accused has been transferred from another province under section 672.86.[282]

The circumstances set out in subsection (b) generally arise when the accused is before the Review Board for the first time. The Board also has authority to direct that assessments of an accused be carried out as part of its general authority to supervise the progress of the accused's rehabilitation.[283]

## Procedure Associated with Assessments

The *Criminal Code* sets out that the following items must be specified in an Assessment Order:

- Who is to make the assessment or the hospital where it is to be made;
- Whether the accused is to be detained in custody while the order is in force; and
- The period of time during which the order is to be in force (including time for the accused to travel to and from the place of assessment).[284]

With regard to specifying the hospital where the assessment is to take place, Part XX.I of the *Criminal Code* defines "hospital" to mean a facility designated by the provincial Minister of Health for the "custody, treatment or assessment of an accused in respect of whom an assessment order, a disposition or a placement decision is made".[285]

279 CC, *supra* note 152, s. 672.12(2) and s. 672.12(3).

280 Fitness to stand trial and the finding that an accused is not criminally responsible are discussed in further detail in Section 3 and Section 4, respectively, of this chapter.

281 CC, *supra note* 152, s. 672.851(1) provides for the Review Board to make a recommendation to the court with jurisdiction over the offence the accused has been charged with, to hold an inquiry as to whether the charges should be stayed, as the Review Board has determined that the accused is permanently unfit and no longer poses a significant threat to the safety of the public.

282 *Ontario (Attorney General) v. Mental Health Centre Penetanguishene [2008] O.J. 2744 (S.C.J.).*

283 *Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services)*, [2006] 1 S.C.R., at paras. 59-60.

284 CC, *supra* note 152, s. 672.13.

285 *Ibid.*, s. 672.1(1).

The *Criminal Code* specifies the following time limits related to assessment orders:

| Time Limits for Assessments | |
|---|---|
| Assessment order | Generally shall not be in force for more than 30 days.[286] |
| Assessment for fitness to stand trial | Generally to take place within five days. Accused and Crown prosecutor may agree to longer period, up to 30 days.[287] |
| "Compelling circumstances" exception | In these circumstances (which are not defined), the court or Review Board may continue the assessment order in force for up to 60 days.[288] |
| Extension | Order may be extended for further period of up to 30 days, provided that total period (initial + extension) does not exceed 60 days.[289] |

During the period that an assessment order is in force, no bail order or other order to hold the accused in custody may be made; the court-ordered assessment takes precedence over other designated orders.[290]

The Assessment order may be in a Form 48 (court ordered assessment) or a Form 48.1 (Review Board ordered assessment). Once the assessment is completed, the accused must be brought back before the court or Review Board that made the order "as soon as practicable". Thus, assessment orders provide for the early return of the accused to detention, and hence to court, should the assessment be completed before the order expires.[291]

## Treatment of the Accused during Assessment

An assessment order may not direct that psychiatric or any other treatment of the accused be carried out or direct the accused to submit to such treatment.[292]

It is a matter of debate as to whether a physician who is carrying out an assessment pursuant to these provisions should consider whether the accused is incapable with respect to treatment and proceed with a finding of incapacity which, subject to whether or not the accused applies to the CCB, might result in early treatment of the accused.

286 *Ibid.*, s. 672.14(1).
287 *Ibid.*, s. 672.14(2).
288 *Ibid.*, s. 672.14(3).
289 *Ibid.*, s. 672.15.
290 *Ibid.*, s. 672.17.
291 *Ibid.*, s. 672.191.
292 *Ibid.*, s. 672.19.

Some physicians are of the opinion that, where they have been directed to assess an accused person, their primary duty is to assist the court by providing evidence of the accused's mental condition in an unmedicated state, as this may be relevant to the accused's fitness or criminal responsibility. Once an accused has been found unfit to stand trial, the Court may order treatment in certain circumstances (discussed below in Section 3 on Fitness to Stand Trial), if such treatment is likely to render the accused fit.

On the other hand, some physicians are of the view that regardless of the assessment order, they have an ethical obligation to consider treating a mentally disordered accused, where, in their clinical opinion, the accused's symptoms would be relieved by treatment.

Section 25 of the MHA provides that any person who is detained in a psychiatric facility under Part XX.I of the *Criminal Code* may be restrained, observed and examined under the MHA and provided with treatment under the HCCA.[293] Therefore, so long as the assessment order requires that the accused be detained in a psychiatric facility, the attending psychiatrist could resort to the provisions of the HCCA to provide the accused with treatment. However, practically speaking, given that an assessment order may not exceed 60 days, the process for determining incapacity under the HCCA may not be concluded until after the assessment order expires, if the accused person challenges the finding.[294]

**A court order for treatment of the unfit accused may be a more efficient way to proceed with treatment, rather than finding the accused incapable with respect to treatment under the HCCA**

If the patient is being assessed for fitness to stand trial, the physician may wish to consider that, once a verdict of unfit to stand trial is made, the court may order that the accused submit to treatment, without the consent of the accused, where there is a medical opinion before the court that the accused would likely become fit within a period of not more than 60 days and that any risk of harm associated with the treatment is not disproportionate to the anticipated benefit.[295]

## Assessment Reports

An assessment order usually requires the person who makes the assessment to submit a written assessment report on the mental condition of the accused. The report is to be filed with the court or Review Board that ordered it, within the period required. This means that the assessing physician, together with the facility where the accused has been ordered detained, if any, should arrange to have it delivered to the registrar's office of the court that ordered it and have it made to the attention of the justice who ordered the assessment. The court staff will make arrangements for copies of the assessment report to be provided to the Crown, the accused and any counsel representing the accused.[296]

293 MHA, *supra* note 100, s. 25.

294 Under the HCCA, no treatment may be commenced until the appeal of the Board's decision "has been finally disposed of." See HCCA, s. 18(3)(d)(ii) and our discussion of treatment pending appeal in Chapter 2. This issue was discussed in by the Court in *Centre for Addiction and Mental Health v. Al-Sherewadi* 2011 ONSC 2272, at para 11.

295 CC, *supra* note 152, s. 672.58. This is the only circumstance in which a court may compel the accused to submit to treatment without the accused's consent.

296 *Ibid.*, s. 672.2.

# 3. Fitness to Stand Trial

When an accused is charged with an offence and appears to be suffering from a mental disorder, a preliminary issue that the court must determine is whether or not the accused is fit to stand trial. As Bloom and Schneider point out,

> *The requirement that an accused be 'fit to stand trial' stems from the ancient notion that an accused must be present to respond to accusations of the state. That basic requirement developed in a more refined view that the accused must not only be physically present but mentally present as well.*[297]

The common law principle that an accused should be fit to stand trial was eventually incorporated into the *Criminal Code*, where the term "unfit to stand to trial" is defined as follows:

> "unfit to stand trial" means unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, **and** in particular, unable on account of mental disorder to
>
> (a) Understand the nature or object of the proceedings,
>
> (b) Understand the possible consequences of the proceedings, or
>
> (c) Communicate with counsel.[298] (emphasis added)

An accused is presumed to be fit to stand trial unless the court is satisfied on the balance of probabilities that the accused is unfit.[299]

To be found fit to stand trial, the accused must able to understand the process and concepts involved in a criminal trial. The Ontario Court of Appeal in *R. v. Taylor* held that the test is one of "limited cognitive capacity," such that the accused need only possess sufficient mental capacity to have a basic understanding of the charges and court process. While the "**fit**" accused should be able to meaningfully participate in the proceedings; the accused does not have to act in his or her best interests.[300] Bloom and Schneider have suggested that the Taylor test focuses too exclusively on cognitive ability and therefore may miss the accused who may be unfit but whose fitness issues relate to mental disorders other than cognitive impairment or overt psychosis, such as depression, paranoia or mania.[301]

The issue of fitness to stand trial may be determined at any point prior to a verdict being rendered, where there are reasonable grounds to believe that the accused is unfit. The court, of its own motion or on the application of the accused or the Crown, may order that the issue of the fitness be tried.[302] Where the issue will be tried and the accused is not represented by counsel, the court shall order that the accused have counsel.[303] If after the trial of the issue, the verdict is that the accused is fit to stand trial, the remaining stages of the proceeding continue as if the issue of fitness of the accused had never arisen.[304]

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297 Hy Bloom & Richard D. Schneider, *Mental Disorder and the Law: A Primer for Legal and Mental Health Professionals* (Toronto: Irwin Law, 2006) at 60.
298 CC, *supra* note 152, s. 2.
299 *Ibid.*, s. 672.22.
300 *R. v. Taylor* (1992), 17 C.R. (4th) 371 (Ont. C.A.); as cited in Schneider, *supra* note 276 at 438.
301 See Bloom & Schneider, *supra* note 297 at 76-78 for further discussion of this issue.
302 CC, *supra* note 152, s. 672.23(1).
303 *Ibid.*, s. 672.24(1).
304 *Ibid.*, s. 672.28.

## Examples of Common Fitness-Related Issues Follow.

| | |
|---|---|
| **Keep fit orders** | Where the accused is detained in custody on delivery of a verdict that the accused is fit to stand trial, the court may order the accused to be detained in a designated psychiatric facility until the completion of the trial, if the court has reasonable grounds to believe that the accused would become unfit to stand trial if released.[305] This is often referred to as a "keep fit" order. |
| **Court ordered treatment following a finding of unfit to stand trial** | Where an accused is found unfit to stand trial and the court has not made a disposition with regard to the accused, the court, may order the treatment of the accused to be carried out, regardless of whether the accused person consents, for a period not exceeding 60 days and subject to any conditions that the court considers appropriate, including the detention of the accused at a designated psychiatric facility for the purposes of the treatment.[306] While the court has discretion to order the treatment, based on expert medical evidence that certain criteria are met,[307] the court is prohibited from ordering psychosurgery or electro-convulsive therapy.[308] Courts may not order that treatment is to take place while the patient is detained in hospital, the Court **must** seek the consent of the person in charge of the hospital where the accused is to be treated.[309] |
| **After the accused is found unfit** | Where a verdict of unfit to stand trial is rendered, the court may choose on its own motion, but must, on the application of either the accused or the Crown, hold a disposition hearing. At a disposition hearing, the court shall make a disposition if the court is satisfied that it can do so **and** it considers that a disposition should be made without delay.[310] If these two conditions are not present, the Court will generally refer the matter to the Review Board for an initial hearing, which must generally place no later than 45 days after the Court renders the verdict of unfit to stand trial. Even where the Court does make an initial disposition, provided that it is for the accused's detention or discharge subject to conditions, the Review Board is still required to hold a hearing within 90 days of the Court rendering a disposition.[311] In other words, the Review Board will eventually see the unfit accused for an initial hearing following the unfit verdict; either within 45 days if the court makes no disposition, or within 90 days to review the initial disposition made by the Court. |

305 *Ibid.*, s. 672.29.
306 *Ibid.*, s. 672.58.
307 *Ibid.*,s. 672.59.
308 *Ibid.*, s. 672.61.
309 *Ibid.*, s. 672.62(1). See *Centre for Addiction and Mental Health v. Al-Sherewadi,* 2011 ONSC 2272. The Court quashed a forthwith warrant of committal, which a lower court judge had issued without regard to the evidence that a bed was not available at the hospital to which the court had ordered the accused be detained. The reviewing Court held where courts issue a treatment order, there is nothing in the wording of s. 672.61 that imposes a time limit on the consent of the hospital or that requires that the consent be immediate and unqualified. Consequently, treatment orders may be issued to take effect from a certain date, pending the availability of a bed at the proposed receiving hospital. (*Al-Sherewadi*, at para. 17). See also *Centre for Addiction and Mental Health v. Ontario,* 2012 ONCA 342, which dealt with a similar situation involving an unfit accused. This Court of Appeal decision is discussed below.
310 *Ibid.*, ss. 672.45(1)-(2).
311 *Ibid.*, s. 672.47.

As noted above, the authority of a court to order an unfit accused to submit to treatment, without the person's, or incapable person's substitute decision maker's consent, is an exceptional authority. In any other circumstance, treatment of the accused may only proceed with the accused's or his or her substitute decision maker's consent, in accorandance with the provisions of Ontario's *Health Care Consent Act*. When making a treatment order in respect of an unfit accused, the court must first obtain the consent of the person-in-charge of the hospital where the accused is to be detained and treated.[312]

Recently, the Court of Appeal considered a case where the court had made a treatment order effective forthwith, and had refused to delay the effective start date of the treatment order.[313] There was evidence before the court that a bed would be available within six days, however, the court ordered that the treatment order commence forthwith and that the accused be taken to the designated hospital nonetheless. The hospital appealed the order. The Court of Appeal allowed the appeal and held that the court had not obtained the consent of the person in charge, as required by s. 672.62. The Court of Appeal found that implicit in a consent to accept patients subject to a treatment order, is an understanding that:

> …hospitals will have the necessary facilities, personnel, and in-patient beds available at the time the order becomes operative, to enable them to provide the treatment required in a manner that is effective and ensures the safety of the patient, the medical and hospital staff, and the other patients at the hospital.[314]

The Court of Appeal also took the opportunity to comment on the historical context of the exceptional power to order treatment for persons found unfit to stand trial:

> The purpose of the treatment order regime in the *Criminal Code* is to restore an unfit accused's fitness to stand trial as expeditiously as possible, thus enabling the trial process to proceed in a timely fashion and, in turn, enhancing both the accused's fair trial and other Charter rights and society's interest is seeing that criminal matters are disposed of on their merits. Experience shows that the majority of accused who are the subject of treatment orders suffer from a serious psychotic illness, such as schizophrenia, schizo-affective disorder, or bipolar disorder. Experience also shows they can often achieve a return to fitness for trial through the administration of anti-psychotic drug treatment for a period of 30-60 days: hence, the 60-day limit on a s. 672.58 order.[315]

This decision is helpful authority for hospitals, as it makes clear that courts are required to obtain the hospital's consent prior to ordering that an unfit accused be sent to the hospital for treatment.

The nature of the Ontario Review Board hearing for an unfit accused is discussed in further detail below; however, by way of summary, the Review Board is required to determine whether the accused is fit to stand trial as at the time of the Review Board hearing.[316]

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312 *Ibid*, s. 672.62.
313 *Centre for Addiction and Mental Health v. Ontario*, 2012 ONCA 342.
314 *Ibid.*, at para 29.
315 *Ibid.*, at para. 39.
316 CC, *supra*, note 152., s. 672.48(1).

# 4. The Defence of "Not Criminally Responsible by Reason of a Mental Disorder"

For many years, persons charged with a criminal offence had open to them the defence of insanity. This was based on the principle that a person should not be found guilty of an offence if it was committed at time when he or she was "insane", which would thus deprive the accused of the ability to form a criminal intent to commit the crime. In 1992, following a successful constitutional challenge to the prior insanity defence and legislative scheme governing "insanity acquittees", Parliament replaced the "insanity defence" with the defence of NCRMD. This defence is codified in subsection 16(1) of the *Criminal Code:*

> *No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.*[317]

"Mental disorder" is defined by the Criminal Code to mean "a disease of the mind". The Supreme Court of Canada has interpreted "disease of the mind" to be any illness, disorder or abnormal condition that impairs the human mind and its functioning, but generally, it does not include a self-induced state caused by alcohol or drugs or transitory mental states such as hysteria or concussion,[318] although sometimes a substance-induced psychosis may be found to be a disease of the mind.[319] A personality disorder may also be a disease of the mind for the purposes of subsection 16(1).[320]

Subsection 16(1) sets out two branches to the test: first, the mental disorder must be causally related to the person being incapable of appreciating the nature and quality of the act or omission which is the subject of the criminal offence; or second, the disorder makes the person incapable of knowing that the act or omission was wrong. The two branches are alternatives; if the accused suffers from a mental disorder such that the test set out in either branch is met, the accused may be excused from criminal responsibility.[321]

The first branch of the test requires evidence that the accused, by reason of a disease of the mind, was deprived of the mental capacity to foresee and measure the physical consequences of the act.[322]

The second branch of the test is not only about the intellectual ability to know right from wrong in an abstract sense but also the ability to apply that knowledge in a rational way to the alleged criminal act. In other words, the NCRMD defence will be available to the accused who is deprived by mental disorder of the capacity for rationally choosing between rightness or wrongness of the act at the time it was committed[323] and deprived of knowing that the act committed was something the accused ought not to have done.[324]

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317 *Ibid.*, s. 16(1) [emphasis added].

318 *R. v. Cooper* (1979) 51 C.C.C. (2d) 129 (S.C.C.) [Cooper], as summarized by David Watt and Michele Fuerst, *The 2012 Tremeear's Annotated Criminal Code*, Part XX.I, (Canada Review Board Edition, Thomson Carswell, 2012) ("Watt & Fuerst"), at p. 60.

319 *R. v. Mailloux* (1985), 25 C.C.C. (3d) 171 (Ont. C.A.); aff'd (1988), 45 C.C.C. (3d) 193 (S.C.C.); as summarized in *Watt & Fuerst, supra* note 318, at 60. Note that in *Mailloux*, the accused already suffered from active symptoms of a paranoid personality disorder at the time the drugs were taken. For a more thorough discussion of the contextual approach courts are required to take in determining whether a s. 16 defence will be available to an accused suffering from a substance induced psychosis at the time of the index offence, see: *R. v. Bouchard-Lebrun* [2011] S.C.J. No. 58. Essentially, the SCC makes clear in *Bouchard-Lebrun* that voluntary self-intoxication by a person who does not suffer from a mental discorder will not afford a s. 16 defence.

320 *Cooper*, as summarized in *Watt & Fuerst, supra* note 318, at 60.

321 Commentary to s. 16(1), *Watt & Fuerst, supra* note 318, at p. 59.

322 *Cooper,* as summarized in *Walt & Fuerst supra* note 318 at 60; see also *R. v. Landry* (1991), 62 C.C.C. (3d) 117 (S.C.C.); as summarized in *Watt & Fuerst, supra* note 318 at 62.

323 *R. v. Oommen* (1994), 91 C.C.C. (3d) 8 (S.C.C.); as summarized in *Watt & Fuerst, supra* note 318 at 62.

324 *R. v. Chaulk* (1990), 2 C.R. (4th) 1 (S.C.C.); as summarized in *Watt & Fuerst, supra* note 318 at 63.

Subsection 16(2) presumes that the accused does not suffer from a mental disorder, unless proven otherwise on a balance of probabilities. The burden of proving that the accused suffers from a mental disorder rests on the party who raises it.[325] While the Crown may raise the issue of mental disorder, for the purpose of querying whether the accused has a defence of not criminally responsible open to him or her, the Crown may only do so after the trier of fact has concluded that the accused is otherwise guilty of the offence charged. The Crown may raise the issue of whether the accused suffers from a mental disorder prior to a positive finding that the accused committed the offence, only if the accused first puts his or her mental capacity for intent at issue during his or her defence.[326]

Where the trier of fact, either a jury or a judge, "finds that an accused committed the act or made the omission that formed the basis of the offence charged, but was at the time suffering from mental disorder so as to be exempt from criminal responsibility by virtue of subsection 16(1), the jury or the judge shall render a verdict that the accused committed the act or made the omission but is not criminally responsible on account of mental disorder".[327] The jury or judge must first be satisfied that the evidence establishes beyond a reasonable doubt that the accused committed the act or made the omission, before going on to consider whether, at the time of the offence, the accused was suffering from a mental disorder that rendered the accused incapable of appreciating the nature or quality of the act or omission, or of knowing that it was wrong.[328]

Generally, in determining whether to reach a verdict of NCRMD, the court will look to the expert evidence of a forensic psychiatrist, usually by way of a written assessment report, which may assist the court in determining whether or not the accused suffered from a mental disorder at the time of the offence such that the NCRMD defence is available to him or her. Bloom and Schneider in their text, *Mental Disorder and the Law*, thoroughly review the component parts of the psychiatric assessment for criminal responsibility. In their view, a forensic psychiatrist should not conclude that the mere presence of a serious mental disorder or psychosis signals that the accused was not criminally responsible at the time of the index offence. More important, in their view, is whether "the symptoms of the mental disorder have expressed themselves robustly enough at the critical time [such that] a clinician can reasonably say that the symptoms of the mental disorder were instrumental in bringing about the behaviour" giving rise to the charges.[329]

Where a verdict of NCRMD is rendered in respect of an accused, the court that reached the verdict may hold a disposition hearing, on its own motion. Where the Crown prosecutor or the accused applies to the court to hold a disposition hearing, the court is required to conduct one.[330] However, as with findings that the accused is unfit to stand trial, the court will only make a disposition if the court is satisfied that it can do so and it considers that a disposition should be made without delay.[331]

If the court makes a disposition, the Review Board is still required to hold an initial hearing to review that disposition (if it is other than an absolute discharge), and make a new disposition within 90 days after the court's disposition was made.[332] If the court makes no disposition in respect of an accused, the Review

325 CC, *supra* note 152, ss. 16(2)-16(3).
326 *Swain, supra* note 272 at 939-940, 948.
327 CC, *supra* note 152, s. 672.34.
328 *R. v. David* (2002), 169 C.C.C. (3d) 165 (Ont. C.A.); as summarized in *Watt & Fuerst, supra* note 318 at 1384.
329 Bloom & Schneider, *supra* note 297 at 118, and more generally at 117-130.
330 CC, *supra* note 152, s. 672.45(1).
331 *Ibid.*, s. 672.45(2).
332 *Ibid.*, s. 672.47(3).

Board is required to hold a hearing and make a disposition within 45 days after the verdict of NCRMD was rendered, although in exceptional circumstances, the court may extend the time for holding the initial Review Board hearing to no later than 90 days from the time the verdict is rendered.[333]

It is, in practice, rare that a court makes a disposition regarding a new NCRMD accused. Where the court does create a disposition that detains an accused in hospital or places the accused on a conditional discharge under the general authority of a designated facility, that order has immediate effect. Alternatively, the court has the authority, where it does not make a disposition, to nonetheless make an order for the interim release or detention of the accused that the court considers to be appropriate in the circumstances, including an order directing that the accused be detained in custody in a hospital pending a disposition by the Review Board in respect of the accused.[334]

# 5. An Overview of Ontario Review Board Hearings

## General Introduction to Review Boards

The establishment, jurisdiction, powers and procedure of ORBs are set out in Part XX.I of the *Criminal Code*.

ORBs are established by section 672.38 of the *Criminal Code* for the purpose of making or reviewing dispositions concerning "any accused in respect of whom a verdict of [NCRMD] or unfit to stand trial is rendered. ORBs shall consist of not fewer than five members appointed by the Lieutenant Governor in Council of the province".[335] An ORB must have at least one member who is a duly qualified psychiatrist and where only one member is so qualified, there must be at least one other member who has training and experience in the field of mental health and qualified to practice either medicine or psychology.[336]

The Chairperson of an ORB shall be a judge, a retired judge or a person who is qualified for appointment to a judicial office (i.e., a lawyer who has been called to the Bar for 10 or more years).[337] When the ORB meets, quorum is constituted by the chairperson, a psychiatrist member and any other member.[338] While an ORB panel generally meets in panels of five, there may be occasions, such as inclement weather, where not all members can convene, and this provision allows the ORB to conduct a hearing with a minimum of three members, two of whom must be the chairperson and a psychiatrist.

When the ORB holds a hearing to review or make a disposition and there is a split in the views of the panel as to the appropriate disposition, the decision of the majority of the members prevails and is treated as a decision of the ORB.[339]

333 *Ibid.*, ss. 672.47(1)-672.47(2).
334 *Ibid.*, s. 672.46(2).
335 CC, *supra* note 152, s. 672.38(1).
336 *Ibid.*, s. 672.39.
337 *Ibid.*, s. 672.4(1).
338 *Ibid., s. 672.41(1).*
339 *Ibid.*, s. 672.42.

## Who is a "Party"?

The *Criminal Code* provides that there are certain statutory parties to an ORB hearing:

(a) The accused;

(b) The person in charge of the hospital where the accused is detained or is to attend pursuant to an assessment order or a disposition;

(c) The Attorney General of the province where the disposition is to be made, and where the Accused is transferred from another province, the Attorney General of the province from which the accused is transferred;

(d) Any interested person designated by the court or ORB, where the person has a substantial interest in protecting the interests of the accused, if the court or ORB is of the opinion that it is just to do so; or

(e) Where the disposition is to be made by a court, the prosecutor of the charge against the accused.[340]

In terms of "interested parties", ORBs have sometimes made parents of the accused "interested parties" where they have requested standing, and also the person in charge of the hospital to which the accused may be detained or required to report in the future.

## Types of Dispositions

Section 672.54 of the *Criminal Code* provides for the types of dispositions that may be made by courts and ORBs in respect of the Unfit or NCRMD accused. This section also lists the four factors that a court or ORB must consider in determining which of the possible dispositions should be made. Those factors are:

- The need to protect the public from dangerous persons;
- The mental condition of the accused;
- The reintegration of the accused in to society; and
- The other needs of the accused.

Taking those four factors into account, the legislation requires the ORB to make the disposition that is the "least onerous and least restrictive" to the accused.[341] In making such a disposition, the ORB must consider not only the general type of disposition (absolute discharge, conditional discharge or detention order), but must also consider the effect of the conditions of the disposition, so that the disposition taken as a whole is the least onerous and least restrictive.[342] Further, where the ORB makes a detention order, the court or ORB must consider the totality of the circumstances in which the accused is detained to determine which of the available options for detention is the least restrictive and least onerous.[343]

340 *Ibid.*, s. 672.1.
341 *Ibid.*, s. 672.54.
342 *Mental Health Centre Penetanguishene v. Ontario (Attorney General)*, [2004] 1 S.C.R. 498 at 503, 517-519.
343 *Mental Health Centre, Penetanguishene v. Magee*, 2006 CanLII 16077 (Ont. C.A.), at paras. 59-60 and 64.

The ORB must consider the "mental condition of the accused" at the time of the disposition hearing and not at the time of the index offence.[344] The words "mental condition" connotes a broader appreciation of the accused's condition involving the accused's overall mental state, rather than the more restrictive "mental disorder" which was present when the verdict of unfit or NCRMD was originally made.[345]

The ORB is required to gather and review all available evidence pertaining to all four factors set out in s. 672.54. If the parties do not present sufficient information, it is up to the ORB to seek out the information it requires. For example, where the ORB has failed to consider the other needs of the accused, the Court of Appeal has ordered a new hearing. In *R. v. Aghdasi*, the ORB's Reasons for Disposition had failed to address the role that the accused s cultural and linguistic isolation might play in preventing his successful reintegration into the community. Further, the ORB in that case had failed to seek out information about the resources that would address those needs. The Court of Appeal found the ORB's Reasons deficient and ordered a new hearing.[346]

Recently, the Supreme Court of Canada held that ORBs have the jurisdiction to consider and grant remedies under s. 24(1) of the Charter.[347] This means that where a forensic patient alleges that his or her *Charter* rights have been infringed, the ORB may hear and decide that issue and award an appropriate remedy. However, the Court also held that the ORB must consider whether the Charter remedy sought is consistent with its statutory mandate. For example, if the patient seeks an absolute discharge, granting that remedy will not be available to the ORB if it has concluded that patient poses a significant threat to public safety.[348] The Court also directed the ORB to consider whether the remedy can be granted without resort to the *Charter*, by simply addressing the patient's complaint through the exercise of the ORB's statutory mandate and discretion in accordance with *Charter* values.[349]

## Absolute Discharge Where no Significant Threat to the Safety of the Public by NCRMD

In making or reviewing a disposition for the NCRMD accused, the court or ORB must make a positive finding that the accused represents a significant threat to the safety of the public in order to continue to exercise jurisdiction over the accused. If the ORB cannot conclude on the evidence before it, or is uncertain based on the evidence, that the accused poses a significant threat to the safety of the public, an absolute discharge is required:

> *Section 672.54 does not create a presumption of [the accused's] dangerousness. There must be evidence of a significant risk to the public before the court or Review Board can restrict the NCR accused's liberty.*[350]

A "significant threat to the safety of the public" has been considered by the Supreme Court of Canada to mean a "real risk of physical or psychological harm to members of the public... [that goes] beyond the merely trivial or annoying. The conduct giving rise to the harm must be criminal in nature".[351] The Supreme Court also wrote that:

344 *Peckham v. Ontario (Attorney General)* (1994), 19 O.R. (3d) 766 at 775 (C.A.) [Peckham].
345 *Ibid.*
346 *R. v. Aghdasi*, 2011 ONCA 57, at para 19, citing *Winko, supra* note 268, at para. 55 and 62, and at paras 24 – 26.
347 *R. v. Conway*, 2010 SCC 22.
348 *Ibid.*, at para 101.
349 *Ibid.*, at para 103.
350 *Winko, supra* note 268, at para. 49; CC, *supra* note 152, s. 672.54(a).
351 *Winko, supra* note 268 at 668.

> *There is no presumption that [an NCRMD] accused poses a significant threat to the safety of the public. Restrictions on his or her liberty can only be justified if, at the time of the hearing, the evidence before the court or Review Board shows that the [NCRMD] accused actually constitutes such a threat.... If [the court or Board] cannot come to a decision with any certainty, then it has not found that the [NCRMD] accused poses a significant threat to the safety of the public.*[352]

Because there is no presumption that the accused continues to pose a significant threat to public safety, the accused is not required to disprove his or her dangerousness. It is well established that proceedings before the ORB are inquisitorial: "the ORB has an obligation to gather and review available evidence pertaining to the four factors set out in section 672.54 of the *Criminal Code*".[353] To discharge this obligation, the ORB has the power to subpoena records and witnesses and to order assessments where necessary to assist it in making a disposition.

In this regard, the ORB will look to the hospital where the accused has been detained, or has to report, for evidence on the accused's current mental condition, progress towards reintegration into the community and the accused's other needs. The hospital's evidence will also be germane to the issue of significant threat, particularly in the form of any actuarial or other risk assessments that speak to the likelihood of future recidivism and any recent incidents of violent behaviour, for example. While relying principally on the evidence adduced by the hospital, the Crown will likely emphasize evidence that relates to the index offence, the accused's insight into the relationship between his or her mental disorder and the offence, the accused's criminal history or past history of violent conduct, as this evidence relates to the Crown's obligation and interest in protecting public safety. In making the determination as to whether the accused poses a significant threat to the safety of the public, the Board or court may consider a broad range of evidence including but not limited to evidence of:

- The past and expected course of treatment for the accused;
- The accused's present mental condition at the time of the hearing, including the presence or absence of symptoms of mental disorder and, importantly, the accused's insight into the relationship between his or her mental disorder and the index offence and his or her insight into the need for medication (as the case may be);
- The accused's plans for the future, and their feasibility;
- Available community support for the accused;
- The accused's criminal history and the gravity of the index offence;
- The health care teams' assessment of the accused; including the clinical risk assessment of the likelihood that the accused will engage in violent or otherwise criminal conduct in the future.[354]

Recently, the Court of Appeal considered the use of a CTO to mitigate an accused's risk to the public, such that the Court found that he no longer posed a significant threat to the safety of the public and ordered an absolute discharge for the accused.[355] The Court of Appeal stated:

352 *Ibid.*
353 *Ibid.*, at para. 55.
354 *Winko supra* note 268 at 667, 669; we have also included items which we regularly see Review Boards consider.
355 *R. v. Stanley*, 2010 ONCA 324.

> *[based on] the record before the Board and the reasons underpinning its decision, it is clear that the justification for denying the appellant an absolute discharge rested upon the concern that absent a legal compulsion requiring him to do so, he would not take his medication and that he was not integrated with the non-forensic case management system. The appellant had demonstrated a record of consistent compliance for the past several years. Moreover the CTO implements a legal mechanism that requires the appellant to continue taking his medication. [The patient's attending physician] is satisfied that the appellant will adhere to the CTO. The fresh evidence is the vital link missing at the time of the hearing. The fresh evidence also indicates that the appellant has been linked with the community mental health care network to the satisfaction of his treating physician.…the only reasonable outcome in light of the fresh evidence is to grant the appellant an absolute discharge.*[356]

In other words, in the right circumstances, a CTO may be instrumental in mitigating an accused's risk such that he or she no longer poses a significant threat to the safety of the public, resulting in an absolute discharge.

In summary, if the evidence taken as a whole does not allow the ORB to conclude with any certainty that the accused presents a significant threat at the time of the hearing, the ORB must absolutely discharge the accused.

The wording of the *Criminal Code* makes it clear that an absolute discharge is available only to the accused who has been found NCRMD.

## The Permanently Unfit Accused: No Absolute Discharge but a Stay of Proceedings

The Supreme Court of Canada, in *R. v. Demers*, ruled that by making an absolute discharge available only to NCRMD accused and not to the unfit accused, Parliament had infringed the *Charter* rights of the unfit accused. The infringement arose due to the risk of an indeterminate detention, where the accused was unlikely to ever become fit to stand trial and no longer posed a significant threat to the safety of the public.[357]

As a result of the Supreme Court's ruling in *Demers*, Parliament introduced new provisions to Part XX.I, requiring the Review Board or court to consider whether the accused is permanently unfit. If the evidence demonstrates that the accused's capacity to stand trial will never be regained or acquired, and that the accused does not pose a significant threat to public safety, then the ORB may recommend that the court with jurisdiction over the accused's offence should hold a hearing to inquire into whether a stay of proceedings should be ordered.[358] The court may also take this step on its own motion whenever the accused appears before it.

356 *Ibid.*, at para. 27 – 29.
357 *R. v. Demers,* [2004] 2 S.C.R. 489 at 513-515.
358 CC, *supra* note 152, s. 672.851.

When holding the hearing to determine whether a stay of proceedings is appropriate, the court must consider not only whether the accused is permanently unfit to stand trial and no longer poses a significant threat, but also whether the stay is in the interests of the proper administration of justice.[359] If the court orders a stay of proceedings, any disposition in respect of the accused ceases to have effect,[360] similar to the effect of an absolute discharge for the NCRMD accused.

It should also be noted that Mental Disorder provisions of the *Criminal Code* also afford some protection from indeterminate detention to the unfit accused by requiring that the Crown hold a "*prima facie* hearing" every two years once the accused has been found unfit. The purpose of this hearing is to require the Crown to demonstrate to the court with jurisdiction over the offence that there is still sufficient evidence to put the accused on trial.[361] In other words, the Crown must show that it has evidence, which on its face may prove that the accused committed the offence in question. If there is not sufficient evidence at the time of the *prima facie* hearing, the court must acquit the accused.

## Discharge Subject to Conditions, or "Conditional Discharge"

Where the court (initially) or the ORB finds that the accused poses a significant threat to the safety of the public, there are two possible types of dispositions that may be made: a discharge subject to conditions or a detention order.

The discharge subject to conditions[362] is a "discharge" in that the accused may no longer be detained in hospital under the terms of the ORB's order. Consequently, the ORB cannot conditionally discharge an accused and also provide a term in the disposition that the accused be detained in hospital, or a term that the accused reside in the community in accommodation approved by the person in charge.[363] If the person in charge were to have discretion to approve the accused's accommodation in the community, under the terms of a conditional discharge, this would effectively give the person in charge veto power over the discharge from hospital, contrary to the discharge order of the ORB. In a recent appeal of an ORB detention disposition, the Court of Appeal held that where a hospital wishes to retain the continued authority to alter the accused's community living arrangements or to compel his or her return to the hospital, should either option become necessary due to deterioration in the accused's condition, a detention disposition is required.[364]

In crafting terms for the conditional discharge, the ORB will look to whether the evidence supports the inclusion of the terms.

359 *Ibid.*, ss. 672.851(7)-(8).
360 *Ibid.*, s. 672.851(9).
361 *Ibid.*, s. 672.33.
362 *Ibid.*, s. 672.54(b).
363 *Brockville Pyschiatric Hospital v. McGillis* (1996), 93 O.A.C. 266 (C.A.). If the person in charge were to have discretion to approve, or not approve, the accused's accommodation in the community, under the terms of a conditional discharge, this would effectively give the person in charge veto power over the discharge from hospital, contrary to the discharge order of the Board.
364 *R. v. Capano*, [2008] O.J. No. 1712 (C.A.), at para. 8.

While the following list is not exhaustive, the terms of a conditional discharge may require that the accused:

- Report to the person in charge of the hospital, or his or her designate, at certain intervals;
- On the accused's consent, comply with treatment, or take medications, as prescribed by his or her attending physician, pursuant to subsection 672.55(1);
- Keep the peace and be of good behaviour;
- Refrain from possessing any weapons;
- Refrain from taking any non-prescription drugs, or illicit substances and alcohol and to participate in random drug screens;
- Refrain from contact or communication, direct or indirect with any victims of the index offence, except with their written revocable consent;
- Refrain from attending at a specified place, generally related to places of residence, education or employment of victims of the index offence;
- Reside at a certain address in the community or with a certain person;
- Advise the ORB and the hospital of any change of address or telephone number in advance of such a change;
- Attend before the ORB, as required.

The Ontario Court of Appeal has held that it is permissible under a conditional discharge to set conditions that require the accused to:

- Upon notice by the person in charge of the hospital, immediately submit to attendance and for readmission to hospital; and
- Upon the request of the hospital, attend for psychiatric assessment.[365]

Such terms cannot be used to forcibly return an accused to the hospital, and keep the accused there against his or her will. Rather, these terms give a hospital the power to require the accused to reattend, and require the accused to comply with a hospital's direction. If the accused then does not comply, he or she is in breach of a term of his or her disposition and the mechanisms under s. 672.91, 672.92 and 672.93 (discussed in further detail below) would be available for the return of the accused to hospital.[366]

On the issue of whether conditional discharges should include a term, on the consent of the accused, requiring the accused to comply with prescribed treatment, the Ontario Court of Appeal has held that:

> *... where an NCR accused seeks a conditional discharge from a mental health facility and such a disposition is a potentially realistic option based on the evidence adduced before the Board, the Board should consider whether the NCR accused might consent to any treatment conditions thought by the Board to be reasonable and necessary in the interests of the NCR accused. This type of inquiry would position the Board to impose treatment conditions, where appropriate, as provided for under s. 672.55(1) of the Code. It would also further the Board's full consideration of the least onerous and least restrictive disposition for the NCR accused, as mandated by s. 672.54 of the Code.*[367]

365 *Re Young*, 2011 ONCA 432.
366 *Ibid.*, at para. 32.
367 *R v. Coles*, 2007 ONCA 806, at para 4.

In other words, where the ORB is considering whether an accused should be either discharged subject to conditions, or maintained on a detention order with provision for community living, the ORB should explore the accused's willingness to consent to a condition requiring him or her to comply with prescribed treatment. Although the hospital may explore that with the accused prior to the hearing, ORB will often look to the accused's legal counsel for confirmation that the accused has consented to such a condition at the time of the hearing. The ORB will also be interested to know whether the accused has a history of medication non-compliance in evaluating the necessity of such a condition.

Recently, the Court of Appeal has held that if there is an "air of reality" as to whether an accused may be managed in the community on a conditional discharge (meaning that such a disposition is a potentially realistic option based on the evidence adduced before the ORB), the ORB must consider two things:

- Whether the accused will consent to a condition requiring the accused to take medications as prescribed under section 672.55; and
- The potential mechanisms for accomplishing the accused's return to hospital.

The Court held that the ORB is required to explore these two issues even where none of the parties to the hearing have recommended a conditional discharge.[368]

One of the challenges posed by a conditional discharge, often cited by hospitals and their clinical staff, is the difficulty of returning the accused to hospital if there are warning signs of medication non-compliance and deterioration in the mental condition of the accused.

Provisions in Part XX.I of the *Criminal Code* provide authority for the police to arrest an accused without a warrant at any place in Canada if the police have reasonable grounds to believe that the accused has contravened or wilfully failed to comply with a disposition or any of its terms, or an assessment order, or is about to do so.[369] Consequently, if the accused has breached a condition of his or her disposition, the arresting officer may release the accused from custody and deliver him or her to the hospital named in the disposition or assessment order.[370]

The arresting officer may also detain the accused in custody, if necessary, to determine the accused's identity and to establish the terms and conditions of a disposition in respect of the accused.[371]

The legislative scheme for the return of the conditionally discharged accused to his or her supervising hospital is helpful but not without its inherent limitations. It functions only in so far as the accused has breached, or there is an anticipated breach of, conditions of the disposition.

368 *R. v. Breitwieser,* 2009 ONCA 784.
369 CC, *supra* note 152, s. 672.91 and s. 672.92.
370 *Ibid.*, s. 672.92(1).
371 *Ibid.*, s. 672.92(2).

Section 672.91 would not be helpful where an accused has discontinued or reduced his or her medications if compliance with treatment is not a term of the disposition. In that circumstance, if the non-compliance has lead to a deterioration, hospital staff would have to resort to the involuntary assessment provisions of the MHA (i.e., Form 1 or Form 2), in order to return the conditionally discharged accused to hospital.

Furthermore, it should be noted that although section 672.92 provides for the return of the accused to his or her supervising hospital, this section, and the conditional discharge itself, provides no inherent authority for the hospital to detain the accused once he or she has been returned to the facility. The attending psychiatrist will still need to assess the accused and determine if the accused meets the criteria for an involuntary or informal admission under the MHA, or seek the accused's consent to a voluntary admission. Where an accused has been residing in the community, and has been returned to and admitted to hospital for longer than seven days, the person in charge will need to provide notice to both the accused and the ORB of a "significant increase"[372] in restriction of the accused's liberty and a mandatory hearing will be convened (see the following page for further discussion of restriction of liberty hearings).

## Detention Orders

The other type of disposition for either an unfit accused, or the NCRMD accused, who has been found to pose a significant threat to the safety of the public, is a custodial disposition requiring the accused to be detained at a specific hospital.[373] In Ontario, there are 12 hospitals that have been designated by the Minister of Health and Long-Term Care as places for the custody, treatment or assessment of an accused who is subject to an assessment order or disposition under Part XX.I of the *Criminal Code*.[374]

Where the ORB or court (initially) directs that the accused be detained in custody in a hospital, the detention order, like the conditional discharge, will contain certain conditions that the ORB will determine based on the evidence before it.

One of the fundamental conditions to be determined is the level of security under which the accused shall be detained. There is one maximum secure forensic psychiatric facility in Ontario that being the Structured Intervention Program at the Waypoint Centre for Mental Health (formerly the Mental Health Centre Penetanguishene). The other forensic facilities in the province generally provide both medium and minimum secure units. In determining what level of security is appropriate for a particular accused, the ORB will consider the following factors:

- The recommendation of the clinical team and person in charge of the hospital where the accused is detained;
- The nature and circumstances of the index offence(s), including the accused's potential for serious personal injury offences and lethal acts;
- The accused's insight into his or her mental condition and its relationship to his or her actions at the time of the index offence;
- The different treatments and programs available in different levels of security; and
- The need to protect the public from dangerous persons.[375]

372 *Ibid.*, s. 672.56(2)(b).

373 CC, *supra* note 152, s. 672.54(c).

374 See http://www.orb.on.ca/scripts/en/about.asp#hospitals for a list of Ontario hospitals that have been designated by the Minister of Health as forensic psychiatric facilities with in-patient and out-patient programs for mentally disordered offenders.

375 *Beauchamp v. Mental Health Centre Penetanguishene* (1999), 138 C.C.C. (3d) 172 at 181 (Ont. C.A.), as summarized in Watt & Fuerst, *supra* note 318 at 1405.

In *R. v. Magee*, the Ontario Court of Appeal held that an ORB must consider all of the factors in section 672.54 when determining the least onerous and least restrictive disposition for the accused. The Court held that it was an error of law for the ORB to focus solely on the level of security as indicative of whether a disposition would be less restrictive to the accused.

The ORB's reasons had focused on whether Mr. Magee's risk could be managed on a medium secure unit, without considering how the move from a maximum secure facility where certain recreational, education and vocational programs were offered (and which were not necessarily available at the medium secure facility) would negatively affect his mental condition, thereby increasing his risk to public safety. Further, there was evidence before the ORB that the accused's request for a transfer to a medium secure unit in part related to a desire for increased access to women, which in the context of the accused's history of violent sexual offences, the appeal court ruled should have been taken into account.[376]

In the result, the Court held that the ORB should consider not only the level of security in determining what is least onerous and least restrictive, but should also look to the conditions of detention viewed in their entirety.[377]

It is common for an accused subject to a detention order, at a minimum security level, to be granted a term providing for community living subject to the approval of the person in charge. This allows for the gradual transition of the accused to community living, with trial placements at a group home, for example, before moving to the community on a more long-term basis. It also allows the person in charge to revoke the community living privilege if the accused deteriorates and requires secure detention in hospital.[378]

The terms of a detention order will also specify the level of control over the accused, and may include terms that provide for the accused's access to hospital grounds, whether accompanied or "indirectly supervised", meaning that the accused may enter hospital grounds unaccompanied but with requirements to check in with hospital staff at regular intervals. Similarly, there may be terms governing access to the community, either in the company of staff or an "approved person", or indirectly supervised; geographical limits may be imposed. Similar to the conditions discussed above in relation to conditional discharges, a detention order may have terms requiring the accused to refrain from ingesting alcohol, non-prescription drugs or illicit substances and to submit to random testing for such substances.

At one time, there were published guidelines for the terms of detention dispositions. These have not been updated since 1995[379] and there is some variation in practice in drafting the terms of ORB dispositions and in the interpretation of terms.

376 *R. v. Magee*, [2006] O.J. No. 1926 (C.A.).

377 *Ibid.*, at para 93, citing *Mental Health Centre Penetanguishene v. Ontario* (A.G.), [2004] 1 S.C.R. 498, at para 3. (also known as the *Tulikorpi* decision).

378 Joan Barrett and Riun Shandler, *Mental Disorder in Canadian Criminal Law* (Carswell, 2011), ("Barrett & Shandler") at p. 9-43.

379 These guidelines are still available at the Ontario Review Board's website and may be accessed at: http://www.orb.on.ca/scripts/en/legal/psych-hosp-guidelines.pdf (accessed on May 28, 2012).

## Transfers between Facilities

The Ontario Review Board's Rules of Practice require that where any party will recommend that a forensic patient be transferred to another facility, notice must be given to the potential receiving facility.[380] At hearings where a transfer is recommended, it is common practice for the proposed receiving hospital to provide documentary evidence, usually by way of a letter form the person in charge or his or her designate, as to its opinion on the transfer and importantly, if the transfer were ordered by the ORB, the likely wait time, if any, before a bed is available.

Following a 2010 decision of the Court of Appeal, it is now common practice for the ORB to grant authority for the interim or residual custody of the patient to the transferring hospital, with appropriate privileges, pending the transfer of the patient to another hospital.[381] Such interim custody and privileges allows for the continued progress and rehabilitation of the patient while awaiting transfer.

## Inter-Provincial Transfers

As noted above, when making or reviewing a disposition, the ORB must consider not only the mental condition of the accused and the need to protect the safety of the public, but also the other needs of the accused and the reintegration of the accused into society. It is not unusual for a mentally disordered offender to have had an itinerant lifestyle while ill, that may have led the accused to leave his or her home province and to the alienation of his or her family. As the accused becomes better with treatment, there is sometimes reconciliation with family members who reside in a province other than where the accused is receiving treatment.

In these cases, it may serve the accused's eventual reintegration into the community to see the accused's care and treatment transferred to a forensic psychiatric facility in another province, closer to family members who will eventually provide support in the community. Sometimes the transfer occurs for treatment related reasons. For example, accused from other provinces and territories have been transferred into Ontario for detention and treatment at the maximum secure Oak Ridge facility, where the transferring province or territory did not have appropriate resources to meet the needs of the accused.[382]

An inter-provincial transfer is available to an accused who is subject to a detention order under section 672.54(c) or a treatment order while unfit to stand trial (under section. 672.58), and allows the accused to be transferred to any other place in Canada provided that:

- The ORB of the province where the accused is detained recommends a transfer for the purpose of the reintegration of the accused into society, or the recovery, treatment or custody of the accused; and
- The Attorneys General of both the province to which the accused is being transferred and the province from which the accused is being transferred, give their consent.[383]

380 Rule 13, Ontario Review Board, Rules of Practice; http://www.orb.on.ca/scripts/en/legal/orb-rules.pdf. The Rule calls for notice four weeks in advance of annual hearing, and without delay in the case of other hearings.

381 *Mental Health Centre Pentetaghishene v. Ontario*, 2010 ONCA 197.

382 Communication from Dr. Brian Jones, Chief – Forensic Division, Mental Health Centre Penetanguishene.

383 CC, *supra* note 152, s. 672.86(1).

In considering whether to make a recommendation for transfer, the ORB may consider evidence as to whether the treatment offered in the new location would be more beneficial to the accused and whether another institution in the new location is prepared to accept the accused.[384]

As with a transfer to another facility within the province, where the hospital team is recommending an inter-provincial transfer, the transferring hospital should provide notice to the potential receiving hospital prior to the ORB hearing, and obtain evidence from the receiving hospital as to whether it is willing and able to take on the custody, care and treatment of the accused.[385]

Once the ORB makes the recommendation, the Attorneys General of the transferring and receiving provinces must review the recommendation and decide whether to consent. This can, in practice, take many months.

## Types of Hearings

### • Initial Hearings

ORBs are required to hold initial hearings under section 672.47, where the court has rendered a verdict of NCRMD or unfit to stand trial and has made no disposition. These initial hearings are to take place as soon as practicable after the verdict but no later than 45 days after the verdict was rendered, unless the court is satisfied that there are exceptional circumstances in which case, the hearing must be held within 90 days.

An initial ORB hearing is also convened when the court makes a disposition, other than an absolute discharge. In this case, the initial ORB hearing must take place within 90 days of the date of the court's disposition.

### • Annual Review Hearings

The ORB is required to hold a hearing every 12 months to review a disposition it has made, so long as the disposition remains in force (other than as an absolute discharge). Where the accused, who is represented by counsel, consents, and the Attorney General consents, the ORB may extend the time for holding an annual review hearing to a maximum of 24 months. The ORB may also extend the time for holding an annual review hearing to 24 months, in the absence of consent, if:

(a) The accused has been found NCRMD in relation to a serious personal injury offence;

(b) The accused is subject to a detention order; and

(c) There is evidence before the ORB that satisfies it that the condition of the accused is not likely to improve during the extended period of time, during which a detention order remains necessary.[386]

384 *Krueger v. Ontario Criminal Code Review Board* (1994), 95 C.C.C. (3d) 88 at 92-93 (Ont. C.A.), as cited in Bloom & Schneider, supra note 297 at 478.

385 Rule 13, *supra* note 380. Arguably, this Rule applies to notice of transfers within the province only; however, in our view, there should be evidence of whether there is a hospital willing to assume care and treatment of the accused in the other jurisdiction.

386 CC, *supra* note 152, s. 672.81(1.2).

Where the ORB extends the time for holding the next annual hearing to 24 months, notice must be given to the accused, the Crown and the person in charge of the hospital where the accused is detained.[387] The ORB's decision to extend the time for holding the hearing is deemed to be a disposition and may be appealed according to the provisions governing appeals of ORB dispositions.[388]

### • Early Mandatory Reviews

Where an accused is subject to a detention order or a conditional discharge, and the person in charge of the place where the accused is detained or directed to attend requests a review, the ORB shall hold a hearing for that purpose as soon as practicable after receiving notice from the person in charge.[389] This creates a mandatory obligation to hold a hearing where the person in charge has requested a review. Such hearings may be requested where the accused's condition has either improved or deteriorated to the extent that the current disposition no longer meets the needs of the accused or does not include measures that are adequate for the protection of public safety. Further, an ORB may specify a term in its disposition that the ORB shall hold a hearing within a certain period of time from the date of the Disposition, usually within six months.

### • Restriction of Liberties

Where an ORB makes a disposition ordering that an accused be detained in a psychiatric facility or be discharged from the facility subject to certain conditions, the ORB may delegate to the person in charge of the hospital where the accused is detained, or to which the accused must report, the authority to increase or decrease the restrictions on the liberty of the accused within any limits and subject to any conditions set out in the disposition.[390] However, where the person in charge increases the restrictions on the liberty of the accused "significantly", the restriction must be recorded in the accused's file and notice of the increase must be given to the accused. If the restrictions remain in force for a period exceeding seven days, notice must also be given to the ORB.[391]

When the ORB has received such notice, it is required to hold a hearing as soon as practicable, for the purpose of reviewing the decision to significantly increase the restrictions on the liberty ("ROL") of the accused.[392] The Court of Appeal has set aside the ORB's interpretation of the statutory requirement to hold a ROL hearing "as soon as practicable" to mean that an ROL hearing should be scheduled within 30 days. The Court simply stated that an ROL hearing should be "set, held and concluded expeditiously."[393]

The mandatory obligation to hold a restriction of liberties hearing arises from a 2005 amendment to the *Criminal Code*; prior to these amendments the accused could waive the hearing.

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387 *Ibid.*, s. 672.81(1.4).
388 *Ibid.*, s. 672.81(1.5).
389 *Ibid.*, s. 672.81(2).
390 *Ibid.*, s. 672.56(1).
391 *Ibid.*, s. 672.56(2); See *Re Saikaley,* 2012 ONCA 92, at para 65, where the Court of Appeal commented favourably on the Review Board's guidance in this case that a hospital must give detailed written notice as soon as practicable after the expiration of the seven day period and that the hospital must follow up if the Board fails to schedule a timely ROL hearing.
392 CC, *supra* note 152., s. 672.81(2.1).
393 *Re Saikaley, supra* note 391, at para 68.

The *Criminal Code* is silent as to what would constitute a significant restriction on the liberty of the accused. A review of ORB decisions dealing with restrictions on the liberty of the accused indicate that these hearings are typically called where the accused has been living in the community but, due to a deterioration of his or her mental condition, has been returned to hospital and admitted for a period exceeding seven days. There are of course, other circumstances that could constitute a signficant restriction on the liberty of an accused. In *R. v. M.L.C.* , the Court of Appeal stated that "Any restrictions that the hospital places on the patient must fall within the envelope of the conditions enumerated by the ORB in its disposition. As a safeguard, any decision by a hospital that signficantly restricts a patient's liberty for more than seven days must be considered by the ORB in a restrictions review."[394]

Where a restriction of liberties hearing is going to be held, the attending forensic psychiatrist, in conjunction with the person in charge will need to determine whether they anticipate that the restrictions in liberty of the accused will be relatively short term, such that once stabilized, the accused will be able to be maintained on his or her current disposition. If the deterioration requiring the restriction in liberties is more profound and likely to require a change to the current disposition, notice should be given to the ORB and the accused that the person in charge is also requesting an early review of the accused's disposition, pursuant to subsection 672.81(2).

In addition to reviewing the grounds on which a hospital decided to restrict the accused's liberties, the ORB must also review the ongoing nature and circumstances of the restriction on the patient's liberty from the date of the initial restriction up to the date of the review, if the restrictions remain in place. The purpose of a restriction of liberties review is to provide "a mechanism to monitor significant changes in the patient's liberty and to ensure that liberty is infringed only to the extent necessary to protect public safety in the time frame between the patient's annual dispositions."[395]

- ## Dual Status Offender or Placement Hearings

Where an accused has been found unfit to stand trial or NCRMD in relation to what is called the index offence, he or she will come under the jurisdiction of a provincial ORB. Subsequently, the accused may commit a further offence. If the accused is fit to stand trial on the charges related to the subsequent offence, the accused may be found guilty of that offence, if both the act or omission and criminal intent are proved. Where an accused, who has been found NCRMD and is subject to a custodial disposition requiring his or her detention in hospital, is subsequently found guilty of another offence and subject to a sentence of imprisonment, the accused becomes known as a "dual status offender".[396]

The legislation dictates that the sentence of imprisonment imposed by the court takes precedence over any prior custodial disposition of the ORB. Therefore, the ORB is required to hold a hearing to review the disposition as soon practicable after receiving notice of that sentence.[397]

The order of events may also be reversed. Where an offender, who is subject to a sentence of imprisonment, commits a subsequent offence for which he or she receives a mental disorder verdict (either unfit to stand trial or NCRMD) and a subsequent custodial disposition is imposed by the court, the ORB is also required to hold a hearing to make a placement decision.[398]

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394 *R v. M.L.C.*, 2010 ONCA 843, at para 28, emphasis added.
395 *Ibid.*, at para 35.
396 CC, *supra* note 152, ss. 672.1, 672.67.
397 *Ibid.*, s. 672.81(3).
398 *Ibid.*, s. 672.67(2).

In either case, the most recent court order or disposition takes precedence until the ORB holds a hearing to review its disposition and make a placement decision whether the accused should be detained in hospital or in prison. In making a placement decision for a dual status offender, the ORB is required to consider:

(a) The need to protect the public from dangerous persons;

(b) The treatment needs of the offender and the availability of suitable treatment resources to address those needs;

(c) Whether the offender would consent to or is a suitable candidate for treatment;

(d) Any submissions made to the ORB by the offender or any other party to the proceedings and any assessment report submitted in writing to the ORB; and

(e) Any other facts that the ORB considers relevant.[399]

These are different factors than those that the ORB must consider in a hearing concerning the NCRMD or unfit offender under section 672.54. For example, the ORB at a placement hearing is not required to consider the accused's reintegration into the community, and, overall, the ORB is not required to fashion the least onerous, least restrictive disposition.

Further, because Corrections Services Canada is able to provide most psychiatric and related medical treatments through a network of Schedule 1 hospitals (Regional Treatment Centres), the issue of placement is often decided in relation to factor (c) listed above, that is, the accused's history of engagement/compliance with treatment and/or the historical effectiveness of those treatments.[400]

If the ORB decides that the offender should be detained in prison, either the federal Minister of Public Safety or the Minister responsible for the correctional services of the province to which the offender is to be sent assumes responsibility for the offender.[401] The Minister is required to be a party to any proceeding before the ORB relating to the placement of a dual status offender.[402] A representative of the Minister, or the dual status offender, may apply to the ORB for a review of the placement decision. A hearing will be convened where the ORB is satisfied that a "significant change in circumstances" warrants it. The ORB may also convene a hearing to review placement of its own motion, on notice to the Minister and the offender.[403]

Although the placement decision may determine that the accused will be placed in prison to serve a custodial sentence in respect of the offence for which he or she has been criminally convicted, there will always be a hospital named as a place of detention to which the accused will be transferred once the term of custody in prison, imposed by the sentence, has been completed. If the dual status offender is placed in custody in a designated psychiatric facility, as a result of a placement decision or a custodial disposition, each day in custody in the hospital is treated as a day of service of the term of imprisonment, and the offender is deemed, for all purposes, to be lawfully confined in a prison.[404]

399 *Ibid.*, s. 672.68(3).
400 Communication from Dr. Brian Jones, Chief – Forensic Division, Mental Health Centre Penetanguishene.
401 CC, *supra* note 152, s. 672.68.
402 *Ibid.*, s. 672.69(4).
403 *Ibid.*, s. 672.69(2) and (3).
404 *Ibid.*, s. 672.71(1).

- ### Hearing Following Arrest for Breach of a Disposition

If an accused who is subject to a disposition of the ORB breaches any term of that order, he or she may be arrested for failure to comply with a disposition.[405] In certain circumstances, this may result in a hearing before a justice who may, in turn, detain the accused pending a hearing before the ORB, if certain criteria are met.[406] The ORB is required to hold a hearing to review the disposition as it would in other circumstances.[407]

Amendments to Part XX.1 of the *Criminal Code* were considered in 2005, including a provision for the warrantless arrest of an accused where the accused has breached an assessment order or disposition. However, the amendments did not go so far as to make failure to comply with a disposition order an offence. Although some may argue that breach of a disposition should be an offence comparable to failure to comply with a probation order, in the context of the mentally disordered offender, Parliament elected not to make such a breach a punishable offence in and of itself.[408] Rather, failure to comply with an order or disposition is evidence to be considered by an ORB when the accused is next before it and will be weighed in the ORB's determination of the least onerous and least restrictive disposition.

- ### Discretionary Reviews

The ORB has the jurisdiction to hold a hearing to review any of its dispositions at any time, on its own motion, or at the request of the accused or any other party.[409] If the ORB decides to hold a review at its own instigation, the ORB must provide notice to the Crown, the accused and any other party.[410] Where any party requests a review of a disposition, the party is deemed to abandon any appeal against the disposition.[411]

## Procedure and Practice Before the ORB

Procedure at an ORB hearing is governed by section 672.5 of the *Criminal Code*, which provides for various issues that may arise regularly at ORB hearings. As a general proviso, the section provides that a hearing may be conducted in as informal a manner as is appropriate in the circumstances.[412]

**The ORB has also made Rules of Procedure, which are available online at http://www.orb.on.ca.**

Of note to forensic psychiatric facilities, the Rules require the delivery of the Hospital Administrator's Report within three weeks of an annual hearing, and as soon as reasonably practicable in relation to other hearings (Rule 19).

405 *Ibid.*, s. 672.91.
406 *Ibid.*, s. 672.93(2).
407 *Ibid.*, s. 672.94.
408 See Barrett & Shandler, *supra* note 378, at 1-26.
409 CC, *supra* note 152, s. 672.82(1).
410 *Ibid.*, s. 672,82(1.1).
411 *Ibid.*, s. 672.82(2).
412 *Ibid.*, s. 672.5(2).

Where any party is going to propose that an accused be transferred to another institution, that party shall provide notice to the potential receiving institution (Rule 13). Similarly, where any party is of the view that a particular hearing will be contentious and require longer than the normally allotted time, that party is required to give notice to the ORB and a pre-hearing conference will be scheduled in order to try and narrow the issues (Rules 28 and 29).

## Adjournments

The legislated procedural provisions allow for the adjournment of a hearing for a period of not greater than 30 days, where necessary for the purpose of ensuring that relevant information is available to permit the ORB to make or review a disposition or for any other sufficient reason.[413] The statutory provisions on adjournment are supplemented by the ORB's Rules of Procedure which require that any party seeking an adjournment shall serve every other party with a Notice of Motion and file the Notice with the Review ORB, along with any supporting materials, within certain timelines, depending on when the hospital has provided its report (Rules 32 and 33).

## Victim Impact Statements

Recent amendments to the *Criminal Code* require an ORB to notify every victim of the index offence that they are entitled to file a Victim Impact Statement where an "assessment report" received by the Review Board indicates that there has been any change in the mental condition of the accused since the last disposition that may provide grounds for an absolute or conditional discharge.[414] Whether an "assessment report" includes the Hospital Administrator's Report to the ORB has not been judicially interpreted; however, the ORB now makes it a matter of practice to notify the victims of the index offence where the Hospital Administrator's Report is recommending an absolute or conditional discharge.

## Other ORB Related Issues

- ### Can the ORB or Court Order Treatment be a Part of a Disposition?

As noted above, the court with jurisdiction over an accused may order treatment, in the absence of the accused's consent. This represents a very narrow circumstance in which the court may compel the treatment of the accused. It may happen only when the accused has been found unfit by the court and the court is satisfied on the basis of expert medical evidence that a specific treatment should be administered to the accused for the purpose of making the accused fit to stand trial. The treatment period may be no greater than 60 days and certain criteria set out in the legislation must be met.[415]

In contrast, an ORB does not have the authority to make a disposition in which the ORB directs the accused to submit to any treatment, in the absence of the accused's consent. However, where the accused consents to such a condition, and the ORB considers the condition to be reasonable and necessary in the interests of the accused, a condition "regarding psychiatric or other treatment" may be included in the disposition.[416] If the accused subsequently withdraws his or her consent to the condition, it could give rise to circumstances in which an early review of the disposition is sought.[417]

413 *Ibid.*, s. 672.5(13.1).
414 CC, *supra* note 152, s. 672.5(13.2).
415 *Ibid.*, ss. 672.58-672.59.
416 *Ibid.*, s. 672.55(1).
417 See Ontario Review Board website, at http://www.orb.on.ca.

The Supreme Court of Canada has held that the provision of the Criminal Code that provides the ORB with the authority to make such a condition should be interpreted narrowly:

> *Despite the fact that ORBs have the authority to make their orders and conditions binding on hospital authorities, this power does not extend so far as to permit Boards to actually prescribe or impose medical treatment for an NCR accused. Such authority lies exclusively within the mandate … of the hospital where the NCR accused is detained, pursuant to various provincial laws governing the provision of medical services to persons in the custody of a hospital facility. It would be an inappropriate interference with provincial legislative authority (and with hospitals' treatment plans and practices) for Review Boards to require hospital authorities to administer particular courses of medical treatment for the benefit of an NCR accused.*[418]

In other words, the role of ORBs with respect to medical treatment is supervisory, to ensure that appropriate treatment happens in order to reduce the accused's level of risk and to allow for the accused's eventual reintegration into the community. The ORB is therefore able to make orders "regarding" treatment, under subsection 672.55(1), provided that the accused consents and the ORB considers the condition reasonable and necessary in the interests of the accused. In considering section 672.55, the Supreme Court of Canada held that the provision does not allow the ORB to prescribe treatment but rather provides for a condition in the disposition that the accused consented to following a course of treatment for the purpose of managing the accused's threat to public safety.[419]

Further reinforcement of the principle that NCR or unfit accused's treatment is to be provided pursuant to provincial legislation may be found in section 25 of the MHA, which states that any person detained in a psychiatric facility under Part XX.I of the *Criminal Code* may be restrained, observed and examined under the MHA, and provided with treatment under the HCCA.[420]

## Appeal Rights

Any party may appeal against a disposition made by a court or ORB, or a placement disposition made by the ORB, to the Court of Appeal of the province where the disposition or placement decision was made.[421]

These appeals are governed by the provisions in Part XX.I of the *Criminal Code* and by the Ontario Court of Appeal's *Criminal Appeal Rules*. Where an accused is detained in hospital, pursuant to the disposition being appealed from, the hospital, upon the accused's request, shall provide the accused with a form of Notice of Appeal (a Form E). The person in charge, or his or her designate, must transmit to the Registrar of the Court of Appeal any notice of appeal served upon him or her by the accused. Further, the person in charge or his or her designate, must deliver "forthwith" to the accused any documents that are transmitted to the accused by the Registrar, and subsequently report to the Registrar that this has been done.[422]

418 *Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services)*, [2006] 1 S.C.R. 326 [*Mazzei]* at para. 31 [emphasis added].
419 *Ibid.* at para. 55.
420 For further discussion of the consent to treatment law that will apply to the Unfit or NCRMD accused in the normal course, please see Chapter 2.
421 CC, *supra* note 152, s. 672.72(1).
422 *Criminal Appeal Rules,* SI/93-169, ss. 39(5)-39(6).

The Notice of Appeal from a disposition must be given with 15 days from the day the parties are provided with the Reasons for Disposition.[423]

Under s. 672.75, where any party appeals against an absolute discharge, or an order directing that the unfit accused submit to treatment without his or her consent,, the filing of a notice of appeal suspends the application of the disposition pending the determination of the appeal.[424] In May 2012, the Court of Appeal held that the automatic stay of the absolute discharge that arises from section 672.75 violates the liberty interests of the accused person, under both sections 7 and 9 of the *Charter*. Accordingly, the Court declared that the reference to an automatic stay of an absolute discharge that arises from section 672.75 was of no force and effect and further, suspended the declaration of constitutional invalidity for 12 months, in order to allow Parliament time to consider changes to the legislation that would provide for a process to allow the Crown or Hospital to seek restrictions on the liberty of an absolutely discharged accused pending the resolution of the appeal of the absolute discharge.[425]

Where party appeals a conditional discharge or detention order, the disposition appealed from takes effect nonetheless and is not suspended. However, any party may apply to a judge of the Court of Appeal for an order providing that the new detention order or conditional discharge should not take effect, and that the prior disposition remain in place pending the resolution of the appeal.[426]

Where the ORB has interpreted and applied the law, the standard of review is correctness. However, generally, the Court of Appeal will apply a "reasonableness" standard of review to a disposition of the ORB. That means that where the ORB's Disposition and Reasons for Disposition are supported by the evidence, as demonstrated by the transcript of the hearing, the Court will not interfere with the Disposition, even if it might have come to a different conclusion on the same evidence. The appeal may also be based on "any other evidence that the Court of Appeal finds necessary to admit in the interests of justice."[427]

Ordinarily, appeals are initiated by the accused and in some cases, by the Crown. In some circumstances, the Disposition and Reasons may deal with issues of importance to the hospital, and consideration will need to be given as to whether the "person-in-charge" should appeal the Disposition. Where the hospital wishes to advance its own appeal, or take a position or intervene on an appeal initiated by another party, we recommend that the hospital consult with legal counsel.

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423 CC, *supra* note 152, s. 672.72(2).

*424* *Ibid.*, s. 672.75(1).

425 *Re Kobzar,* 2012 ONCA 326, at paras 82, 88 and 89. Please note that the Federal Crown has sought leave to appeal this decision to the Supreme Court of Canada,: *Attorney General of Canada v. Yuriy Kobzar* (SCC Docket: 34925, August 13 2012).

426 CC, *supra* note 152, s. 672.76(2). In *Re Kobzar, supra* note 425, the fact that an absolutely discharged patient could bring an application for an order that the absolute discharge be carried out notwithstanding the automatic suspension under s. 672.76(2)(a), was not a sufficient procedural safeguard to cure the constitutional defect of the automatic stay. The Court held that "a subsequent review, especially one that places the onus on the accused, does not change the fact that the initial restriction of the NCR accused's liberty is automatic upon the completion of an administrative act [the file of a notice of appeal], without any due process." (para 62).

427 CC, *supra* note 152, s. 672.73(1) and (2). The Supreme Court has held that "interests of justice" test refers not only to justice for the NCR detainee, but also justice to the public, whose protection is to be assured. Particularly where the appeal could result in the absolute discharge of the detainee, the Supreme Court held that an absolute discharge should be granted "only upon consideration of all of the reliable evidence available both at the time of the Board hearing, and, if appealed, at the time of the appellate review." *R. v Owen* (2003), 174 C.C.C. (3d) 1 (S.C.C.), at paras 54 and 59.

Recently, the Ontario Court of Appeal agreed to amend the Rules of Practice governing the delivery of materials in appeals of ORB dispositions, such that where the accused has appealed the disposition, the Hospital may file its responding factum, if any, no later than four clear days following receipt and filing of the Crown's factum.[428] The Crown's factum is due two weeks before the week in which the appeal is scheduled to be heard.[429] In general, the issue of whether to take a position on an accused's appeal should be reviewed in consultation with the hospital's legal counsel.

# 6. Other Criminal Issues

## Interim Judicial Release: Bail

Where a person has been charged with an offence, the accused may be released from custody pending trial provided that certain criteria are satisfied.[430] This form of interim release is called bail. If the Crown is able to demonstrate to a judge that a person charged with an offence should only be released into the community to await trial subject to certain conditions, the judge will craft a bail order, which is sometimes referred as a recognizance or undertaking.

The terms of the bail order are binding on the accused, and on any "surety" (other person) named in the bail order.

Where the court has made an assessment order for the evaluation of an accused's mental condition, the assessment order takes precedence and no order for judicial interim release may be made.[431]

If hospital staff know that a patient is subject to a bail order, and learn that the patient is breaching terms of his or her bail order, the question arises as to what obligation hospital staff have to report a breach of the bail order to police. Essentially, the answer to this question is: it depends. That is, it depends on the terms of the bail order, the seriousness of the breach, the risk of harm to other persons, and the effect that reporting the breach may have on the patient's therapeutic relationship with his or her treating team, as well as duties of confidentiality.[432] Generally, it is recommended that the hospital consult with its risk management department, who may in turn wish to consult legal counsel.

428 Communication from the Steering Committee for the ORB Appeal Project Committee, Court of Appeal, December 15 2011.
429 Communication dated February 9, 2009 from Caroline Mandell, Judicial Research Lawyer, Ontario Court of Appeal. Note that this proposed change applies to inmate appeals only. Where the Crown or Hospital appeals, different timelines apply. Consultation with legal counsel on an appeal of any disposition is strongly recommended.
430 CC, *supra* note 152, s. 515(10).
431 *Ibid.*, s. 672.17. For a further discussion of the implications of bail for psychiatric patients and their clinicians, see Bloom & Schneider, *supra* note 297 at 100-102.
432 We discuss privacy issues in further detail in Chapter 7.

## Probation

Where an accused person is convicted of an offence, the court may suspend the passing of sentence and direct that the offender be released on the conditions prescribed in a probation order. There are certain compulsory conditions of a probation order; for example, the offender must keep the peace and be of good behaviour.[433] However, the court may prescribe certain other conditions, including a condition requiring the offender to participate actively in a treatment program approved by the province, if the offender consents and the program director accepts the offender into the program.[434] "The agreement of the accused is a necessary pre-condition to the ordering of any such treatment."[435]

## The Conditional Sentence Regime – Alternatives to Incarceration

In order for an accused person to be found guilty of an offence, the Crown must prove beyond a reasonable doubt that the accused committed the act or omission, and that the accused intended to do so (or for some offences, that the accused was reckless, negligent, or willfully blind to the consequences of his or her act or omission). It then falls to the Court to impose a sentence or fine on the accused who has been found guilty. At that stage, the fact that the offender was or is still suffering from a mental disorder may be relevant to the sentencing process and although found guilty, the presence of mental disorder may diminish the offender's culpability, even if not to the extent of being found NCRMD.[436]

The *Criminal Code* has a conditional sentencing regime, which provides for certain conditions, such as allowing the offender "to attend a treatment program approved by the province".[437] This applies where a person is convicted of an offence, provided that the offence is not subject to a mandatory minimum term of imprisonment, the court has imposed a sentence of imprisonment of less than two years, and the court is satisfied that the offender does not pose a danger to the safety of the community. In these circumstances, the court may order that the offender serve the sentence in the community, which would include attendance at an approved treatment program.[438] In *R. v. Knoblauch*[439] the majority of the Supreme Court of Canada held that the provisions of the conditional sentencing regime could be interpreted to allow a judge to order the accused to spend the period of the conditional sentence in a secure psychiatric treatment unit.

433 CC, *supra* note 152, s. 732.1(2).
434 *Ibid.*, ss. 732.1(3)(g)-(g.1).
435 See Barrett & Shandler, *supra* note 378 at 6-44.
436 For a further discussion of this issue, see generally Chapter 9, "Disposition and Sentencing", of Bloom & Schneider, *supra* note 297 at pp. 230 ff.
437 CC, *supra* note 152, s. 742.3(2)(e).
438 CC, *supra* note 152, s. 742.1.
439 [2000] 2 S.C.R. 780.

# 7. Mental Health Courts and Diversion Programs – A Brief Overview

In Ontario, since 1994, there has been a diversion program for the mentally disordered accused in the *Crown Policy Manual*.[440] This program provides a protocol for the Crown counsel to use discretion on a case-by-case basis to not prosecute a mentally disordered accused, by withdrawing or staying the charges of a "divertible" (generally non-violent) offence, and arranging instead for the accused to receive some from of psychiatric or rehabilitative program in the community.[441]

In order to proceed with diversion, there are a number of criteria that must be met, including the nature of the underlying offence. For a "serious" offence, such as ones involving violence, sexual assault or arson, the Crown may not divert the accused away from the criminal justice system. Further, there must be a reasonable prospect of conviction (since it would not be fair to subject the accused to an alternative if the Crown is not in a position to prove the offence), and the accused must appear to be suffering from discernible psychiatric symptoms that would likely respond to treatment.[442]

Even before the accused reaches the courthouse and comes into contact with Crown counsel, there is another opportunity for diversion in the form of the discretion that may be exercised by the police officer who has first come into contact with the accused. As Bloom and Schneider have pointed out, police officers have the discretion to decide against laying a charge against a person who has been found committing a minor criminal offence and may instead choose to exercise their authority under section 17 of the MHA to apprehend the person and take them into custody to an appropriate place for examination by a physician. In some instances, rather than invoke that authority, the police may try to convince the person to attend at the emergency department of the local hospital on their own account, or to cooperate with concerned family members.[443]

440 Ontario Ministry of the Attorney General, "Diversion of Mentally Disordered Accused," *Crown Policy Manual*, looseleaf ed., (Toronto: Ministry of the Attorney General 1993), cited in Bloom & Schneider, *supra* note 297 at 102.
441 See Bloom & Schnieder, *supra* note 297 at p. 102-106 for further discussion.
442 *Ibid.*, at pp. 103 – 105.
443 *Ibid.*, at p. 106.

Chapter 7

# Privacy and Mental Health Care

## 1. Introduction

It is well established in law that personal information relating to the provision and receipt of health care is highly private and personal to the individual. It is considered the individual's own information, held in trust by his or her health care provider for the individual's benefit, and may be disclosed or communicated to others only with the individual's permission unless the law otherwise authorizes the disclosure.[444]

Since November 2004, the main statute governing personal health information in Ontario is *Personal Health Information Protection Act* (PHIPA). PHIPA provides a comprehensive set of rules that apply to all parts of the health care sector, in order to protect the privacy of personal health information, while at the same time providing for its collection, use and disclosure in a manner that will facilitate the effective provision of health care.[445]

Prior to the enactment of PHIPA in 2004, sections 35 and 36 of the MHA set out a code for the management of and protection of privacy of the personal health information of patients who were admitted to a psychiatric facility pursuant to the provisions of the MHA.

These provisions were in addition to the provisions of the Hospital Management Regulation under the *Public Hospitals Act* that generally governed the confidentiality of health records in public hospitals (at law, psychiatric facilities are now also public hospitals). In addition to PHIPA, other Ontario statutes recognize the confidentiality of personal health information. For example, the *Regulated Health Professions Act*, and its related statutes governing individual professions, recognize that it is an act of professional misconduct for the regulated health professional to provide information about a client to anyone other than the client or his or her authorized representative, except with the consent of the client or representative, or as required by law.[446]

Following the enactment of PHIPA, many of the former provisions in both the PHA and MHA were repealed and replaced by the procedures and obligations set out in PHIPA. However, some provisions governing the confidentiality of psychiatric health care records were retained and amended in the MHA, recognizing certain special considerations that arise in the mental health care context. The purpose of this chapter is to review the provisions of the MHA that deal with privacy of personal health information of patients admitted to, detained at or receiving out-patient care at a psychiatric facility, and to demonstrate how these provisions are different from the general rules under PHIPA. The chapter will also consider other aspects of privacy that frequently arise when dealing with mental health patients.[447]

444 *McInerney v. MacDonald*, [1992] 2 S.C.R. 138.

445 *Personal Health Information Protection Act*, 2004, S.O. 2004, c. 3, Sch. A [PHIPA], s. 1(a).

446 See for example, the Professional Misconduct Regulation, O.Reg, 856/93, section 1(1), para 10, enacted under *Medicine Act, 1991*, S.O. 1991, c. 30; which applies to physicians.

447 Please refer to the OHA's *Hospital Privacy Toolkit: A Guide to the Ontario Personal Health Information Protection Act* (Publication #314), for any general privacy questions not covered in this chapter.

# 2. *Mental Health Act* Interplay with PHIPA General Rules

Information relating to a person's mental health and psychiatric care is "personal health information" as defined by and for the purposes of PHIPA. Personal health information is broadly defined by PHIPA as "identifying information about an individual in oral or recorded form" that "relates to the individual's physical or mental health, including family history, and relates to providing health care to the individual". It includes the identity of the person's health care providers and the identity of the individual's substitute decision maker.[448]

Consent is at the heart of PHIPA. The legislation provides that a health information custodian shall not collect, use or disclose personal health information about an individual unless the individual has consented in accordance with the provisions of PHIPA, and the consent, use or disclosure, as the case may be, is necessary for a lawful purpose; or is permitted or required by PHIPA.[449] The consent may be expressed or implied, but it must be obtained from the individual, or if the person is incapable with respect to decisions about their personal health information, from the individual's substitute decision maker.[450]

## Documenting Consent to Disclose Personal Health Information

Many psychiatric facilities and community hospitals continue to use the MHA's Form 14 to record a patient's authorization for the disclosure of personal health information contained in his or her clinical record. Although there is nothing wrong with this practice per se, Form 14 has been revoked and is no longer a form approved by the Ministry of Health. Where consent for the disclosure of personal health information is required under PHIPA or the MHA, and no exception to obtaining the required consent applies, health information custodians should document that consent has been provided. While no particular form of consent is required by PHIPA, or its regulations, health information custodians may use the sample consent form that the Ministry of Health has developed, which is available online at the Ministry of Health's web site.[451]

## Collection, Use and Disclosure without Consent: PHIPA and *Mental Health Act* Exceptions

Although the current regime governing the privacy of personal health information focuses on obtaining consent, express or implied, for all collection, use and disclosure, there are circumstances where consent is not required.

For example, subsection 40(1) of PHIPA provides that a health information custodian "may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons". This provision may be relied on when health information custodians are considering disclosing personal health information to the police. In addition, PHIPA permits disclosure

448 PHIPA, *supra* note 445, s. 4(1).
449 *Ibid.*, s. 29(1).
450 *Ibid.*, s. 21(1), sets out the test for determining whether an individual is capable of consenting to the collection, use or disclosure of PHI.
451 See http://www.health.gov.on.ca/english/providers/legislation/priv_legislation/consent/consent_disclose_form.doc; accessed May 31 2012.

of personal health investigation for the purpose of facilitating an inspection, investigation or similar procedure that is authorized by warrant or under Ontario or federal legislation.[452] We discuss these exceptions in further detail below in section 7.8.

In the context of mental health care, PHIPA also provides that a health information custodian may disclose personal health information about an individual to the head of a penal or other custodial institution in which the individual is lawfully detained or to the OIC of a psychiatric facility in which the individual is being lawfully detained, for the following purposes:

- Arrangements for the provision of the health care to the individual;
- The placement of the individual into custody, detention, release, conditional release, discharge or conditional discharge under Part IV of the *Child and Family Services Act*, the *Mental Health Act*, the *Ministry of Correctional Services Act*, the *Corrections and Conditional Release Act* (Canada), Part XX.I of the *Criminal Code* (Canada), the *Prisons and Reformatories Act* (Canada) or the *Youth Criminal Justice Act* (Canada).[453]

PHIPA also permits the disclosure of personal health information for the purposes of determining, assessing or confirming capacity under the HCCA, SDA or PHIPA.[454]

While PHIPA provides for limited disclosure of personal health information in circumstances related to psychiatric care, the MHA was amended at the time of PHIPA's enactment to provide for the collection, use and disclosure of personal health information, with or without the patient's consent, for purposes relating to the care and custody of persons under the MHA and pursuant to the provisions of Part XX.I of the *Criminal Code*.[455] Subsection 35(2) provides that:

> The officer in charge of a psychiatric facility may collect, use or disclose personal health information about a patient, with or without the patient's consent, for the purposes of:
>
> (a) Examining, assessing, observing or detaining the patient in accordance with the MHA; or
>
> (b) Complying with Part XX.I of the Criminal Code or an order or disposition made pursuant to that Part.

Section 35 defines "patient" broadly to include former patients, out-patients, former out-patients and anyone who is or has been detained in a psychiatric facility. The reference to "any person who has been or is detained in a psychiatric facility" would include persons detained on a Form 1 or Form 2 application for psychiatric assessment, who have not yet been admitted to the facility for treatment, as well as patients who are detained pursuant to dispositions of the ORB.

Essentially, this section means that the OIC, or his or her delegate, may choose to seek the patient's consent for the collection, use or disclosure of the patient's personal health information. However, if consent is withheld, the collection use or disclosure may proceed without the patient's consent, if it falls within the purposes of subsection 35(2). The ability to deal with personal health information without consent supports the underlying purposes of the MHA and the *Criminal Code* provisions for the mentally disordered offender; that is, to facilitate treatment and the eventual reintegration of the mentally ill patient into the community.

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452 PHIPA, *supra* note 445, s. 43(1)(g).
453 PHIPA, *supra* note 445, ss. 40(2) and 40(3).
454 *Ibid.*, s. 43(1)(a).
455 See Chapter 6, Forensic Patients and the Criminal Law.

**The MHA makes clear that these "without consent" exceptions have been made knowing that they conflict with the general requirement for consent set out in PHIPA. Section 34.1 of the MHA provides that where there is a conflict between PHIPA and section 35 or 35.1 of the MHA, the provisions of the MHA apply. This allows the MHA provisions to "trump" PHIPA in the event of a conflict.**

When read together, section 34.1 and subsection 35(2) provide psychiatric facilities with the ability to collect personal health information from other health care institutions and practitioners who have provided care to the patient in the past, as well as from the patient's family and friends.

Recall that the definition of personal health information includes anything that relates to the person's mental health, and includes family history. Although subsection 35(2) "trumps" the general consent principle of PHIPA, it should be noted that subsection 35(2) is permissive in nature and does not prevent a hospital from obtaining patient consent even though such consent is not required. Deciding whether to proceed without the patient's consent will depend on the clinical or legal purpose for which the information is required, and the potential effect of proceeding without consent on the therapeutic relationship between the patient and the clinical team.

## 3. Disclosures for Proceedings

There are other circumstances where the provincial legislature has determined that the delivery of mental health care permits certain disclosures in the context of legal proceedings, and also provides for restrictions on the disclosure of personal health information in the same context. The following paragraph refers to the provisions of section 35 that provide for disclosure in proceedings and related investigations. Both PHIPA and the MHA contain provisions that deal with permitted disclosures of personal health information for the purpose of a proceeding or contemplated proceedings.

- **Subsection 35(3):** "In a proceeding before the CCB, whether under the [MHA] or any other Act, the OIC shall, at the request of any party to the proceeding, disclose to the Board the patient's record of personal health information."
- **Section 35(4.1):**"The OIC shall disclose or transmit a clinical record to, or permit its examination by, [a representative of the Public Guardian and Trustee] who is entitled to have access to the record under section 83 of the *Substitute Decisions Act*," that is, for the purpose of conducting an investigation into allegations that a person is suffering serious adverse effects as a result of the person being allegedly incapable of making personal care decisions or of managing his or her property.
- **Subsection 35(5):** The OIC, or his or her designate, subject to certain qualifications discussed below, shall disclose, transmit or permit the examination of a record of personal health information where the record is subject to a summons, order, direction, notice or similar requirement in relation to a matter in issue or that may be in issue in a court or under any Act.
    - We recommend that when a health care provider is served with a summons or court order directing disclosure of personal health information, the organization's legal counsel or risk management office should review the order to determine its validity in the circumstances. Even in the face of a valid court order for disclosure, where the attending physician states in writing that he or she is of the opinion that the disclosure is "likely to result in harm to the treatment or recovery of the patient"; or is likely to result in injury to the mental condition or,

bodily harm to a third person", the clinical record may not be disclosed until a court hearing the matter first holds a hearing to inquire into the physician's statement **(subsection 35(6))**. An example of a situation where a physician might object to the production of the clinical record would be where the patient has reported fears concerning allegedly assaultive or abusive behaviour of third parties, which if such information became known, might give rise to retaliatory and physically injurious behaviour toward the third person, or, which could disrupt the therapeutic alliance, thus harming the treatment or recovery of the patient.

- **Subsection 35(9):** "No one shall disclose in a proceeding in any court or before any [tribunal or] body, any information in respect of a patient obtained in the course of assessing or treating a patient, or in the course of assisting in his or her assessment or treatment, or in the course of employment in the psychiatric facility" unless the patient is mentally capable of consenting to the disclosure, as set out in PHIPA, and has consented, or where the patient is incapable with respect to information decisions, with the consent of his or her substitute decision maker; or where consent has been withheld, there has been a judicial hearing to determine that the disclosure is essential in the interests of justice. This section applies to personal health information that may be provided orally by a health care provider who has been involved in the psychiatric care of the patient. It does not apply to hearings before the CCB, or a proceeding that has been commenced by the patient and relates to the assessment or treatment of the patient in a psychiatric facility (subsections 35(9) and 35(10)).

## 4. Community Treatment Orders

Subsection 35(4) and section 35.1 of the MHA provides for certain disclosures that relate to the contemplation and monitoring of CTOs. These disclosures include:

- Subsection 35(4): "The officer in charge may disclose or transmit a person's record of personal health information to, or permit the examination of the record by:
    1) A physician who is considering issuing or renewing, or who has issued or renewed, a CTO under s. 33.1;
    2) A physician who has been appointed by the physician who has issued or renewed a CTO, to carry out the issuing physician's duties in his or her absence [see MHA, subsection 33.5(2)];
    3) Another person named in the person's community treatment plan as being involved in the person's treatment or care and supervision, having first received a written request from the issuing physician or another named person; or
    4) [A rights adviser] providing advocacy services to patients in the prescribed circumstances".
- Subsection 35.1(1) allows a physician who is considering issuing or renewing a CTO with respect to a particular patient, to disclose personal health information for the purpose of consulting with other regulated health care professionals, social workers and any other concerned person, to determine whether the person should be subject of a CTO.
- Once the CTO has been issued, subsection 35.1(2) permits health care professionals or any other person named in a CTO as participating in the treatment or care and supervision of a person who is subject to the CTO, to share information with each other relating to the person's physical and mental health, for the purpose of carrying out the community treatment plan.

- Subsection 35.1(3) makes clear that subsection 35.1(1) is an exception to the general rule that no person shall disclose the fact that a person is being considered for or is subject to a CTO without first obtaining the consent of the person or his or her substitute decision maker.
- Subsection 35.1(4) further provides that persons who receive personal health information under subsections 35.1(1) or (2) (i.e., in the course of consultations regarding a CTO), must not further disclose that information unless the disclosure is permitted by the sections discussed for the purpose of issuing or implementing CTOs.

## 5. Disclosure of the Purpose of Receiving Rights Advice

The MHA requires that patients and their substitute decision makers, if applicable, must be provided with rights advice in certain circumstances. Chapter 3 sets out the eight situations in which the MHA mandates the provision of rights advice to patients. For example, the involuntary admission of a patient to a psychiatric facility triggers the requirement for rights advice. The fact that a patient is the subject of a Form 3 or Form 4, constitutes personal health information, as it is identifying information that relates to the person's mental health.

Consequently, the psychiatric facility where the patient is detained is required by the provisions of the MHA to disclose personal health information to a rights adviser, for the purpose of providing rights advice to the patient.[456]

Although rights advisers are not health information custodians as defined by PHIPA, the duties of confidentiality set out in PHIPA still apply to them, since they receive personal health information from a health information custodian.[457]

## 6. The Patient's Access to the Health Record and Rights of Correction

Formerly, section 36 of the MHA provided a procedure by which patients who were examined, assessed or treated in a psychiatric facility could have access to their own clinical record and to file a statement of disagreement or correction. Part V of PHIPA now governs that process.[458]

**The OHA's *Hospital Privacy Toolkit* deals extensively with rights of access to and correcting the individual's record of personal health information.**

456 MHA, *supra* note 100, s. 35(4)(d).
457 PHIPA, *supra* note 445, s. 7(1)(b).
458 *Hospital Privacy Toolkit: A Guide to the Ontario Personal Health Information Protection Act* (OHA Publication #314), deals extensively with rights of access to and of correcting the individual's record of personal health information.

Under clause 52(1)(e) of PHIPA, there are circumstances in which the right of access may be refused, notably where the access could reasonably be expected to result in a risk of serious harm to the treatment or recovery of the individual, or a risk of serious bodily harm to the individual or another person. While this will not always be the case, it is a consideration which should form part of the decision-making process prior to granting access. In the mental health care context, it would be prudent to consult with the patient's attending physician prior to granting a request for access by the patient, or his or her substitute decision maker.

Once the patient has been granted access to his or her record of personal health information, if the patient believes that the record is inaccurate or incomplete, the patient may request in writing that the custodian correct the record.[459] Once a request has been made in writing, the health information custodian must reply stating whether or not the request will be granted within a certain period of time. Where a custodian refuses the request, the patient must be provided with the reasons for the refusal. Even though PHIPA requires the custodian to correct a record if the individual is able to demonstrate that the record is incomplete or inaccurate, the custodian is not required to correct a record if it consists of a professional opinion or observation that has been made in good faith about the individual.[460]

## 7. Privacy Exceptions Regarding Communications To and From the Psychiatric Patient

The MHA contains provisions that govern the privacy of communications to and from patients in a psychiatric facility.

Section 26 of the MHA provides that the general rule is that "no communication written by a patient ... shall be opened, examined or withheld and its delivery shall not in any way be obstructed or delayed". However, there are exceptions that allow the OIC, or a person acting under his or her authority, to open and examine the contents of a written communication to or from a patient. If there are reasonable grounds to believe that the following conditions are met, the communication may be withheld from delivery:

(a) That the contents of a communication written by a patient would,
  (i) Be unreasonably offensive to the addressee, or
  (ii) Prejudice the best interests of the patient; or
(b) That the contents of a communication sent to a patient would,
  (i) Interfere with the treatment of the patient, or
  (ii) Cause the patient unnecessary distress.

Based on a reasonable belief that one of the conditions is met, the OIC or his or her delegate, may open and examine the contents of the communication. Upon examination of the contents, if any condition mentioned in either clause (a) or (b) exists, the communication may be withheld from delivery **unless** certain exceptions apply. If the communication appears to be written by a patient, or is sent to a patient from, a lawyer, a member of the CCB or a Member of Parliament, or the Ombudsman of Ontario, the communication may not be withheld and must be delivered.[461]

459 PHIPA, *supra* note 445, s. 55(1).
460 PHIPA, *supra* note 445, s. 55(9).
461 MHA, *supra* note 100, s. 26(1), (2) and (3); see also the *Ombudsman's Act*, R.S.O. 1990, c. O. 6, s. 16(2).

# 8. Communicating with the Police

Prior to PHIPA, disclosure of personal health information to police was guided by the common law or by other legal authority, such as a court order, warrant or subpoena. This has historically been an area of concern to health care providers, who are mindful of their obligations to maintain patient confidentiality.

With the enactment of PHIPA, the starting point for disclosure of personal health information, including disclosures to the police, continues to be consent. In the absence of a patient's or substitute decision maker's consent, a health information custodian must look to legal authority referenced in PHIPA, that allows for disclosure in the absence of consent. Typically, the police approach health care providers for information obtained in the course of treatment, which the police believe may be relevant to an investigation. With reference to police requests for information, the authority to disclose personal health information about an individual usually derives from a warrant, subpoena or court order issued in a criminal proceeding, which PHIPA recognizes as an authorized disclosure without consent.[462]

It is recommended that organizations develop a procedure to facilitate responses to police requests for personal health information. The procedure may include: who to contact, what questions should be asked to verify lawfulness of the requests, what documentation / information may be required from the police to support the request, such as a warrant, summons or court order, what should be documented in the chart and what, if any, information to disclose to the patient who is the subject of the police request.

Health care providers may also want to contact the police regarding concerns about criminal activity that have come to their attention in the course of providing health care with the patient's consent, or without the patient's consent, if the concern rises to the level of a duty to warn. The duty to warn is triggered where the health care provider believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.[463]

In situations where police are in attendance on hospital premises for the purpose of a police investigation, the police presence should not interfere with the safe and efficient operation of a Hospital and the provision of patient care.

There is no general legislative authority that requires health care providers or citizens to report alleged criminal activity to the police.[464] Rather the *Criminal Code* requires citizens to not obstruct the police in the course of exercising their duties or omit, without reasonable excuse, to assist a police officer in the course of exercising his or her duties.[465] It is reasonable for health care providers to ensure that there is a lawful basis for disclosing personal health information to the police, in the absence of consent.

**As these situations are very fact-specific, health care providers should contact the Hospital's Risk Management department and/or legal counsel for advice.**

462 PHIPA, *supra* note 445, ss. 41(1)(a)(d) and 43(1)(g).
463 PHIPA, *supra* note 445, s. 40(1).
464 One exception to this rule is Ontario's recently enacted *Mandatory Gunshot Wounds Reporting Act*, 2005, discussed below.
465 CC, *supra* note 152, s. 129.

Under PHIPA, certain permissible disclosures that were not previously covered by the common law have been provided for. For example, under clause 43(1)(g), a health information custodian may disclose personal health information about an individual to a person carrying out an inspection, investigation or similar procedure that is authorized by a warrant or by any statute of Ontario or Canada, for the purpose of complying with the warrant **or for the purpose of facilitating the inspection, investigation or similar procedure** (emphasis added).[466]

Section 43(1)(g) allows for disclosure of personal health information to police without patient consent and in the absence of a warrant or subpoena, so long as the police are lawfully conducting an inspection or investigation that is authorized by statute. Where a patient is the subject of a police investigation for criminal activity, this section may allow disclosure of patient information to police prior to the issuance of a warrant or subpoena. However, this section has not yet been interpreted by the courts or the Information and Privacy Commissioner of Ontario ("Commissioner"), and should be considered with caution where disclosure is requested by police in the absence of a warrant, order or patient consent.[467] Given that significant legal issues are at stake, for the patient and potentially for the custodian, it is advisable for the health informative custodian to seek legal advice on any questions in this area, to ensure that the disclosure, or any refusal to disclose, is permitted by law.

Some statutes require reports to authorities other than police. For example, under the *Child and Family Services Act*, a health care professional must report to a Children's Aid Society a reasonable suspicion that a child is in need of protection, where that suspicion is based on information acquired in the course of his or her professional duties.[468] Similarly, under the *Mandatory Gunshot Wounds Reporting Act*, a facility that treats a person for a gunshot wound is required to disclose to the local municipal or regional police force or the local Ontario Provincial Police detachment, the fact that a person is being treated for a gunshot wound, as well as the person's name, if known, and the name and location of the facility.[469] PHIPA preserves and recognizes these types of disclosures under the category of disclosures permitted by law (clause 43(1)(h)). Examples of other statutes requiring mandatory reports include:

- *Coroners Act*, R.S.O. 1990, c. C.37;
- *Regulated Health Professions Act*, 1991, S.O. 1991, c.18, including the Health Professions Procedural Code, being Sch. 2 to the Act;
- *Highway Traffic Act*, R.S.O. 1990, c. H.6;and
- *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7.

A description of each of the various legislated reporting obligations is outside of the scope of this Toolkit. Healthcare professionals will generally find information about their profession's mandatory reporting obligations on their health college's website.

466 Subject to the requirements and restrictions, if any, that are prescribed (and to date there are none).

467 For further guidance in this area, see "Best Practices in Drafting Documents to Comply with PHIPA: Disclosure of Personal Health Information to Police," Kristin Taylor, Borden Ladner Gervais LLP, conference paper presented at the Ontario Bar Association's First Annual Privacy Law Summit, November 9, 2006.

468 *Child and Family Services Act*, R.S.O. 1990, c. C.11, s. 72.

469 *Mandatory Gun Shot Wounds Reporting Act*, S.O. 2005, c. 9, s. 2.

## 9. The Duty to Warn

PHIPA provides for disclosure related to risk in circumstances where a health information custodian believes on reasonable grounds that disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.[470]

In its December 2004 "Guide to the *Personal Health Information Protection Act*", the Commissioner provided an example of a situation in which a health information custodian could disclose personal health information about an individual over his or her objection, as permitted by subsection 40(1) of PHIPA.[471] In the example, the Commissioner described a student who had been attending a University Health Centre for counselling. The counsellor noted that the student appeared to be severely depressed and that the student could be addicted to prescription medication. Having assessed the risk of suicide, the counsellor wanted to involve the student's family and family physician, but was instructed by the student not to disclose any information. The student subsequently contacted the Centre by telephone, speaking in a slurred voice and indicated an intention to end his own life. In this type of situation, the Commissioner stated that the counsellor would be permitted to disclose personal health information to the student's family or family physician, if he or she had formed the opinion that there were reasonable grounds to believe it was necessary to do so to reduce the risk of suicide in the student.

It should be added that this is a permissive and not a mandatory disclosure under PHIPA. Subsection 40(1) begins "A health informative custodian may disclose . . ." However, where the situation is such that there are significant risks of harm, disclosure to the appropriate person or authority is recommended. The case law supports the imposition of a common law duty to warn in such circumstances, even where the statute is permissive.[472]

## 10. Limits of Confidentiality in Court-Ordered Assessments

Under the *Criminal Code* provisions dealing with the mentally disordered offender, the court may order an assessment only where the court has reasonable grounds to believe that evidence obtained by the assessment is necessary to determine any of the enumerated matters set out in section 672.11, such as fitness to stand trial and criminal responsibility.[473] Under the MHA, a judge also has the authority, where a person suffers from mental disorder and is charged with or convicted of an offence, to require the person to attend a psychiatric facility for examination and assessment.[474]

Whether issued pursuant to the *Criminal Code* provisions or the MHA, the assessment has been ordered for the purpose of assisting the Court or the Review Board to arrive at a just outcome. The health care professional who conducts the assessment, usually a forensic psychiatrist, is subject to a Court or Review Board order to provide the criminal justice system with his or her clinical opinion on whether the person who is before the court suffers from a mental disorder and to educate the court about the various psychiatric variables that may be at play in a case.[475]

470 PHIPA, *supra* note 445, s. 40(1).
471 A Guide to the *Personal Health Information Act*", Office of the Information and Privacy Commission, December 2004, Example 8 at p. 28. Available online at http://www.ipc.on.ca/images/Resources/hguide-e.pdf (accessed May 31,2012).
472 *Smith v. Jones,* [1999] 1 S.C.R. 455; *Tarasoff v. Regents of the University of California,* [1976] 17 Cal. 3d. 425.
473 CC, *supra* note 152, s. 672.11 and s. 672.121 and s. 672.13. See Chapter six on forensic psychiatric patients for further discussion of the matters.
474 MHA, *supra* note 100, s. 21 – 24.
475 See Bloom & Schneider, *supra* note 297 at p. 35.

It is important to note that the court-appointed, assessing psychiatrist is generally not in a doctor/patient relationship with the person being assessed, although in the context of providing evidence at annual hearings of the ORB, the psychiatrist witness may well be.

In these circumstances, physicians will usually explain to patients that they are under an obligation to report to the court or Review Board on the outcome of the assessment such that the normal parameters of doctor/patient confidentiality do not apply.

## 11. Invasion of Privacy Claims: Intrusion Upon Seclusion

Prior to 2012, there was no free standing claim in negligence, or tort, for the invasion of privacy at common law. Individuals had and continue to have the right to complain about a privacy breach to the Office of the Information and Privacy Commissioner of Ontario.[476]

In early 2012, Ontario's Court of Appeal considered an appeal of a claim that had been dismissed by way of summary judgment that concerned an employee of a bank who had accessed the personal banking information of the employee's common law partner's former wife.[477] Contrary to bank policy, the employee accessed the former wife's banking records at least 174 times over a period of four years. The former wife sued the employee for breach of privacy, and her claim had been dismissed by the summary judgment motion judge, on the grounds that Ontario law does not recognize the tort of breach of privacy.

On appeal, the Court of Appeal confirmed the existence of a right of action for "intrusion upon seclusion." Where someone intentionally or recklessly intrudes, physically or otherwise, upon the seclusion of another or his or her private affairs or concerns, that person will be liable to that other person for invasion of his or her privacy, if the invasion would be highly offensive to a reasonable person.[478] The Court recognized that where a plaintiff has suffered no pecuniary loss, damages could be awarded in the range of $20,000, in order to mark the wrong that has been done. In this case, the Court ordered the defendant employee to pay damages in the amount of $10,000 to the injured party.

It is likely that a court would find the improper or unlawful disclosure or use of personal health information to be "highly offensive" given the law's recognition that healthcare records contain personal and private information. It is anticipated that claims for breach of privacy will be brought in the health care context, although none have been finally determined as of the date of publication.

476 See http://www.ipc.on.ca for further information.
477 *Jones v. Tsige*, 2012 ONCA 32.
478 *Ibid.*, paras. 70 – 71.

## 12. *Freedom of Information and Protection of Privacy Act*

As of January 1, 2012, Ontario hospitals are now subject to the *Freedom of Information and Protection of Privacy Act* (FIPPA). Public and private hospitals are now designated as "institutions" subject to FIPPA.

The legislation applies to all records in the custody or under the control of a hospital on or after January 1, 2007. Under FIPPA, the general public will have a right of access to these records, unless the records are excluded from the right of access or subject to an exemption under FIPPA. Where a record is excluded, FIPPA does not apply to it at all; however, exempt records are still subject to FIPPA, except in specified circumstances where the hospital is able to justify the exemption.

This right of access applies to every person. Unlike PHIPA, which allows a person to access records about him or herself, FIPPA allows anyone to access any record held or controlled by an institution on any issue, subject to the exclusions and exemptions set out in the Act.

The legislation amends the *Quality of Care Information Protection Act*, 2004 (QCIPA) so as to exclude "quality of care information" (as defined in QCIPA) from the application of FIPPA. PHIPA already provides that the right of access in FIPPA **does not** apply to records of "personal health information" (as defined in PHIPA) in the custody or under the control of health information custodians, unless the personal health information can be reasonably severed from the record. The obligation in FIPPA to disclose records, where the disclosure is in the public interest and the records reveal a grave hazard to the public, does apply.

For further information on FIPPA and it applicability to Hospitals, please see the *OHA's Hospital Freedom of Information Toolkit*.

# Chapter 8 Developing Mental Health Law Expertise at Your Hospital

The purpose of this Chapter is to discuss several issues that arise when dealing with mental health patient that are not addressed elsewhere in this Toolkit.

## 1. The Use of Restraints

### What is "Restraint"?

"Restrain" means to "place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient".[479] The use and meaning of "restraint" is distinct from "detaining" a patient, and detention is discussed elsewhere in this Toolkit.

Restraint may involve physically laying hands on a patient. Mechanical restraint involves devices, including jackets, straps and bedside rails. Locked observation rooms may be considered a mechanical or an "environmental" restraint. Chemical restraint is the administration of medication to control a patient's movements. Legally there is no distinction between the types of restraints used, however there are some issues, reviewed below, around the documentation and monitoring of patients where different types of restraints are employed.

### The Authority to Restrain

The HCCA specifically provides that:

> *This Act does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others.*[480]

The common law duty is:

> A right and a duty to restrain [the patient] when necessary to protect him, other patients, or others lawfully on the premises (staff or other patients) from harm and to prevent endangerment to the safe environment of the hospital or facility.[481]

479 MHA, *supra* note 100, s. 1.
480 HCCA, *supra* note 12, s. 7.
481 *Conway v. Fleming*, [1996] O.J. No. 1242 at paras. 278-279 (Ont. Gen. Div.) (QL).

### Example of the Common Law Duty to Restrain

A patient had been angry and agitated, yelling at staff in a manner that caused staff to fear for their safety. He was placed in seclusion where he continued to yell and scream, and kick doors and walls for some time. There was a cause of concern about the affect the behaviour was having on other patients as well as a concern of harm that may come to patient.

Chemical restraint was used in addition to the physical restraint.

The patient brought an action claiming damages and an alleged breach of the *Charter* due to the use of chemical restraints.

The Court upheld the decision to employ the chemical restraint and in doing so considered the factual context as well as the potential consequences of not restraining.

The Court held that the plaintiff posed a threat of serious bodily harm to himself, possibly to staff, and while once he was in his room there was no danger to other patients, his degree of agitation was such that he was upsetting other patients, and there was a risk of a different type of injury to himself as a result of recriminations by other patients.[482]

Under the MHA, there is an express provision that "nothing in this Act authorizes a psychiatric facility to detain or to restrain an informal or voluntary patient".[483] This does not preclude the use of restraints in an emergency in accordance with the HCCA or the common law. However, where restraint is used on a person detained or admitted under the MHA, the restraint must be documented.[484] Although the following suggestions exceed the statutory requirements for documentation of restraint, it is prudent to:

(a) Describe the means of restraint (what and how);

(b) Describe the behaviour of the patient that required the use and/or continuation of restraint (why);

(c) Include the time restraint was initiated and discontinued, and the frequency of observation during the restraint period (when); and

(d) Describe the effect on the patient.

Additionally, where chemical restraint is used, documentation must include the type of medication, the method of administration, and the dosage.[485]

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482 *Ibid.*

483 MHA, *supra* note 100, s. 14.

484 *Ibid.*, s. 53. If this is not done, there is support for the allegation that there has been a "battery" of the patient: *Illingworth Estate v. Humber River Regional Hospital* (1999), 126 O.A.C. 332, [1999] O.J. No. 4217 (C.A.). Here, there was no record as required by s. 53 of the *Mental Health Act*, describing the behaviour of the patient that required that he be restrained by handcuffs, the statutory requirement for restraint, as set out in the definition of "restrain" in s. 1 of the MHA, was not met and a claim for battery against the hospital was allowed.

485 MHA, *supra* note 100, s. 53(2).

For facilities to which the MHA does not apply, the *Patient Restraints Minimization Act* ("PRMA") must be considered. The PRMA permits the use of restraints, in accordance with the common law duty, when immediate action is necessary to prevent serious bodily harm to the person or to others[486] and in non-emergent situations only if restraints are necessary to enhance the patient's quality of life and prevent serious harm to the patient or another person.[487]

Finally, there may be a situation in which restraint is used as part of, or ancillary to, treatment. If the treatment is being administered in accordance with substitute consent, and restraint is necessary to administer the treatment, the restraint itself forms part of the treatment.[488]

## The Use and Application of Restraints

Policies of "least restraint" are common at health care facilities, including psychiatric facilities. The acuteness of an individual patient's disorder and the risk it may pose for both self-harm and harm to others should be assessed and documented, and the patient should be managed accordingly. Patients may require restraint from time to time, and staff needs to be trained in how to deal with restraint appropriately, having regard to managing the patient's risk of harm that gave rise to the restraint, and the safe use of the restraint in the circumstances.

### What is "Reasonably Foreseeable"?

A suicidal psychiatric patient who threw himself at a glass window, shattering the window and consequently suffering significant injuries to which he eventually succumbed.

The Ontario Court of Appeal upheld the trial judge's finding that both the attending psychiatrist and hospital were negligent.[489]

The Court confirmed that the **self-destructive harm that materialized was "well within the range of harm that the defendants could reasonably foresee". Consequently, the conduct of hospital staff who failed to increase the level of observation on the patient when he posed a high suicide risk came under scrutiny, as did the hospital's failure to place the patient in a room with shatterproof glass in the windows.** The Court also found that both the hospital and medical staff failed to hold an intake conference, as required by hospital policy, to develop a plan to address the patient's increased suicidality. (emphasis added)

The use of restraint, whether mechanical or chemical, may pose a risk to the patient by virtue of the restraint itself. Inherent risks associated with the type of restraint must be weighed and balanced with the risk of harm to the patient or others if the patient is not restrained. Having weighed the risks and benefits, the reasons for the restraint application should be documented in the clinical record. In situations in which restraints are being used and the MHA does not apply, there should still be documentation on the reason for, and use of, restraints.

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486 *Patient Restraints Minimization Act*, 2001, s. o. 2001, c. 16, s. 6(2) [PRMA].

487 *Ibid.*, s. 5.

488 *S.M.T. v. Abouelnasr*, [2008] O.J. No. 1298 at para. 53 (QL) suggests that "restraint" may be considered a "treatment" under the HCCA.

489 *De Jong Estate v. Owen Sound General and Marine Hospital*, [1999] O.J. No. 4369 (Ont. C.A.).

It is normal practice for a hospital to ensure that its staff, both employed staff and credentialed physicians, are duly qualified and trained in the treatment and procedures that the staff members will undertake in relation to the patients who are receiving care at the hospital. This includes ensuring that staff is adequately trained to deal with health care issues that the hospital can reasonably foresee will arise in the hospital or psychiatric facility setting, including the application of any restraint, whether mechanical or chemical.

With regard to mechanical restraints, hospitals generally have control over purchasing and maintaining the equipment employed by health care providers on its premises for the purpose of restraining patients. Hospitals should ensure that mechanical restraints are used according to the manufacturer's instructions and are maintained in good working order. Further, staff should be trained in the proper use of such equipment, again in accordance with the manufacturers' instructions.

A manufacturer's instructions may include not only how the restraint should be applied to the patient, but also how frequently the patient should be monitored while subject to the restraint. Hospital policy on restraint practices may also set out general guidelines on the frequency of monitoring and there may be other applicable standards of practice to consider. Any departure from recommended use or recommended monitoring should be undertaken only on a doctor's orders, with the clinical reasons clearly documented in the patient chart.

Regulated health professionals should also be familiar with their professional obligations when dealing with patients and restraints, as set out by their respective Colleges.[490]

### Recent Recommendations on the use of Restraints[491]

Facilities are encouraged to:

- Move towards a restraint free environment.
- Consider alternatives to physical restraint and using restraint for the shortest period of time possible.
- Track episodes of physical restraint.
- Conduct in-person physician assessments of the restrained patient's physical health every 24 hours.
- Ambulate the patient every eight hours of continuous restraint where this can be safely accomplished.
- Hold an external review of the use of restraints every 72 hours by a physician who is not on the unit.
- Conduct a "debrief" following restraint use.

490 The College of Nurses has a "Restraints Practice Standard" which is available on line at http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/learning-modules/restraints.

491 This summary is based on the extensive recommendations made in September 2008 following an Inquest into the death of a patient in a Schedule 1 psychiatric facility. Information with respect to Verdicts and Recommendations may be found at: http://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/VerdictsRecommendations/AlphabeticalList/OCC_verdicts_alpha.html.

Following the Coroner's Inquest which gave rise to the recommendations set out above, the Ontario's *Coroners Act* was amended to require that if a person dies while being restrained and while detained in a psychiatric facility, either as an involuntary patient under the *Mental Health Act* or as a forensic patient under Part XX.1 of the *Criminal Code*, the officer in charge of the psychiatric facility notify the Coroner immediately and further, the Coroner is required to hold an Inquest concerning the death. Coroners Inquests are addressed in more detail later in this Chapter.

## 2. Patients Leaving Against Medical Advice

A capable patient can make a decision to leave a hospital against medical advice. If this occurs, steps should be taken to minimize the risk of allowing the patient to leave the hospital – for example, ensuring that the patient has appropriate prescriptions, notifying the patient's family doctor (if one exists), discussing plans for return to the hospital or otherwise accessing medical care if the patient's condition worsens. As the risks to the patient of leaving against medical advice increases, the prudence of documenting in detail the nature of conversation in the patient's chart also increases.

If a decision to leave hospital against medical advice is being made on behalf of an incapable person by a SDM, there are other issues to consider. First and foremost, the patient's capacity to make decisions at that point in time should be assessed. Although patient capacity has already been considered, the decision to remove a patient from hospital and medically necessary treatment is a significant decision – one that raises the issue of whether the SDM is acting in the best interests of the patient.

If the patient is a minor, and there is a concern that the decision to leave against medical advice is not being made in accordance with the principles of substitute decision making as set out in the HCCA, then in addition to the above there may need to be consideration of whether a report is required by law to a Children's Aid Society about a child who may be in need of protection.

If the patient is an adult, and there is a concern that the decision to leave against medical advice is not being made in accordance with the principles of substitute decision making as set out in the HCCA, then an application to the CCB may be appropriate.[492]

## 3. Clinical Risk Management in Mental Health Care Settings

### Training and Continuing Education of Staff

Generally speaking, health care practitioners are bound to exercise a degree of care and skill that could reasonably be expected of a prudent and diligent practitioner in the same field and in similar circumstances.[493] Where a practitioner holds him or herself out as a specialist, regardless of location, a higher degree of skill is required as compared to someone who does not claim to be so qualified.[494] Generally, specialists (whether in nursing or medicine) are held to the standards of other specialists who possess the same or similar levels of knowledge, skill and training.[495] A health care provider will not be held

492 Please see Chapter 2.

493 *See Crits v. Sylvester* (1956), 1 D.L.R. (2d) 502 at 508 (Ont. C.A.), aff'd [1956] S.C.R. 991 [Crits]. See also Tiesmaki v. Wilson, [1974] 4 W.W.R. 19 (Alta. S.C.), aff'd [1975] 6 W.W.R. 639 (Alta. C.A.).

494 *Crits, ibid.; Wilson v. Swanson,* [1956] S.C.R. 804, 5 D.L.R. (2d) 113 at 119, 124.

495 *Crits, ibid.*

accountable for "errors in judgment" so long as the clinical judgment is exercised diligently, taking into account the health care provider's own assessment of the patient and all of the information available from other sources.[496]

**What is considered a reasonable expectation will be derived from all of the circumstances in any given case.**

A hospital has an obligation to meet standards "reasonably expected" by the community it serves in the provision of competent personnel and adequate facilities and equipment and also with respect to the competence of physicians to whom it grants privileges for providing medical treatment.

Based on case law, the hospital's size, location, and the community it serves will be relevant factors in evaluating whether it met the standard required in any given case. While these factors will not be determinative, they will be considered along with all of the other circumstances in a particular case.

## Documentation and Charting

Documentation serves both a clinical and legal purpose. Clear, effective and complete documentation is an important tool of communication for the health care team. Courts have recognized that charting information relevant to a patient's presentation and treatment is an important component of intra-team communication and the chart is evidence of compliance with requirements for content, retention and disclosure of medical records.[497]

### Example of the Importance of Documentation

A patient underwent a bilateral carotid arteriography following which he became a quadriplegic.

The patient claimed that he had not been warned of the risks, and that he had received minimal and inappropriate care after the surgery.

The Court held that the testimony of the plaintiff was entirely unreliable as it was inconsistent with, and contradictory to, the documentation found in the chart. The Court summarized its finding as follows:

It is necessary that I say that the testimony of the plaintiff is unreliable. Whether it was because of failing memory, because of the effluxion of time between the events and the testimony, or because of the effect of the enormity of the calamity suffered by him or because of any other reason, the fact is that the plaintiff's evidence about so many of the events during that period is entirely inconsistent with and contradicted by the documentation in the hospital record.[498]

496 See *Wilson v. Swanson*, [1956] S.C.R. 804 at 812-813, 5 D.L.R. (2d) 113. See also *Fullerton (Guardian ad litem of) v. Delair*, 2005 BCSC 204 at para. 176, varied on other grounds 2006 BCCA 339.

497 *See Joseph Brant Memorial Hospital et al. v. Koziol et al.* (sub nom *Kolesar v. Jefferies*) (1977), 77 D.L.R. (3d) 161 at 165 (S.C.C.); *Rose v. Dujon* (1990), 108 A.R. 352, 1990 CarswellAlta 464 at paras. 137-142 (Alta. Q.B.) (WLeC).

498 *Ferguson v. Hamilton Civic Hospital et al.* (1983), 40 O.R. (2d) 577 (H.C.J.) at p. 4 (QL).

Documentation should meet statutory, institutional and professional requirements. Documentation should be legible, objective, include all pertinent information, use specific terminology, be completed contemporaneously where feasible and avoid subjective conclusions or assumptions.

Many Ontario hospitals have introduced a system known as "Charting by Exception". The underlying philosophy is to chart only significant findings or exceptions to norms in narrative format. Routine care and normal interventions are documented in an abbreviated method, typically on flow sheets designed for this purpose.

The "Charting by Exception" documentation system is based on the assumption that the care was provided in accordance with written standards of care, unless otherwise noted. It is a shorthand method of documentation in which it is presumed that a normal or expected event occurred unless documented otherwise. It does not mean an absence of documentation. In particular, and contrary to a common misconception, it still requires that a health care provider document at regular intervals when no change in the patient's condition has been observed.

The Ontario Court has supported the "Charting by Exception" practice, as long it is documented somewhere in the chart that a check or assessment of the patient had been completed.[499]

All of the same principles for documentation and charting apply to electronic charting. The expectations for documenting are the same whether the health care provider documents on paper or electronically.

The bottom line is that no matter what type or kind of charting is used, anyone reviewing the chart must be able to determine what transpired.

## Occupational Health and Safety[500]

There has been significant change in the legislation that deals with occupational health and safety in Ontario in recent years which impacts the delivery of mental health care.[501] Caring for the acutely mentally ill may sometimes involve the assessment and management of the risk of serious harm to both the patient and others as a result of a mental disorder.

The definitions in the legislation address both "harassment" and "violence". Harassment is vexatious "comment" and "conduct," which ought reasonably to be known to be unwelcome. Violence is actual, attempted or threatened physical harm.

499 *Ferguson v. Hamilton Civic Hospital, ibid.* The Court dismissed the allegation that monitoring of the patient was too infrequent, by pointing to the medical record, which showed frequent monitoring and assessments had been done.

500 OHA's Legislative Update: *Legislative Changes Impacting Mental Health and Addictions Services: An Update*, October 2010, pp. 7-10.

501 This section is focused on some specific issues for mental health care providers that may arise as a result changes to this legislation. The OHA provides more detailed and specific resources relating to Health Human Resources and Healthy Work Environments.

One of the recognized challenges that face staff working on an in-patient mental health unit is the risk posed by patient behaviours that may fall within the definitions of harassment or violence. While this challenge is certainly not limited to mental health units, it is a concern for staff working in this environment and particularly with patients who have met the harm-based criteria for involuntary admission or who are detained as forensic patients having been found not criminally responsible for violent criminal offences.

The *Occupational Health and Safety Act* (OHSA) requires that staff be provided with information, including personal information, related to the risk of workplace violence from a person with violent behaviour, if the staff person can be expected to encounter the person in the course of work and if the risk of physical violence is likely to expose the worker to physical injury. While the legislation notes that this may involve the disclosure of "personal information", if required, in order for identification / disclosure of risk to take place, the legislation does not set out the type and amount of information that should be disclosed. The legislation does require that the information disclosed be "reasonably necessary" in the circumstances "to protect the worker from physical injury".

Where a patient has a history of violence, information relating to this history may be contained in clinical notes and records. While this information will likely be known to the staff who have clinical interactions with the patient, the obligations set out in the OHSA extend to all staff who can be expected to encounter the patient – including staff who are not directly involved in the care of the patient and therefore not ordinarily accessing this information. Organizational policies will need to develop criteria to determine whether a patient is someone who has a "history of violence" such that disclosure pursuant to the OHSA is required.

These policies should also consider how to identify these individuals to staff members[502], as well as when a patient / substitute decision maker should be involved in and notified of this determination. The steps taken to identify and disclose that a patient has a "history of violence" must balance the organization's obligations under the OHSA with the privacy of the patient, particularly where the information upon which the determination is being made comes from the patient's personal health information.

As noted above, "persons with a history of violence" may include patients in any unit of a hospital, not only a mental health unit. Scenarios in which a staff member or visitor to the facility may have a "history of violence", including "domestic violence", must also be considered. In the case of staff members, the organization's policies will also have to address the balance between the staff member's privacy and the OHSA duties, and how any disclosure should be managed or made. There are significant human resources issues which arise as a result of a situation in which there is disclosure of a staff member as having a "history of violence".

While it is possible that a visitor to a hospital may have a "history of violence", obligations to disclose this and to address the risks posed by the visitor arise where this history is known to the hospital. It should be remembered that a hospital has the authority to control who is on its premises, and may decide to limit visitors where the risks posed by the visit outweigh the benefits the patient may derive from maintaining social contact with the visitor.

502 Depending on the environment into which the patient is admitted, or within which interactions occur, this may include colour coded stickers on wrist bands and/or charts, beds etc.

Health care organizations have a number of obligations to address and reduce incidents of workplace violence or harassment, including:

- having workplace violence and workplace harassment policies in place;
- conducting assessments of risk for workplace violence within the organization;
- developing violence and harassment programs as required for the implementation of the policies and any recommendations arising from the assessment, which must include;
    - measures for requesting immediate assistance
    - measures for reporting violence or harassment
    - measures and procedures for conducting an investigation into incidents or complaints of workplace violence
- providing information and training to staff about the policies and programs; and,
- posting the policies within the organization.

While the focus of the obligations of health care organizations is to their employees, there are legal[503] and ethical obligations to patients and visitors that also have to be considered. Creating a safe setting within which to provide mental health care services is a combination of management commitment, staff involvement, education and evaluation, all of which is consistent with the theme and requirements of the legislation.

In creating a safe environment, for staff, patients and visitors alike, the following are some tools that may be used on an on-going basis and to addressing specific situations or concerns:

- Staff training and education, particularly with respect to policies, de-escalations techniques and incident management, including in response to harassment and violence.
- Zero tolerance policy of harassment and violence and Codes of Conduct setting out expectations.
- Provide written policy to patients, staff, visitors.
- Clear behaviour contracts with patients and visitors, and even staff, where appropriate.
- Development of individual treatment plans for patients with a risk of harassment or violence.
- Rotational or shared care.
- Consider what other options or resources may be available for specific situations, which may include consultation with security, risk management, other hospital administration or legal counsel.

While these tools cannot ensure a safe environment, the continuing commitment of health care organizations, management and front line staff to safely manage the risks inherent in providing health care to all individuals regardless of their history or presenting health care issues, is a significant factor to achieving this goal.

503 In addition to the *Occupational Health and Safety Act*, there are obligations on Hospitals to provide a safe environment, as well as treatment and care to patients, which are set out in the *Occupier's Liability Act*, s.3 and the *Public Hospitals Act*, s. 20.

## 4. Coroner's Inquests

The *Coroner's Act* requires that, when a person dies while a resident or in-patient in a psychiatric facility as defined in the MHA, the person in charge of the facility "shall immediately give notice of the death to a coroner and the coroner shall investigate the circumstances of the death".[504] Following an investigation, the Coroner may decide to hold an inquest into the death.[505]

The primary purpose of an inquest is to "inquire into the circumstances of the death and determine:

(a) Who the deceased was;

(b) How the deceased came to his or her death;

(c) When the deceased came to his or her death;

(d) Where the deceased came to his or her death; and

(e) By what means the deceased came to his or her death.

The inquest jury answers these questions. The jury "shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to" in answering the above questions.[506] The jury "may make recommendations directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest".[507]

It is recommended that all organizations obtain legal advice when advised of the possibility of an inquest into a death that occurred at its facility.

## 5. Discharge Planning

Discharge planning may have many challenges and should be started as soon as clinically appropriate. This process may involve several members of the multi-disciplinary team in hospital; as well as the CCAC, community service providers, family members, substitute decisions makers and, of course, the patient.

When a patient's care needs change, they may be designated as Alternate Level of Care, or "ALC". This is a clinical determination based on the patient's care needs and is applicable to patients in mental health programs, as well as other areas in the hospital. The term "ALC" has a provincial definition, which is as follows:

504 *Coroner's Act*, R.S.O. 1990, c. C.37, s. 10(2)(3). If the patient if not on the premises of the facility at the time of their death, but is a "patient" as defined under the *Mental Health Act* at the time, this provision also applies.

505 *Ibid.*, see also s. (4) – There is no discretion for the Coroner if the person is "in custody" at the time of their death. The Divisional Court of Ontario ruled that provisions of the *Coroner's Act* that permitted discretion in whether to hold an inquest into the death of psychiatric patients is not discriminatory: Ontario (Attorney General) v. Ontario Human Rights Commission, 2007 CanLii 56481 (ON S.C.D.C), leave to appeal to the Ontario Court of Appeal was subsequently denied.

506 *Ibid.*, s. 31(2).

507 *Ibid.*, s. 31(3).

## Definition

When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC)[1] at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination[2] (or when the patient's needs or condition changes and the designation of ALC no longer applies).

**Note 1:**

The patient's care goals have been met *or*

- progress has reached a plateau *or*
- the patient has reached her/his potential in that program/level of care *or*
- an admission occurs for supportive care because the services are not accessible in the community (e.g. "social admission").

This will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.

**Note 2:**

Discharge/transfer destinations may include, but are not limited to:

- home (with/without services/programs),
- rehabilitation (facility/bed, internal or external),
- complex continuing care (facility/bed, internal or external),
- transitional care bed (internal or external),
- long term care home,
- group home,
- convalescent care beds,
- palliative care beds,
- retirement home,
- shelter,
- supportive housing.

This will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.

**Final Note:**

The definition **does not** apply to patients:

- waiting at home,
- waiting in an acute care bed/service for another acute care bed/service (e.g., surgical bed to a medical bed),
- waiting in a tertiary acute care hospital bed for transfer to a non tertiary acute care hospital bed (e.g., repatriation to community hospital).[508]

508 https://www.cancercare.on.ca/cms/one.aspx?objectId=43214&contextId=1377.

The discharge and transfer destinations listed in Note 2 above may be applicable to patients in a psychiatric facility awaiting discharge from hospital. In some cases, ALC patients may be charged a "co-payment" while they are awaiting discharge.[509]

There are limited circumstances in which patients who refuse to leave hospital after being discharged may be charged a "per diem" or daily rate, should they choose to remain in hospital. It is anticipated that hospitals will have specific policies and internal resources to address these issues. For more information on this and other ALC issues, please go to the OHA website.

While most organizations have developed policies and procedures with respect to ALC patients these are not typically specific to mental health patient and programs. Some of the specific challenges in dealing with mental health patients may include:

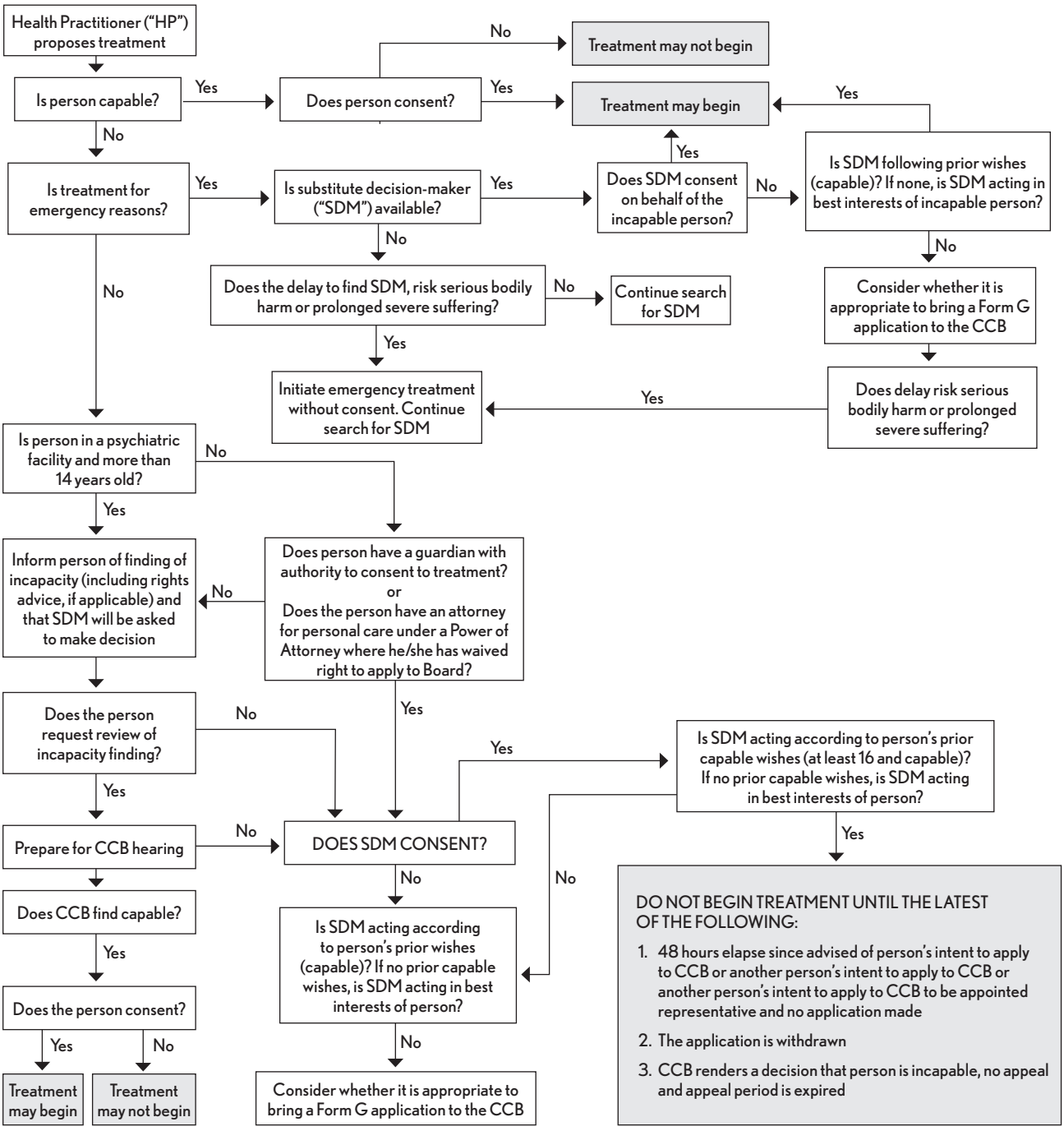
- finding appropriate discharge destination, including facilities that may be listed in Note 2 above;
- accessing appropriate supports in the community; and
- legal and clinical considerations that impact discharge, for example ORB disposition conditions or CTO provisions.

In some cases, the Consent and Capacity Board may be involved in determining issues relating to the discharge plan, for example capacity to make decisions with respect to admission to a care facility.

509 *Health Insurance Act*, R.S.O. 1990, c.H.6, s. 46 and General Regulation R.R.O. 1990, Reg, 552, s. 10. Whether a co-payment may be changed to a particular patient will depend on their status within the hospital and may also depend on the classification of a Hospital under the *Public Hospitals Act*. For example, the co-payment does not apply to an insured person in a Group H Hospital (psychiatric hospital providing facilities for giving instruction to medical students of any university). A listing of the classifications of hospitals may be found at: http://www.health.gov.on.ca/english/public/contact/hosp/hospcode.html.

# Appendix A

## Decision Tree for Obtaining Consent Under the *Health Care Consent Act*




This decision tree does not contemplate all scenarios, but is intended to be a general guide to consent issues.

# Appendix B

## Acronyms

| | |
|---|---|
| Community Treatment Plan | CTP |
| Community Treatment Order | CTO |
| Consent and Capacity Board | CCB |
| *Health Care Consent Act* | HCCA |
| Information and Privacy Commissioner of Ontario | Commissioner |
| *Mental Health Act* | MHA |
| Not Criminally Response by Reason of Mental Disorder | NCRMD |
| Ontario Hospital Association | OHA |
| Ontario Review Board | ORB |
| Officer in Charge | OIC |
| *Patient Restraints Minimization Act* | PRMA |
| *Personal Health Information Protection Act* | PHIPA |
| Psychiatric Patient Advocate Office | PPAO |
| Public Guardian and Trustee | PGT |
| *Substitute Decisions Act* | SDA |
| Substitute Decision Maker | SDM |

# Appendix C

## Quick Guide to Applications to the Consent and Capacity Board[510] provided for in the *Mental Health Act* and the Health Care Consent Act[511]

| Form | Title | Legislative Reference | Statutory Parties[512] | Notes |
|---|---|---|---|---|
| Form 16 | Application to the Board to Review a Patient's Involuntary Status | s.39(1) of the MHA | • patient<br>• usually the attending physician | |
| Form 17 | Notice to the Board of the Need to Schedule a Mandatory Review of a Patient's Involuntary Status | s.39(4) of the MHA | • patient<br>• usually the attending physician | |
| Form 18 | Application to the Board for a Review of a Finding of Incapacity to Manage Property | s.60 of the MHA | • patient<br>• usually the attending physician | |
| Form 19 | Application to the Board for an Involuntary Patient's Transfer to Another Psychiatric Facility | s.39.2 of the MHA | • the patient<br>• the officer in charge of the patient's current psychiatric facility<br>• the officer in charge of the psychiatric facility to which transfer is being sought<br>• any other person who has required the hearing<br>• any other person who has applied to the Board for a hearing on behalf of the patient<br>• the Minister is entitled to be heard at the hearing and may be a party | |

510 The applications listed are those that may be brought under the Health Care Consent Act and Mental Health Act. The Board all has jurisdiction to hear specific applications under the *Personal Health Information Protection Act* and the *Substitute Decisions Act*.

511 The legislative references to the HCCA applications are to the treatment provisions of Part II of the HCCA. Please note that these forms also apply to Part III (Admission to a Care Facility) and Part IV (Personal Assistive Services).

512 s. 42 of the MHA provides that the attending physician, the patient or other person who has required the hearing and such other persons as the Board may specify are parties to proceedings before the Board. The parties listed in this column are the most common parties to these applications, and as provided within the section of the MHA relating to application.

| Form | Title | Legislative Reference | Statutory Parties[512] | Notes |
|---|---|---|---|---|
| Form 25 | Application to the Board to Review the Status of an Informal Patient who is a Child between 12 and 15 Years of Age | s.13(1) of the MHA | • patient<br>• usually the attending physician | |
| Form 26 | Notice to the Board of the Need to Schedule a Mandatory Review of the Informal Patient who is a Child between 12 and 15 Years of Age | s.13(2) of the MHA | • patient<br>• usually the attending physician | |
| Form 48 | Application to Board to Review Community Treatment Order<br>and<br>Notice to Board by Physician of Need to Review Community Treatment Order | s.39.1(1) of the MHA<br>and<br>s.39.1(4) of the MHA | • the person who is the subject of the CTO<br>• the physician who issued the CTO<br>• patient<br>• any other person who has required the hearing<br>• any other person required for the hearing<br>• such other persons as the Board may specify are parties | |
| Form A | Application to the Board to Review a Finding of Incapacity | s. 32 of the HCCA<br>s. 37.1 of the HCCA when it is a "deemed" application | • the person applying for the review<br>• the health practitioner (usually the attending physician)<br>• any other person the Board specifies | In situations in which there is a "deemed" Form A application, this will proceed unless the person's capacity to consent to the proposed treatment has been determined by the Board in the previous 6 months. |

| Form | Title | Legislative Reference | Statutory Parties[512] | Notes |
|---|---|---|---|---|
| Form B<br>Form C | Application to the Board to Appoint a Representative | s.33(1)(2) of the HCCA | • the incapable person<br>• the proposed representative<br>• every person described in paragraphs 4, 5, 6 or 7 of s. 20(1) of the HCCA<br>• the health practitioner who proposed the treatment (usually the attending physician)<br>• any other person the Board specifies | The Form B is the application as brought by the patient and the Form C is the application brought by the proposed representative<br>There is a deemed Form A application to review the capacity of the person, prior to consideration of the Form B or C. |
| Form D | Application to the Board for Directions | s.35 of the HCCA | • the substitute decision maker<br>• the incapable person<br>• every person described in paragraphs 4, 5, 6 or 7 of s. 20(1) of the HCCA<br>• the health practitioner who proposed the treatment (usually the attending physician)<br>• any other person the Board specifies | The Form B is the application as brought by the patient and the Form C is the application brought by the proposed representative<br>There is a deemed Form A application to review the capacity of the person, prior to consideration of the Form D. |
| Form E | Application to the Board for Permission to Depart from Wishes | ss.36 of the HCCA | • the substitute decision maker<br>• the incapable person<br>• the health practitioner who proposed the treatment (usually the attending physician)<br>• any other person the Board specifies | There is a deemed Form A application to review the capacity of the person, prior to consideration of the Form E. |
| Form F | Application to the Board with Respect to Place of Treatment | s.34 of the HCCA | • the person who is applying for the review<br>• the person who consented to the admission<br>• the health practitioner who proposed the treatment (usually the attending physician)<br>• any other person the Board specifies | There is a deemed Form A application to review the capacity of the person, prior to consideration of the Form F. |

| Form | Title | Legislative Reference | Statutory Parties[512] | Notes |
|---|---|---|---|---|
| Form G | Application to the Board to Determine Compliance with s. 21 | s.37 of the HCCA | • the health practitioner who proposed the treatment (usually the attending physician)<br>• the incapable person<br>• the substitute decision maker<br>• any other person the Board specifies | There is a deemed Form A application to review the capacity of the person, prior to consideration of the Form G. |
| Form H | Application to the Board to Amend the Conditions of or Terminate the Appointment of a Representative | ss.33(7) (8) of the HCCA | • the person bringing the application<br>• the incapable person<br>• the representative<br>• the health practitioner who proposed the treatment (usually the attending physician)<br>• any other person the Board specifies, which may include those described in paragraphs 4, 5, 6 or 7 of s. 20(1) of the HCCA | There is a deemed Form A application to review the capacity of the person, prior to consideration of the Form H. |

# Appendix D

## Quick Guide to Forms under the *Mental Health Act*[513]

| Form | Title | Legislative Reference | Notes |
|---|---|---|---|
| Form 1 | Application By Physician for Psychiatric Assessment | s. 15 MHA | Form 1 authorizes apprehension and detention for up to 72 hours in a psychiatric facility for purposes of psychiatric assessment.<br><br>Form 42 (Notice to Person) is required. |
| Form 2 | Order for Examination | s.16 MHA | Form 2 is an order from a Justice of the Peace that authorizes police officers to bring in an individual for psychiatric examination. |
| Form 3 | Certificate of Involvement Admission | s.20 MHA | Form 3 is completed on involuntary admission to a psychiatric facility and may have authority for up to two weeks.<br><br>Form 30 (Notice to Patient) and Form 50 (Confirmation of Rights Advice) are required.<br><br>Form 16[514] is the related application to the Board. |
| Form 4 | Certificate of Renewal | s.20 MHA | Form 4 renews involuntary admission to a psychiatric facility, if completed prior to expiry of Form 3, and may have authority for one, two, or three months, depending on whether it is a first, second or third / subsequent renewal.<br><br>Form 30 (Notice to Patient) and Form 50 (Confirmation of Rights Advice) are required with each Form 4.<br><br>Form 16 is the related application to the Board unless it is a mandatory review on a 4th Form 4, in which case a Form 17 is used.[515] |
| Form 5 | Change to Informal or Voluntary Status | s.20(7) MHA | Form 5 indicates a change from involuntary status to informal or voluntary status. |

513 Some forms are "Ministry approved" and others set out in regulations to the *Mental Heath Act*. For a complete listing of all forms, with "fill and print" or "view and print" features, go to: http://www.health.gov.on.ca/en/public/forms/mental_fm.aspx. This Appendix does not include the forms listed in Appendix "C".

514 See Appendix "C".

515 *Ibid.*

| Form | Title | Legislative Reference | Notes |
|---|---|---|---|
| Form 6 | Order for Attendance for Examination | s.21(1) MHA | Form 6 is an Order from a judge for psychiatric examination, when an individual is charged with, or convicted of, a criminal offence, and is suspected of suffering from a mental disorder. |
| Form 7 | Confirmation to Informal or Voluntary Status | s.48(12) MHA | Form 7 shall be filled out by the patient's attending physician when involuntary status comes up for renewal while a current Form 3 or 4 is under appeal; patient may not challenge involuntary status while appeal is pending. |
| Form 8 | Order for Admission | s.22(1) MHA | Form 8 is an Order obtained from a judge for involuntary admission to psychiatric facility, when an individual is charged with a criminal offence and is suspected of suffering from a mental disorder; valid for a maximum of 2 months. |
| Form 9 | Order for Return | s.28 MHA | Form 9 is an Order issued by the Officer-in-Charge of a psychiatric facility when a person who is subject to detention is absent without leave.<br><br>Must be issued within one month of patient's absence and authorizes police officers to apprehend the person for return to the facility. |
| Form 10 | Memorandum of Transfer | s.29 MHA | Form 10 is a memorandum from one psychiatric facility to another. |
| Form 11 | Transfer to a Public Hospital | s.30 MHA | Form 11 is the authorization by the officer in charge of a psychiatric facility for a patient to be transferred for the purpose hospital treatment that cannot be provided at the psychiatric facility. |
| Form 13 | Order to Admit a Person Coming into Ontario | s.32 MHA | Form 13 is an order by the Minister for a person coming into Ontario to be taken into custody and admitted to a psychiatric facility.<br><br>Form 42 (Notice to Person) is required. |
| Form 15 | Statement of Attending Physician | s.35(6) | Form 15 is a written statement from physician that disclosure, transmittal or examination of a record of personal health information is likely to result in harm to the treatment or recovery of the patient, or injury to the mental or physical condition of a third person. |

| Form | Title | Legislative Reference | Notes |
|---|---|---|---|
| Form 21 | Certificate of Incapacity to Manage One's Property | s.54(4) | Form 21 is certificate to reflect a finding of incapacity with respect to managing property while an in-patient at a psychiatric facility.<br><br>Form 33 (Notice to Patient) and Rights Advice (confirmed by Form 50) are required, as well as a Form 22.<br><br>Form 18 is the related application to the Board.[516] |
| Form 22 | Financial Statement | s.55 | Form 22 is used to transmit information to the PGT when a Form 21 is issued. |
| Form 23 | Notice of Cancellation of Certificate of Incapacity to One's Property | s.56 | Form 23 is used to cancel a certificate of incapacity to manage property. |
| Form 24 | Notice of Continuance of Certificate | s.57(2) | Form 24 is used to inform a patient that he or she continues to be incapable of managing property upon discharge from a psychiatric facility.<br><br>Form 33 (Notice to Patient) and Form 50 (Confirmation of Rights Advice) are required, as well as a Form 22.<br><br>Form 18 is the related application to the Board.[517] |
| Form 27 | Notice by Officer-in-Charge to a Child who is between 12 and 15 Years of Age, who is an Informal Patient | s.38(6) | Form 27 notifies the Officer-in-Charge that a child is entitled to a hearing before the Board.<br><br>Form 50 (Confirmation of Rights Advice) is required.<br><br>Forms 25 and 26 are the related applications to the Board.[518] |
| Form 30 | Notice to Patient | s.38(1) | Form 30 constitutes written notice to the patient when a certificate of involuntary admission is completed.<br><br>If the certificate is a fourth Form 4, then a Form 19 is attached.[519]<br><br>See comments for Form 3 and Form 4. |

516 *Ibid.*
517 *Ibid.*
518 *Ibid.*
519 *Ibid.*

| Form | Title | Legislative Reference | Notes |
|---|---|---|---|
| Form 33 | Notice to Patient | Clause 15(1)(a) of Regulation 741, to the MHA.<br><br>s.59 MHA<br><br>Clause 15.1(a) of Regulation 741, to the MHA. | Form 33 constitutes written notice to the patient of a finding of:<br>• incapacity with respect to treatment of a mental disorder<br>• incapacity to manage property, or<br>• incapacity with respect to collection, use, or disclosure of personal health information.<br><br>Form 50 (Confirmation of Rights Advice) is required.<br><br>Forms A, 18 and P-1 are the related applications to the Board.[520] |
| Form 42 | Notice to Person | s. 38.1 MHA | Form 42 constitutes written notice for a Form 1 or Form 13.<br><br>See related comments for Form 1 and Form 13. |
| Form 45 | Community Treatment Order | s.33.1 MHA | Form 45 is the CTO. Copy must be given to patient.<br><br>Form 50 (Confirmation of Rights Advice) and Form 46 (Notice to Person) are required. |
| Form 46 | Notice to Person of Issuance or Renewal of Community Treatment Order | s.33.1(10) MHA | Form 46 constitutes written notice to a person that they are subject to the CTO, and confirms right to apply to Board.<br><br>See comments for Form 45. |
| Form 47 | Order for Examination | ss.33.3(1), 33.4(3) MHA | Form 47 is issued for a violation of the terms of a CTO; authorizes police officers to apprehend patient and return him or her to psychiatric facility. |
| Form 49 | Notice of Intention to Issue or Renew Community Treatment Order | s.33.1(4), 33.1(8) | Form 49 constitutes written notice to patient that their CTO is going to be renewed.<br><br>Form 50 (Confirmation of Rights Advice) is required. |
| Form 50 | Confirmation of Rights Advice | ss.59, 33.1(4)(e) MHA | Form 50 confirms patient was given rights advice.<br><br>See comments for Form 3, Form 4, Form 21, Form 24, Form 27, Form 30[521], Form 33, Form 45 and Form 49. |

520 *Ibid.*, with the exception of the Form P-1, which is an application under the *Personal Health Information Protection Act*, 2004.

521 The Form 30 notice on a fourth certificate of renewal is significant as it advises of the right to apply for a transfer to another facility and attaches the Form 19.

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