MENTAL HEALTH LAW IN ONTARIO:
AN OVERVIEW

FINAL REPORT

GAIL CZUKAR

&

DYKEMAN DEWHIRST O’BRIEN LLP

June 15, 2013
TABLE OF CONTENTS

TABLE OF CONTENTS........................................................................................................... 2

EXECUTIVE SUMMARY ........................................................................................................ 8
  Report Overview .................................................................................................................. 8
  Materials Reviewed .......................................................................................................... 9
  Key Recommendations .................................................................................................... 9

Introduction ......................................................................................................................... 11

Consultants .......................................................................................................................... 12

Methodology ....................................................................................................................... 12

CHAPTER 1 - INVOLUNTARY ADMISSION TO HOSPITAL ........................................... 14
  Overview/Summary .......................................................................................................... 14
  How the legislation works: the committal provisions ....................................................... 15
    Application for Psychiatric Assessment by a Physician (Form 1) .................................. 17
    Order of Justice of the Peace (Form 2) ........................................................................ 18
    Police Powers .............................................................................................................. 18
  Assessment & Admission ............................................................................................... 19
  Substitute Consent for Involuntary Admission (“Informal admission”) ......................... 20
  Community Treatment Orders (“CTOs”) ................................................................. 20
  Criminal Committal & Treatment ............................................................................... 21
  Review of Committal by Board and Courts ............................................................... 21
  How the legislation has changed: Amendments ......................................................... 22
    Policy intent of the legislation & amendments ......................................................... 26
    Role of the Charter ..................................................................................................... 27
  Issues ............................................................................................................................... 28
    Refusal of admission ................................................................................................. 28
    Interpretation of “Serious Bodily Harm” & “Serious Physical Impairment” .......... 28
    Mental or Physical Deterioration (“Box B” criteria) ................................................. 30
    Availability of hospital services .............................................................................. 31
    Early release .............................................................................................................. 32
    Admission of an Incapable Person .......................................................................... 33
  Conclusion ...................................................................................................................... 33

CHAPTER 2 - TREATMENT: CONSENT, CAPACITY AND SUBSTITUTE DECISION-MAKING ................................................................. 34
  Overview/Summary ......................................................................................................... 34
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent to treatment</td>
<td>35</td>
</tr>
<tr>
<td>Capacity for decision-making</td>
<td>36</td>
</tr>
<tr>
<td>Substitute decision-makers</td>
<td>37</td>
</tr>
<tr>
<td>How the legislation works</td>
<td>39</td>
</tr>
<tr>
<td>Requirement of Capacity to Consent</td>
<td>39</td>
</tr>
<tr>
<td>Presumption of Capacity</td>
<td>40</td>
</tr>
<tr>
<td>Meaning of Capacity</td>
<td>40</td>
</tr>
<tr>
<td>Requirements for Valid Consent</td>
<td>42</td>
</tr>
<tr>
<td>Substitute Decisions for Incapable Person</td>
<td>42</td>
</tr>
<tr>
<td>Emergency Treatment without Consent</td>
<td>43</td>
</tr>
<tr>
<td>Rights to Review and Appeal</td>
<td>44</td>
</tr>
<tr>
<td>The policy intent of the legislation</td>
<td>47</td>
</tr>
<tr>
<td>Issues</td>
<td>49</td>
</tr>
<tr>
<td>Separation of committal and capacity to consent to treatment</td>
<td>49</td>
</tr>
<tr>
<td>Prior capable wishes (right to be free of unwanted treatment)</td>
<td>49</td>
</tr>
<tr>
<td>Delays in Legal Processes</td>
<td>51</td>
</tr>
<tr>
<td>CHAPTER 3 - PRIVACY</td>
<td>53</td>
</tr>
<tr>
<td>Overview/Summary</td>
<td>53</td>
</tr>
<tr>
<td>Policy intent of the legislation</td>
<td>53</td>
</tr>
<tr>
<td>Personal health information and individual autonomy</td>
<td>53</td>
</tr>
<tr>
<td>How the legislation works: the provisions</td>
<td>56</td>
</tr>
<tr>
<td>Scope of PHIPA</td>
<td>56</td>
</tr>
<tr>
<td>Consent</td>
<td>57</td>
</tr>
<tr>
<td>Capacity</td>
<td>58</td>
</tr>
<tr>
<td>Issues</td>
<td>59</td>
</tr>
<tr>
<td>Who “needs to know”?</td>
<td>59</td>
</tr>
<tr>
<td>Limitations on collection and use</td>
<td>63</td>
</tr>
<tr>
<td>Disclosure in risk situations</td>
<td>65</td>
</tr>
<tr>
<td>Lockbox</td>
<td>67</td>
</tr>
<tr>
<td>Conclusion</td>
<td>68</td>
</tr>
<tr>
<td>CHAPTER 4 - CHILDREN’S MENTAL HEALTH</td>
<td>69</td>
</tr>
<tr>
<td>Overview/Summary</td>
<td>69</td>
</tr>
<tr>
<td>How the legislation works: the provisions</td>
<td>70</td>
</tr>
<tr>
<td>Health Care Consent Act</td>
<td>70</td>
</tr>
</tbody>
</table>
Mental Health Act ........................................................................................................ 74
Child and Family Services Act ...................................................................................... 76
Issues ............................................................................................................................... 80
Protecting the Personal Health Information of Children ........................................ 82
Youth Criminal Justice Act ............................................................................................. 84
Conclusion ........................................................................................................................ 86
CHAPTER 5 – OTHER JURISDICTIONS ............................................................................ 88
Introduction ....................................................................................................................... 88
Canada .............................................................................................................................. 88
British Columbia ............................................................................................................. 89
Admission ......................................................................................................................... 89
Capacity and Consent to Treatment ............................................................................... 91
Substitute Decision-Making ............................................................................................ 92
Children ........................................................................................................................... 92
Alberta ............................................................................................................................... 93
Admission ......................................................................................................................... 93
Capacity and Consent to Treatment ............................................................................... 93
Substitute Decision-Making ............................................................................................ 94
Children ........................................................................................................................... 95
Saskatchewan .................................................................................................................... 95
Admission ......................................................................................................................... 95
Capacity and Consent to Treatment ............................................................................... 96
Long-Term Detention ...................................................................................................... 98
Children ........................................................................................................................... 98
Manitoba .......................................................................................................................... 98
Admission ......................................................................................................................... 99
Capacity and Consent to Treatment ............................................................................... 99
Children ........................................................................................................................... 100
Quebec ............................................................................................................................. 100
Admission ......................................................................................................................... 100
Capacity and Consent to Treatment ............................................................................... 101
Children ........................................................................................................................... 101
Newfoundland and Labrador ......................................................................................... 102
Admission ......................................................................................................................... 102
EXECUTIVE SUMMARY

The mental health regime in Ontario is complex. It is governed by several different statutes that have each evolved over time to reflect changing attitudes to mental health and shifting policy intents. This Report provides a comprehensive description and analysis of the regime’s legislation – the Mental Health Act,¹ Health Care Consent Act,² Personal Health Information Protection Act,³ Substitute Decisions Act⁴ and to a lesser extent, the Child and Family Services Act⁵ and Youth Criminal Justice Act.⁶ It describes key mental health law provisions in all other Canadian jurisdictions and select international jurisdictions. It concludes with a chapter on implications for policy, strategy and research in Ontario.

Report Overview

The Ontario law and issues are canvassed in the first four chapters of the Report. Each of these chapters is divided into an overview section, followed by a description of how the legislation works, the major case law relevant to the topic, and finally, an analysis of the law as it applies to key issues.

Chapter 1: This chapter discusses involuntary hospital admission for adults

Chapter 2: This chapter outlines the consent to treatment regime, including substitute decision-making and how it affects admission and treatment

Chapter 3: This chapter reviews the collection, use and disclosure of personal health information related to admission and treatment, with some discussion of consent for information-sharing

Chapter 4: This chapter outlines the framework applicable to children with mental health issues including information-sharing

Chapter 5 of the Report summarizes statutes and seminal case law on admission, capacity and consent, substitute decision-making and children’s mental health in select other jurisdictions. This information provides some assistance in considering alternatives to Ontario’s current provisions as well as actions in the realms of policy, strategy and

¹ Mental Health Act, R.S.O. 1990, c. M.7 (“MHA”).
research which could effectively reduce some of the barriers identified by the all-party Select Committee of the Ontario Legislature\(^7\) (the “Select Committee” or “Committee”).

**Chapter 6** concludes with suggestions for policy, strategy and research directions which may be useful in addressing some of the problems identified in the Select Committee report.

**Materials Reviewed**

Statutes, case law, secondary sources such as Hansard debates, scholarly articles, published and unpublished dissertations, mental health reform reports since the 1980s that have recommended legislative changes (e.g., Heseltine, Graham Report), media reports as well as various exhibits placed before the Select Committee were reviewed. A more detailed methodology is set out on pages 12 and 13 of the Report.

**Key Recommendations**

The province may or may not opt to undertake a new policy direction with respect to the management and delivery of mental health services and the intersection with treatment and consent. Changing the current regime in any substantial way will be the work of months, if not years. In the meantime, patients, families and substitute decision-makers (“SDMs”) will have to utilize and navigate the current system. For that reason, and for the immediate short term, the Report makes the following four key recommendations:

**Recommendation 1:** Improve access to information and educational opportunities for patients, families and health practitioners about the laws, their interpretation and application

**Recommendation 2:** Provide educational opportunities for physicians and other health practitioners about how to communicate treatment options to persons with mental illness, SDMs and families

**Recommendation 3:** Continued investment and support in providing a comprehensive range of community services and supports

---

**Recommendation 4:** Continue to invest in research, particularly to increase choice of treatment medications (with emphasis on those whose efficacy is not outweighed by debilitating side effects)
Introduction

In response to a request for proposal (“RFP”) issued by the Ontario Mental Health Foundation, Dykeman Dewhirst O’Brien LLP and Gail Czukar (together, the “Consultants”) submitted a proposal to provide a report (“Report”) that details many of the issues covered by the all-party Select Committee. In its deliberations, the Committee concluded that:

- Barriers are experienced by families in accessing hospital admission and treatment for relatives, and families have been told by health professionals that these barriers are related to legislation pertaining to involuntary committal;
- Ontario’s mental health laws are applied “flexibly” by medical and legal experts to ensure clients receive treatment;
- Although courts, including the Supreme Court of Canada, have interpreted the “bodily harm” criterion in the committal criteria to include psychological harm, this interpretation is neither widely known, nor practised;
- Other jurisdictions named in the Select Committee Report have broader involuntary admission criteria which may go some distance towards solving these problems, without unduly jeopardizing autonomy of patients;
- Too many individuals are receiving care as a result of contact with the criminal justice system;
- Families find it difficult to get information about the care and treatment of their family members, and these difficulties are believed to stem from Ontario’s health privacy legislation, PHIPA; and
- Involuntary detention and treatment of children and youth “in need of protection” under the CFSA is governed by an entirely different framework than adult mental health committal; as such, there are gaps in the children/youth legal framework, including with respect to information-sharing.

This Report is written to provide the current state of the Ontario laws and related developments here and in other jurisdictions on the issues set out above. The Consultants’ preliminary analysis has focused on a review of the intersection between the MHA, HCCA, PHIPA, SDA and to the extent applicable, the CFSA and YCJA.

The purpose of this review is to investigate the application of Ontario’s mental health legislation pertaining to involuntary admission and treatment and to identify barriers, if any, created by health privacy and other relevant information-sharing provisions in select Ontario laws. It will touch briefly on constitutional implications that may arise if significant changes were made to the present laws.
Consultants

Dykeman Dewhirst O’Brien LLP (“DDO”) is a boutique health law firm in Toronto. Gail Czukar is a consultant and lawyer with senior management experience in a major mental health and addictions hospital. The work for this project was completed under the leadership of Mary Jane Dykeman and Gail Czukar, with the support of Sharon Walker, DDO Health Law Counsel and Lisa Feldstein, then a DDO Associate. The Consultants bring significant mental health and legal experience to this initiative, and have particular strengths in health privacy law, mental health and addictions, the broader health system and the framework within which health care organizations operate.

Methodology

We have reviewed and provided a plain language description and analysis of the legal provisions in the Acts that are relevant to the issues set out above, including how these provisions are intended to work together.

We have provided a summary of the major jurisprudence interpreting provisions related to:

- Involuntary civil admission for adults
- Consent to treatment, including substitute decision-making and how it affects admission and treatment
- Information-sharing related to admission, treatment and consent

A review was undertaken of the MHA amendments since 1978, Hansard debates on these changes, and major mental health reform reports since the 1980s that have recommended legislative changes (e.g., Heseltine, Graham Report, and others). We have also reviewed various exhibits placed before the Select Committee.

In the Report we summarize:

a. Proposed or recommended revisions, and the policy issues which gave rise to the proposals;
b. Amendments which became law;
c. Legal and policy issues raised by the Charter of Rights and Freedoms, with particular attention to the right to be free of unwanted treatment;

---

8 DDO would like to thank Stephanie Abu-Jazar, then a DDO intern and law student at the University of Ottawa, for her assistance on this project.
d. Legislative amendments that were made in response to mental health law issues raised by the Charter;

e. The mental health legislative policy issues addressed in Charter jurisprudence; and

f. The rationale underlying the substitute decision-making provisions in the SDA.

We also briefly review and comment on the detention and secure treatment of children and youth in Ontario under the CFSA in contrast to the legislation mentioned above.

We provide a description of the statutes and seminal case law on civil committal, treatment and substitute decision-making including in select jurisdictions named in the RFP (i.e., British Columbia, Nova Scotia and, to the extent practical, Norway and the Netherlands), as well as others across Canada.

Finally, we consider potential amendments to Ontario’s mental health laws, the barriers these could eliminate and the likely results of such changes.
CHAPTER 1 - INVOLUNTARY ADMISSION TO HOSPITAL

Overview/Summary

1. How the legislation works: the committal provisions
2. How the legislation has changed: amendments
3. Policy intent of the legislation & amendments
4. Issues

Overview/Summary

Ontario law permits the involuntary hospital admission of a person suffering from a mental disorder that poses a risk of harm to self or others, or is deteriorating to the point of serious physical impairment. A person may also be involuntarily hospitalized if he or she has previously had mental illness, has been treated with positive results, and is deteriorating once again.

When a person is taken to hospital by family members, mental health workers, police officers or others, the physician at the hospital uses clinical judgment as well as knowledge of the law to decide whether the ill person can or cannot be held against his or her will, once certain criteria are met. When a clinical decision is made that the person cannot be held in hospital, it is sometimes attributed to the law (“I’m sorry I can’t admit your son - it’s because of the Mental Health Act”).

Mental health legislation permits society’s intervention based on the behaviour and state of mind of the individual, balancing this against the individual’s freedom. In some cases, a physician must explain to a concerned family member that a loved one simply does not meet the clinical threshold established under the MHA for a psychiatric assessment, or that even after having undergone an assessment; the criteria for involuntary hospitalization have not been met. This chapter explains the law that applies to examinations, assessments and admission to hospital in Ontario, otherwise known as the “committal” process.

Mental health law has been the subject of polarized views for a long time. However, the law of Ontario regarding mental health is well settled. Common misunderstandings about the committal criteria sometimes result in the law being misconstrued or misapplied in practice. Generally speaking, physicians and hospital staff receive some
education about this law and how it should be applied, but the depth, scope and frequency of that training may vary across professions and settings.

Questions have been raised about whether the law could be changed so that the need for treatment, or potential to benefit from treatment, can be made a more compelling consideration in involuntary committal of a person, in addition to prevention of harm to self or others. Arguably, expansion of the committal criteria in the year 2000 was a step in this direction, but did it go far enough? To change the MHA in this direction would require a very significant shift away from the current policy emphasis in Ontario law on autonomy and respect for individual liberty, and the adoption of a protectionist or welfare approach. The protectionist approach, known legally as the *parens patriae* doctrine, whereby the state (historically, the King) is responsible for looking after vulnerable citizens, has been expressly rejected in the mental health law of Ontario and many other common law jurisdictions. In the past decades, a human rights approach has empowered individuals to use the law to look after themselves, supported by services and programs funded largely by the state.

By and large, the law in Ontario deals with consent to treatment separately from admission, on the basis that consent is a requirement for treatment of all patients by all health practitioners. People with mental illness are subject to the same consent or capacity requirements as people with any other kind of illness. The law of capacity, consent and substitute decision-making is discussed in Chapter 2 of this Report.

**How the legislation works: the committal provisions**

When a person is ill but does not seek help, a family member, friend, community mental health worker, police officer, or anyone else who is concerned has several courses of action open to them. They can try to persuade the person to see his or her family physician or another health practitioner, or to connect with a community mental health or addiction program. If this fails, they can seek the person’s involuntary examination and assessment, which could ultimately lead to admission to hospital.

Detention is usually only authorized under the law when a person is suspected of having committed an illegal act. For this reason, mental health law carefully specifies how and under what circumstances a person can be forcibly taken to a hospital and admitted when he or she resists such admission. The person is not being “arrested” as he or she would be under criminal law. That said, detaining and forcibly confining persons against their will, even for a well-intentioned purpose, is a serious infringement of personal freedom and liberty. It is illegal, unless authorized by law,
and the law which authorizes detention itself must meet strict due process and other constitutional requirements.

Admission is a two-stage process: it consists of an examination of the person, followed by an assessment. Persons who are accepted for assessment may be held and assessed for up to 72 hours in hospital against their will, without recourse to any legal review. There is no right of appeal to the Consent and Capacity Board for review of a Form 1 application for psychiatric assessment (“Form 1” or “APA”), although failure to adhere to the requirements related to the Form 1 may or may not be the basis for a Form 3 later being found invalid.11

The concerned family member, community worker, or anyone else may take the person to a physician who will examine the person and may complete a Form 1 under the MHA within 7 days of having seen the person. In the alternative, anyone can go to a justice of the peace and ask him or her to order the person to be taken to hospital for examination.12 In either case, the family, friend, or community mental health program worker will often enlist the assistance of police in taking a person to the hospital. In addition to a signed Form 1 or Form 2 being sufficient authority for police to find and take the person to a Schedule 1 psychiatric facility, police may rely on their own statutory authority to take the person to hospital if the person meets certain criteria (described below).13 As a practical matter, most examinations by physicians take place in a hospital emergency room after the person has been transported there by police.

Two situations can result in the person being taken to hospital for an assessment. These can be referred to, very generally, as the immediate situation (“Box A”) and the deterioration situation (“Box B”). With respect to Box A, the immediate situation, the three aspects that must be taken into account are: (1) the individual’s behaviour (is he or she acting threateningly or violently or showing incompetence in self-care); (2) whether the behaviour is caused by a mental disorder (“any disease or disability of the mind”);14 and (3) whether that mental disorder will likely result in serious bodily harm

11 By contrast, in S.C. (Re), 2005 CanLII 7113 (ON CCB), where the Form 3 was upheld despite a defect on its face, the panel stated with respect to whether a Form 3 is valid when a Form 1 is incomplete: “This is a controversial issue on which panels of the Board are divided; see, inter alia, Re S .M. (TO 020733, 755), Re G. M. (TO 031123), Re S. K. (TO 031454), Re C.A. (TO 030814), Re GJL (TO 030846), Re SSP (TO 030968), Re E.S. (TO 030998), Re O.L. (TO 030902), Re KLM (TO 021063), Re G. B. (TO 04-0189, 0190, 0191, 0212).”
13 MHA, s 17.
14 MHA, s 1.
(including psychological harm, although those words are not spelled out in the criteria but are the result of interpretation by the Supreme Court of Canada\textsuperscript{15}) to the person or another person, or serious physical impairment of the person. Under Box B, the person’s history of treatment and likelihood of deterioration are also taken into account. This will be described in more detail below.

**Application for Psychiatric Assessment by a Physician (Form 1)**

To make an APA, the physician who has examined the person must have “reasonable cause to believe” that the person is likely to cause harm to himself or herself or others\textsuperscript{16}, or is unable to take care of himself or herself\textsuperscript{17} and the physician must also form the opinion that the person has a “mental disorder”\textsuperscript{18} that likely will result in serious bodily harm to the person or another person, or serious physical impairment of himself or herself.\textsuperscript{19} The MHA requires the physician to link the observed behaviour of likely causing harm or being unable to care for oneself to the mental disorder as the cause, and it must be likely that the intended harm or impairment will occur within a reasonable time.\textsuperscript{20}

There are additional provisions for the “revolving door patient”, that is, the individual who improves in hospital with treatment, leaves the hospital and lives for a time successfully on his or her own, but eventually opts to discontinue treatment and as a result begins to deteriorate. Under these circumstances, the physician can make an APA under Box B, the deterioration situation, if certain criteria are met. The physician can consider the person’s history of treatment which resulted in clinical improvement\textsuperscript{21} and whether the person is likely to suffer substantial mental or physical

\textsuperscript{15}“Significant risk of serious bodily harm” includes both emotional and psychological harm. The CCB has adopted the definition of “serious bodily harm” from a SCC case in criminal law, 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.” (RE. J.S., 2004 CanLII 46818 (Ont.C.C.B.), adopting the definition in R. v. McCraw, [1991] 3 S.C.R. 72 at 81; emphases added).

\textsuperscript{16}“has threatened or is threatening or attempting to cause bodily harm to himself or herself” (MHA, s.15(1)(a); “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”(MHA, s 15(1)(b)).

\textsuperscript{17}“Has shown or is showing a lack of competence to care for himself or herself,” MHA, s 15 (1)(c).

\textsuperscript{18}Section 1(1) of the MHA defines “mental disorder” as “any disease or disability of the mind”.

\textsuperscript{19}MHA, s 15(1)(d)-(f).

\textsuperscript{20}With respect to the meaning of “reasonable time”, numerous Consent and Capacity Board cases, up to 2005, stated that “[t]he Act does not establish a required time period within which the likely serious bodily harm to oneself or another must take place, but arguably, it must be expected to occur within some reasonable time after the discharge so as to be connected to the illness. The amount of time after discharge for those prerequisites is somewhat flexible.” See, e.g., CP (Re), 2005 CanLII 1047 (ON CCB).

\textsuperscript{21}MHA, s (1.1)(a),(b).
deterioration if he or she does not receive treatment,\textsuperscript{22} in addition to the serious bodily harm to self or others, or serious physical impairment grounds under Box A. As well, the person’s mental disorder must be the same or similar to the one previously treated, the physician must have the opinion that the person is incapable of consenting to treatment, and the SDM’s consent must be obtained.\textsuperscript{23}

\textbf{Order of Justice of the Peace (Form 2)}

Sometimes the ill person will not agree to be examined by a physician (or no physician is available), and an order is sought from a justice of the peace ("JP") for the person to be taken by the police for an examination.\textsuperscript{24} The JP must consider information on oath or recorded information that meets the same criteria as the physician considers – threats or attempts to cause bodily harm to self or others, or lack of competence to care for self – and the JP must have reasonable grounds to believe that the person is apparently suffering from a mental disorder that will result in serious bodily harm or serious physical impairment.\textsuperscript{25} The JP can also consider sworn information under Box B, that the person has previously received treatment for an ongoing or recurring mental disorder that, if not treated, likely will result in serious harm to the person or others, or in substantial mental or physical deterioration or physical impairment, and that the person is apparently suffering from the same or similar mental disorder for which he or she was previously treated, that if untreated will likely cause harm to self or others or suffer substantial deterioration or impairment and that the person is apparently incapable of consenting to treatment.\textsuperscript{26}

\textbf{Police Powers}

A police officer can take a person to hospital for examination by a physician if the officer has reasonable and probable grounds to believe that a person has acted or is acting in a disorderly manner, has reasonable cause to believe that the person has threatened or attempted or is threatening or attempting to cause bodily harm or has behaved or is behaving violently toward another person or has caused or is causing another person to fear bodily harm, or is showing a lack of competence to care for himself or herself, and the officer if of the opinion that the person is apparently suffering from a mental disorder of a nature or quality that is likely to result in serious

\textsuperscript{22} “substantial mental or physical deterioration”, MHA, s 15(1.1)(a).
\textsuperscript{23} MHA, s 15(1)(c),(d),(e).
\textsuperscript{24} MHA, s 16(1).
\textsuperscript{25} MHA s 16(1).
\textsuperscript{26} MHA, s.16(1.1). In that instance, the consent of the SDM must have been obtained.
bodily harm to that person or someone else, or serious physical impairment. The police officer cannot consider the substantial physical or mental deterioration criteria; this category is reserved only for the physician considering a Form 1 or the JP considering the Form 2.

Assessment & Admission

A physician at the psychiatric or other health facility must observe and examine the person “forthwith” and within 72 hours, determine whether he or she should be released (which must occur if the person does not meet the criteria under the Act), admitted as an informal or voluntary patient, or admitted as an involuntary patient. The conditions to be met for involuntary admission are the same as the Box A and B conditions for an order for psychiatric assessment: the patient is suffering from a mental disorder that will likely result in serious bodily harm to the patient or another person, or serious physical impairment of the patient, or the patient is likely to suffer substantial mental or physical deterioration as a result of not being treated, is incapable of making treatment decisions, and the SDM has consented on behalf of the incapable patient. In addition, the patient is not suitable for voluntary or informal admission. An informal admission occurs when the SDM consents to the admission on behalf of the ill person under the HCCA.

The first certificate of involuntary admission (also known as “Form 3”) authorizes the person to be detained, restrained, observed and examined in a psychiatric facility for up to 2 weeks. Certificates of renewal (a “Form 4”) can be issued by an attending physician for one additional month, then two additional months, then three additional

---

27 MHA, s 17(1). Since the enactment of Bill 68 in December 2000 and resulting amendments to the MHA (2000, c. 9, ss. 1-30), police no longer need to observe the behaviours in question (i.e., only reasonable and probable grounds of past or current behaviour are now required, rather than observation of an individual behaving “in a normal person would be considered disorderly”). There is, however, a caveat in section 17 that permits the officer to act only where it would be dangerous to proceed under section 16 to seek a Form 2 from a Justice of the Peace. The section 17 changes were made largely as a result of the year 2000 inquest into the 1997 death of a young boy, Zachary Antidormi, at the hands of a person with mental illness.

28 MHA, ss 16(3) and 18.

29 The meaning of “forthwith” was considered in CB v Sawadsky [2005] OJ No 3682, aff’d [2006] OJ No 4050, 82 OR (3d) 661, application for leave to appeal to SCC dismissed, [2006] SCCA No 479. In that case, the court recognized the difficulty in determining precisely when an examination is conducted forthwith but accepted that the emergency department was busy and that patients brought in under the MHA are a priority.

30 A common misconception is that the person will be held for 72 hours, rather than up to 72 hours.

31 MHA, s 20(1)(a),(b),(c).

32 MHA, s 20(1.1) & (5).

33 MHA, s 1(1), HCCA, s. 24.

34 MHA, s 20(4)(a)
months, when the proper form is completed by the attending physician and filed with the officer in charge.  

An examination may also be ordered by a judge who believes that a person appearing before him or her charged with or convicted of an offence has a mental disorder. Likewise, if a judge has reason to believe that a person in custody who appears before the judge suffers from a mental disorder, the judge can order the person for admission as a patient in a psychiatric facility for up to two months. In both cases, the judge must have obtained agreement from the facility to which the person will be sent that the services of the psychiatric facility are available to the person named in the order.

Substitute Consent for Involuntary Admission (“Informal admission”)

If a person with a mental disorder who is not in hospital requires treatment but is found to be incapable of consenting to that treatment, the SDM who has the power to make the treatment decision can also consent to the person’s admission to hospital for that treatment. However, if the prospective patient is over 16 and objects to the admission, the SDM must have specific legal authority to consent to the admission decision.

Community Treatment Orders (“CTOs”)

Detailed requirements for the committal of persons for treatment in the community were enacted in Ontario in the year 2000. However, this report will not address this aspect since two dedicated government reviews have been completed to date with respect to CTOs.

---

35 MHA, s 20(4),(b)
36 MHA, s 1(1). The many roles of the officer in charge are ably captured in the Ontario Hospital Association’s “A Practical Guide to Mental Health and the Law in Ontario” (March 2009, updated October 2012), Ch. 3, p. 52.
37 MHA, s 21.
38 MHA, s 22.
39 MHA, s 23.
40 HCCA, s 24(1).
41 HCCA, s 24(2); viz., The SDM must be the guardian of the person with the power to consent to the admission, or a Power of Attorney for Personal Care with a special provision to use necessary but reasonable force to take the person to hospital.
42 MHA, ss 33.1-33.9.
43 MHA, s 33.9 requires such a review every five years. The first review was conducted by Dreezer & Dreezer in 2005 (www.eopa.ca/reports/CTO%20Review%20Report-English.pdf); the most recent report is by R.A. Malatest & Associates Inc. and is dated May 23, 2012, available on-line at the following link:
Criminal Committal & Treatment

If a person with a mental disorder is charged with a criminal offence, he or she may be found unfit to stand trial or not criminally responsible on account of mental disorder under the Criminal Code of Canada. A person who is found unfit can be ordered to receive treatment for up to 60 days; this is one of very few instances in Ontario where a person may be treated without consent.

Review of Committal by Board and Courts

Patients who are admitted as involuntary patients do not always agree with such decisions. A patient can apply to the Consent and Capacity Board ("the Board" or "CCB"), a specialized tribunal, to review the admission decisions (and continuation thereof) made by physicians. Unless the parties consent, the Board must hold a hearing within seven days after the day the Board receives the application and the patient has the right to be represented by counsel and to tell his or her own story. If the Board finds that the statutory requirements have not been met for the involuntary admission, the certificate is revoked and the patient is free to go. If the Board agrees with the physician’s decision, the certificate is upheld and the patient has the right to appeal to a court. Even if the patient does not appeal the Board’s decision, or seek review of subsequent Forms 4, the Board must hold a review on every fourth renewal certificate to determine whether the conditions for committal continue to be met.


44 Criminal Code of Canada, Part XX.1 ("CCC" or "Criminal Code"), s 672.1.
45 CCC, s 672.58.
46-48 Note also that under s. 5.1 of the Health Protection and Promotion Act, R.S.O. 1990, c. H.7, the HCCA does not apply to either a physician’s examination of a person pursuant to an order of a medical officer of health to submit to an examination by a physician; nor to a physician’s care and treatment of a person pursuant to an order under s. 5.1 requiring the person to place himself or herself under the care and treatment of a physician. A judge of the Ontario Superior Court may issue an order for treatment under s. 35(3)(c). Similarly, the Health Protection and Promotion Act requires neonatal eye prophylaxis to be administered to newborns, with a corresponding report to the medical officer of health by the health practitioner of non-compliance; a court may order its administration, and the HCCA does not apply, see s. 33.
47 MHA, s 39.
48 HCCA, s 75(1) & (2).
49 MHA, s 39(7) & HCCA, s. 73(3)(a), s. 73(4) and ss. 74 to 80 re procedure for hearings and appeals; the Statutory Powers Procedure Act, R.S.O. 1990, c. S.22, applies.
50 HCCA, s 80.
51 MHA, s 39(4).
This guarantees a time-limited review, even where a patient may be too ill, or merely disinclined, to pursue the review.

**How the legislation has changed: Amendments**

Amendments to the MHA since 1954 are summarized in Appendix 1. This section presents a brief overview of the changes and the policy rationale behind those changes.

In 1967 procedural provisions were added to the Act\(^{52}\) following an incident in which it became clear that the existing criteria were not sufficient - hospitalization was also necessary in the interests of safety.\(^{53}\) However, these new provisions were still quite arbitrary. In the 1970s, the Civil Liberties Association publicized the inadequate protections and arbitrary ways in which the MHA could be used to incarcerate people without much recourse to legal review.\(^{54}\) A 1973 study found that in over 80% of the certificates of involuntary committal, the required conditions were either not met or not documented properly, and that there was not much difference in this rate before and after the changes that were made in 1967.\(^{55}\) It appeared that nothing much had changed, and it was still possible to have people committed to psychiatric hospitals with little scrutiny.

This spurred another change, and major amendments were made to the Act in 1978\(^{56}\) amid much controversy among lawyers and psychiatrists. Patient rights advocates labelled involuntary committal as preventive detention, since a person was held in custody against his or her will without having committed a criminal offence. Lawyers asserted that committing persons in the interests of the safety of others required hard evidence, that is, a prediction of dangerousness. Even psychiatrists did not claim that they could predict a person’s dangerousness with sufficient certainty to meet a strict legal standard; they did not want to be held legally responsible for those judgments, although they did stand by their ability to form clinical opinions about mentally ill persons’ prospective dangerousness.\(^{57}\) Some 35 years later, assessments of the risk of

---

\(^{52}\) SO 1967, ss 27-30.
\(^{55}\) Ibid at 358.
\(^{56}\) An Act to amend the Mental Health Act, SO 1978, c 50.
\(^{57}\) The amendments were introduced on March 2, 1978 by then Minister of Health Dennis Timbrell. The Hansards of May 9, 14, 15 and 16, 1979 before the Social Development Committee, address closures of one mental health facility and the construction of another, with a focus on the need for committal criteria and services to support mentally ill individuals.
dangerousness remain challenging, despite the creation of multiple tools and emerging methodologies.\(^{58}\)

In the end, the criteria for hospitalization were changed from “in the interests of his own safety or the safety of others” to likelihood of causing “serious bodily harm” or “imminent and serious physical impairment”. The lack of competence to care for oneself was introduced. Justices of the peace and police officers had to have “reasonable cause to believe” that a person was likely to be a danger to self or others, and not merely be “satisfied that the person should be examined in the interests of safety”, thus adding an objective evidence requirement.\(^{59}\) Procedural safeguards were added in the requirement that different physicians had to perform the initial assessment (Form 1) and the examination leading to a certificate of involuntary admission (Form 3), so that there would be an independent assessment. The initial detention (without review) was limited to 120 hours (5 days) and the initial committal period was reduced to two weeks from one month. Perhaps most significantly, a section was added requiring consent to treatment and a substitute consent from “a nearest relative” if the patient was not mentally competent. Confidentiality of clinical records was also added to the MHA at this time.\(^{60}\)

In 1986 and 1987, further changes were made to bring the MHA into compliance with the *Charter*,\(^ {61}\) principally with respect to procedures to ensure that section 7 and 9 liberties would be protected by *Charter*-compliant due process.

With respect to the *Charter* issues, the power of the review board was modified so that it could not override the treatment consent nor refusal of treatment by patients who were competent. The substitute decision-making provisions were strengthened and broadened to apply to all incompetent patients, not solely to involuntary incompetent patients, and rules were added to clarify how physicians should proceed in particular situations. Treatment could be authorized by the review board for incompetent people if the SDM consented and the physicians certified that there was danger to life, limb or a vital organ. Psychosurgery and electro-convulsive shock therapy (“ECT”) were

---

\(^{58}\) Various academics and authors cite at least three approaches: actuarial (empirical), including the Violence Risk Appraisal Guide (Harris, Rice, Quinsey et al.); clinical - based on consideration which involves clinical judgment of risk cues (see Odeh et al., “Cues they use: clinicians’ endorsement of risk cues in predictions of dangerousness” Behavioral Sci Law 2006;24(2):147-156); and the more recent hybrid, a structured clinical approach (including the HRD-20).

\(^{59}\) MHA, ss 16 and 17.

\(^{60}\) MHA, s 29

excluded from treatment for involuntary patients. Prior capable wishes were to guide the treatment decision of the SDM, or, if no prior capable wishes were known, best interest factors were the guiding considerations.

Provisions were also added allowing children between 12 and 15 years of age to apply to review boards for review of their committal by a parent; prior to this, such review was not allowed and any parent or person standing in loco parentis (such as a Children’s Aid Society) could commit a child without any recourse to review. References to the “age of majority” were replaced with “16 years of age”.

The provisions regarding access to records were changed to include further procedural protections. The requirement for the review board to hold hearings within seven days and other procedures of the review board to review findings of incompetency as well as committal were added at this time. The Act was also amended to make explicit provision for rights advice, access to representation by Legal Aid supported legal counsel, and other protective features. More specific rules about substitute decision-making were also added.

In 1992, following a lengthy review of guardianship law and powers of attorney, the SDA and the Consent to Treatment Act were introduced to deal with substitute decision-making in many different circumstances. Many provisions from the MHA were incorporated into the new SDA and the Consent to Treatment Act for psychiatric patients. The Consent to Treatment Act applied to consent by all persons for whom treatment was proposed by a health practitioner, as well as other consent situations. The SDA also applied to people in long-term care facilities and other vulnerable situations. In 1996, the HCCA replaced the Consent to Treatment Act with substantially similar provisions. This legislation is dealt with in Chapter 2 of this Report.

In the year 2000, several major changes were made to the MHA. First, criteria were added to facilitate committal and treatment of chronically ill patients who experience

---

62 The Attorney-General’s Advisory Committee for Substitute Decision Making for Mentally Incapable Persons, commonly known as the Fram Committee in honour of its Chair, Stephen Fram, Senior Policy Lawyer at the Ontario Ministry of the Attorney General, was set up in 1984 with the mandate to review the law related to mental capacity and substitute decision making for mentally incapable adults and to make recommendations for reform of this law. The Committee released its report and recommendations in 1988.

63 SDA; Consent to Treatment Act, 1992, S.O. 1992, c. 31 (“CTA”).

64 CTA, s 2.

the so-called “revolving door” syndrome,\textsuperscript{66} and community treatment orders were added to the Act.\textsuperscript{67} The additional committal criteria were “substantial mental or physical deterioration” as a result of an ongoing or recurring mental disorder for which treatment had previously been effective (i.e., clinical improvement).\textsuperscript{68} The MHA required that the person be incapable of consenting to treatment and the SDM had consented to the treatment.\textsuperscript{69} The word “imminent” was removed in various parts of the Act, including from the “risk of serious physical impairment” ground for committal, thereby broadening the criteria as some physicians had interpreted “imminent” to mean “immediate”.\textsuperscript{70}

These changes were made in response to the murder of an Ottawa broadcaster, Brian Smith, by a person with a chronic mental illness.\textsuperscript{71} Mr. Smith’s death served as a precipitating event that allowed the government to respond to increasing demands by families and some mental health professionals to facilitate treatment of persons with ongoing or recurring serious mental illness.\textsuperscript{72} They said that the combined effect of tightly drawn committal criteria, SDMs being required to follow prior capable wishes of incapable patients, and lengthy procedural delays was resulting in seriously delayed treatment or no treatment at all for people with serious mental illness.\textsuperscript{73}

The argument was made by some that the increasing numbers of people with serious mental illness who were coming into hospital through the criminal justice system were a symptom of this failure of treatment in the civil mental health system.\textsuperscript{74} In their view, this doubly stigmatized people by hospitalization in a mental health facility and criminal justice involvement. The so-called “Box B” criteria and community treatment orders were seen to be potential solutions to this problem.\textsuperscript{75} Whether these measures have resulted in the desired outcomes remains an open question.

\textsuperscript{66} MHA, s 20(1.1).
\textsuperscript{67} MHA, s 33.1-33.9.
\textsuperscript{68} MHA, s 20(1.1)(b).
\textsuperscript{69} MHA, s 20(1.1)(e).
\textsuperscript{70} MHA, s 20(5).
\textsuperscript{71} The individual who murdered Brian Smith suffered from paranoid schizophrenia and was found not guilty by reason of mental disorder under the CCC; he was granted an absolute discharge by the Ontario Review Board in 2006.
\textsuperscript{74} John Dawson and George Szmukler, “Fusion of mental health and incapacity legislation” (2006) BJP188:504-509.
\textsuperscript{75} John Dawson and George Szmukler, “Fusion of mental health and incapacity legislation” (2006) BJP188:504-509.
Recent amendments to the MHA in 2010 allow patients to apply for transfers to other hospitals in a narrow set of circumstances and changed some details of the community treatment order provisions. To date, there have been a limited number of CCB cases heard under the patient transfer section and at the time of writing, none had been successful for the patient applicants, typically because the transfer is found not to be in the patient’s best interests. It is often the case that the facility to which the patient wishes to be transferred would be a highly restrictive environment with limited freedoms and privileges. This concern has outweighed the benefits of being closer to family. It is notable that upon completion of every fourth Form 4, a patient may also apply under the patient transfer provisions, as long as at least 12 months have passed since the last application, unless the Board has granted leave based on material change in circumstances.

Policy intent of the legislation & amendments

The MHA does not include a section describing the purposes of the Act, and therefore the intent of the legislators is not explicitly stated there. Hansard debates on amendments over the years confirm that the balance of liberty and autonomy interests against protection and treatment in the ill person’s best interests is a debate that has occurred repeatedly in the history of mental health legislation in Ontario, as it has elsewhere. The pendulum appears to have shifted from an emphasis on liberty, which was predominant from 1967 to the early 1990s, to a more predominantly protectionist attitude since the late 1990s.

The essential purposes of the Act have been stated by the courts, the Board and by various expert commentators. In *Khan v. St Thomas Psychiatric Hospital*, Justice

---

77 MHA, ss. 33.1, 33.2, and 39.2.
78 Note that decisions are published on CanLii only where written reasons have been provided, and therefore some cases may have been heard and decided but not published online. None of the published cases to date have been successful for patients applying for transfer.
79 CD (Re), 2010 CanLii 55562 (ON CCB); GJ (Re), 2010 CanLii 47505 (ON CCB); SR (Re), 2011 CanLii 32706 (ON CCB).
80 See s. 39.2(1)-(4).
82 Sawadsky (Karatsanis, SCJ, as she then was) at 53: “The detention under the MHA is not for the same public purpose as detention for the purpose of investigation or charging someone with a criminal offence. It is remedial and permitted only to the extent necessary to determine whether a person’s mental health may put the safety of the person or others at risk and to provide the public health care necessary to remove that risk of harm”
83 *MBG (Re)*, 2003 CanLii 14360 (ON CCB).
Arbour clearly stated that “the purpose of involuntary detention under the Act is prevention of danger and not compulsory treatment”.

The existence of an active patient rights bar in Ontario has meant that patients have litigated their rights more aggressively in Ontario than in some other jurisdictions. It is possible that patients have used their rights to refuse treatment, and have consequently been committed but untreated for long periods in psychiatric facilities. It is recognized that while this is what the current laws permit, this situation can make care in the facility difficult for both staff and other patients, and is often distressing to patients’ families.

**Role of the Charter**

Liberty is an interest that Ontario law staunchly defends, and it is well protected. The state needs to have very compelling interests expressed in valid statutory provisions in order to hold or authorize detention of anyone against their will. To be legally and constitutionally valid, procedures must ensure fairness and equity, and the substantive requirements of the law (in this case, the committal criteria) must suit the purpose of the law and be proportional to the state interest as expressed in the objects of the legislation.

A significant Charter case on committal criteria in mental health legislation is *Thwaites v Health Sciences Centre Psychiatric Facility*[^86], a Manitoba case decided in 1988. The criteria were found to be lacking in objectivity and violated the Charter’s section 9 right not to be arbitrarily detained. At that time, there was no reference in the Act to dangerousness or even safety of the patient. Manitoba had amended its legislation but it had not yet been proclaimed in force. A subsequent case, *Bobbie v Health Sciences Centre*,[^87] considered the amended provisions and declared that they satisfied Charter requirements.

Ontario’s committal criteria have been found to comply with Charter requirements in several cases where convicted offenders have been transferred to psychiatric facilities for assessment under section 15 shortly before their release from prison, having served

[^87]: Bobbie v Health Sciences Centre (1998) 56 Man R (2d) 208, 12 ACWS (3d) 278 (QB).
their sentence. The MHA procedure was found not to contravene sections 7 or 12 of the Charter.88

Issues

The Select Committee identified some issues and potential barriers to admission.89 These are discussed in this section.

Refusal of admission

While there are several legal pathways to involuntary admission to a psychiatric facility, many families and police officials complain that they cannot obtain admission for a person they believe clearly needs to be admitted. As described above, a person may be released after being examined at the hospital because it is the clinical judgment of the examining or assessing physician that the person does not meet the criteria in the Act. The physician may find that the person meets the definition of mental disorder in the Act, and may also believe that he or she would benefit from a period of hospitalization and treatment, but if the person does not meet the criteria, he or she cannot be forced to stay in hospital. This is separate and apart from the de facto refusal of admission due to delay in the ability to access a Schedule 1 psychiatric facility assessment bed, i.e., not being transferred “forthwith” as required under the MHA, as discussed further below in the context of the inquest into the death of Barbara Skultety, who died in the year 2000.

Interpretation of “Serious Bodily Harm” & “Serious Physical Impairment”

Sometimes the reasons provided to families for the refusal of admission are incorrect. The interpretation and application of the requirements of “serious bodily harm” and “serious physical impairment” give rise to three common misconceptions:

(a) Serious bodily harm

There is sometimes a misconception that psychological or emotional harm does not justify committal and that the person must be physically dangerous to himself or herself or others. This is simply untrue. However, the authors acknowledge that this fact may not be readily known by health practitioners and families attempting to support a mentally ill person.

“Serious bodily harm” in the MHA was interpreted by the Consent and Capacity Board in 2004 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.” Thus, involuntary committal can occur if the person is causing psychological harm that interferes with another’s psychological health or well-being, provided that the behaviour which is causing the psychological harm is caused by the person’s mental disorder, and the other requirements of the Act are met.

The Consent and Capacity Board has routinely held that “Serious’ bodily harm means more than trifling”. In 2010 the Board stated that:

While the Board has found in past cases that harm of a psychological nature can qualify as physical bodily harm, the onus is on the physician to provide clear and compelling evidence that psychological harm is likely, and that it would be serious.

(b) Serious physical impairment

Generally speaking, serious physical impairment includes harms that are experienced indirectly as a result of the mental disorder. For example, serious physical impairment has been demonstrated to be likely where a patient refused to eat due to paranoia about food, resulting in significant weight loss and malnutrition. Serious physical impairment has also been found to be likely in cases where the patient is likely, if returned to the community, to neglect self-care, wander into oncoming traffic, dress inappropriately in cold weather, or inflict self-harm.

---

90 RE JS, 2004 CanLII 46818 (ON CCB), adopting the definition in R v McCraw, [1991] 3 SCR 72 at 81; emphasis added.
91 See LDS (Re), 2012 CanLII 20401 (ON CCB); SJ (Re), 2012 CanLII 18182 (ON CCB); FS (Re), 2012 CanLII 4752 (ON CCB). Note that it is unclear from which case this interpretation was derived, as the statement is consistently made without citation.
92 PT (Re), 2010 CanLII 68912 (ON CCB).
93 VJ (Re), 2010 CanLII 31298 (ON CCB); EW (Re), 2011 CanLII 47918 (ON CCB)
94 SF (Re), 2010 CanLII 26688 (ON CCB) at 13; LQ (Re), 2012 CanLII 18304 (ON CCB) at 4 and 9
The Board has also been persuaded that a person may experience serious physical impairment as a result of retaliation by persons who are provoked as a result of the person’s mental disorder (such as tendency to assault other persons). It is significant, however, that the behaviour leading to retaliation must be caused directly by the mental disorder. A person with a mental disorder who happens to have an irritating and provocative personality would not be captured under serious physical impairment even if such behaviour resulted in physical retaliation. Serious physical impairment can also be of a more general nature. In 2010, a panel of the Board accepted that there was a likelihood of serious physical impairment because a patient was “unable to identify situations which would put [her] in harm’s way”.

(c) Imminent harm or impairment

As has been stated above, the requirement of imminence of the impairment was removed from the Act in 2000. Some health practitioners, as well as families, may not be aware of this change. In fact, the term appears even in Consent and Capacity Board decisions as late as 2004, so it is not surprising that there is misunderstanding. There remains a temporal element to this criterion because the impairment cannot be merely a vague or hypothetical possibility. It has been stated in Board decisions that “the anticipated harm would have to occur within some reasonable time after discharge so as to be connected to the mental disorder and be related to the risks arising as a result of not being hospitalized.”

Mental or Physical Deterioration (“Box B” criteria)

Under the requirements for “Box B” committals, the mental and physical deterioration criterion is not applicable to someone who does not have a history of mental illness. This has been criticized as problematic because people experiencing a first episode of psychosis or other serious mental illness cannot be admitted until they become dangerous or seriously physically impaired (within the meaning of the “Box A”

---

95 T(Re), 2009 CanLII 24054 (ON CCB); G (Re), 2009 CanLII 45565 (ON CCB)
96 SF (Re), 2010 CanLII 26688 (ON CCB) at 14
97 The word “imminent” was removed from the MHA as part of the year 2000 amendments, precisely because of the lack of consensus as to what the temporal requirement would be. It is noteworthy that during the 2000 amendments there was a motion made in Legislative Committee hearings for serious physical impairment to be amended to “within three months” but the motion was lost, and the Act does not include those words.
98 In J.M. (Re), 2004 CanLII 56497 (ON CCB), for example, the decision goes to great lengths to explain the meaning of “imminence”.
99 See the Ontario Hospital Association’s, “A Practical Guide to Mental Health and the Law in Ontario” (March 2009, updated October 2012), Ch. 3, p. 38; no case citation.
criteria). The result is that they may be unable to receive care in a timely manner for their first episode of illness. There is ample evidence that early treatment can make a significant difference to the long-term prognosis in the course of psychotic illness.\textsuperscript{100}

**Availability of hospital services**

Psychiatric facilities occasionally find their beds to be at full capacity, yet a person requires assessment and/or admission. The judgment of the physician regarding a prospective patient’s committal status cannot be based on whether there are sufficient staff and facilities available in the psychiatric facility to care for the patient. If a person meets the requirements for involuntary admission, the physician is obligated to complete a certificate of involuntary admission.\textsuperscript{101} The psychiatric facility, assuming it is a designated Schedule 1 facility, must then make room for the person or find another psychiatric facility that can admit the person; but practically speaking, some of the burden may fall on a Schedule 2 psychiatric facility or the community where that person resides. For example, if a Form 1 has been filled out by a physician in the community or a physician at a Schedule 2 psychiatric facility, the next step is to transfer the person to a Schedule 1 facility “forthwith”. There is potential risk in detaining involuntarily, releasing, or failing to adequately monitor, a person who requires psychiatric assessment on a Form 1 and/or civil committal on a Form 3.\textsuperscript{102}

Whether a psychiatric facility may refuse admission when its services are at maximum capacity and it would be dangerous or negligent to admit a patient for care that cannot reasonably be given has been considered in the context of criminally committed patients. The availability of beds was addressed in the case of *Centre for Addiction and Mental Health v. Ontario*\textsuperscript{103}, in which a trial judge made a treatment order under


\textsuperscript{101} MHA, s. 20(1)(c).

\textsuperscript{102} As noted this was true in the 2002 Skultety inquest, which examined the year 2000 death of a woman placed on a Form 1 by a physician in the community, then transferred to a Schedule 2 psychiatric facility to await assessment at, and possible admission to, a Schedule 1 facility that had a backlog of individuals waiting for Form 1 assessment. The inquest record shows that on a prior Form 1, she waited at home several days to be assessed, notwithstanding the legal requirement that she be taken to a Schedule 1 psychiatric facility “forthwith”. Several days into her stay in 2000, Ms. Skultety left the Schedule 2 facility to smoke which she had done routinely since arriving (with the permission of one of the physicians, perhaps recognizing that the hospital had no legal authority to detain her and to some extent was treating her as a voluntary patient) and she was found the next day in freezing temperatures, having died of cardiac arrest secondary to exposure and drug overdose (the jury characterized the death as “suicide”). The inquest recommendations included reference to the difficulty of complying with the MHA in circumstances where a bed is not readily available in a Schedule 1 psychiatric facility. See [http://www.sse.gov.on.ca/mohltc/PPAO/en/Documents/sys-inq-sku.pdf](http://www.sse.gov.on.ca/mohltc/PPAO/en/Documents/sys-inq-sku.pdf), last accessed January 14, 2013.

\textsuperscript{103} *Centre for Addiction and Mental Health v. Ontario*, 2012 ONCA 342 (CanLII).
the *Criminal Code* that required the accused to receive treatment in a psychiatric facility. CAMH sought to set the order aside on the basis that the order requiring treatment to be conducted at CAMH was made without consent of CAMH as required by section 672.62 of the *Criminal Code* and in circumstances where the hearing judge was aware that there were no beds available. The Court of Appeal found that the requirement of consent was not met, that such requirement does not violate section 7 of the *Charter*, and is neither vague nor arbitrary. Justice Blair stated that:

> although the effect of s. 672.58 is to overcome the common law’s unwillingness to compel someone to submit involuntarily to medical treatment, the consent requirement in s. 672.62 provides an important safeguard for the unfit accused. A treatment order is, in itself, a profound interference with the unfit accused’s security of the person. The consent requirement ensures that the designated psychiatric facility has the necessary bed and staff ready to execute the treatment order safely. Rather than stripping the hearing judge of authority, this requirement provides the hearing judge with some assurance that the treatment order process is initiated and more likely to produce positive results.¹⁰⁴

Further, it was acknowledged that the principal function of the order was legal, not medical, and that “unfit accused and NCR accused do not have a monopoly on scarce public resources to the exclusion of all others”.¹⁰⁵ Note, however, that the person would remain in custody even though not in the hospital.

**Early release**

A patient may be detained, restrained, observed and examined, as well as treated (with consent) for up to 72 hours on a Form 1 APA. This allows for an extended period of observation and interaction with clinical staff at the hospital. There is no legal review of the person’s status during this time, nor is rights advice provided. However, a notice must be given to the patient that explains the meaning of the APA and that he or she has the right to retain and instruct a lawyer.¹⁰⁶ Once the examination is complete, or in any case prior to the 72-hour mark, the person must either be admitted as a voluntary or involuntary patient, or be released.¹⁰⁷ If the person does not stay voluntarily, and

---

¹⁰⁴ *Centre for Addiction and Mental Health v. Ontario*, 2012 ONCA 342 (CanLII) at 52.
¹⁰⁵ *Centre for Addiction and Mental Health v. Ontario*, 2012 ONCA 342 (CanLII) at 59 and 61.
¹⁰⁶ Ministry of Health, Form 42 - Notice to Person under Subsection 38.1 of the Act of Application for Psychiatric Assessment under Section 15 or an Order under Section 32 of the Act, online: <http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-1787-41-1/$File/1787-41_.pdf>.
¹⁰⁷ MHA, s 20(3).
does not meet the requirements for committal, he or she must be released from the hospital. Family members and police officers who bring the person to the hospital often find this frustrating, but the requirements of the Act must be met in order for the person to be held.

**Admission of an Incapable Person**

If a person is incapable of consenting to proposed treatment, and the SDM has given consent, the SDM can also consent to the person’s admission for the purpose of receiving the treatment. However, if the person objects to the admission to a psychiatric facility for treatment of a mental disorder, the consent may only be given by a guardian or power of attorney who has specific authority in the guardianship order or POA to consent and use reasonable force to take the incapable person to hospital for treatment. Additional requirements apply to this extraordinary power, known informally as a “Ulysses contract”.

**Conclusion**

The circumstances within which people with serious mental illness may be hospitalized against their will are clear in the law of Ontario, as are the legal protections provided for their rights to liberty and bodily integrity. These are sometimes interpreted as barriers to needed treatment and confinement by frustrated families, health practitioners, and police officers. Whether the correct balance has been struck in the law is a matter of perennial debate by many parties, but the law has been applied more consistently over the years as the courts and review boards have considered the many legal challenges brought before them. Health practitioners who are responsible for applying the law can make their clinical judgments within the context of well-known rules. Possible changes to the MHA will be considered in Chapter 6 of this report, as well as the consequences for policy, education and research.

---

108 HCCA, s 24(1).
109 HCCA, s 24(2).
110 SDA, s 50(1).
CHAPTER 2 - TREATMENT: CONSENT, CAPACITY AND SUBSTITUTE DECISION-MAKING

Overview/Summary

1. How the legislation works
2. The policy intent of the legislation
3. Issues

Overview/Summary

This chapter describes the legislation and case law relating to consent to psychiatric and related treatment, capacity to make those decisions, and substitute decision-making. Although the HCCA also applies to consent, capacity and substitute decision-making for admission to care facilities and personal assistance services, this chapter does not deal with those matters.

The law of Canada protects every person’s right to self-determination and minimizes the state’s interference to ensure it imposes the least amount of intrusion necessary to maintain a safe environment. People generally assume that they are entitled to make their own decisions and to take risks, even if others may believe them to be foolish. But when they become incapable of making those decisions (that is, they pose a danger to self or others, or are unable to take care of themselves), the state provides protection for incapable persons and others through the legislation considered here.

When the fundamental right to decide is taken away by law, resulting in a loss of liberty or interference with one’s person, the rules must be clear: the person must have recourse to an independent process of review and the law and process must comply with the Canadian constitution, especially the Charter.

In general, under common law, any medical treatment, including psychiatric treatment, can only be given with a valid consent from a capable person – the patient, or where the patient is incapable, his or her SDM.\(^\text{111}\) Without such consent, any intentional

\(^{111}\) As discussed in Chapter 1, there are few exceptions to the rule that one cannot be treated without informed consent; the most obvious arises under the Criminal Code where a person may be ordered to be treated for up to 60 days to attempt to render him or her fit to stand trial (in this case, we are unaware of any Charter challenges arising out of this apparent dichotomy between federal and provincial laws); or
bodily touching can give rise to a criminal assault and a civil suit for battery and/or negligence against the treating professional.

In Ontario, commitment to hospital and capacity to consent to treatment are largely separate matters. A person who is involuntarily committed may still be able to consent to or refuse treatment. The assessment of capacity to make treatment decisions is based on a person’s ability to understand his or her illness and the proposed treatment, and his or her appreciation of the consequences of the decision (or lack of decision), not the circumstances that led to being involuntarily committed.

**Consent to treatment**

The HCCA stipulates that no treatment can be administered by a health practitioner without a valid consent. The definition of treatment in the Act is very broad, and includes psychiatric treatment. A valid consent must be informed, voluntary, and not obtained by any kind of misrepresentation or fraud, and the person giving the consent must be mentally competent to give it (“capable” is the term used in the HCCA). If the person is incapable of consenting to the treatment, then consent must be sought from the person’s SDM under the HCCA.

To be properly informed, the patient must have the ability to understand the material risks and benefits of the treatment that is being proposed. There has been a great deal of case law regarding the nature and extent of the information that must be provided to the patient in order for him or her to make an informed decision. It is incumbent on the health practitioner proposing the treatment to ensure that the patient has the ability to understand, and does understand, the information and the risks and benefits to be weighed in making a decision.

---

under Ontario laws, the HCCA very specifically does not apply to situations under the *Health Protection and Promotion Act*, such as administration of neonatal eye prophylaxis (s. 33) or care and treatment by a physician for a communicable virulent disease (s. 35(2)(c)).

112 HCCA, s 10(1).
113 HCCA, s 2(1).
114 HCCA, s 11 (1).
115 HCCA, s 10(1)(b).
116 HCCA, s 11(2).
118 HCCA, s 10(1)(2); *Starson v Swayze* 2003 SCC 32, [2003] 1 SCR 722; *Ciarlariello v Schacter* [1993] 2 SCR 119, SCJ No 46.
Capacity for decision-making

Competence to make decisions is a concept that has been around for many years in common law, principally with respect to wills and trusts. For example, if a person is not capable of understanding the consequences of a decision with respect to property, that person cannot make a valid will. The same principle applies in treatment decision-making. However, in practice, health practitioners often work on the assumption that the treatment they recommend is in a person’s best interests, and would be the best course of action for the patient. If the patient disagrees or otherwise challenges the advice, or simply does not “comply” with the recommended treatment, the health practitioner may wrongly assume the person misunderstands the information and is therefore incapable of making the decision. This approach (called “the medical judgment standard” by the Supreme Court of Canada)\(^{119}\) has been refuted by the Supreme Court on more than one occasion, and the right of the patient to make the treatment decision, however unwise it may be objectively, has been confirmed several times since the landmark 1980 case *Reibl v. Hughes* which introduced the concept of informed consent to treatment.\(^ {120}\)

In both the HCCA and the *Substitute Decisions Act* (“SDA”), it is assumed that every person is capable of making treatment decisions until he or she is found to be incapable.\(^ {121}\) The law requires that the health practitioner proposing the treatment assess the person’s decision-making capacity and make a reasoned decision based on objective evidence about whether the person has the capacity to make the decision or not, regardless of the decision itself.\(^ {122}\) In practice, the issue arises mainly in situations when the person refuses the proposed treatment, but the physician needs to ensure that a valid refusal has been given and must document this. The mere agreement of an incapable person to accept the treatment is not a capable consent.

Capacity to make treatment decisions applies to people wherever they may be required to make a decision about treatment – in their homes, in physicians’ offices, clinics, long-term care homes, community programs – wherever treatment that is covered by the requirements of the HCCA is proposed.

\(^{119}\) See, for example, *Ciarlariello v Schacter* [1993] 2 SCR 119, SCJ No 46.
\(^{120}\) *Reibl v Hughes* [1980] 2 SCR 880.
\(^{121}\) HCCA, s 4(2).
\(^{122}\) HCCA, s 10(2); *Malette v Shulman* [1990] OJ No 450, 72 OR (2d) 417 (CA); *AC v Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 SCR 181.
Substitute decision-makers

If a person is incapable of making a particular treatment decision, the HCCA provides a ranked list of people who may make the decision for the incapable person, as well as a set of rules the SDM must follow in making the decision.\textsuperscript{123} In short, the SDM must follow a prior capable wish applicable to the circumstances, if known and made after the person was 16 years of age. If the SDM does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the SDM shall act in the incapable person’s best interests.\textsuperscript{124}

The HCCA defines “best interests” in a manner that requires the SDM to consider the person’s prior capable wishes concerning treatment, which may not seem objectively to be the best choice in the opinion of the SDM. The SDM may also consider wishes that were made, even if they were made while the person was under 16 years of age or incapable. The SDM must also consider the following factors:

1. 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.
2. Whether the incapable person’s condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.\textsuperscript{125}

There are certain circumstances that can bring an SDM before the Board with respect to making treatment decisions. One such example is where the SDM wishes to depart from a prior capable wish. Under the HCCA, the SDM may apply to the Board for permission to consent to the treatment despite the prior capable wish. As well, the health practitioner who proposed the treatment may apply to the CCB to obtain

\textsuperscript{123} HCCA, ss. 20-21.
\textsuperscript{124} HCCA, s 21.
\textsuperscript{125} HCCA, s 21(2)(c).
permission for the SDM to consent to the treatment despite the wish. An application may also be made to the CCB for clarification of the wish.

A health practitioner may also apply to the CCB if he or she is of the opinion that the SDM did not comply with the decision-making rules under the Act. This provision of the HCCA was challenged by a SDM in *AM v Benes*, in which a physician recommended electro-convulsive shock therapy (“ECT”) for an incapable patient and the SDM, who had previously given consent for the administration of ECT, refused. Believing that the SDM was not acting in the patient’s best interests, the physician applied to the CCB for a review of the SDM’s decision. The CCB found that the SDM did not comply with her obligations under section 21(2) and directed her to consent to the treatment pursuant to section 37 of the Act. The SDM appealed, arguing that section 37 of the HCCA violated section 7 of the *Charter* insofar as it permitted the CCB to review and override an SDM’s decision. The Court of Appeal overturned the trial court finding that section 37 was unconstitutional. Instead, the appeal court confirmed that “s. 37(3) does not infringe the liberty or security interests of an incapable person under s. 7 of the *Charter*” and that the CCB had the power to order SDMs to consent to treatment if these SDMs had not fulfilled their obligations under the HCCA.

In addition, this case established that the CCB need not show deference to an SDM. Rather, the court found that after considering the submissions of all parties, “…Board is likely better placed than either the [SDM] or the health practitioner to decide what is in the incapable person's best interests”.

The SDA provides formal processes and mechanisms for SDMs to be appointed by a court or chosen by an individual and given specific powers of decision-making over the incapable person about personal matters, including treatment, housing,

---

126 HCCA, s 36(1). This is known as a Form E application, available on-line at:
127 HCCA, s. 35(1). This is known as a Form D application, available on-line at:
128 HCCA, s 37. This is known as a Form G application, available on-line at:
129 *AM v Benes* [1999] OJ No 4236, 46 OR (3d) 271 (CA).
130 *AM v Benes* [1999] OJ No 4236, 46 OR (3d) 271 (CA).
131 *AM v Benes* [1999] OJ No 4236, 46 OR (3d) 271 (CA) at 46.
132 SDA, s 55(1).
133 SDA, s 46.
personal care, and others.\textsuperscript{134} The latter mechanisms, known in Ontario law as powers of attorney, are sometimes called advance directives. In Ontario, an advance directive must meet the requirements of the SDA for powers of attorney, principal among which is the appointment of an attorney for property. A document which states a person’s preferences about treatment, personal care or living circumstances will have value as a statement of wishes within the meaning of the Act,\textsuperscript{135} but those preferences cannot provide direction directly to a care provider or anyone else; they will be information the SDM must take into account and, in most cases, be bound by. Valid substitute decisions for incapable people must always be made by an SDM, except in emergency situations as described below.

\section*{How the legislation works}

\section*{Requirement of Capacity to Consent}

The HCCA stipulates that treatment is not to be given without the consent of a capable person, or an SDM if the person is incapable.\textsuperscript{136} It is the physician’s (or proposing health practitioner’s\textsuperscript{137}) responsibility to form an opinion about the person’s capacity to consent, and the burden of proof that a person is incapable of consent will be on the physician in any review proceeding.\textsuperscript{138} The physician must also be able to demonstrate that the person was capable to provide consent if the physician administered treatment and the validity of the consent were later challenged. It is noteworthy that where a physician prescribes medication and another health practitioner administers it at a different time, both health practitioners must be satisfied that the person is capable. This provides a check and balance that the person is capable at the time the treatment is actually administered, as long as it is not a case of an acquiescent but incapable person accepting the treatment, as discussed below.

\textsuperscript{134} Substitute decision-making powers regarding property (powers of attorney for property) can be given while a person is still capable; for example, to allow someone else to manage one’s property while one is out of the country, or for convenience. This sometimes occurs in the case of a capable elderly person, whose property decisions are made by an adult child for the sake of convenience, and not because the elderly person is incapable.

\textsuperscript{135} HCCA, s 5.

\textsuperscript{136} HCCA, s10(1).

\textsuperscript{137} For purpose of the discussion here related to psychiatric treatment, we will use the term “physician”. However, any health practitioners proposing treatment as defined under the HCCA are bound to follow the rules as well as the standard of their health regulatory Colleges.

Presumption of Capacity

Although a person is always presumed to be capable, and although the physician is allowed to rely on the presumption of capacity “unless he or she has reasonable grounds to believe the … person may be incapable,” administering treatment to an incapable person without getting valid substitute consent is contrary to the statute. An issue can arise when a patient accepts and complies with treatment but is, in fact, incapable. If there are any negative consequences, the physician may be required to defend his or her decision to accept the implied consent of a merely acquiescent patient.

Meaning of Capacity

A person is capable if he or she is able to understand the information that is relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

The meaning of the words above was examined closely by the Supreme Court of Canada in the leading case of Starson v. Swayze. Two key elements are required if a person is to be found capable of making a decision: being able to understand the information and being able to appreciate the reasonably foreseeable consequences of providing consent or not. A person can have the ability to understand the information relevant to making a decision without actually understanding; similarly, the person can have the ability to appreciate the reasonably foreseeable consequences of a decision but not actually appreciate those consequences, and still be found capable.

For example, this may be because a person, while able to understand the information provided, was not given sufficient information to make a meaningful decision, or does not speak the language in which the information was explained. For various reasons a person could be found not to understand or appreciate the information or consequences while still having the ability to do so.

In most cases decided by the CCB, the physician’s assessment of incapacity is confirmed, and very few such findings are overturned upon further appeal to a
court. This suggests that the test is consistently understood and applied by physicians, the CCB and the courts; it is also possible that post-Starson, documentation and citation of the test for capacity (i.e., the ability to understand, rather than the mere understanding itself) has improved and is used to substantiate clinical evidence in hearings. However, at least one more recent case has emphasized the need for health practitioners to back up their position with appropriate evidence.

A common scenario is that the patient does not agree that he or she has a mental disorder. Such persons are often found to lack insight into their disorders and are determined to be unable to appreciate the consequences of a decision to accept or refuse treatment. However, even if he or she agrees there is a problem and understands the information relevant to making a decision, he or she may still believe that no treatment is needed in order to get better, and that he or she feels better without it, and this has been found to be an inability to appreciate the consequences of the treatment. It is clear that, particularly after Starson, persons are entitled to disagree with their health practitioners, and neither disagreement nor agreement renders a person incapable. As explained in Starson at para. 3:

First, Professor Starson recognizes that he has mental problems. Unquestionably, he has a deep distrust of psychiatry, which he likens to a religion. His reply to the question whether he recognizes he is mentally ill was unresponsive but logical: He answered that the question left him in a “catch 22” situation. If he said “yes”, the authorities would say he

---

145 In one study, it was shown that only 1.5% of treatment incapacity decisions were overturned upon appeal to the Consent and Capacity Board. The study was done on a 10-year timeframe at two Ontario psychiatric facilities, and Two hundred and thirty-seven patients made 334 applications to the review board. Fifteen patients appealed the review board's finding to the courts, and none was successful. In the absence of an appeal to the courts, the average delay in initiating treatment was found to be 25 days. See M. Kelly, S. Dunbar, J.E. Gray & R.L. O’Reilly, “Treatment delays for involuntary psychiatric patient associated with reviews of treatment incapacity”, Can J Psychiatry. 2002 Mar;47(2):181-5.

146 UPDATE to this Report: In a decision released by the Ontario Court of Appeal on July 31, 2013, it was determined in Anten v. Bhalerao, [2013] O.J. No. 3459, 2013 ONCA 499, that a psychiatrist’s finding that a patient was incapable to consent to treatment under the HCCA was unreasonable and must be set aside. The finding of the psychiatrist, Dr. Bhalerao, was first upheld at the Consent and Capacity Board in a decision rendered February 6, 2010; and on appeal to the Superior Court of Justice, on February 14, 2012. In short, while the decision does not change the legal test for capacity established under the HCCA, it does point to the need to bring forward appropriate evidence to ground the test. While the decision in Anten does not change that test substantively, the Court of Appeal has reinforced the fact that health practitioner must back up their findings of incapacity with appropriate evidence. This includes the health practitioner providing information about the anticipated benefits of the treatment, and how the benefits will outweigh any potential side effects; it is also important to ground the evidence regarding potential decline of the patient if left untreated. Otherwise, a finding of incapacity under s. 4(1) of the HCCA may be set aside.

must be treated for it; if he said “no”, the authorities would say he must be treated because he lacks insight into his illness.\textsuperscript{148}

\textbf{Requirements for Valid Consent}

The additional requirements for a valid consent are spelled out in the HCCA: it must relate to the treatment in question, be informed, given voluntarily, and not obtained through misrepresentation or fraud.\textsuperscript{149} The HCCA specifies the information that must be given to the person about the treatment: the nature of the treatment, the expected benefits, the material risks and side effects, alternative courses of action and the likely consequences of not having the treatment,\textsuperscript{150} as well as the standard for this information: it must be the information that a reasonable person in the same circumstances would require in order to make a decision, plus the answers to any questions they may have.\textsuperscript{151} This is an objective standard; if something goes wrong, and the patient later decides that he or she required more details about the proposed treatment in order to make an informed decision, the health practitioner can review the information provided and argue that it was reasonable and responsive to the person’s questions. These requirements are based on the case law that had evolved up until the time the HCCA came into force in 1996.\textsuperscript{152}

\textbf{Substitute Decisions for Incapable Person}

If the person is incapable, the highest-ranked SDM who qualifies under the section 20 hierarchy of SDMs in the HCCA will be asked to make the decision and must do so according to the principles set out in section 21. It should be noted that the SDM of last resort for treatment is the Public Guardian and Trustee (“PGT”).\textsuperscript{153} This is important for incapable persons who have nobody to act for them; neither someone appointed under a power of attorney for personal care (who need not be a family member) or further down the list, family members who meet the criteria to be an SDM (i.e., willing, available, 16 or over unless the parent of a child, not prohibited by court

\begin{footnotes}
\item[148] Starson \textit{v. Swayze}, 2001 CanLII 7651 (ON CA) at 9.
\item[149] HCCA, s 11(1).
\item[150] HCCA, s 11(3).
\item[151] HCCA, s 11(2).
\item[153] HCCA, s 20(5). Interestingly, while this is also true for long-term care admission, the role of the PGT as SDM of last resort is discretionary in the case of personal assistive services under the HCCA, as well as for consent to the collection, use or disclosure of personal health information under the \textit{Personal Health Information Protection Act} (“PHIPA”).
\end{footnotes}
order or separation agreement and capable themselves with respect to the proposed
treatment). The PGT is also required to act (although not as SDM of last resort, and
potentially ahead of other individuals named in the hierarchy) where equally ranked
SDMs (such as adult children, or the parents or siblings of the ill person) disagree to
such an extent that a decision cannot be reached and the PGT is obliged to make the
treatment decision.

If the incapable person has expressed wishes about the treatment while capable, the
SDM is required to give or refuse consent in accordance with that wish; if there is no
such wish, the SDM must act in the incapable person’s best interests (as defined in the
HCCA). As stated above, those wishes or preferences could be contained in a power
of attorney for personal care, or another document, such as the person’s clinical
record, or they could have been the subject of a discussion between the incapable
person and the SDM, or the person and a third party. Sometimes the person’s wishes
are a matter of record from a prior legal proceeding.

It is important to know that the SDM can also consent to the incapable person’s
hospital admission for the purpose of receiving treatment, although if the person
objects to the admission, the SDM must have been granted specific powers to use
reasonable force to admit the person in the guardianship order or the power of attorney
giving the SDM their power to decide.

**Emergency Treatment without Consent**

Under the HCCA, it is considered an emergency if the person for whom the treatment
is proposed is apparently experiencing severe suffering or is at risk, if the treatment is
not administered promptly, of sustaining serious bodily harm. Specific rules apply
in an emergency, depending on whether the person is capable or incapable; the
common variable is that treatment can be given without consent if the delay in seeking
consent person is suffering severely or is at risk of serious bodily harm unless the
treatment is administered before consent can be obtained. Efforts must then be made
to find the SDM and obtain a valid consent, and the treatment can only continue
without consent until the SDM is found, in the case of the incapable person; or if the
person becomes capable and provides consent. However, if the health practitioner is

---

154 HCCA, s 21(1); Fleming v Reid [1991] OJ No 1083, 4 OR (3d) 74 (CA).
155 This could be the CCB or the Ontario Review Board under the Criminal Code.
156 HCCA, s 24.
157 HCCA, s 25.
158 For further details, particularly in relation to the additional factors that apply in the case of a capable
person, see subsections 25(2) and (3) of the HCCA.
made aware that the person expressed a capable wish prior to the emergency not to have the treatment, it cannot be administered, as long as the person was 16 or older at the time the prior capable wish was made. The classic example is the case of blood transfusions for severely injured members of the Jehovah’s Witness faith.\textsuperscript{159}

### Rights to Review and Appeal

A person who has been found incapable of making a treatment decision has the right to a speedy review of that finding by a legal tribunal with special expertise in this law, the CCB. The physician proposing the treatment is obligated to notify and inform the patient about this right of review,\textsuperscript{160} and in a psychiatric facility, the physician must also notify a rights adviser. The rights adviser must visit the patient within 48 hours, give the patient information about the review process, and assist the patient with making the application and obtaining legal help if the patient requests it.\textsuperscript{161}

If the CCB confirms the physician’s incapacity decision, the patient has the right to appeal that decision to a court.\textsuperscript{162} With few exceptions, treatment cannot be given until the appeal is finally determined.\textsuperscript{163} Under section 18 of the HCCA, a health practitioner who has proposed treatment, and is informed that the person intends to apply to the CCB for a review of the finding of the patient’s incapacity, is not permitted to begin the treatment\textsuperscript{164} unless:

- the application is withdrawn\textsuperscript{165}
- 48 hours have passed since the health practitioner was informed of the patient’s intention to apply to the CCB, and the patient failed to apply\textsuperscript{166}
- there is an emergency\textsuperscript{167}
- the CCB upholds the finding of incapacity.\textsuperscript{168}

\textsuperscript{159} HCCA, s 26; Malette v Shulman [1990] OJ No 450, 72 O.R. (2d) 417 (CA); H (B) v Alberta (Director of Child Welfare), 2002 ABQB 371, AJ No 518, aff’d 2002 ABCA 109, AJ No 568.

\textsuperscript{160} HCCA, s17; MHA, s. 59(1).

\textsuperscript{161} MHA, s 59(1)-(4); R.R.O. 1990, Reg. 741, s. 15.

\textsuperscript{162} HCCA, s 80.

\textsuperscript{163} HCCA, s 18(d)(ii).

\textsuperscript{164} HCCA, s 18(1).

\textsuperscript{165} HCCA, s 18(3)(b).

\textsuperscript{166} HCCA, s 18(3)(a).

\textsuperscript{167} According to section 25(2) of the HCCA, treatment may still be administered without consent to a person who is incapable and appealing such decision if the person is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm if the treatment is not administered promptly. This is an “emergency” provision and still requires consent from the SDM, unless the delay required to obtain a consent or refusal on the person’s behalf will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm.
However, if treatment began prior to the health practitioner becoming aware of the intention to apply to the CCB, then treatment may be continued. This is true even if treatment is temporarily suspended during the appeal.169

There are several levels of court through which an appeal of an incapacity finding may proceed, including to the Supreme Court of Canada, and in a minority of cases, it can take many years for the appeal process to be finally concluded and the patient’s capacity at the time of the original finding to be determined.170 If the patient becomes capable during the time that the appeal is pending, the appeal may be dismissed or abandoned by either party, since it becomes moot. The HCCA also recognizes that capacity can fluctuate, both over time and with respect to the treatment being proposed, but the law limits the patient’s reviews to once every six months, unless the person is able to demonstrate a material change in circumstance.171

When an appeal is filed by the patient, it is possible for the physician to apply to court for an order that would allow the patient to be treated until the appeal is heard, with the consent of his or her SDM.172 However, the conditions are stringent and few of these applications are made; even fewer succeed. In SR v Hutchinson, an order authorizing treatment pending appeal was successfully sought.173 In this case, the final disposition of the appeal was only three weeks away and therefore the person would not be treated for a long period of time without consent. Further, improvement was likely within 7-10 days of treatment, the person was at risk of suicide without treatment, and there was no less restrictive or intrusive treatment available.

In another case, Gunn v Koczerginski, the court decided that the criteria under section 19 of the HCCA had not been met. Treatment was not likely to substantially improve the person’s condition prior to the appeal and the person’s condition did not make it necessary to require him to take medication; in fact, he was described as non-threatening and pleasant.174

168 HCCA, s 18(3)(c).
170 For example, in the Starson case, the incapacity finding was made in 1998 and the Supreme Court overturned it in 2003. See Starson v Pearce [2009] OJ No 21 (Sup Ct J) at 6.
171 HCCA, s 32(5), (6).
172 HCCA, s 19.
173 SR v Hutchinson, [2009] O.J. No. 516 (S.C.J.). In a more recent unreported case, SR v Balderson (Court File No. 03-91/12 (Toronto)), a s.19 motion was ultimately abandoned after amicus curiae had been appointed and the parties agreed to expedite the hearing of the appeal of the finding of incapacity to consent to or refuse treatment. This appeal was ultimately abandoned which resulted in the patient being treated with the consent of the SDM.
174 Gunn v Koczerginski [2001] OJ No 4479 (Sup Ct J).
The court is more likely to expedite the appeal than to grant a motion that essentially renders the appeal meaningless, since the patient will have been treated despite his or her potentially capable refusal of consent. The lengthy delay in treatment incapacity appeals being heard and decided by the courts is a very serious problem for everyone concerned. The patient remains untreated, yet may be incapable and could otherwise be treated with SDM consent. The staff of the psychiatric facility must respect the patient’s autonomy but also protect the person from harming himself or herself, or other patients or staff. This can create significant management problems for the facility.

The patient, even while incapable, can apply to the CCB to appoint a higher-ranked SDM (known as a personal representative) who would rank ahead of most other SDMs. Likewise, another person can apply to become the incapable person’s representative. This may arise when the patient has relatives on the HCCA list of SDMs, but they are estranged; or, the patient may have other reasons for not wanting those relatives making his or her treatment decisions, such as having a stronger relationship with a lower ranked SDM or non-relative whom the incapable patient feels is better able to put forward his or her values and beliefs, or prior capable wishes.

The CCB can also review a decision by an SDM to admit an incapable person to hospital for treatment under section 24 of the HCCA. The admission can take place and the treatment can be administered even if the incapable patient intends to apply or has applied for a review. This is unusual; in almost all other instances of review under the Act, the treatment cannot take place until a decision is reached. The likely reason for this is that section 24 requires that the SDM have a high level of authority, either through guardianship or a special power of attorney to admit the person despite their objections.

Either the SDM or the physician can ask the CCB to give directions for decision-making if the patient expressed prior wishes but it is not clear how the wishes can be interpreted or applied to the situation at hand. It is also possible for the SDM or the physician to apply to the CCB for permission to depart from the patient’s prior capable

---

175 HCCA, s 33(1).
176 HCCA, s 33(2).
177 HCCA, s 34.
178 The exception, of course, is the case where a section 19 application for an interim treatment order is made under the HCCA.
179 HCCA, s 24(2), with reference to s. 50(1) of the SDA, which contemplates what is commonly referred to as a “Ulysses” contract.
180 HCCA, s 35.
wishes, if the Board is satisfied that the person would probably consent because the likely result would be significantly better than would have been anticipated at the time the wish was expressed.\textsuperscript{181} Again, relatively few of these latter applications are either made or granted.

Finally, it is possible for the physician to request a review of the SDM’s decision if the physician believes that the SDM is not following the principles for consent and other requirements of the Act in making the substitute decision.\textsuperscript{182} This has come into play when the SDM is unfamiliar with the person’s wishes but the physician and/or hospital staff are aware of express wishes that the SDM refuses to follow, or become concerned that the SDM is putting his or her interests ahead of the patient’s. It can also be relevant when the SDM is also the person’s attorney for property. There is a perverse incentive for the SDM to refuse treatment, keeping the person in an incapable state while continuing to control their property. This can also affect substitute decision-making with respect to admission to care facilities where the incapable person would be obligated to pay for certain accommodation and services, diminishing the property that could go into an estate once the person dies, or be used while alive to the benefit of the SDM.

**The policy intent of the legislation**

Six purposes are articulated in the HCCA, which can be paraphrased as follows:

1. To provide consistent rules for consent to treatment in all settings
2. To facilitate treatment and other decisions for persons lacking capacity to make those decisions
3. To enhance personal autonomy by allowing for a tribunal review of a finding of incapacity, allowing an incapable person to choose their own SDM, and respecting prior capable wishes

\textsuperscript{181} HCCA, s 36.
\textsuperscript{182} HCCA, ss 37 and 21. UPDATE to this Report: In a 5-2 decision released October 18, 2013, the Supreme Court of Canada in *Cuthbertson v. Rasouli* [2013 SCC 53] reinforced that withdrawal of life support (in this case, mechanical ventilation and artificial nutrition/hydration) is considered “treatment” under the HCCA and therefore consent for withdrawal must be obtained from the SDM. Mr. Rasouli had developed bacterial meningitis after undergoing surgery for a benign brain tumour. Believing him to be in a persistent vegetative state, his physicians wished to withdraw him from life support. He was later upgraded to “minimally conscious”. The Court ruled that a physician who disagrees with the SDM cannot unilaterally withdraw life-sustaining treatment but instead must place the matter before the Consent and Capacity Board (rather than the courts). The Court upheld the reasoning that withdrawal of treatment is part of a “treatment package” along with administration of palliative treatment, requiring SDM consent.
4. To promote communication and understanding between patients and physicians and other health practitioners
5. To ensure a significant role for supportive family members in treatment decisions
6. To permit the PGT to act as SDM of last resort.

It is clear that autonomy and self-determination are paramount policy goals of the legislation. This is consistent with, and essentially codifies, the common law in Ontario from earlier cases. The courts have been clear that a person’s right to “control his or her own body is a concept that has long been recognized at common law” and that the “right to determine what shall be done with one’s own body is a fundamental right in our society”. “Competent adults...are generally at liberty to refuse medical treatment even at the risk of death” and “[t]he doctor is bound in law by the patient’s choice even though that choice may be contrary to the mandates of his own conscience and professional judgment.” In other words, a patient may capably choose to make an objectively poor decision, just as anyone may.

The legislative histories and debates as reported in Hansard of Committee hearings and the Legislature regarding the Consent to Treatment Act, and then the HCCA, indicate the importance of autonomy, respect for individual choice and family participation in decision-making as the underlying values of the legislation. Consequently, Ontario’s law has never regarded mental disorder as a condition that justifies entirely removing decision-making from individuals and putting that decision-making into the hands of health practitioners, unlike the law in some other jurisdictions such as British Columbia. When a person becomes incapable of making financial or treatment decisions, someone close to them (or if nobody fulfils such a role, the PGT) is given the power and responsibility to make the decisions. The decision to consent or not rests with the capable person or if incapable, the SDM. The decision is never the health practitioner’s.

183  HCCA, s 1.
184  Malette v Shulman [1990] OJ No 450, 72 OR (2d) 417 (CA); Reibl v Hughes [1980] 2 SCR 880.
185  Malette v Shulman [1990] OJ No 450, 72 OR (2d) 417 (CA) at 17.
186  Malette v Shulman [1990] OJ No 450, 72 OR (2d) 417 (CA) at 41.
187  Malette v Shulman [1990] OJ No 450, 72 OR (2d) 417 (CA) at 36.
188  Ontario, Legislative Assembly, Official Report of Debates (Hansard), (20 June 1991) at 1640 to 1820.
189  UPDATE to this Report: See, however, commentary in note 182 above, regarding the Supreme Court decision in Cuthbertson v. Rasouli [2013 SCC 53] which in a case regarding withdrawal of life-sustaining treatment, the Court held that any challenge to the SDM’s decision-making must be done as a Form G application to the Consent and Capacity Board (rather than the courts). The Court upheld the reasoning that withdrawal of treatment is part of a “treatment package” along with administration of palliative treatment, requiring SDM consent; for that reason, the physicians involved in Mr. Rasouli’s care could not unilaterally withdraw artificial nutrition/hydration and mechanical ventilation.
**Issues**

**Separation of committal and capacity to consent to treatment**

A person who is detained in hospital because his or her mental disorder is causing behaviour which is likely to cause serious harm to themselves or others, or serious physical impairment, may nevertheless be capable of understanding the illness and be able to make decisions about proposed treatment. This also means that a person may remain in hospital as an involuntary patient refusing treatment for months, if not years. Although this is not an ideal situation, it is often considered to be necessary to preserve respect for the autonomy and liberty of capable persons by allowing them to make their own decisions. An alternate view is that it is unjustified to confine persons who are dangerous to themselves or others without giving them treatment that could result in their regaining the capacity to make their own decisions, and facilitate a return to society, even though that forcible treatment involves violating their bodily integrity.

Some feel that this is a “slippery slope”; if treatment could be forced against a person’s will in order to facilitate release from hospital, the pressures on health system resources could determine treatment more than the person’s needs. Patients who have experienced forced treatment, as, for example, in an emergency situation, have reported that the experience is extremely traumatic and can inhibit recovery for a long time. However, others who have recovered after being treated against their will (with SDM consent) have been grateful that their incapacity was restored and their mental health improved with that treatment.

**Prior capable wishes (right to be free of unwanted treatment)**

An issue that vexes some families and mental health professionals is the matter of prior capable wishes. Although advance directives are well-grounded in the law of many jurisdictions, some find it hard to accept that a person who has episodes of serious mental illness can decide, during capable phases, that he or she will refuse certain kinds of treatment later if treatment incapacity returns (a decision some patients will make).190

---

190 See R. O’Reilly, R. Solomon and J. Gray, “An Exchange of Views: What constitutes a reasonable review of treatment incapacity” in Lawson Research’s Research Themes (vol. 6, no. 2, 2009); available on-line at: [https://www.lawsonresearch.com/research_themes/Mental%20Health/pdfs/v6n2-2009.pdf](https://www.lawsonresearch.com/research_themes/Mental%20Health/pdfs/v6n2-2009.pdf), last accessed February 1, 2013. In that article, the authors contrast the advance directives and their application
In that case, the SDM is bound to refuse the treatment for the incapable person unless the SDM is prepared to apply to the CCB to argue that the person, had he or she been privy at the time of the wish to information now available about a proposed medication (e.g., fewer side effects in a newer generation of anti-psychotics), he or she would likely consent in the circumstances. If not, or if that does not succeed, a different treatment must be found for which consent was not refused, or the patient cannot be treated.

The classic case is Starson v. Swayze. Starson had episodes of serious bipolar disorder periodically since 1985. In 1999, he was confined to a hospital having been found not criminally responsible by reason of mental disorder for threatening death. He was found incapable of consenting to treatment and his mother was willing to provide substitute consent for psychotropic medication. Starson applied for a review of his incapacity finding, and the CCB dismissed his application, thus clearing the way for him to be treated with his mother’s consent. He appealed to the court, and the CCB’s decision was overturned. Starson was declared capable. Thus, his stated wish to not have treatment had to be followed. Furthermore, that wish was binding on his mother should he become incapable again. He remained in hospital untreated while the physicians appealed to the Court of Appeal and then the Supreme Court of Canada, which took approximately four years from the initial application to the CCB.

Starson was an unusually intelligent and aware patient. He had published scientific articles and noted scientists wrote letters in his support. He could recognize that he had a “problem with his brain” (although he denied having delusions of communicating with extraterrestrials and grandiose thoughts) but he did not want to take the medications because they slowed him down and he was unable do the physics he loved to do.

A minority of patients who have taken neuroleptic and psychotropic medications express wishes while capable not to be treated with those medications in future, should the illness return and they are found to be incapable with respect to treatment. While it is true that the side effect profiles for these medications have improved over the years, they remain powerful medications with debilitating side effects, often for weeks or months, while different medications or dosages are tried and adjusted. These side effects can seriously impair a person’s day-to-day life functioning, and it is difficult for the person to appreciate that these effects may be preferable to those that would

---

occur if the person were not treated at all. Patients describe feeling slowed down, blunted and out of touch with the real world when taking some of the medications; in one reported case, the patient said she felt “like a vegetable” and “dying alive”.\textsuperscript{192}

Even though those around these patients tend to see great improvement and some patients agree that they are able to function better while taking the medications, the negative effects lead some patients to discontinue the medications, and their health and behaviour deteriorates. This can cause great difficulty to those close to them, particularly in the “grey zone” prior to reaching a state of dangerousness where the committal process is reinitiated.

Improved treatment options might make a difference to the patients’ experiences and may tempt them to try it again. Perhaps more could be done to educate patients while they are capable about what happens when they remain untreated for long periods, so that they can make truly informed decisions about their treatment. There is strong evidence that in many cases, the longer the person remains untreated, the more dismal the prognosis for recovery becomes.\textsuperscript{193}

It is particularly difficult to understand why an advance directive or consent to a plan of treatment under the HCCA (which by definition may include withholding or withdrawal of a particular treatment) made while the person is capable should be overridden to impose treatment. An advance directive is considered a “wish” made by the individual while he or she is capable, while the consent to a plan of treatment is a consent provided by either the capable individual or if incapable, his or her SDM. The consent to a plan of treatment is linked to the current health condition and all of the requirements of a valid informed consent apply. Certainly this approach has not been upheld by courts in relation to people who make advance directives for reasons based on religious beliefs (e.g. the Jehovah’s Witness refusal of blood transfusion cases such as \textit{Malette v. Shulman}, where damages were awarded against the physician and hospital) or personal preferences, articulated while capable (or if incapable, a consent to a plan of treatment given by the SDM) to stop treatment at a certain stage of a terminal illness (e.g., do not resuscitate or DNR orders).

\textbf{Delays in Legal Processes}

The CCB is required to begin its hearing within seven days, and usually does so unless the parties consent otherwise. A decision must be made within one day after the

\textsuperscript{192} \textit{Neto v Klukach} [2004] OJ No 394, 128 ACWS (3d) 1008 (Sup Ct J).
\textsuperscript{193} \textit{Sevels v Cameron} (Ont Ct (Gen Div)) [1994] OJ No 2123 at 3.
hearing ends, and reasons, if requested, must be delivered within four business days after the request is received.\textsuperscript{194} However, if a patient files an appeal, or even expresses an intention to appeal a Board decision confirming his or her incapacity, treatment cannot begin. Appeals can take months, even years, to be heard. The obvious response in this situation is for the courts to case manage these appeals so that they can be decided much more quickly, where the result is either the incapable person is found capable and makes a decision that could result in future decline; or most often, the incapacity finding is upheld and substitute consent is sought, although some time may have passed since the finding of incapacity by the physician. As in the case of \textit{SR v Hutchinson}, decline could occur within a week to 10 days, and despite the 7-day timeframe under the HCCA for these matters to be heard, there is suggestion that treatment may take closer to a month on average to effect. The option of bringing a section 19 application for an order authorizing treatment pending appeal cannot yet be characterized as a sure means of effecting treatment of the individual.

\textsuperscript{194} HCCA, ss 75(2)-(4).
CHAPTER 3 - PRIVACY

Overview/Summary

1. The policy intent of the legislation
2. How the legislation works
3. Issues

Overview/Summary

Ontario law allows information about a person’s health\textsuperscript{195} to be collected, used and disclosed by physicians, hospitals and other health practitioners and providers\textsuperscript{196} in a variety of ways. Special rules in PHIPA tell us how that information can be shared to support the person’s care and treatment, and how it may be shared with others who are not health practitioners, such as the person’s family members. Privacy, as it relates to personal health information, gives a person the right to know, and control how, his or her information will be collected, used and disclosed. PHIPA also gives the person a general right of access to personal health information in the custody or control of a health information custodian, and to request that corrections be made to that information. The person may also make complaints about these issues, either directly to the health information custodian or to the Information and Privacy Commissioner/Ontario.

Policy intent of the legislation

Personal health information and individual autonomy

A person’s autonomy is inherently linked to his or her ability to control how information about him or her is collected, used and disclosed. Questions arise about whether the legislation, regulations, professional standards and court cases about privacy issues have struck an appropriate balance regarding how much information is made available in the health system and how much control a person maintains over

\textsuperscript{195} “Personal health information” is broadly defined in PHIPA, but there is some information that is excluded from application of the Act; see PHIPA, section 9.

\textsuperscript{196} Under PHIPA, such “health information custodians” who collect, use and disclose personal health information are subject to certain duties under the Act, including to safeguard the information in their custody and control. It is a general principle, enshrined in PHIPA and arising out of the 1981 Supreme Court of Canada decision in \textit{McInerney v. McDonald}, [1992]2 SCR 138, that the health practitioner owns the physical record (today, either paper or electronic) containing a person’s health information, but that the information itself belongs to the patient and is held in fiduciary trust by the health practitioner.
that information. How much emphasis should be placed on individual privacy and the right to have one’s personal health information kept confidential, as opposed to the flow of personal health information across the system to support provision of clinical care? This also raises issues about consent: although in some cases a person must provide consent for the information to be used or disclosed, for which legitimate purposes can it be shared without consent? Who is entitled to information in order to support the care of the ill person? The latter issue is particularly sensitive because for the most part (e.g., unless they have assumed the role of SDM for the individual under the HCCA, family members do not receive details of a person’s mental illness and treatment unless the ill person has consented, yet the ill person may be living with them or be closely supported by them.

Clearly, many individuals are reluctant to consent to the disclosure of their personal health information, sometimes due to the lack of insight created by the illness, but also due to concerns about how it could be used against them. Personal information (including personal health information) is sometimes used in ways that lead to the loss of a person’s rights, privileges, property or other material possessions, including in custody battles and divorce proceedings, employment situations, and with respect to their rights to travel. Despite progress being made in this regard, including at the systemic level, stigma persists. It is therefore understandable that a person who is ill may want to safeguard his or her information. In some cases, the wishes of the person will not accord with the wishes of concerned others; in Ontario, the wishes of the person continue to have some primacy (although many uses and disclosures of personal health information without consent are permitted under PHIPA).

The manner in which records of personal health information are maintained may also impact the individual. Arguably, an electronic health record permits more ready access across a greater number of settings to support the person’s clinical care than does a paper record. However, the fact that electronic records can be disseminated very broadly with an errant (or intended) keystroke suggests that great care must be taken to safeguard against human error, as well as malicious intent. Some will argue that electronic records are actually more secure than traditional paper health records, which were not always held securely by health care providers; and if paper records were

198 See http://www.mentalhealthcommission.ca/English/Pages/OpeningMinds.aspx; the Mental Health Commission of Canada launched its Opening Minds initiative in 2009 to address the issue of mental health and stigma.
199 PHIPA, s. 37 (uses without consent) and s. 38-50 (disclosures without consent).
subject to inappropriate access, there was no reliable way to determine this was the case. There is an argument to be made on both sides. Audit technology, while helpful in the electronic realm, also has limitations.

For example, audit technology, which is now fairly standard in electronic health records systems, must be enabled in the system (i.e., turned on). The authors have found in investigating health sector privacy breaches that this does not always occur, or that the system is enabled only once unauthorized access to a health record is suspected or complained of. From the affected person’s perspective, audit technology will also only show, after the fact, who has viewed or used the records. That is little protection in the eyes of the affected individual, as was evidenced in the Information and Privacy Commissioner/Ontario’s order against a teaching hospital that failed to communicate the patient’s wish to shield her personal health information from the prying eyes of her estranged spouse (with whom she was engaged in an ongoing child custody battle) and his girlfriend, both of whom were hospital employees. In the discourse on privacy and autonomy, mechanisms that merely flag a privacy breach after it occurs, or that are not a full response to the breach, cannot right the wrong for the person whose information has been shared. As noted by the Information and Privacy Commissioner/Ontario:

The negative consequences flowing from the unauthorized access and use of a patient’s health information are extensive and far-ranging. Patients have enough to deal with – any additional stress arising from an unauthorized party peering into their health records is completely unacceptable.

This type of unchecked access and apparent inability to effectively prevent a privacy breach does create concerns about the ease of access to personal health information, particularly in an electronic age. It goes to the core of one’s autonomy to think that highly sensitive information in the hands of a health information custodian may not be adequately protected.

These concerns also extend beyond the health sector; a recent landmark decision in Ontario creates a new right of civil action related to the failure of a corporation to protect personal information in the custody and control of a bank.

---

200 See IPC Order HO-010, December 2009.
202 In Jones v. Tsige, 2012 ONCA 32 (CanLii) a bank employee accessed, without authority, the financial records of her husband’s ex-spouse, to determine whether her husband was making payments to his ex-spouse. The Ontario Court of Appeal confirmed that a type of invasion of privacy known as “intrusion-
These occasional public reminders that one’s information may not always be held securely, when paired with the fact that stigma is often part of the lived experience of a mentally ill person, have the potential to make individuals reluctant to share personal health information even where it could benefit them. PHIPA attempts to facilitate the effective provision of health care, while creating rules that protect confidentiality of personal health information as well as individual privacy. It is too simplistic to offer that if societal stigma could be addressed, individuals would share more information and their concerned family members would be better positioned to assist them. Whether some of the issues raised by the Select Committee are attributable to gaps in legislation versus whether the privacy rules are simply not being applied as they should be by health information custodians will be discussed further below.

How the legislation works: the provisions

Scope of PHIPA

A change in the law that is not well appreciated relates to the scope of PHIPA’s application. With some exceptions, personal health information includes every record held by a health information custodian that relates to the individual’s physical or mental health, provision of care to the individual, and other related matters. When PHIPA became law in 2004, what was then informally referred to in clinical circles as “the chart” (i.e., the collection of health information set out in a single paper file for a patient) was effectively expanded to capture “records of personal health information”. This meant that other than records expressly excluded from PHIPA’s application, anything that satisfies the broad definition of “personal health information”, whether in the patient chart or otherwise, is brought under PHIPA. This includes all clinical notes, reports prepared for Review Board and Consent and Capacity Board hearings, family history, information that links the person to the health care provider (i.e., that a person is a patient or client of that provider, such as a hospital or physician’s office), and transfer or placement records between health care facilities. It also applies to all forms of technology that were still relatively new in

upon seclusion” is a valid cause of action in Ontario, and granted summary judgment in favour of the plaintiff, whose privacy had been invaded by the actions of the defendant. The defendant bank was ordered to pay $10,000 in damages. The Court of Appeal also noted that this type of breach could attract damages of up to $20,000.

A full list of PHIPA’s purposes are set out in s. 1(a) of that Act.

For example, s. 9 states that the Act does not apply to personal health information about an individual after the earlier of 120 years of creation or 50 years after the death of an individual; s. 8 sets out limitations related to freedom of information legislation; and there are exceptions to the definition of personal health information in s. 4(4) related to records of employees and records maintained primarily for purposes other than provision of, or assistance in providing health care to employees or other agents.

PHIPA, s 4.
2004 (e.g., email communications, telehealth and telemedicine) versus technologies that have since emerged (e.g., various social media including text messaging, which is used by many mental agencies particularly those with youth clients; discussion boards; Skype and others). It has taken considerable effort for health information custodians to change their systems and general institutional culture, to ensure that all such information is protected in the same way that “the chart” once was. For many, the process is ongoing, and as new technologies continue to become the norm in the health sector, the scope of “personal health information” will continue to expand.

Consent

The general rule under PHIPA is that consent is required for the collection, use or disclosure of personal health information, unless the law permits or requires otherwise. The law does, in fact, provide many circumstances in which such information may be collected, used or disclosed without consent, and as noted above, individuals concerned about stigma and discrimination may feel exposed by these provisions. As evidenced in the submissions to the Select Committee, there is ongoing debate about whether the balance weighs too heavily in the direction of personal privacy or in favour of disclosure. Many family members and health practitioners argue that disclosure will allow the ill person to be better supported in the community, for example, and express frustration that consent of the ill person is too often required before information can be shared with them. This sometimes results in community service providers and family members feeling deprived of important information, even as they are called on to care for a person whose mental illness is progressing while in the community. In these and other situations, the person’s express consent may still be required before information can be shared.

A health information custodian who makes available a written notice can rely on it to ground the individual’s knowledgeable consent, unless it is not reasonable to do so in the circumstances. Many custodians do so by posting the notice in a conspicuous location, or by providing it to each patient or client as they come into hospital, physician’s office or community mental health agency. It is unclear whether health information custodians regularly consider what is “reasonable in the circumstances”, i.e., an acutely ill person in an emergency or admitting, or who is clearly experiencing an acute psychotic break, is unlikely to be paying attention to a poster on a wall or a

206 See PHIPA, ss 36 (collection), 47 (use) and 37-50 (disclosures) for the many circumstances in which this can occur.

207 PHIPA, section 18(3) sets out the rules for express consent. A community service provider that is a health information custodian may be entitled to receive pertinent clinical information based on implied consent; however, either express or implied consent may be withdrawn under section 19(1) of PHIPA.
brochure describing the custodian’s information practices. PHIPA makes it clear under section 18(5) that the custodian would not be entitled to rely on the knowledgeable consent of the person at that juncture; however, it is speculated that some health information custodians do so. In other cases, particularly in mental health settings, some health information custodians have chosen to maintain the express consent model rather than rely on a person’s implied consent.

In addition to a notice of information practices which grounds a knowledgeable consent, the principal drafters of PHIPA state in their Guide to the Ontario Personal Health Information Protection Act: 208

The interpretation of the term “health care” should also reflect the policy of section 20(2) of the Act. This provision permits health care practitioners and specified health information custodians who collect personal health information from a patient or another health information custodian to assume the individual’s implied consent to the collection, use, and disclosure of that information for the purpose of providing health care or assisting in the providing of health care, unless the patient expressly instructs otherwise. A very broad reading of the definition of health care, and thus the definition of health care practitioner, can run contrary to the policy behind this provision, which can be described as facilitating collections, uses and disclosures in the health care system that individuals generally expect to occur without requiring express consent. 209 (emphasis added)

The issue of “what an individual generally expects to occur” is noteworthy, since the concept of the information flowing freely to other health practitioners may or may not be well understood by some patients and clients.

Capacity

Similar to the framework in Ontario governing treatment under the HCCA, capable people have the right to make decisions about how their personal health information will be collected, used and disclosed. If the person has been found incapable under PHIPA for information-sharing purposes, based on a test for capacity almost precisely mirroring the test for treatment capacity set out in the HCCA, 210 an SDM will step into the shoes of the person to make that decision. The test for capacity with respect to

209 Ibid at 42.
210 HCCA, s 4(1).
personal health information rests on the person’s ability to understand the information that is relevant to deciding whether to consent to the collection, use or disclosure (as the case may be) of personal health information, as well as the ability to appreciate the reasonably foreseeable consequences of giving, not giving, withholding or withdrawing the consent.\textsuperscript{211}

In other words, an ill person who remains capable to make such information decisions may choose not to share personal health information with certain individuals (e.g., friends or family members) even if, practically speaking, these are precisely the individuals attempting to provide support to that person at home or in the community, or even while the person is hospitalized. If the ill person has been found incapable with respect to information decisions, and the family member is the highest ranked SDM, information will be shared so that the family member can make appropriate decisions about care, treatment and placement. (Substitute decision-making is discussed further in Chapter 2 of this Report, and the principles applicable in treatment situations are similar to information-sharing under PHIPA.) The capable individual, despite having a serious mental illness, may be found to be unsuitable to be admitted to hospital under the MHA, as discussed in Chapter 1 of this Report, yet even while in the community in the care of family members, may refuse to provide any information to about his or her health status. This creates a potentially difficult situation for families, who have advocated quite vigorously (in their capacity as individuals as well as through such groups as the Schizophrenia Society of Ontario) that changes are needed to PHIPA to remove what they consider to be barriers to receiving necessary information.

\textbf{Issues}

\textbf{Who “needs to know”?}

The Select Committee has asked whether privacy legislation has created barriers in the mental health system. It focused on whether personal health information should flow more readily beyond the realm of health practitioners with a clinical “need to know”, in order to provide broader care and support to an ill person who chooses to withhold potentially relevant information. Expanding the “circle of care” in which health practitioners involved in a person’s care can readily share information without consent

\begin{footnotesize}
\textsuperscript{211} PHIPA, s 21(1).
\end{footnotesize}
to include family members has been discussed as a potential solution. At present in Ontario, family members cannot receive personal health information in this manner.

When a motion was made in the Ontario Legislature to move forward in 2008 with a statutory 3-year review of PHIPA, the emphasis was in part on enhancing the flow of personal health information to support health care. But even at that time, the Standing Committee on Social Policy heard significant feedback about the ways in which PHIPA has limited the flow of information if an individual does not wish the information to be shared. One group appearing before the Committee noted a key difference between PHIPA in Ontario and what is permitted under British Columbia law:

Here is an excerpt from the Guide to the Mental Health Act, 2005, from British Columbia: “If a client’s personal information was collected for health care purposes, public bodies may release necessary information to third parties for ‘continuity of care.’ This means public bodies may disclose personal information to health care professionals, family members, or to other persons, such as friends and relatives, involved in a client’s care for the purpose of that care. The release of the information must be in the best interests of the health of the client.”

PHIPA does not contain a provision that would permit disclosure without consent to family members for purposes of ‘continuity of care’. Similar to the HCCA, upon which the consent and capacity rules were modeled, PHIPA remains a consent-based statute. Coupled with this, there is sometimes uncertainty on the part of health information custodians about what can and cannot be shared with family members; and what role that family member plays or authority has been given to that family member statutorily.

---

212 PHIPA does not incorporate the term “circle of care”. It is a colloquial term sometimes used in Ontario, often a source of confusion, to generally describe the health information custodians involved in the provision of care to a person, who are thereby entitled to use (section 37(1)) and disclose (section 38(1)) personal health information for purposes related to health care. It is also used in other Canadian provinces; see, the Saskatchewan Office of the Information and Privacy Commissioner’s “Glossary of HIPA terms” at: http://www.oipc.sk.ca/Resources/HIPA%20Glossary%20-%20Blue%20Box.pdf (last accessed July 9, 2012).

213 Ontario, Legislative Assembly, Official Report of Debates (Hansard), No 52 (3 June 2008) at 2223.

Expanding the concept of the circle of care to include family members has occurred in other Canadian jurisdictions. For example, the perils of limiting information-sharing to a narrow, clinical “circle of care” have been discussed in the context of Saskatchewan’s *Health Information Protection Act*: 215

(1) It puts the focus on a variety of roles and persons within trustee organizations as to whether they are or are not a member of the “club” instead of focusing on the patient and the particular care transaction in question. The better approach is to utilize the “need to know” principle in section 23 of HIPA which focuses not on the provider as much as it does on the individual patient and the health needs presented in any particular health transaction.

(2) It suggests a static kind of entitlement to information. In fact, the circle of care should likely change, even for the same patient, if the patient seeks treatment on Day 1 for a fractured femur and then returns to the same facility on Day 2 for a dietary issue or a mental health problem. There will perhaps be an entirely different group of health workers dealing with the injury on Day 2 than treated the fracture on Day 1. Every member of the Day 2 health care team may not be entitled to all of the [personal health information] collected, used or disclosed on Day 1. A number of trustee organizations in their policies and training material have developed long lists of suggested or possible circle of care members. In our experience this is often misunderstood as a kind of green light for sharing [personal health information] among all of those members without regard to the particular patient and the particular health transaction.

(3) The circle of care in the training material and policy of a number of trustee organizations is restricted to trustees and their employees. In our view this is unduly restrictive. Reliance on need-to-know permits disclosure in appropriate circumstances to non-trustees. Using the need-to-know principle, it is not uncommon that even non-trustees may, from time to time, require certain [personal health information] in the course of the diagnosis, treatment or care of the patient (e.g. a police officer who is transporting a sick individual to a different care facility, an adult child providing temporary housing for a senior being discharged from an acute care facility or even a teacher or day care worker who needs to monitor a child for certain adverse drug reactions).

215 *Health Information Protection Act*, being Chapter H.0.021 to the *Statutes of Saskatchewan*, 1999 (“HIPA”).
In our experience, a much better practice is to focus on the patient’s particular needs and the particular health transaction. This can be done by concentrating on which individuals/roles have a demonstrable need-to-know (per section 23 of HIPA) for some or all of the patient’s [personal health information].

In Ontario, the important role of non-clinical supporters in an ill person’s life is generally acknowledged:

Family members and friends often serve as caregivers to people with mental illnesses, providing informal case management, crisis intervention and assistance with system navigation, while also observing health changes and maintaining records of previous treatment and medication regimes.\(^{216}\)

Nonetheless, it would be a very significant step to change the balance struck in PHIPA to broaden the flow of personal health information based on implied consent beyond health information custodians involved in a person’s care. Family members, other than those who have assumed the role of a person’s SDM or who fall under only a few other provisions in PHIPA to receive personal health information without consent\(^ {217}\) are currently subject to the express consent rules. Expanding PHIPA to include family members as part of the largely clinical group currently permitted to receive personal health information based on implied consent would be a significant shift from the current emphasis in Ontario law on autonomy (strongly evidenced in chapter 2 of this Report in terms of bodily integrity, and here with respect to an individual’s right to control his or her own personal health information).


\(^{217}\) For example, under s. 38(3), if the health information custodian is a public hospital or long-term care home, it also has discretion under PHIPA to confirm the fact that the individual is a patient or resident in the facility; general health status (in general terms further described in the Act), and the location in the facility (which arguably could tell something about the care being provided in the facility, e.g. Jane X is on the Mood Disorders Unit). However, the health information custodian must have first offered the individual the option, at the first reasonable opportunity after admission to the facility, to object to such disclosures, and if the individual objects, the information cannot be disclosed. In practice, some mental health facilities, based on their historical practice (and perhaps with regard to whether and how they would provide clients a meaningful opportunity to say No) do not exercise this discretion to disclose without express consent of the individual. That provision also does not address the question of disclosure of relevant personal health information as the ill person returns to the community, often into the care of family members. PHIPA also permits disclosure of personal health without consent in a number of circumstances if an individual is deceased (s. 37(4)).
An additional consideration is that given PHIPA’s implied consent rules, merely amending PHIPA to expand what is thought of as a “circle of care” may not accomplish what a concerned family member wishes. That is because in Ontario, the individual retains the right under PHIPA to withdraw implied consent from those health information custodians involved in his/her care. This is quite a different proposal than allowing disclosure for continuity of care in the best interests of the individual.

**Limitations on collection and use**

Health practitioners are generally familiar and comfortable with their confidentiality obligations not to disclose information without the consent of the patient unless the disclosure is permitted or required by law. These requirements have been part of their professional obligations for many years, predating PHIPA for most health professions. However, the principle of “limiting collection” of personal health information is a new concept for many.

PHIPA also espouses a number of general limiting principles, including that health information custodians must only collect the minimum information required to fulfill the particular purposes. If personal health information is not required, personal health information must not be collected. The limiting collection principle also introduces an imperative to collect personal health information from an individual directly where possible.

In the mental health sector, there is significant reliance on the collection of personal health information from sources other than the individual to whom the information relates, such as family members, other health practitioners, the police and the courts. PHIPA allows a health information custodian to collect personal health information indirectly (that is, from someone other than the patient) for any of the following reasons (among others):

- With the individual’s consent;

---

218 PHIPA, s 30(1) and (2).
219 Under s 36(2) of PHIPA, direct collection of personal health information from the individual may occur even if the person is incapable of consenting, if the collection is reasonably necessary for the provision of health care and it is not reasonably possible to obtain consent in a timely manner.
220 PHIPA, s 36(1)(a).
• The information is reasonably necessary to provide or assist in providing health care and it is not reasonably possible to collect accurate or complete information directly from the individual, or in a timely way;221
• The Information and Privacy Commissioner/Ontario authorizes it (to date, there is no indication that she has made any such decisions);222 or
• The custodian is permitted either under PHIPA or another law (such as a Form 1 collection of collateral information from family or others) to collect indirectly.223

Some health information custodians are unaware that even when they collect information from a third party because they cannot get that information from the individual (or elsewhere) in a timely or accurate way, the individual can later require that the information not be relied on (of course, in a Form 1 situation, collateral information can always be collected and relied upon).224 Although not all family members are aware of this rule in PHIPA, it is possible that this could also be a source of frustration to them in that they are successful in providing important information, only to have the ill person later instruct that the information not be used. (Whether the health information custodian actually appreciates the nuance and has a system to ensure that the information not be used is a different question.)

The MHA also allows an officer in charge of a mental health facility to collect information without the consent of the individual in order to examine, assess, observe or detain the individual under the MHA.225 Further, it allows an officer in charge to collect personal health information without consent for the purposes of complying with Part XX.1 of the Criminal Code (the mental disorder or “forensic” provisions) or to comply with an order or disposition under that Part. These forensic provisions are usually relied upon in the mental health system for mentally ill accused subject to court ordered assessments or detained under a disposition of the Ontario Review Board. It should also be noted that reliance on s. 35(2) of the MHA is not subject to oversight of the Information and Privacy Commissioner/Ontario; the MHA prevails over PHIPA in this instance.226 As a result, a person detained in a mental health facility under the MHA or the forensic provisions will have little success in

221 PHIPA, s 36(1)(b)(i) and (ii).
222 PHIPA, s 36(1)(f).
223 PHIPA, s 36(1)(h).
224 PHIPA, s 37(1)(a), in reference to personal health information collected under s. 36(1)(b) and the individual expressly instructs the health information custodian not to use the information.
225 MHA, s 35(2).
226 MHA, s 34.1.
challenging the collection, use or disclosure of his or her personal health information in the circumstances described above.

However, subsection 35(2) of the MHA does underscore the balance society strikes, in that a person detained involuntarily in those circumstances gives up certain rights to protect his or her personal health information in accordance with PHIPA. The Legislature considered carefully that to permit an involuntarily detained person to refuse to share some or all personal health information with his or her health practitioners, yet remain involuntarily detained under legislative authority (whether the MHA or the *Criminal Code*), would be contrary to the purposes of PHIPA, which are:

1(a) to establish rules for the collection, use and disclosure of personal health information about individuals that protect the confidentiality of that information and the privacy of individuals with respect to that information, while facilitating the effective provision of health care; (emphasis added)

(b) to provide individuals with a right of access to personal health information about themselves, subject to limited and specific exceptions set out in this Act;

(c) to provide individuals with a right to require the correction or amendment of personal health information about themselves, subject to limited and specific exceptions set out in this Act;

(d) to provide for independent review and resolution of complaints with respect to personal health information; and

(e) to provide effective remedies for contraventions of this Act.

**Disclosure in risk situations**

While many health care providers, including mental health facilities and those working in community mental health settings, are well versed about the privacy rules and are poised to deploy them, others sometimes experience what is informally referred to as “privacy paralysis”. An earnest desire to follow the rules is undermined by uncertainty about what the rules are, resulting in not sharing relevant personal health information, even when the information can and should be disclosed. For example, in a risk situation, disclosure is permitted under PHIPA as a “discretion to
warn”, to eliminate or reduce “a significant risk of serious bodily harm”. \(^{227}\) In that circumstance, relevant information can be shared with anyone, including family members. In the authors’ own experience, this provision is rarely if ever relied on to share personal health information with family members, likely because it is unlikely that the risk threshold would be met. Families appear to be seeking highly relevant yet more routine kinds of information, to optimize their ability to assist a loved one long before an elevated risk scenario unfolds.

It is also the authors’ view, as noted in Chapter 1 of this Report, that the nuance that “serious bodily harm” includes psychological harm is generally not well understood among health practitioners, nor by families who support mentally ill persons. To wit, one presenter stated before the Select Committee:

The problem in Ontario is this: In order to be admitted involuntarily on a first episode, a seriously mentally ill person must be likely to be physically dangerous; that is, in the words of the act, likely to cause “serious bodily harm.” And it doesn’t include psychological harm, as was mentioned by the previous speaker. This leads to many people with a psychosis who are not likely to cause serious bodily harm to themselves or others, but who suffer or cause other serious harms, not being admitted.\(^{228}\)

The inherent issue may be that while the Supreme Court of Canada has confirmed that serious bodily harm includes psychological harm, this is not well understood at the front line as an additional means to share information in order to seek and/or facilitate assistance for someone who is ill, and to share personal health information under s. 40(1) of PHIPA.

It is also sometimes misunderstood that the s. 40(1) discretion to warn provision permits health information custodians to disclose personal health information to “any person”, whether police, a concerned family member, or some other third party. While we do not suggest that it would be appropriate to see this provision used in an overly

\(^{227}\) PHIPA, s 40(1). “Significant risk of serious bodily harm” includes both emotional and psychological harm. The CCB has adopted the definition of “serious bodily harm” from a SCC case in criminal law, 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.” (RE. J.S., 2004 CanLII 46818 (Ont.C.C.B.), adopting the definition in R. v. McCraw, [1991] 3 S.C.R. 72 at 81; emphases added).

broad manner, it does offer some option for custodians to be able to share information in a circumstance that is not widely relied on at this time.

**Lockbox**

It is also important for health care providers and patients to understand what is meant by “lockbox” (a term which is commonly used but is not used or defined in the legislation. PHIPA creates a relatively narrow opportunity for a person to restrict personal health information from being provided to other health care providers.\(^\text{229}\) The person has the right to expressly request that certain health care providers not be provided with select personal health information. This express instruction cannot be used to stop information from being shared outside that context (for example, where PHIPA provides that certain information can be used or disclosed without consent, this can and will continue to happen). It comes as a surprise to some individuals that the lockbox does not extend to collections, uses and disclosures of personal health information that are otherwise permitted or required under PHIPA (or other Acts) without consent. Similarly, some families assume that the ill person can “lock” information away for all purposes, a view sometimes perpetuated by health information custodians.

This section cannot be used to restrict information sharing with “non-health care providers”, such as family, employers, police, schools, insurers and others, because those disclosures require express consent and an individual can refuse to provide consent. Individuals do sometimes have unrealistic views on what an express instruction (or informally, a “lockbox”) can give them – because they believe that by putting one in place, none of their information will be shared unless they expressly authorize it. The only duty of the health information custodian who receives an express instruction not to share the information is that he or she must advise any intended recipients if the full record is not being provided.\(^\text{230}\) In practice, it is simply left to the would-be recipient to raise with the person whether (or what) he or she wishes to share, giving rise to an opportunity to emphasize that the best care depends on reliable health information being provided, and perhaps a nuanced explanation of what limited information is needed in the circumstance in order to provide care.

\(^{229}\) PHIPA, s 38(1).

\(^{230}\) PHIPA, s 38(2).
Conclusion

The question remains, do the rights of the individual vis à vis their personal health information create the appropriate balance between flow of information to support care and that person’s autonomy? It can be a frustrating situation for all concerned: the ill person, the deeply concerned family members who just want their loved one to be well and achieve or return to a good life and the health practitioners (including case workers in the community) who are at odds about how much personal health information can and should be shared.

That said, while it is unlikely that privacy laws would be changed so drastically as to remove all controls on how personal health information is shared, some changes may be possible which would help both mentally ill persons and those seeking to help them (e.g. family members or concerned others). In some jurisdictions, expanding the informal concept of “circle of care” now reserved for health practitioners currently involved in the person’s care to include families remains a live issue. But first and foremost, further education about the scope of significant bodily harm and the current discretion under PHIPA to actually share related information may also be helpful. It is not necessarily a full answer, since families and some advocates would suggest that the information should flow much earlier than s. 40(1) contemplates. Subsection 40(1) creates an opportunity to disclose only where the risk is highly elevated, and not in the more preventive and/or proactive manner desired by families who wish to intervene earlier than that.

One of the perils of PHIPA will always be the extent to which health information custodians and patients alike understand the nuances of their rights and/or obligations under it. Education of health information custodians and their “agents”\(^\text{231}\) is an ongoing challenge, as evidenced by the authors’ personal experience in providing PHIPA training over the more than eight years since the Act came into force in Ontario. The Information and Privacy Commissioner/Ontario also notes the need to make privacy part of the culture of the organization.\(^\text{232}\) One surmises that if that were to occur, greater trust in the system could lead to more sharing of the information that is sometimes a barrier to accessing required care.

\(^{231}\) PHIPA, s. 4(1); an agent is someone who collects, uses or discloses personal health information on behalf of the health information custodian.

CHAPTER 4 - CHILDREN’S MENTAL HEALTH

Overview/Summary

1. How the legislation works
2. The policy intent of the legislation
3. Issues

Overview/Summary

This chapter outlines the various legislative provisions that define the legal landscape for consent to psychiatric and related treatment and the capacity to make those decisions as well as substitute decision-making, specifically as they relate to children.

According to the Office of the Provincial Advocate for Children and Youth for Ontario, 15-21% (or between 467,000 and 654,000) children and youth have a mental health need. Though mental health services are available for children and youth, there is no single legislative scheme that unifies all of them. Instead, care is offered by several different agencies and ministries (including the Ministry of Children and Youth Services, the Ministry of Health and Long-Term Care and the Ministry of Education) acting on the basis of or in accordance with different mandates (legislated or otherwise). The result may be that whereas many of the key legal mental health concepts are understood (despite the need for improvement in this area) in relation to adults, they may be less so in relation to children.

Currently, the CFSA, HCCA and MHA are the three pieces of legislation that define, for the most part, the legal contours of the provision of mental health services for children (the YCJA does to a much lesser extent). The CFSA’s primary purpose is to “…to promote the best interests, protection and well-being of children”. It explicitly recognizes the need for child treatment services and provides access to treatment for

---

234 CFSA, s 1(1).
235 In the CFSA, s 1(1), a “child treatment service” is defined as a service for a child with a mental or psychiatric disorder, for the family of a child with a mental or psychiatric disorder or for the child and family. However, as of the date of publication of this Report, no regulations have been put forward identifying what these treatment services would entail.
children with mental health issues by establishing a civil committal regime that is distinct from the MHA. Committal to a secure treatment program and the subsequent administration of psychotropic drugs are the only two treatment options contemplated by the CFSA, and issues of capacity and consent are discussed only in that very narrow context. The CFSA does not address a child’s committal to other types of health care settings nor does it outline broader rules relating to consent to treatment or capacity that may be unique to children. As currently drafted, the CFSA is not a comprehensive code governing the provision of mental health services (including treatment) for children. Rather, it provides an alternative route to receiving treatment for mental disorders in children.

By contrast, the HCCA (as discussed in detail in section 2) applies broadly to persons of any age. The HCCA creates a legislative framework for treatment, and in relatively narrow circumstances, for the admission and treatment of informal patients in designated psychiatric facilities. A young person may certainly be treated pursuant to the HCCA and detained under the MHA (although the latter is somewhat rare).

Similarly, the rules under PHIPA have general application, although unlike the HCCA, there are special rules that apply to children which will be discussed further below. Lastly, a brief commentary on the information-sharing limitations in the federal *Youth Criminal Justice Act* (“YCJA”) is provided.

**How the legislation works: the provisions**

**Health Care Consent Act**

**Capacity**

As described in Chapter 2, the HCCA assumes that every person is capable of making treatment decisions until he or she is found to be incapable.236 Furthermore, a person is capable if he or she is *able* to understand the information that is relevant to making a decision about the treatment and *able* to appreciate the reasonably foreseeable consequences of a decision or lack of decision.237

So how does this presumption of capacity play out in the case of children? Practically speaking, when one thinks of a “child”, assumptions are often made about age, and in so doing, about capacity – despite the fact that both the HCCA and the common law have

236 HCCA, s 4(2).
237 HCCA, s 4(1), emphases added.
held that age is not dispositive of capacity. No one would dispute that babies and toddlers are incapable of making decisions relating to their treatment by the fact of age alone. At the other end of the spectrum, most would allow that “children” between the ages of 16 and 18 are increasingly less childlike and therefore more likely to be considered capable of making treatment decisions related to their care. This is evident even in the HCCA where, for example, SDMs (who must themselves be capable to make the treatment decision in question, among other criteria) must follow the prior capable wishes of a person who at the time the wish was made was both capable and 16 years or older. In the CFSA, “child” is defined as “a person under the age of eighteen years” while a young person is someone who, “…appears to be 12 years or older but less than 18 years old…”

While decisions relating to capacity are not always straightforward, they are particularly nuanced where they are being made in relation to a child between the ages of 12 and 15 or even younger. In these cases, there is real difficulty when assessing capacity to adhere to the presumption of capacity in the HCCA without giving undue consideration of a child’s age. In the “mature minor” line of cases, the courts have tried to reconcile these two imperatives by asserting that, consistent with the HCCA, for children in this age group, capacity is a matter of maturity, not age. For example, in A.C. v. Manitoba (Director of Child and Family Services), a 14-year old girl of the Jehovah’s Witness faith who was suffering from gastrointestinal bleeding attributed to Crohn’s disease had signed an advance directive indicating her wish not to receive blood under any circumstances.

On the recommendation of her physician, the Director of Child and Family services sought a treatment order from the court under the Manitoba Child and Family Services Act by which the court could order treatment that it considered in the best interests of the child. The Act further presumed that the best interests of a child who was 16 or older would be most effectively promoted by allowing the child’s views to be determinative, unless otherwise shown. For a child under 16, there was no such presumption. The court ordered that the girl receive the proposed treatment. She and her parents subsequently claimed that the legislative scheme was unconstitutional because it unjustifiably infringed the girl’s rights under ss. 2(a), 7 and 15 of the Charter.

---

238 This is implicit in the presumption of capacity under the HCCA.
239 HCCA, s 21(1) para 1.
240 CFSA, s 3(1).
241 CFSA, s 3(1).
243 The Child and Family Services Act, CCSM c C.80.
In upholding the contested sections of the Manitoba Act as constitutional, the Supreme Court of Canada ostensibly established that the capacity of children under 16 to make their own treatment decisions was, “…ultimately calibrated in accordance with maturity, not age…” Furthermore, the court outlined several factors relevant in assessing a child’s maturity including:

- The nature, purpose and utility of the recommended medical treatment and its risks and benefits;
- The adolescent’s intellectual capacity and the degree of sophistication to understand the information relevant to making the decision and to appreciate the potential consequences;
- The stability of the adolescent’s views and whether they are a true reflection of his or her core values and beliefs;
- The potential impact of the adolescent’s lifestyle, family relationships and broader social affiliations on his or her ability to exercise independent judgment;
- The existence of any emotional or psychiatric vulnerabilities and the impact of the adolescent’s illness on his or her decision-making ability; and
- Any relevant information from adults who know the adolescent.

Despite the court’s guidelines, there is no doubt that in some instances maturity will be conflated with age. However, health care providers should keep in mind that deciding on a person’s capacity is always a contextual exercise. Therefore, while age may be a consideration when it comes to children, it is by no means the only, or sometimes not even the most, important consideration.

Discussions of age when assessing capacity aside, children, like adults, also have to be able to demonstrate their ability to appreciate the reasonably foreseeable consequences of a decision or lack of decision. For example, in L. C. v. Pinhas, a 15-year old girl with a diagnosis of anorexia was found incapable with respect to the aspects of her treatment dealing with her nutritional rehabilitation. On appeal to the Ontario Superior Court, the judge held that the CCB finding of incapacity was reasonable. It distinguished the case from Starson saying that, unlike Professor Starson, it was L.C.’s disorder itself which impeded her ability to appreciate the reasonably foreseeable consequences. The court went on to say that:

…if it is the disease or disorder itself which creates the circumstances in which
the patient behaves in a manner inconsistent with the recommended treatment, then the behaviour is simply a manifestation of the way in which the disease or disorder causes the patient to be unable to appreciate the reasonably foreseeable consequences. In those circumstances, it would be reasonable for a Board to rely on that behaviour without the reliance constituting a third criterion.248

In practice, it can be challenging to make a determination of capacity for children especially when they are younger than 16. However, emerging clinical tools have been designed to assist health care practitioners to make determinations of incapacity of their young clients.249 For the purposes of the ensuing discussion, a child will be presumed to be a person between the ages of 12 to 17250 unless otherwise indicated and who is in the care of a parent or legal guardian, not a society or Crown ward.

**Prior capable wishes (right to be free from unwanted treatment)**

The HCCA recognizes that a person who was at least 16 years of age when he or she expressed capable wishes with respect to certain treatments, should have those wishes respected.251 This holds true even in emergency situations252 though there is an outlined process whereby those wishes may be overridden in certain circumstances.253 Additionally, in emergencies, the authority to treat can include the authority to have the person admitted to a psychiatric hospital for the purposes of treatment. However, regardless of age, this can only be accomplished if the person does not object to the admission and the treatment is not primarily treatment of a mental disorder.254 By contrast, as further discussed below with respect to informal admissions, a child between the ages of 12 and 15 may be admitted to hospital under the MHA if incapable, by his or her SDM, for purposes of treatment, despite his or her objection. The HCCA does not contemplate the reliance by children of this age on prior capable wishes not be treated.

---

250 A “child” as defined in section 3(1) of the CFSA is “under the age of 18”.
251 HCCA, s 21(1) para 1.
252 HCCA, s. 26.
253 For example, together sections 25 – 27 generally contemplate emergency treatment without consent for both capable and incapable persons though considerations must also be given to an incapable person prior capable wishes.
254 HCCA, s 28.
Committal of Children for Treatment

A child may be committed for treatment under either the CFSA or the MHA. Chapters 1 and 2 broadly outline the process for the involuntary admission of a person to a psychiatric facility under the MHA and the rules with respect to consent and capacity respectively. It is assumed that those same concepts apply to children though there may be an age at which a child is objectively considered too young to be admitted involuntarily under the MHA. As noted in Chapter 1, provisions were also added in the 1986 and 1987 amendments to the MHA allowing children between 12 and 15 years of age to apply to review boards for review of their committal by a parent; prior to this, such review was not allowed and any parent or person standing in loco parentis (such as a Children’s Aid Society) could commit a child without any recourse to review. References to the “age of majority” were replaced with “16 years of age”.

This section will therefore first focus on the relevant sections of the MHA and HCCA as they apply to children with mental disorders who are admitted to psychiatric facilities as informal patients. Secondly, this section will outline the CFSA scheme for committal as well as the administration of psychotropic drugs.

Mental Health Act

A child can be admitted to a psychiatric facility under the MHA as an informal patient upon the recommendation of a physician who believes that the child is “…in need of the observation, care and treatment provided in a psychiatric facility”. An informal patient is one who is incapable and whose SDM has consented to their admission to a psychiatric facility under section 24 of the HCCA.

Informal patients – 16 and over

If the proposed informal patient is a child who is 16 or older and who objects to admission to a psychiatric facility, the child can only be admitted if his or her SDM is his or her guardian of the person (properly authorized) or his or her attorney for personal care if the power of attorney contains certain provisions.

It is important to note that under this section, it is only when the incapable child is objecting to the admission to a psychiatric facility for the purpose of treatment of a mental disorder, does his or her admission require a SDM with the special powers

---

255 MHA, s 12.
256 HCCA, s 24(2).
detailed above. Presumably then, where consent is otherwise given for admission to a hospital or other health care facility, and the incapable child objects, his or her broader rights of appealing the admission decision are outlined in section 34(1) of the HCCA. Here, the SDM can consent to the admission after which the child can make an application to the Board for review. Section 34 allows the child to be admitted and treatment administered even though a disposition of the consent decision might be still pending. 257

After being admitted as an informal patient, a child who is 16 years or older who continues to object to his or her admission to the psychiatric facility for the treatment of a mental disorder can potentially leave the facility against medical advice since he or she cannot be made to stay against his or her wishes. 258 As detailed in a talk given at the 2009 Osgoode National Symposium on Mental Health Law:

…an incapable person aged 16 years or older who objects to being admitted to a psychiatric facility for treatment of a mental disorder could only be detained on the basis of an involuntary admission under the MHA…; that is, a parent as SDM does not have the simple ability to provide a substitute consent to a detention on an adolescent aged 16 or over in a psychiatric facility over the adolescent’s objection (except arguably, in an emergency situation). 259

Even where a facility may decide that it does have the legal right to detain an incapable child over 16 who is objecting to the admission, it is clear that sometimes a practitioner may decide against detention for clinical as opposed to legal reasons:

…there would appear to be some consensus among physicians that short of needing to do something to literally save a child’s life, limb or organ, the action of restraint and detention is not therapeutic, and would therefore be withheld not so much for legal reasons as for clinical reasons. 260

Alternatively, the child can make an application to the CCB for review of the consent decision of his or her SDM. 261

---

257 HCCA, s 34(3).
258 MHA, s 14.
261 HCCA, s 34(1).
Informal patients between the ages of 12 and 15

Unlike older informal patients, section 24 of the HCCA does not contemplate or provide for the objections of proposed informal patients between the ages of 12 and 15. Rather, where the proposed informal patient is a child who is at least 12 years old but not yet 16 and who objects to the consent given by his or her SDM for admission to a hospital, psychiatric or other health care facility, the HCCA explicitly forecloses the child’s right to apply to the CCB for review of the consent decision. Presumably then, as long as the SDM is acting in the best interests of the child and the other admission requirements are met, he or she will be admitted as an informal patient regardless. However, once the child has been admitted to a psychiatric facility as an informal patient, he or she is empowered under the MHA to apply to Board to “inquire” into the ongoing necessity of his or her continued observation, care and treatment. With the assistance of a rights adviser, the child can make an application to the Board every three months for a review of his or her status as an informal patient.

Two final points must be made. First, it is not clear how young is too young to be admitted as informal patient (or, for that matter, an involuntary patient). Commentary appearing on the Psychiatric Patient Advocate Office’s website seems to suggest that there can be informal patients under the age of 12. Nothing in the HCCA or the MHA would seem to preclude this. Secondly, once a child has been admitted to a psychiatric facility, the rules with respect to his or her capacity and consent or refusal treatment as outlined by the HCCA apply.

Child and Family Services Act

Secure Treatment Programs

Committal under the CFSA is a separate civil regime than the one outlined in the MHA. Coming under Part VI (Extraordinary Measures) of the Act, the CFSA sets out the

---

262 HCCA, s 34(2).
263 MHA, s 13. An “inquiry” seems to suggest something less than a review – the process for which is prescribed by the legislation.
264 MHA, s 13(5).
265 See http://www.sse.gov.on.ca/mohltc/ppao/en/Pages/InfoGuides/ListofallInfoGuides.aspx?openMenu=smenu_InfoGuides where children under 12 are advised that they cannot apply to the Consent and Capacity Board for a hearing about their admission as an informal patient. However, they can apply to the Board to review the doctor’s finding that they are incapable with respect to a treatment and if the Board agrees, children will be able to make their own decision about the treatment. There will be no authority to admit the child as an informal patient.
process for admission to a “secure treatment program”. Secure treatment programs are established or approved by the Minister of Children and Youth Services specifically for the treatment of children with mental disorders, in which continuous restrictions are imposed on the liberty of children. As of July 20, 2010, there were only three programs that had been established or approved under this section: Youthedale (Toronto, 10 beds); the Robert Smart Centre (Ottawa, 8 beds) and the Syl Apps Youth and Secure Treatment Centre (Oakville, 20 beds). Committals under the CFSA can take place through standard processes or via emergency provisions.

Admission

Unlike the MHA, where involuntary admission is a two-stage process consisting of an examination and an assessment, and an informal admission which takes place upon the recommendation of a physician, admission via the CFSA begins with an application for an order of committal by a child or his or her parent. CFSA applications for orders of committal for children between the ages of 12 and 15 may be made by the child’s parent, among others. However, where the application for committal is being made by the parent of a child who is 16 or older, the child must also consent to the application. Alternatively, the child may apply on his or her own behalf. Lastly, where an application is being made with respect to a child who is younger than 12, there is an additional requirement of the Minister’s consent to the commitment before the court order can be made.

An order for committal may be granted where the courts are satisfied that a number of criteria have been met including:

- that the child has a mental disorder;
- that there has been recent successful or attempted seriously bodily harm to self and others; and
- that the secure program would be effective in preventing the child from causing or attempting to cause serious bodily harm to self or others.

266 CFSA, ss. 112 and 113(1).
268 CFSA, s 114(1) para 1.
269 CFSA, s 114(1) para 2(ii).
270 CFSA, s 114(1) para 2(i).
271 CFSA, s 117 (2).
272 CFSA, s 117(1).
When considering these criteria, the court may determine that it needs additional information to assist with its decision and so arrange for the child to be assessed. The assessment is performed by a “specified person who is qualified” but not necessarily a physician\textsuperscript{273} and the resulting report must be provided to certain persons, including a parent, the administrator of the secure treatment program, and, where the child is an Indian or a native person, a representative chosen by the child’s band or native community.\textsuperscript{274} The grant of a committal order is discretionary – despite hearing oral evidence and other additional information, the court may decide that the order is not in the child’s best interest.\textsuperscript{275} However, once a court order is made for secure treatment of a child, the court must provide reasons for its decisions, a statement of the plan, if any, for the child’s care on release from the secure treatment program; and a statement of the less restrictive alternatives considered by the court, and the reasons for rejecting them.\textsuperscript{276} Additionally, the order can be extended or terminated upon review.

**Emergency Committal under the CFSA**

The process outlined above is substantially the same in the case of emergency admissions with some key differences. First, in an emergency, applications for commitment are made to the administrator, not to the courts.\textsuperscript{277} In assessing the suitability of the order, the administrator takes into account many of the same criteria considered by the courts. Secondly, an emergency order cannot exceed thirty (30) days. In contrast, orders made by the courts cannot initially exceed 180 days.\textsuperscript{278} Third, in an emergency, a child may be admitted by the administrator even where the child has not caused, attempted to cause or by words or conduct made a substantial threat to cause serious bodily harm to self or others if the child consents (after obtaining legal advice) or, where the child is younger than 16, the parent consents.\textsuperscript{279} Lastly, the legislation provides for applications for review of emergency committals though treatment may be administered even while a resolution of the application is pending.\textsuperscript{280}

\textsuperscript{273} CFSA, s. 116(1). A similar scheme exists in section 34 of the federal *Youth Criminal Justice Act*, which will be discussed further below, for medical or psychological assessment on order of a youth justice court.

\textsuperscript{274} CFSA, s 116(4).

\textsuperscript{275} CFSA, s 117(1) and *Children’s Aid Society of the Niagara Region v. H.P.* [2003] O J No 3815, para 47.

\textsuperscript{276} CFSA, s 119(1).

\textsuperscript{277} CFSA, s. 124(1).

\textsuperscript{278} CFSA, s. 118(1).

\textsuperscript{279} CFSA, s. 124(3).

\textsuperscript{280} CFSA, s. 124(9).
Secure Isolation

Within a secure treatment facility, secure isolation rooms or locked rooms may be used as a temporary de-escalation strategy in risk abatement in situations where a child’s or a young person’s conduct is suggestive of imminent risk of serious damage to property or harm to others. In this section of the CFSA, a distinction is drawn between a “child” (a person under the age of 18) and a “young person” (a person who is, or in the absence of evidence to the contrary, appears to be 12 years of age or older but less than 18 years old and, if the context requires, includes any person who is charged under the federal Act with having committed an offence while he or she was a young person or who is found guilty of an offence under the federal Act.

Time limits and observation

When a child is younger than 12 years of age, a Director must give permission for the child to be placed in a secure isolation room. Generally, the legislation limits the time a child or young person can spend in an isolation room to one hour unless the person in charge of the premises approves a longer period in writing and records the reasons for not restraining the child or young person by a less restrictive method. However, with longer isolation periods come observation obligations. Depending on his or her age, a child or young person must be observed in 30-minute intervals (young person under the age of 16) or in two-hour intervals (young person aged 16 or older).

The presence of a secure isolation room or locked room within a facility must be approved by the Director but approval may be withdrawn if the Director believes the room is not necessary or being used in a manner that contravenes the CFSA. A secure isolation room should not be used as a bedroom for a child or young person who is in secure isolation and should contain:

---

281 Generally, under s 127, the limit of detention in a locked room in any one instance is 1 hour (unless otherwise approved and documented) to a maximum of eight hours in any one 24 hour period or an aggregate of 24 hours in a given week. Additionally, the child or young person must be released as soon as the risk of their causing serious property damage or seriously bodily harm in immediate future has diminished.
282 CFSA, s 127(7).
283 CFSA, s 1(1).
284 CFSA, s 1(1).
285 CFSA, s 127(3)(b).
286 RRO 1990, Reg 70, s 47 (1) and (2).
287 CFSA, s 126 (1) and (2).
- a window that is unbreakable or some other means of observing the child or young person;
- lighting that is adequate to ensure compliance with the continuous observation requirement (for children under 16);
- no objects that could be used by the child or young person as instruments of injury or damage.\(^{288}\)

**Psychotropic Drugs**

The CFSA also establishes rules for the administration of psychotropic drugs, presumably as treatment for a mental disorder. Under the CFSA, this class of drugs can only be administered with consent – either the child’s (where he or she is 16 or older) or the child’s parent (where the child is younger than 16).\(^{289}\) In addition, where the child is younger than 16 or lacks capacity, no drugs shall be administered without first considering the child’s views and preferences, where they can be reasonably ascertained.\(^{290}\) The legislation ensures that a child or his or her parent cannot consent to the administration of psychotropic drugs generally. The consent must be specific with respect to what drug; what condition the drug is addressing; the range of intended dosages; the risks and possible side effects; the frequency with drug will be given; and the period of time during which the psychotropic drug will be administered.\(^{291}\)

**Issues**

There is a general presumption that any gaps left by the CFSA are filled by the HCCA – with the HCCA stipulating the rules for consent to treatment. This presumption of the applicability of the HCCA to children exists for two key reasons. The first is that neither the HCCA (nor the MHA) explicitly excludes children from their scope (the HCAA only references “person” which is an undefined term in the legislation). Secondly, as noted earlier, the scope of the CFSA with respect to children’s mental health is fairly narrow and it is silent on matters of capacity and consent outside its own prescribed committal regime.

That being said, for families and health practitioners, it may not always be immediately clear or obvious how these pieces of legislation should be read together, especially with

\(^{288}\) RRO 1990, Reg 70, s 44(1).
\(^{289}\) CFSA s 132 (1).
\(^{290}\) CFSA s 132 (3).
\(^{291}\) CFSA s 132 (2).
respect to secure treatment and administration of psychotropic drugs under the CFSA, and depending on whether a child is under 16, or 16 and older. As noted earlier, the CFSA prescribes its own rules with respect to the administration of psychotropic drugs—which are not entirely aligned with the HCCA (other than for a child 16 or older, which is where the CFSA concept of “nearest relative” triggers the HCCA rules). The CFSA mentions capacity as consideration with respect to consent or refusal of treatment, but the test is also different from that in the HCCA:

4.(1) In this section,

“capacity” means the capacity to understand and appreciate the nature of a consent or agreement and the consequences of giving, withholding or revoking the consent or making, not making or terminating the agreement;

“nearest relative”, when used in reference to a person who is less than 16 years old, means the person with lawful custody of him or her, and when used in reference to a person who is 16 years old or more, means the person who would be authorized to give or refuse consent to a treatment on his or her behalf under the Health Care Consent Act, 1996 if he or she were incapable with respect to the treatment under that Act.

Elements of valid consent or agreement, etc.

(2) A person’s consent or revocation of a consent or participation in or termination of an agreement under this Act is valid if, at the time the consent is given or revoked or the agreement is made or terminated, the person,

(a) has capacity;

(b) is reasonably informed as to the nature and consequences of the consent or agreement, and of alternatives to it;

(c) gives or revokes the consent or executes the agreement or notice of termination voluntarily, without coercion or undue influence; and

(d) has had a reasonable opportunity to obtain independent advice.

Where person lacks capacity

(3) A person’s nearest relative may give or revoke a consent or participate in or terminate an agreement on the person’s behalf if it has been determined on the basis of an assessment, not more than one year before the nearest relative acts on the person’s behalf, that the person does not have capacity.

Subsection 4(3) also creates a temporal element, making the authority to consent time-limited, something that is not contemplated specifically in the HCCA (although it is recognized that capacity may fluctuate).
So what happens if a child who is 16 years old and capable refuses to consent to the administration of psychotropic drugs? He or she will make that decision. If incapable, the nearest relative under the CFSA (established according to the HCCA SDM ranking) makes the decision. By contrast, what happens if the parents (or children’s aid society, as applicable) of a capable child under the age of 16 agree to the treatment but the child does not? The child apparently has some voice, through a requirement that his or her views and preferences be canvassed where they can reasonably be ascertained.292 However, he or she does not have ultimate decision-making as would be the case if committed involuntarily to a psychiatric facility under the MHA and psychotropic drugs were proposed under the HCCA.293 Consent is required, but it may not be the consent of an otherwise capable child.

Based on this, the question of alignment of the MHA/HCCA and CFSA is likely a *bona fide* legal issue, and in any case, it is clear that education is required at the front line as to how these statutes align.

Appendix 2 summarizes key differences between the MHA and CFSA on committal, and the intersection of treatment.

**Protecting the Personal Health Information of Children**

As discussed in Chapter 3, PHIPA establishes rules for collection, use and disclosure of personal health information and protects confidentiality while facilitating the effective provision of health care. Most relevant for this chapter is that PHIPA does provide some guidance regarding who may or may not give, withhold or withdraw consent to the collection, use and disclosure of a child’s personal health information.

Similar to the HCCA and the capacity to consent to treatment, PHIPA presumes capacity to consent to the collection, use and disclosure of one’s personal health information.294 However, if the child is under the age of 16, PHIPA provides that either the capable child or his or her parent may give the consent, with a caveat. The parent or other lawful SDM

292 CFSA, s. 132(3).
293 This apparent disjunction has also been noted by the Office of the Provincial Advocate for Children and Youth who has suggested that “…they do not align with the Health Care Consent Act [Section 4, Capacity and Section 10, No treatment without consent].” Office of the Provincial Advocate for Children and Youth, *Submission to the Ministry of Children and Youth Services on the Review of the Child and Family Services Act*, online: [http://www.provincialadvocate.on.ca/documents/en/OPACY%20CFSA%20Review.pdf](http://www.provincialadvocate.on.ca/documents/en/OPACY%20CFSA%20Review.pdf), at page 8 (last accessed April 12, 2013).
294 PHIPA, s 21(4).
may consent on the child’s behalf as long as the information that is subject of the consent does not relate to:

- treatment within the meaning of the HCCA about which the child has made a decision on his or her own in accordance with that Act; or
- counselling in which the child has participated on his or her own under the CFSA.\(^{295}\)

The decision of the child with respect to consent prevails over any conflicting decision or wish of the parent of SDM.\(^{296}\)

As such, while PHIPA was drafted largely based on provisions in the HCCA with respect to consent and capacity, this is a significant difference between the two statutes. The HCCA is discussed in further detail in Chapter 2 of this Report; as previously stated, age is not determinative of capacity in that statute. In contrast, PHIPA creates some ability for a parent (or children’s aid society or other person, as above) to make information-sharing decisions on behalf of a child of a specific age range.

Information-sharing provisions also exist in statutes other than PHIPA. Although PHIPA is close to a complete regime for collection, use and disclosure of personal health information in the hands of health information custodians, it also accounts for other disclosures permitted or required by law, including under the CFSA. For example, the CFSA creates reporting obligations to a Children’s Aid Society (CAS) with respect to children who are younger than 16 years old who are in need of protection. Physicians (and other health care professionals) have an ongoing duty to report to a CAS where he or she has reason to suspect, “…a child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child’s development and the child’s parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, treatment to remedy or alleviate the condition.”\(^{297}\)

This report should include all the information upon which the professional’s suspicion is based, which may well include personal health information of the child.\(^{298}\)

One could argue that the state has struck the appropriate balance in mandating reports of children in need of protection under the CFSA; safety trumps privacy, in the words of Dr.

---

\(^{295}\) PHIPA, s 23(1) para 2.
\(^{296}\) PHIPA, s 23(3).
\(^{297}\) CFSA, s 72(1) para 10. More broadly, section 72 enumerates the other instances in which the duty to report arises, including suspected sexual abuse, emotional harm, abandonment.
\(^{298}\) Ibid.
An Cavoukian, the Information and Privacy Commissioner/Ontario. Similarly, s. 40(1) of PHIPA permits a health information custodian to disclose personal health information to eliminate or reduce a significant risk of serious bodily harm (in short, discretion rather than a duty to warn).

There are nuances in the CFSA that must be examined given their impact on privacy. Under the CFSA, a child’s “record of mental disorder” must be disclosed pursuant to a summons, order, direction, notice or similar requirement in any matter before a court of competent jurisdiction or under any Act unless a physician demonstrates otherwise in writing. Disclosure of a child’s record of mental disorder applies to all children under the age of 18. A closed hearing (absent the public but on notice to the physician) occurs to consider the potential harms raised by the physician, and if the court agrees, the court shall not order disclosure, transmittal or examination of the records in question unless it is satisfied that it is essential in the interests of justice to do so.

A similar process exists in s. 35(9) of the MHA, which also prevails over PHIPA. While retaining these provisions in a statute other than PHIPA means that individuals do not have recourse to the oversight of the Information and Privacy Commissioner/Ontario, the CFSA and MHA schemes focus on protections of personal health information, and appear consistent as between those two statutes. In other words, a child’s mental health record receives the same degree of protection under the CFSA as it would for a child or adult governed by the MHA.

**Youth Criminal Justice Act**

Section 34 of the YCJA permits a youth justice court, at any stage of proceedings, to order medical or psychological assessment of an accused young person by a “qualified person” who is required to report back to the court in writing. This is done with the consent of the young person and the prosecutor; or on its own motion or on application of

---

299 Dr. Cavoukian has also stated “life trumps privacy” in the context of a university student’s suicide and the fact that personal health information might have been shared to prevent that tragedy: [http://www.ipc.on.ca/images/WhatsNew/up-2008_04_25_LtrtoNtlPost.pdf](http://www.ipc.on.ca/images/WhatsNew/up-2008_04_25_LtrtoNtlPost.pdf).

300 CFSA s 183(1), where “record of mental disorder” is defined as a record made about a person concerning a substantial disorder of emotional processes, thought or cognition of the person which grossly impairs the person’s capacity to make reasoned judgments.

301 CFSA, s 183(2): The physician must disclose unless he or she demonstrates in writing that the disclosure is likely to result in harm to the treatment or recovery of the person to whom the record relates; is likely to result in (i) injury to the mental condition of another person, or (ii) bodily harm to another person.

302 CFSA, s 183(6); (s 183(6.1) goes on to note that these provisions prevail despite anything in PHIPA. It does not make note of the MHA provisions.

303 YCJA, s 34(1).
the young person or the prosecutor, if the court believes a medical, psychological or psychiatric report is necessary. This is done if the court is considering release or detention in custody; a decision is being made on an adult sentence; a youth sentence is being made or reviewed; continuation of custody is being considered; conditional supervision is ordered or the actual conditions for it are being set; certain criteria are met, or information about a young person is authorized to be disclosed subject to the Act, and any of one of the following conditions exists:

(i) the court has reasonable grounds to believe that the young person may be suffering from a physical or mental illness or disorder, a psychological disorder, an emotional disturbance, a learning disability or a mental disability,

(ii) the young person’s history indicates a pattern of repeated findings of guilt under this Act [YCJA] or the Young Offenders Act, chapter Y-1 of the Revised Statutes of Canada, 1985, or

(iii) the young person is alleged to have committed a serious violent offence.

The court may order the young person remanded into custody for purpose of the assessment, however, there is a presumption against custodial remand. The assessment detention may be for a period of up to 30 days, although there is some authority of the court to vary the terms and conditions of the order. Specifically, section 34(6) of the YCJA permits a youth justice court to vary the terms and conditions specified in an assessment order in any manner that the court considers appropriate in the circumstances, provided that the order for assessment is in force. Since there are no reported cases on this provision, it is difficult to ascertain whether the power to vary would include extension of the statutory timeframe.

Such assessments result in reports containing considerable health information about the young person. Of note, there is nothing particularly helpful in PHIPA to address the sharing of protected information under the YCJA with health care providers in the community. PHIPA operates to permit the flow of information the other way, as subsections 40(2) and (3) address a health information custodian sharing personal health information with the head of a penal or custodial facility, to assist in the person’s placement. Reliance on s. 40(1), disclosure to eliminate or reduce a significant risk of serious bodily harm, would also be rarely used by custodians.

---

304 YCJA, s 34(1)(a) and (b).
305 YCJA, s 34(2)(a)-(g).
306 YCJA, s 36(1) and (6).
The YCJA provides stringent rules for the sharing of these reports. As confirmed in the legislation and the federal government’s YCJA guidance document,\(^{307}\) it is clear that s. 119 of the YCJA creates limitations (in some cases, prohibitions) on sharing information about a young person in the youth criminal justice system. More specifically, s. 34 addresses the creation of medical and psychological reports (created with consent of the young person and his counsel or by order of the court), which are very strictly controlled, with release to limited individuals in the youth justice system, e.g. only to youth and his counsel, judge or review Board, Attorney General, parents, peace officer, by judge’s order if it would be desirable in the interest of the administration of justice. There are also provisions that would limit the report being shared with the young person, based on harm-based criteria:

34(10) A youth justice court shall withhold all or part of a report made in respect of a young person under subsection (1) from the young person, the young person’s parents or a private prosecutor if the court is satisfied, on the basis of the report or evidence given in the absence of the young person, parents or private prosecutor by the person who made the report, that disclosure of the report or part would seriously impair the treatment or recovery of the young person, or would be likely to endanger the life or safety of, or result in serious psychological harm to, another person.

This provision is akin to section 52(1)(e)(i) of PHIPA, where the individual’s right of access to his or her record of personal information is not granted where the custodian determines that granting 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”. This right under PHIPA has its roots in the prior MHA scheme, but under that regime, the denial of access to one’s clinical record on the basis of such harm could only occur upon the physician’s application to the Consent and Capacity Board, and the onus was on the physician. By contrast, PHIPA permits a health information custodian to consult a physician or psychologist\(^{308}\) before denying access in this circumstance; however, if that determination is made, the person is left to apply to the Information and Privacy Commissioner/Ontario for a review of that decision.

Conclusion

It is often acknowledged that the number of statutes, Ministries and agencies directed to children’s mental health creates a system that is often fragmented and complex to


\(^{308}\) PHIPA, s 52(5).
navigate for service providers, children, young persons and their families. Issues relating to secure detention and treatment of children have also been the subject of some debate. Modernizing and aligning the statutory framework that applies to children’s mental health, treatment and personal health information, and education about how the statutes dovetail (including with respect to consent, capacity, substitute decision-making and information-sharing) would be a welcome step toward eliminating some of the prevailing confusion, including as children move into an adult system.
CHAPTER 5 – OTHER JURISDICTIONS

Introduction

This chapter reviews mental health legislation across Canada and in other jurisdictions, comparing and contrasting key elements to those found in Ontario. Special attention is focused on the provisions related to whether and how capable (or competent) involuntary patients may be treated without consent.

As discussed throughout this report, various perspectives have influenced how mental health laws are developed and interpreted in each province. Civil committal, consent and substitute decision-making provisions reflect a province or territory’s prevailing values and beliefs about mental illness, the role of the state, the meaning of liberty and the primary purpose of psychiatric facilities (or hospitals) as places for treatment.

Canada

After the introduction of the *Charter of Rights and Freedoms*\(^{309}\) in 1982, concerns were raised that various mental health laws in Canada were potentially infringing upon individuals’ *Charter* rights. This concern led to the development of a working group with provincial and territorial representation under the Uniform Law Conference of Canada, a conference which has been held annually since 1918 for the purpose of “promot[ing] uniformity of legislation among Canada’s provinces and territories on subjects on which uniformity may be found to be possible and advantageous”\(^{310}\).

The working group produced the 1984 *Uniform Mental Health Act*, which was intended to be used as a model by the provinces to ensure compliance with the *Charter* and to uphold the following principles:\(^{311}\)

- A system that promotes voluntary admission and treatment with informed consent is preferred to compulsory services;


Where there is no alternative to involuntary detention and treatment which limit a person’s liberty or right to make decisions, these limitations must conform with the Charter;

- A range of appropriate treatment options, including the least restrictive and intrusive alternatives, are offered and explained to the person;
- The duty of confidentiality of information in the medical file/record is heightened by the vulnerability of mentally-ill persons and the potentially severe consequences of improper release of such information;
- The patient has the right to view, for purposes of accuracy, documents gathered for the purpose of his/her medical treatment;
- If a person’s rights and freedoms are affected by legislation, an independent body or a court can review the decision to determine whether or not the decision was reached fairly

Some jurisdictions have passed legislation that conforms to these principles; however, the interpretation and application of the principles means that the legislation in various jurisdictions continues to differ significantly across the country. See Appendix 3 for summaries of the law on capacity and consent to treatment across Canada.

**British Columbia**

The purpose of the BC *Mental Health Act* \(^{312}\) (“BCMHA”) has been described as “manifestly plain: the treatment of the mentally disordered who need protection and care in a provincial psychiatric hospital” \(^{313}\) and its regime shares many features with its Ontario counterpart. However, there are several key differences which will be discussed below.

**Admission**

B.C. has a two-step process for involuntary admission that is very similar to Ontario’s: the admission process begins with an examination by a physician who, if certain criteria are met, completes a medical certificate (similar to the APA in Ontario) that allows detention for the purposes of assessment for a certain amount of time. As in Ontario, the completion of the first medical certificate constitutes the legal authority for anyone, including police or family, to take the subject of the medical certificate to a facility for

---

\(^{312}\) *Mental Health Act*, RSBC Chapter 288.

\(^{313}\) *McCorkell v Riverview Hospital (Director)* [1993] BCJ No 1518, 104 DLR (4th) 391 (BS SC) at 51.
In Ontario, persons detained pursuant to a Form 1 can be detained for up to 72 hours, whereas in B.C., it is 48 hours. At this stage, it is important to note the difference in the legal status of the patient as between Ontario and B.C. In B.C., when a patient is admitted for psychiatric assessment (pursuant to the first medical certificate), the patient is legally an involuntary patient despite the fact that a second medical certificate as not been completed. In Ontario, in contrast, a patient can only legally become involuntary pursuant to a certificate of involuntary admission or a certificate of renewal.

There are four criteria for involuntary admission in B.C, all of which must be met:

1. The person is suffering from a mental disorder that seriously impairs the person’s ability to react appropriately to his or her environment or to associate with others;
2. The person requires treatment in or through a designated facility;
3. The person requires care, supervision and control in or through a designated facility to prevent the person's or patient's substantial mental or physical deterioration or for the protection of the person or patient or the protection of others; and
4. The person cannot suitably be admitted as a voluntary patient.

The word “protection” in the third criterion includes more than protection from the risk of bodily harm. In the 1993 case of *McCorkell v Riverview Hospital (Director)*, the British Columbia Supreme Court stated that “the Manitoba criteria bear [sic] a close similarity to the British Columbia standard. In the Manitoba legislation, "serious harm" is not qualified; it can include harms that relate to the social, family, vocational or financial life of the patient as well as to the patient's physical condition.”

Upon the completion of a second medical certificate by a different physician, the detention of an involuntary B.C. patient may be continued beyond the 48 hour period – much like the Form 3 process in Ontario which follows a detention of up to 72 hours on a Form 1. The maximum length of the initial hospitalization cannot exceed one month from

---

314 BCMHA, s 22(6). See MHA, s 15(5).
315 MHA, s 1(1).
316 BCMHA, s. 22(3).
318 *McCorkell v Riverview Hospital (Director)* [1993] BCJ No 1518, 104 DLR (4th) 391 (BS SC).
319 *Ibid* at 58.
the date of admission\textsuperscript{320} (though the length of time can be extended subject to review and renewal\textsuperscript{321}).

**Capacity and Consent to Treatment**

B.C.’s mental health regime fundamentally departs from that in Ontario with respect to the issue of consent to treatment when it involves persons who are involuntarily admitted. B.C.’s *Health Care (Consent) and Care Facility (Admission) Act* does not apply in respect of involuntary admissions made under the BCMHA.\textsuperscript{322} What that means is that unlike Ontario, where the HCCA’s principle that there is no treatment without consent applies to all persons admitted under the MHA, in B.C., the BCMHA is the complete code for involuntary admissions and consent for persons involuntarily admitted. The BCMHA defines a “person with a mental disorder” as “…a person who has a disorder of the mind that requires treatment and seriously impairs the person's ability (a) to react appropriately to the person's environment, or (b) to associate with others.”\textsuperscript{323} By making the requirement of treatment integral to the definition of a person with a mental disorder, the BCMHA provides for compulsory treatment of the involuntary patient regardless of capacity or consent as soon as the person is admitted as an involuntary patient. This reading is reinforced by section 31(1) which states:

> If a patient is detained in a designated facility under section 22, 28, 29, 30 or 42 or is released on leave or is transferred to an approved home under section 37 or 38, treatment authorized by the director is deemed to be given with the consent of the patient.

For the involuntary patient, treatment can begin after the first medical certificate has been completed and during the time that the person is being held for examination.\textsuperscript{324} In addition, the definition means that the involuntary patient cannot object or refuse treatment despite the capacity to do so. In fact, where an involuntary patient has been found capable but is refusing to consent to the proposed treatment, the director or designate may complete the consent form on behalf of the patient.\textsuperscript{325} In contrast, a person on a Form 1 in Ontario who is detained for up to 72 hours may only be restrained, observed and examined, but not treated without consent (either the person’s if capable, or

\textsuperscript{320} BCMHA, s 8(a).

\textsuperscript{321} BCMHA, s 24.

\textsuperscript{322} *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996 CHAPTER 181, s 2.

\textsuperscript{323} BCMHA, s 1, emphasis added.

\textsuperscript{324} BCMHA, s 22(1).

\textsuperscript{325} BCMHA, s 31(1).
if incapable, consent of the SDM). (Health care consent in Ontario is considered more fully in Chapter 2 of this report.)

The concept of mandatory treatment in B.C. was challenged in 1990, in *R. v. Rogers*[^326], a case in which psychiatric assessment or treatment was ordered as part of a criminal sentence. The plaintiff argued that the order contravened section 7 of the *Charter*. The court agreed, holding that “a probation order which compels an accused to person to take psychiatric treatment or medication is an unreasonable restraint upon the liberty and security of the accused person... and cannot be saved by s. 1 of the Charter.”[^327] However, this view seems to have gained little traction in the non-criminal context. It is therefore the case that while judicial rulings in the criminal context with respect to deemed consent have been relied upon in the mental health setting and vice versa, the B.C. Supreme Court has said that “the objects and purposes of criminal law and mental health legislation are so different that cases in one area will be of little guidance in the other.”[^328]

**Substitute Decision-Making**

As discussed above, B.C.’s statutory scheme allows treatment decisions for involuntary patients to be made solely by the director of a facility (unless the patient, if capable, consents). This means that the question of substitute decision-making is a non-issue in this context. When the involuntary patient is, in fact, incapable, a “near relative”[^329] can be designated to receive notice about the patient’s rights in certain circumstances, but not to make decisions.[^330]

**Children**

Though the BCMHA explicitly contemplates the voluntary admission of children under the age of 16[^331] (as well as 16 and older), there is no specified upper or lower age limit for children with respect to involuntary admission. Though this might suggest that

[^326]: *R v Rogers* (1990), 61 CCC (3d) 481 (BCCA).
[^327]: *R v Rogers* (1990), 61 CCC (3d) 481 (BCCA).
[^328]: *McCorkell v Riverview Hospital (Director)* [1993] BCJ No 1518, 104 DLR (4th) 391 (BS SC) at 63.
[^329]: British Columbia Ministry of Health, Form 15 Mental Health Act, Nomination of Near Relative, online: <https://www.health.gov.bc.ca/exforms/mhdforms/HLT3515.pdf>. Section 1(1) of the BCMHA defines a near relative as a grandparent, parent, child, spouse, sibling, half sibling, friend, caregiver or companion designated by a patient and includes the legal guardian of a minor and a representative under an agreement made under the *Representation Agreement Act* and a committee having custody of the person of a patient under the *Patients Property Act*.
[^330]: BCMHA, s 34.2.
[^331]: BCMHA, ss 21(1), 34.2
children under the age of 16 may be admitted as involuntary patients if the criteria for admission were met, it is less intuitive that the same concept of “deemed consent”332 would be held to apply in the same way.

Alberta

Alberta’s Mental Health Act333 (“AMHA”) was amended in 2009/2010 to broaden the criteria for certification to permit earlier intervention and treatment of involuntary patients334, among other things.

Admission

The AMHA uses the term “formal patient” to describe what is otherwise known as an involuntary patient in Ontario and B.C.. For consistency, the term “involuntary” will continue to be used in this section. Alberta’s process for admission of a person as an involuntary patient is substantially like Ontario’s – the completion of a Form 1 (called the first admission certificate in Alberta) after a physician’s examination constitutes the legal authority to have the person brought to the psychiatric facility for an assessment. The completion of a second admission certificate constitutes the legal authority for the person to be detained at the facility. The criteria to be met for issuing admission certificates in Alberta are also very similar to the criteria in Ontario, especially with respect to the risk of harm to the person or others.335 However, like B.C., the AMHA does not distinguish between the first-time patient and the revolving door patient – the criteria for the first admission certificate are the same.

Capacity and Consent to Treatment

Like Ontario, Alberta recognizes that an involuntary and capable person has the right to consent or refuse treatment.336 However, the AMHA outlines a process for administering treatment to a capable, involuntary patient despite his or her objections where a review panel finds that the treatment is in the patient’s best interest.337 

---

332 BCMHA, s 31(1).
333 Mental Health Act, RSA 2000, c M-13.
334 Alberta Health Services, Guide to the Alberta Mental Health Act and Community Treatment Order Legislation (September 2010), online: <http://www.albertahealthservices.ca/hp/if-hp-mha-guide.pdf>.
335 AMHA, s 2.
336 AMHA, s 26.
337 AMHA, s 29.
whether a proposed treatment is in the “best interests” of the patient is based on the following factors, which are similar to those in Ontario’s HCCA\textsuperscript{338}:

i. whether the mental condition of the patient will be or is likely to be improved by the treatment;

ii. whether the patient’s condition will deteriorate or is likely to deteriorate without the treatment;

iii. whether the anticipated benefit from the treatment outweighs the risk of harm to the patient;

iv. whether the treatment is the least restrictive and least intrusive treatment that meets the requirements of subclauses (i), (ii) and (iii).\textsuperscript{339}

Where the treatment in question is psychosurgery, the AMHA mandates that it is not to be performed on an involuntary patient unless the patient consents or where ordered by a review panel.\textsuperscript{340}

As in the case of B.C.’s “deemed consent”, Alberta’s scheme allowing for the administration of treatment without consent in the patient’s best interest, marks a significant departure from the legislative regime in Ontario. It should be made clear that the review panel contemplated in the Alberta legislation is not analogous to Ontario’s CCB which makes decisions with respect to capacity. Rather, the review panel adjudicates on the person’s best interests thereby arguably overriding the capable person’s Charter rights. To date, this section appears not to have been challenged in the Alberta courts.\textsuperscript{341}

**Substitute Decision-Making**

For incapable, involuntary patients, substitute decision-making in Alberta is very similar to Ontario; there is an enumerated list of people who may give consent on behalf of the incapable person keeping in mind the person’s best interests.\textsuperscript{342} However, unlike Ontario, nothing in the Alberta legislation explicitly recognizes and requires that the person’s prior wishes (made when capable) be considered as a factor by the SDM when making a consent decision for treatment on behalf of an incapable involuntary patient.

\textsuperscript{338} HCCA, s 21(2)

\textsuperscript{339} AMHA, s 29(3)(b).

\textsuperscript{340} AMHA, s 20(5). In Ontario, in contrast, section 49(1) of the MHA prohibits the administration of psychosurgery to involuntary patients in any circumstances.

\textsuperscript{341} Conclusion based upon noting-up section 29 of the Mental Health Act, RSA 2000, c M-13 on LexisNexis Quicklaw.

\textsuperscript{342} AMHA, ss 26 and 28(1).


**Children**

The involuntary provisions under the AMHA seem to apply equally to child and adult patients. Section 28 allows for treatment decisions to be made on behalf of “minors” (though this term is not defined in the legislation). There is no mention of an age limit in the AMHA, or of any other special considerations where the involuntary patient may be a child.

**Saskatchewan**

According to the government of Saskatchewan, “[t]he overall goal of Saskatchewan's mental health services is to promote, preserve and restore the mental health of the population.”[^343] This goal underlies Saskatchewan’s *Mental Health Services Act*[^344] (“SMHSA”) which permits some treatment without consent.

**Admission**

Saskatchewan follows other previously discussed jurisdictions in so far as its admissions process for involuntary patients – it is a two-step process that requires an examination and assessment followed by an order (or certificate) which has the legal authority to detain the person in the psychiatric facility.[^345] In Saskatchewan, the question of capacity is not a separate inquiry. Its determination is made during a person’s admission. Section 24 (2)(a) of the Act states:

(2) Every certificate issued for the purposes of this section is to be in the prescribed form and is to:

(a) state that the physician has examined the person named in the certificate within the immediately preceding 72 hours and that, on the basis of the examination and any other pertinent facts regarding the person or the person’s condition that have been communicated to the physician, he has probable cause to believe that:

(i) the person is suffering from a mental disorder as a result of which he is in need of treatment or care and supervision which can be

[^343]: Government of Saskatchewan, Mental Health Services, online: <http://www.health.gov.sk.ca/mental-health>
[^344]: SMHSA, s 3.
[^345]: SMHSA, ss 18 and 24.
provided only in an in-patient facility;
(ii) as a result of the mental disorder the person is unable to fully understand and to make an informed decision regarding his need for treatment or care and supervision; and
(iii) as a result of the mental disorder, the person is likely to cause harm to himself or to others or to suffer substantial mental or physical deterioration if he is not detained in an in-patient facility;

(emphasis added)

This provision is intended to limit involuntary admissions to persons who are not “capable” (as it is defined and used in Ontario’s legislation). This approach has been described as reflecting the policy that “incapacity is an essential threshold requirement for committal” and is consistent with how the courts in the jurisdiction have interpreted the Act.

Capacity and Consent to Treatment

In Saskatchewan, the threshold to be met in assessing a person’s capacity (or competence as it is called in) is similar, but not identical, to Ontario’s. In Saskatchewan, a physician completing a certificate for involuntary admission must have probable cause to believe that “as a result of the mental disorder the person is unable to fully understand and to make an informed decision regarding his need for treatment or care and supervision”.

The phrase “fully understand” has been interpreted by the courts to mean “understand completely”, which appears to create a test for capacity at a higher threshold than in Ontario, which requires the “ability to understand”.

The implication of this test and subsequent judicial interpretation is that a patient’s admission and status as involuntary means that he or she is de facto incapable and thus not able to make his or her own treatment decisions. This is different in Ontario where a patient’s admission and status as involuntary does not negate the presumption of

---

346 Note that the Mental Health Services Act actually uses the term “competent” instead of “capable”.
347 Gerald B. Robertson in Mental Disability and the Law in Canada, 2d ed. (Scarborough, Ont: Carswell, 1994) at page 396 in Saskatoon Regional Health Authority v AB, [2005] SJ No 187, SKQB 153 (QB) at 27.
348 Saskatoon Regional Health Authority v AB, [2005] SJ No 187, SKQB 153 (QB).
351 Saskatoon Regional Health Authority v AB, [2005] SJ No 187, SKQB 153 (QB) at 33.
capacity. The SMHSA reflects this view of incapacity in section 25 of the Act, which permits the attending physician to “perform or prescribe any diagnostic procedures he considers necessary to determine the existence or nature of a mental disorder and administer or prescribe any medication or other treatment that is consistent with good medical practice and that he considers necessary to treat the mental disorder, to a patient who is detained pursuant to section 24 or 24.1 without that patient's consent”. On the other hand, the attending physician is required by the Act to consult with the patient (to the extent that it is feasible given the patient's medical condition) and to “give consideration to the views the patient expresses” with respect to the treatment. However, physicians need not follow the patient’s wishes.

Despite this acknowledgment of the patient’s wishes, it seems that by using a different mechanism, the SMHSA, like the BCMHA, mandates the compulsory treatment of all involuntary patients. This interpretation has been supported by commentators such as Barney Sneiderman, John C. Irvine & Philip H. Osborne, who wrote:

Saskatchewan, alone among Canadian jurisdictions, includes in its committal criteria the requirement that the individual be incapable of giving or withholding consent to treatment. This is an interesting technique for avoiding dilemmas involving the obtaining of treatment consent from competent patients. ... The Saskatchewan approach is a different means of ensuring that involuntary committal is closely connected to active treatment of mental disorder. (emphasis added.)

Unlike the Ontario regime, the SMHSA does not include a particular process for re-evaluating a person’s capacity over time. It is therefore possible that an involuntary patient will be treated without consent for the duration of his or stay at a psychiatric facility because: (1) the person was incapable upon admission but later regained capacity

---

352 SMHSA, s 25. This section does not apply to psychosurgery or experimental treatment. See also s 27 which provides that the attending physician shall endeavor with all resources reasonably available in the facility to provide the person with care and treatment as a result of which the detention of the person in the facility will no longer be required. 
353 SMHSA, s 25(3).
354 Canadian Medical Law: An Introduction for Physicians, Nurses and other Health Care Professional, 3d ed. (Scarborough, Ont.: Thomson Carswell, 2003) at p. 274.
355 Though sections 32 to 34 Act describe appeal provisions, they seem to be targeted at reviewing a person’s detention overall, not his or her capacity per se. However, it may be the case that in the review of the issuance of the certificate, there is necessarily a review of the person’s capacity. It is not clear if this is the only mechanism by which an involuntary patient’s capacity can be reviewed or if a physician is obligated to review on a particular schedule.
and was never reassessed; or (2) the person was only incapable in respect of one element of his or her treatment but was nonetheless considered incapable with regard to all.\(^{356}\)

**Long-Term Detention**

Finally, the SMHSA is unique in that it establishes a long-term detention order for patients who have been detained 60 or more consecutive days immediately prior to the date of the application and are suffering from a severely disabling continuing mental disorder that is likely to persist for a period of longer than 21 days, notwithstanding that treatment is being provided (in addition to other criteria).\(^{357}\) The threshold for this order is higher; the person must also be, “…likely to cause bodily harm to himself, herself, or to others.”\(^{358}\) In other jurisdictions, detention orders are reviewed at much shorter intervals and can only be extended if certain criteria are met. In Saskatchewan, the officer in charge of a facility in which a person is being detained may apply by notice of motion to the Court of Queen's Bench for Saskatchewan for an order for detention. If the judge finds that all the criteria are met, he or she can make the order for a period of not longer than one year, for the purposes of treatment or care and supervision.\(^{359}\) The order can be reviewed by applying to courts.\(^{360}\)

**Children**

It is presumed that the SMHSA applies equally to children as it does to adults. Nothing in the SMHSA seems to preclude the admission of children as involuntary patients i.e. there is no mention of an age limit or of any special considerations where an involuntary patient is a child.

**Manitoba**

According to Manitoba Health, the *Mental Health Act*\(^{361}\) (“MMHA”) aims to strike a balance between the rights of individuals under the *Charter* and “society’s obligation to

---

\(^{356}\) However where that treatment is psychosurgery or experimental treatment, the section 25(5) of the Act prohibits the administration to involuntary patients

\(^{357}\) SMHSA, s 24.1.

\(^{358}\) SMHSA, s 24.1(1)(c).

\(^{359}\) SMHSA, s 24.1(3).

\(^{360}\) SMHSA, s 24.1(6). An application for review can be made by the person who is subject of the application, the person’s nearest relative, the officer in charge of the facility, the official representative of the region, and any other person with sufficient interest.

\(^{361}\) *Mental Health Act*, CCSM c M110.
provide care and treatment to those individuals who, at times, may not appreciate their need for treatment due to their mental illness.”

**Admission**

The requirement of an examination by a physician as the initial step to involuntary admission is virtually the same in Manitoba as in Ontario. A person who is taken into custody for an involuntary medical examination under section 11 or 12 of the Act (i.e. by court order or peace officer) must be examined as soon as reasonably possible, but not later than 24 hours after the person arrives at the place of examination. Following the physician examination, a psychiatrist examines and assesses the person’s mental condition and decides whether to release or admit the person (as a voluntary or involuntary patient, as applicable).

In Manitoba, the admission criteria include a reference to a need for treatment. The psychiatrist may only admit the person as an involuntary patient if he or she is of the opinion that:

1. the person is suffering from a mental disorder;
2. because of the mental disorder:
   a. is likely to cause serious harm to self or others, or to suffer substantial mental or physical deterioration if not detained in a facility;
   b. *needs continuing treatment that can reasonably be provided only in a facility* (emphasis added); and
3. cannot be admitted as a voluntary patient because he or she refuses or is not mentally competent to consent to a voluntary admission.

In Ontario there is no requirement that the person “needs continuing treatment that can reasonably be provided only in a facility”.

**Capacity and Consent to Treatment**

Similar to the Ontario framework, the competent, involuntary patient in Manitoba has the right to consent or refuse psychiatric and other medical treatment even in emergency

---

363 MMHA, s 16(3).
364 MMHA, s 17, emphasis added.
situations. In Manitoba, a patient’s capacity or competency is assessed shortly after admission but is reviewed periodically to assess the current state of an individual’s competence. However, unlike Ontario, the MMHA’s test for capacity is calibrated to the higher standard of actual understanding, rather than ability to understand.

Children

It is presumed that the MMHA applies equally to children as it does to adults. Nothing in the MMHA seems to preclude the admission of children as involuntary patients i.e. there is no mention of an age limit or of any special considerations where an involuntary patient is a child.

Quebec

In Quebec, there are two complementary pieces of legislation that govern provincial mental health services. The first is the Civil Code (“CCQ”) and the second is An Act respecting the Protection of persons whose mental state presents a danger to themselves or to others (“Protection Act”). The stated purpose of the Protection Act is to “… complement the provisions of the Civil Code concerning the confinement in a health and social services institution of persons whose mental state [who present] a danger to themselves or to others…”

Admission

In Quebec, civil confinement may be initiated by a physician, peace officer or court order. A physician may place a person under “preventive confinement” for up to 72 hours without consent or court authorization and prior to psychiatric examination if he or she is of the opinion that the mental state of the person presents a “grave and immediate danger” to self or others. This would be similar to a Form 1 in Ontario. For formal

---

365 MMHA, ss 26, 29(1) and 29(5). Though, if a capable person is otherwise unable to give consent and there is imminent and serious danger to the person’s life or limb, treatment may be administered.
366 MMHA, ss 27 (1) and 27(5)
367 MMHA, s 27(2).
368 Civil Code of Québec, LRQ, c C-1991.
369 An Act respecting the Protection of persons whose mental state presents a danger to themselves or to others, RSQ, c P-38.001 [“Protection Act”], s 1.
370 Protection Act.
371 CCQ, s 27 and 30; Protection Act, ss 7-9.
372 Protection Act, s 7.
admission as an involuntary patient (this would be pursuant to a Form 3 in Ontario), it is
the Quebec courts, on the recommendation of two physicians in whose opinion detention
is necessary, that have the sole power to authorize the involuntary admission of the
person. And even then, the psychiatric reports are not dispositive. The courts must
have “serious reasons to believe” that the admission is necessary before allowing the
admission to occur.

Capacity and Consent to Treatment

The Quebec Civil Code prohibits treatment without consent. Though not explicitly stated,
a reading of both the Civil Code and the Protection Act together leads to the conclusion
that where a capable adult refused treatment, the administration of such treatment could
only be done with the court’s intervention or other judicially approved mechanism.

Otherwise, where a person is incapable of giving or refusing consent, the person’s SDM
may do so in that person’s place. The concept of prior expressed wishes does exist
under this legislation such that a person’s SDM is bound to act in the sole interest of the
person, taking into account any wishes he or she may have expressed. Further, where
substitute consent is given, the decision-maker must ensure that the care is beneficial
notwithstanding the gravity and permanence of certain of its effects; that it is advisable in
the circumstances; and that the risks incurred are not disproportionate to the anticipated
benefit. The main difference between Quebec and Ontario is that in Quebec prior
capable wishes ought to be considered by the substitute, whereas in Ontario they must be
followed.

A court may authorize treatment if an SDM is prevented from or refuses to consent to
treatment “without justification”.

Children

In Quebec, the age of 14 is the dividing line between child and adult. The Civil Code
provides that a minor who is 14 or older may consent to treatment as long as the

373 CCQ, s 30.
374 CCQ, s 16.
375 CCQ, s 11.
376 CCQ, s 12. Note that the term “substitute decision-maker” is not used in the Civil Code. Instead, the
377 CCQ, s 12. Code refers to “a person authorized by law or by mandate given in anticipation of his incapacity”.
378 CCQ, s 16.
treatment does not pose a threat of serious bodily harm. Where such a risk exists, then the child’s SDM is empowered to decide on the treatment. If however, that same child refuses non-emergency treatment, then he or she can only be made to undergo said treatment if the courts so direct.\textsuperscript{379} For children under the age of 14, generally all treatment decisions are made by their SDMs unless the treatment “entails serious risk for health or may cause grave damage”, in which case, the courts are required to authorize said treatment.\textsuperscript{380}

**Newfoundland and Labrador**

The definition of “mental disorder” varies across jurisdictions and is not generally significant in a comparative analysis of civil committal and consent to treatment provisions. However, like B.C., the definition of “mental disorder” in Newfoundland is actually linked to treatment. Newfoundland and Labrador’s *Mental Health Care and Treatment Act\textsuperscript{381}* (“MHCTA”) defines “mental disorder” as a disorder of thought, mood, perception, orientation or memory that impairs judgment or behaviour, the capacity to recognize reality, or the ability to meet the ordinary demands of life, *and in respect of which psychiatric treatment is advisable*.\textsuperscript{382}

**Admission**

The Act includes three criteria for a person to be admitted as an involuntary patient:

(1) The person is likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration or serious physical impairment if he or she is not admitted to and detained in a psychiatric unit as an involuntary patient;

(2) The person is unable to fully appreciate the nature and consequences of the mental disorder or to make an informed decision regarding his or her need for treatment or care and supervision; and

(3) The person is in need of treatment or care and supervision that can be provided only in a psychiatric unit and is not suitable for admission as a voluntary patient.

\textsuperscript{379} CCQ, ss 16 and 17.
\textsuperscript{380} CCQ, s 18.
\textsuperscript{381} *Mental Health Care and Treatment Act*, SNL 2006, c M-9.1.
\textsuperscript{382} MHCTA, s 1, emphasis added.
Much like Saskatchewan’s legislation, in Newfoundland, patient incapacity is a threshold issue for involuntary admission. Moreover, the test for capacity is higher than in Ontario as it requires a person to be “fully” able to appreciate the nature and consequences of the mental disorder. The same comments that were made on Saskatchewan’s melding of capacity and admission would apply here in the absence of a process to review a person’s capacity from time to time: capacity is not global and may be expected to fluctuate over time, especially if treatment is being given. The Act does not prevent capable persons from remaining as involuntary patients and receiving unwanted treatment.\(^{383}\)

**Capacity and Consent to Treatment**

The Act states that “[w]here a person is an involuntary patient, the attending physician or other person may, taking into account the best interests of the involuntary patient, perform or prescribe diagnostic procedures that he or she considers necessary to determine the existence or nature of a mental disorder, and administer or prescribe medication or other treatment relating to the mental disorder without the consent of the involuntary patient during the period of detention.”\(^ {384}\) In acting in the best interests of his or her patient, the physician must consider, in addition to other factors, the wishes of the involuntary patient expressed when the involuntary patient was competent.\(^ {385}\) Physicians must also consider the views of the involuntary patient and his or her representative when administering diagnostic tests and administering treatment generally.\(^ {386}\)

**Children**

It is presumed that the MHCTA applies equally to children as it does to adults. Nothing in the MHCTA seems to preclude the admission of children as involuntary patients i.e. there is no mention of an age limit or of any special considerations where an involuntary patient is a child.

\(^{383}\) Section 33 of the MHCTA does provide for automatic reviews at 6 month intervals after the second renewal certificate has been filled. Before that, presumably a patient’s right to have his or her capacity reassessed would lie in making an appeal to the Board.

\(^{384}\) MHCTA, s 35(1).

\(^{385}\) MHCTA, s 35(2). These provisions appear not to have been interpreted or challenged in the courts.

\(^{386}\) MHCTA, s 35(3).
**Prince Edward Island**

**Admission**

In Prince Edward Island, the primary criterion for involuntary admission under its *Mental Health Act*[^387] (“PEIMHA”) is the safety standard, specifically, whether the admission is, “… in the interests of the person's own safety or the safety of others.”[^388]

**Capacity and Consent to Treatment**

Though involuntary patients have the right to consent to or to refuse treatment[^389], there are some circumstances in which treatment may be given to capable, involuntary patients without consent. These include:

1. Where treatment is needed “to keep the patient under control and prevent harm to the patient or to another person”.[^390] This is known as “interim psychiatric treatment” and may be given pending consent on behalf of the patient or an order from the Review Board; and
2. Where a capable, involuntary patient refuses to consent to treatment. In this case the attending psychiatrist of a patient may apply to the Review Board for an order authorizing the giving of specified psychiatric treatment. The Board’s decision is based on best interest-type factors.[^391]

The effect of these provisions is that upon a capable person’s refusal, “interim psychiatric treatment” may potentially be administered and then the Review Board may decide treatment is required in the patient’s best interests. It appears that this section has not been challenged in the courts.[^392]

---

[^388]: PEIMHA, s 13(1)(b).
[^389]: PEIMHA, s 23(1) and (2). Prince Edward Island is similar to New Brunswick and Manitoba in that capacity to consent to treatment is to be assessed “as soon as reasonably possible after admission”. In Ontario there is a presumption of capacity, and it is generally only assessed if there is evidence to suggest it ought to be.
[^390]: PEIMHA, s 23(12).
[^391]: *Mental Health Act*, RSPEI 1988, c M-6.1, s 24(1).
[^392]: Conclusion based upon noting-up section 24 of the *Mental Health Act*, RSPEI 1988, c M-6.1 on LexisNexis Quicklaw.
Children

The PEIMHA specifically contemplates the admission and treatment of children under the age of 16 as involuntary patients. Section 23(2) allows that children under 16 can be treated in a psychiatric facility with the consent of a child, parent or the child’s guardian of the person. This section would seem to imply a presumption of incapacity for children under sixteen despite the right to refuse and consent to treatment stated in section 23(1). Furthermore, children under the age of 16 can be treated without consent (presumably not just their own but their parent or guardian of the person) in emergency situations. 393

Nova Scotia

Nova Scotia’s *Involuntary Psychiatric Treatment Act* (NSIPTA) outlines several principles to guide the treatment of persons with mental disorders. These guiding principles aim to ensure that:

(a) persons of all ages with mental disorders are entitled to be treated with dignity and respect
(b) each person has the right to make treatment decisions to the extent of the person’s capacity to do so
(c) treatment and related services are to be offered in the least-restrictive manner and environment with the goal of having the person continue to live in the community or return to the person's home surroundings at the earliest possible time
(d) the primary mode of admission to a psychiatric facility shall be as a voluntary patient wherever possible
(e) treatment and related services, where possible, should promote the person's self-determination and self-reliance
(f) the person has the right to a treatment plan that maximizes the person's potential and is based on the principles of evidence-based best practice
(g) persons with mental disorders should have access to mental health services as close to the person's home as practicable
(h) any declaration of involuntary admission or declaration of incapacity is made on the basis of evidence” 395

---

393 PEIMHA, s 23(11).
395 NSIPTA, s 2.
This legislation is substantially similar to the mental health legislation in Newfoundland and Saskatchewan. Therefore, only those specific provisions of the NSIPTA that are unique to this Act will be discussed in detail.

**Admission**

According to Nova Scotia Health’s 2007 FAQ document\(^{396}\), the Act applies when someone with a mental disorder:

- is a danger to him/herself or others, or who is likely to deteriorate to the point that they are a danger, and
- needs inpatient care, and
- lacks capacity to make decisions about their care.

The Act makes capacity a threshold issue with respect to admission.\(^{397}\) Like Newfoundland and Saskatchewan, by including the criterion of advisable treatment in the definition of “mental disorder”, the NSIPTA’s attempts to narrow to whom detention under the Act is applicable.\(^{398}\) In fact, it is possible that even when there is a diagnosis of a mental health issue but no advisable treatment, the Act will not be held to apply.\(^{399}\)

Once again, as previously discussed, this means that a patient’s status as involuntary renders that person *de facto* incapable of making his or her treatment decisions.

**Capacity and Consent to Treatment**

As with Saskatchewan and Newfoundland, the NSIPTA’s test for capacity rests on the higher threshold of understanding (compared to Ontario) that requires a patient to “fully” appreciate and understand the elements and consequences of their diagnosis. It is possible that this higher standard may result in more persons, especially children, being found incapable, as compared with requiring the “ability” to understand.\(^{400}\)


\(^{397}\) NSIPTA, s 17(e).


\(^{400}\) NSIPTA, s 18.
Where a person has been found incapable and therefore unable to make decisions related to treatment, an SDM may do so. Nova Scotia’s rules for substitute decision-making are similar to those in Ontario where a person’s prior capable wish must be followed (if known); otherwise, the treatment decisions should be made according to the person’s best interests unless it is the SDM’s belief that following the prior capable wish would endanger the physical or mental health or safety of the patient or another person.”  

**Children**

It is presumed that the NSIPTA applies equally to children as it does to adults. Nothing in the NSIPTA seems to preclude the admission of children as involuntary patients, i.e., there is no mention of an age limit or of any special considerations where an involuntary patient is a child.

**New Brunswick**

The purposes of New Brunswick’s *Mental Health Act* (“NBMHA”) as it relates to involuntary custody, detention, restraint, observation, examination, assessment, care and treatment are:

(a) to protect persons from dangerous behaviour caused by a mental disorder,

(b) to provide treatment for persons suffering from a mental disorder that is likely to result in dangerous behaviour, and

(c) to provide when necessary for such involuntary custody, detention, restraint, observation, examination, assessment, care and treatment as are the least restrictive and intrusive for the achievement of the purposes set out in paragraphs (a) and (b).

In New Brunswick, the criteria for a physician to issue an examination certificate are based upon a safety standard. In other words, a person may be admitted to a facility where he or she “may be suffering from a mental disorder of a nature or degree so as to require hospitalization in the interests of the person’s own safety or the safety of

---

401 NSIPTA, s 39.
402 NBMHA, s 1.1.
A certificate may only be issued if the person is not suitable for admission as a voluntary patient.

Admission

Unlike most other provinces where an initial psychiatric assessment followed by independent confirmation by a second physician suffices for an involuntary admission, in New Brunswick, a third step must take place prior to admission. This third step requires the chairman of a tribunal appointed by the Lieutenant-Governor in Council to ultimately confirm or deny an involuntary admission. If the tribunal agrees with the physician and also is of the opinion that the person requires hospitalization in the interests of the person’s own safety or the safety of others, then it must order that the person be admitted as an involuntary patient. The tribunal is composed of a lawyer and two members of the public in order to authorize the involuntary admission according to the NBMHA and also to authorize the treatment of involuntary patients.

Capacity and Consent to Treatment

The New Brunswick regime is similar to that in Ontario in that the assessment of a person’s capacity to consent to treatment is separate from admission. However, New Brunswick effectively allows for treatment to be administered to involuntary patients, their capacity notwithstanding, where that patient objects to the treatment.

Under the New Brunswick legislation, when an attending physician makes an application to the tribunal for an involuntary admission, he or she must also include a request for an order authorizing the giving of routine clinical medical treatment without consent where the person:

- has not reached the age of sixteen years,
- has reached the age of sixteen years but is not, in the attending psychiatrist’s opinion, mentally competent to give or refuse to give consent in relation to routine clinical medical treatment, or

---

403 NBMHA, s 7.1.
404 NBMHA, s 8.1(1).
405 General Regulation, NB Reg 94-33 made under the Mental Health Act. See also, New Brunswick Psychiatric Patient Advocate Service, online: <http://www.gnb.ca/0055/advocate-e.asp>.
c. has reached the age of sixteen years and is, in the attending psychiatrist’s opinion, mentally competent to give or refuse to give consent in relation to routine clinical medical treatment, but refuses to give consent in relation to such treatment.406

(emphasis added.)

So for example, where a patient is over the age of 16 and is not objecting to the proposed treatment, no such additional application would be made and the patient’s capacity would be assessed at a later date. On the other hand, if the patient meets any one of the descriptions above, the additional application must be filed with the tribunal. Especially in the case of the non-consenting, capable adult, a tribunal’s decision to admit effectively negates the autonomy of the patient. New Brunswick’s regime mitigates this to some extent by providing that where the person is assessed as capable at the time of admission but refuses to consent to treatment, the tribunal must consider if, among other things, the refusal constitutes reliable and informed instructions based on the person’s knowledge of the effect of the treatment and the fact that without the treatment, the person would continue to be detained as an involuntary patient with no reasonable prospect of discharge.407 For patients who have been assessed as incapable at the time of admission but have expressed prior capable wishes in respect of treatment, the provisions mandate that the tribunal can only authorize the giving of certain medical treatment where it holds those prior expressed wishes were unreliable and informed or do not apply to the present circumstances.408

Finally, it is noteworthy that in the application to the tribunal, as discussed above, the application “is sufficient authority...for the attending psychiatrist...without consent, to give such routine clinical medical treatment and to administer such restraint as, in the attending psychiatrist’s opinion, is necessary pending a determination of the application”.409 It appears that this section has not been challenged in the courts.410

**Children**

It is clear from this provincial legislation that children (under the age of 16) can be involuntarily admitted and treated without their consent. Where an attending physician makes an application to the tribunal for the involuntary admission of a child, in making

---

406 NBMHA, s 8.01(2).
407 NBMHA, s 8.11(3).
408 NBMHA, s 8.11(2).
409 NBMHA, s. 8(5).
410 Conclusion based upon noting-up section 8 of the Mental Health Act, RSNB 1973, c M-10 on LexisNexis Quicklaw.
its decision, the tribunal is charged to consider what is in the “best interests” of the child or adolescent patient and whether or not failing to give treatment would result in the child remaining detained indefinitely.\textsuperscript{411} For children under the age of 16, the Act only contemplates substitute consent in relation to the disclosure of certain information, leave of absences and hospitalization in another jurisdiction\textsuperscript{412} – or where the medical treatment is not routine clinical treatment or other psychiatric treatment.\textsuperscript{413}

\textbf{The Territories and Nunavut}

\textbf{Admission}

The process of involuntary admission in the Northwest Territories and Nunavut is governed by the same legislation, the \textit{Mental Health Act}\textsuperscript{414} ("NWTMHA"). The NWTMHA is similar to that of New Brunswick where the ultimate decision with respect to involuntary admission lies with someone other than the applicant physician. In New Brunswick, that authority resides with the relevant tribunal while in The Territories, it lies with the Minister.\textsuperscript{415} In addition, the Minister is also empowered to “…order that a psychiatric assessment be performed of the person who is the subject of the application, within 48 hours after that order, before refusing or approving the application.”\textsuperscript{416}

In an application to the Minister for an involuntary admission, a medical practitioner must be of the opinion that the person is suffering from a mental disorder that is likely to cause serious bodily harm to self or others in addition to imminent and serious physical impairment. Interestingly, the threshold for admission is lower than for the psychiatric assessment that precedes it.\textsuperscript{417} The Territories still apply an “imminent” standard whereas in Ontario, as discussed in Chapter 1, that standard was removed from the provincial MHA in 2000.

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{411} NBMHA, s 8.11(1).
\item \textsuperscript{412} NBMHA, s 8.6(1).
\item \textsuperscript{413} NBMHA, s 8.6(2).
\item \textsuperscript{414} \textit{Mental Health Act}, RSNWT 1988, c M-10.
\item \textsuperscript{415} NWTMHA, ss 16(1), 16(2)(c).
\item \textsuperscript{416} NWTMHA, s 16(2)(b).
\item \textsuperscript{417} NWTMHA, s 14. In contrast, when deciding to detain the person for psychiatric assessment, in addition to the three criteria outlined in section 14, section 8 of Act provides that the medical practitioner must also consider bodily harm, violent behaviour and the person’s competence to care of him or herself.
\end{itemize}
\end{footnotesize}
Capacity and Consent to Treatment

In the Northwest Territories and Nunavut, considerations of capacity are divorced from the considerations related to admission. Here, a patient’s capacity must be assessed prior to administering any treatment. Treatment is only administered with the consent of a capable person or an incapable person’s SDM. An SDM cannot consent to psychosurgery, lobotomy and other irreversible forms of treatment.

Lastly, the Yukon and the Northwest Territories have similar unique provisions with respect to mental health treatment without consent in emergency circumstances. In all cases, the territorial emergency treatment provisions permit treatment without consent where it is necessary to preserve mental health or to “prevent imminent serious... mental harm”.

Children

It is presumed that these Acts apply equally to children as to adults since nothing within them expressly precludes the admission of children as involuntary patients i.e. there is no mention of an age limit nor any references to special considerations where an involuntary patient is a child.

The Yukon

Admission

In the Yukon, the provision of mental health services is governed by the Mental Health Act (YMHA). Similar to Ontario, involuntary admission is based on assessments by two physicians in whose opinion certain criteria have been met. Within 5 days of having completed the requisite certificates for the admission, one or both of the recommending physicians must prepare a treatment plan for the patient.

---

418 NWTMHA, s 19.1(1).
419 NWTMHA, ss 21, 22(1).
420 NWTMHA, s 20(1).
421 Care Consent Act, SY 2003, c 21, Sch B at 21.
422 Mental Health Act, RSY 2002, c 150.
423 YMHA, s 13.
424 YMHA, s 14.
Capacity and Consent to treatment

Competence or capacity in the Yukon is assessed with a view to 4 criteria:

a. the ability to understand the condition for which the treatment is proposed
b. the ability to understand the nature and purpose of the treatment
c. the ability to understand the risks involved in undergoing treatment
d. the ability to understand the risks involved in not undergoing the treatment

Generally, where an involuntary patient is competent, no treatment can be administered without consent. However, where a competent, involuntary patient is refusing to consent to proposed treatment, the attending physician can apply to the Mental Health Review Board for an order authorizing the giving of medical treatment. When the board receives the application, its role is to satisfy itself that, among other things, the mental condition of the patient will be or is likely to be substantially improved by the treatment.

Lastly, unlike many other provinces, the Yukon does not explicitly prohibit substitute consent with respect to psychosurgery, lobotomy and other irreversible forms of treatment. It does say that where an involuntary patient is incompetent, both substitute consent and the consent of the board will be required for treating the mental disorder using chemo-therapy, a procedure that by direct access to the brain, removes, destroys or interrupts the normal connections to the tissues as well as other forms of treatment.

Children

It is presumed that the Act applies equally to children as it does to adults since nothing within it expressly precludes the admission of children as involuntary patients. There is no mention of an age limit nor any references to special considerations where an involuntary patient is a child.

---

425 YMHA, s 19.
426 YMHA, s 21(2)(a).
427 YMHA, s 23(2)(a).
428 YMHA, s 21(4) and (5).
429 YMHA, ss 23(3) and (4).
The purpose of Norway’s Mental Health Care Act (“NoMHCA”) is to “ensure that mental health care is applied and implemented in a satisfactory manner and in accordance with the fundamental principles of the rule of law… [and] to ensure that the measures described in the Act are grounded on the needs of the patient and respect for human dignity”. Like many countries, mental health in Norway has seen the move away from institutionalization and an increased focus on expanding its community-based services. However, similar to Ontario, funding and provision of services have not kept pace with the increasing numbers of people receiving care in the community.

Admission

The NoMHCA distinguishes between compulsory observation and compulsory mental health care. The most recently available version of this legislation (dated 1999, with amendments up to 2006) defines compulsory mental health care as the examination and treatment by specialized health services of persons suffering from mental illness, and the nursing and care that this requires without consent as provided for in chapter 4 of the Act relating to Patients’ Rights. Chapter 4 outlines the provisions with respect to treatment without consent. Such treatment may be provided on an inpatient or outpatient basis.

In many ways, the framework of compulsory mental health care in Norway is similar to Ontario’s regime for involuntary admission. The person must be assessed by two physicians before a person can be admitted. The admission criteria for compulsory mental health care under the NoMHCA are as follows:

1. Voluntary mental health care has been attempted, unsuccessfully, or is “obviously pointless”
2. The patient was examined by two physicians, one of whom is independent of the responsible institution
3. The patient is suffering from a serious mental disorder and application of compulsory mental health care is necessary to prevent the person concerned from either

---

430 Mental Health Care Act: An Act No. 62 of 2 July 1999 relating to the provision and implementation of mental health care (the Mental Health Care Act), with later amendments, s 1-1.
432 NoMHCA, s 1-2.
433 NoMHCA, s 3-5.
a. having the prospects of his or her health being restored or significantly improved considerably reduced, or it is highly probable that the condition of the person concerned will significantly deteriorate in the very near future, or
b. constituting an obvious and serious risk to his or her own life and health or those of others on account of his or her mental disorder

4. The institution is professionally and materially capable of offering the patient satisfactory treatment and care
5. The patient has been given the opportunity to state his or her opinion
6. Even though the conditions of the Act are otherwise satisfied, compulsory mental health care may only be applied when, after an overall assessment, this clearly appears to be the best solution for the person concerned, unless he or she constitutes an obvious and serious risk to the life or health of others. When making the assessment, special emphasis shall be placed on how great a strain the compulsory intervention will entail for the person concerned.434

Patients or next of kin can apply to the responsible mental health professional to have compulsory observation or mental health care terminated.435 Appeal rights with respect to those decisions lie with the patient, who may contest the imposition of compulsory treatment to a supervisory committee.436 Moreover, even if a patient does not appeal the application for compulsory care made of his or her behalf, the supervisory committee will initiate a review of the application three months after having made its decision.437

### Capacity and Consent to Treatment

The concept of capacity may be more of an implicit than an explicit concept in the NoMHCA. A test for capacity is not articulated in the Act though it seems to be a consideration when assessing if a person is able to consent. For example, the Act notes that, “[i]n the case of persons who owing to physical or mental disorders, senile dementia or learning disabilities are clearly not able to understand what consent entails, the responsible mental health professional and any person acting on behalf of the patient, shall sign [the document]…”438 There is a general prohibition on treatment without consent439, though the Act outlines circumstances in which patients can be treated and

---

434 NoMHCA, s 3-3.
435 NoMHCA, s 3-7.
436 Ibid.
437 Ibid.
438 NoMHCA, s 2-2.
439 NoMHCA, s 2-1.
examined without it; for example, where interventions are not considered “serious”\(^{440}\). Or in instances where the need for the treatment has been affirmed and “…there is a great likelihood of their leading to the cure or significant improvement of the patient’s condition, or of the patient avoiding a significant deterioration of the illness”.\(^{441}\)

Efforts must be made to get consent and the person must have been examined such that the proposed treatment must have a great likelihood of their leading to a cure or a significant improvement in the patient’s condition, or the patient avoiding a significant deterioration of the illness.\(^{442}\) On the other hand, where the proposed interventions are more serious, consent from the patient is generally required subject to the following exceptions:

a. The patient may be treated with medicine without his or her own consent. Such medication may only be carried out using preparations which are registered in Norway and in commonly used doses. Medication may only be carried out using medicines which have a favourable effect that clearly outweighs the disadvantages of any side effects.

b. As part of the treatment of a patient with a serious eating disorder, nutrition may be given without the consent of the patient, provided that this is considered to be an absolutely necessary choice of treatment.\(^{443}\)

In addition, where the patient refuses to consent to treatment, the Act provides for alternative, voluntary measures to be proposed.\(^{444}\)

**Children**

The Norwegian legislation does explicitly contemplate the provision of compulsory mental health to children over the age of 12 (see Section 2-1). Section 2-2 seems to suggest that if a child over the age of 12 objects to a treatment measure, the child has recourse to a supervisory committee to adjudicate the matter.

\(^{440}\) This is not a defined term in the legislation.
\(^{441}\) NoMHCA, s 4-4.
\(^{442}\) Ibid.
\(^{443}\) Ibid.
\(^{444}\) Ibid.
NETHERLANDS

Much like Ontario, Norway and many other parts of the developed world, the trend in mental health treatment in Netherlands has been towards community-based services and deinstitutionalization.\(^{445}\)

It was noted in Ontario’s Select Committee on Mental Health and Addictions report that the Netherlands was understood to “have a lower threshold than the risk of serious physical harm for involuntary admission and treatment”\(^ {446}\). We could not determine if this is accurate, having found no primary sources with respect to mental health. A press release from the Ministry of Health indicated that the system of compulsory admission (and accompanying legislation) would be updated as of 2012, but we could find no reference to new legislation.

According to a 2008 Dutch article, the Dutch Mental Health Act contains three criteria governing compulsory admission to psychiatric hospitals: “the subject himself does not agree with admission; he presents a danger to himself and others and the 'last resort' principle applies (i.e. there is no reasonable alternative)” [sic]\(^ {447}\). However, to the best of our knowledge there is no English translation of the legislation available.

NEW ZEALAND

What is apparent from New Zealand’s Mental Health (Compulsory Assessment and Treatment) Act\(^ {448}\) (“NZMHA”) is the extent to which treatment for mental health disorders must be delivered in the form that is most appropriate for the person — whether that is in the community and/or with respect of the person’s particular cultural imperatives.\(^ {449}\) The country has extensive community services that, according to a 2010 report, “...can provide the whole range of services required by people who experience mental health problems”, including:


\(^{448}\) Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ) 2009.

\(^{449}\) See NZMHA, ss 5 and 6.
• responding to people’s mental health crises (e.g. crisis respite houses, peer support, home-based treatment)
• telephone support lines (e.g. Warmline)
• peer support services
• home-based interventions (e.g. addiction counseling in the home, psychological therapy)
• packages of care designed to meet the individual’s needs
• mobile services where staff travel to where the person is
• residential services for people requiring greater live-in support
• emphasis on skills for work such as computing, technical skills, or language skills
• housing services and tenancy management
• links with disability services (particularly for people who have hearing, sight and mobility problems)
• links with other community health providers such as GPs and pharmacists
• cultural support linking people to Māori, Pacific, Asian and other culturally-based agencies
• employment services supporting people into part- or fulltime work
• facilitating people to use existing services in their community of choice (e.g. Alcoholics Anonymous, support groups, gyms, language classes, Age Concern or educational options)
• alternatives to hospitalization for people who are acutely unwell.  

Under this Act, every patient is entitled culturally appropriate treatment and to make informed decisions about that care.  

Admission

Like Ontario, a psychiatric assessment under the NZMHA occurs pursuant to issuance of a certificate signed by the examining physician. Where it is a family member who is trying to access services for a friend or relative, getting that person to be examined can be done formally (with the help of police) or informally (driving the person to the emergency room). In New Zealand, that first step is formalized. Under the Act, a person over the age of 18 who has had recent contact with the potential patient  

---

451 NZMHA, ss 65, 66 and 67.
452 NZMHA, ss 2A, 8 and 8A.
believes that the potential patient may be suffering from a mental disorder\textsuperscript{453} must apply to the Director of Area Mental Health for the person to be assessed. The application must be accompanied by a physician’s certificate stating that he or she has examined the potential patient and there are reasonable grounds for believing that the person may be suffering from a mental disorder.\textsuperscript{454} Mental disorder” is defined as “an abnormal state of mind (whether of a continuous or an intermittent nature), characterized by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it:

\begin{enumerate}
\item poses a serious danger to the health or safety of that person or of others; or
\item seriously diminishes the capacity of that person to take care of himself or herself\textsuperscript{455}.
\end{enumerate}

It should be noted that New Zealand’s expansive definition of “mental disorder” (with its inclusion of risk of harm) means that a separate inquiry into harm does not subsequently take place at the admission phase (as it does in Ontario for involuntary admission). A person found to be mentally disordered is required by the medical practitioner to undergo further assessment and treatment. At that point, the person is said to be in a compulsory status\textsuperscript{456}.

Unlike Ontario, a finding of mental disorder on the second assessment does not result in automatic admission to a facility. In New Zealand, this certificate of preliminary assessment may require an additional period of assessment.\textsuperscript{457} The unique feature of this period is that the assessment can take place in the person’s home or on an outpatient basis (also available if the person was previously been assessed in a hospital).

If assessment and treatment in the community is preferred, then a notice is sent to the patient indicating where he or she is required to attend. If during this time the responsible clinician decides that the out-patient ought to be treated within the hospital, he or she can direct the person to present him or herself at a specified hospital to be admitted and detained for the purposes of assessment and treatment.\textsuperscript{458} At the culmination of the assessment process if the person is still deemed to be mentally disordered and in further need of treatment (as documented in the certificate of final assessment), application must

\begin{itemize}
\item \textsuperscript{453} NZMHA, s 8.
\item NZMHA, s 8B.
\item NZMHA, s 2.
\item NZMHA, s 2.
\item NZMHA, s 2.
\item NZMHA, ss 10(b)(ii) and 11.
\item NZMHA, ss 11 and 14.
\end{itemize}
be made to the court\textsuperscript{459} to authorize a compulsory treatment order.\textsuperscript{460} A compulsory treatment order can either be a community treatment order or an inpatient order.\textsuperscript{461}

**Capacity and Consent to Treatment**

Similar to Norway, the concept of capacity as understood in Ontario, does not seem to explicitly exist in the NZMHA. Generally, the Act provides that patients and proposed patients may refuse to consent to treatment\textsuperscript{462} and that responsible clinicians seek to obtain consent from their patients, even when the treatment may be authorized by the Act.\textsuperscript{463} That, however, is not the case while the person is undergoing assessment (treatment must be accepted\textsuperscript{464}) or in emergency situations\textsuperscript{465}. It is also the case that in the first month that a person is subject to a compulsory treatment order, the person is required to accept treatment.\textsuperscript{466} After that, a person subject to a compulsory treatment order has the right to refuse treatment unless they consent or the treatment is considered to be in the best interests of the person.\textsuperscript{467} As a last note, provisions are made for a deemed withdrawal of patient consent. What this means is that if a patient withdraws consent for treatment (can do this any time in instances related to brain surgery, electro-convulsive therapy and treatment under a compulsory treatment order past the one month mark), any subsequent treatment will be deemed to be given without consent.\textsuperscript{468}

**Children**

Under the NZMHA, children under the age of 17 may be subject to compulsory treatment and mandates that when they are assessed for mental disorder, the assessment must be done by a psychiatrist practising in the field of child psychiatry.\textsuperscript{469} Where the child is 16

\begin{itemize}
\item It is interesting to note that decisions for compulsory treatment orders related to the provision of mental health services are adjudicated, wherever practicable, by a family court judge (regardless of the age of the person who is the subject of the order). Furthermore, section 18 of the Act requires that the judge examine the patient and consult with other health professionals involved in the case (in addition to the responsible clinician) and whomever else he or she thinks relevant.
\item NZMHA, ss 14, 17-22. Compulsory treatment order is not defined in the Act.
\item NZMHA, s 28(1).
\item NZMHA, s 57.
\item NZMHA, s 59(4).
\item NZMHA, s 58.
\item NZMHA, s 62. Urgent circumstances include when treatment is necessary to save the patient’s life; to prevent serious damage to health of the patient; or to prevent the patient from causing serious injury to himself or herself or others.
\item NZMHA, s 59(1).
\item NZMHA, s 59(2).
\item NZMHA, s 63.
\item NZMHA, s 86.
\end{itemize}
or older, the Act provides that the consent to treatment or assessment by that child’s parent or guardian will not constitute sufficient consent for the purposes of the Act.\textsuperscript{470} Certain interventions, such as brain surgery for the purposes of mental health, are prohibited for children of this age group.\textsuperscript{471} Lastly, where the child’s condition is being reviewed by the Tribunal, the Act mandates that one of the members be a psychiatrist practicing in the field of child psychiatry.\textsuperscript{472}

\footnotesize
\begin{itemize}
\item \textsuperscript{470} NZMHA, s 87.
\item \textsuperscript{471} NZMHA, s 88.
\item \textsuperscript{472} NZMHA, s 89.
\end{itemize}
CHAPTER 6 - IMPLICATIONS FOR ONTARIO

1. Implications for Policy
2. Implications for Strategy
3. Implications for Research

Implications for Policy

Policy frameworks differ from one jurisdiction to another regarding how people with mental disorders are treated, but they generally fall into two categories: the autonomy approach and the best interests approach; the latter is also sometimes referred to as the protectionist or welfare approach.

The autonomy framework is strongly rooted in the tradition of common law which protects the bodily integrity of the person, the right of the individual to determine what will be done to his or her person; courts have called this the essence of one’s identity and personhood.\(^ {473}\) Treatment refusal decisions have been respected when they are made on religious or spiritual belief grounds, such as the Jehovah’s Witness cases where life-saving blood transfusions are refused.\(^ {474}\) The best interests approach, by contrast, relies on the historical \textit{parens patriae} duty of the sovereign to look after citizens who cannot care for themselves, literally acting in the position of a parent to a child.\(^ {475}\)

The key concept which influences the boundary between these two approaches is the mental competence, or capacity, of the subject. Mental competence is a nebulous and changing status. A person can be competent for some purposes and not others, at some times and not others.\(^ {476}\) A person may be competent to make simple decisions but not complex decisions involving more risk. A great deal of effort has been put into circumscribing how professionals and courts determine a person’s mental competence\(^ {477}\) because so much depends on it. Taking away a person’s right to make decisions is a serious matter, and goes to the essence of individual identity and personhood.

\(^{473}\) Malette \textit{v} Shulman [1990] OJ No 450, 72 OR (2d) 417 (CA); AC \textit{v} Manitoba (Director of Child and Family Services), 2009 SCC 30, [2009] 2 SCR 181.
\(^{474}\) Ibid.
\(^{475}\) E (Mrs) \textit{v} Eve [1986] 2 SCR 388, SCJ No 60 at 40-41.
\(^{476}\) As is reflected in HCCA, s 15.
Many strongly believe that a competent person should be able to make his or her own decisions and the state should fiercely protect this right, even when the person rejects life-saving treatment or makes decisions that may objectively be considered foolish or imprudent. However, when a person is judged to be mentally incompetent to make decisions, the state sometimes mandates by way of legislation that decisions and actions be made according to the person’s best interests, rather than requiring an SDM to attempt to ascertain and abide by what the person would decide if he or she were mentally competent.

It is evident from the history of Ontario’s mental health, consent and substitute decision-making legislation, that a strong value and tradition of respecting personal autonomy is the foundation of our law. In the law of property, there is a long history of allowing a competent person to give another person the right to deal with their property (through a power of attorney) whether they are mentally capable or not, and the power survives incapacity. When it comes to psychiatric treatment decision-making, though, less deference may be given to the autonomy of the individual.

The consequences of respecting the prior capable wishes of a mentally incapable person facing decline as a result of a refusal to be treated are sometimes regarded as unacceptable, such that the legislation in some jurisdictions allows those wishes to be disregarded entirely or overridden by a review board.

This approach has its advocates in Ontario and in other parts of Canada. The rationale given for dismissing the person’s wishes is that he or she has a brain disease which has taken over any decision-making capabilities. The courts in Ontario are likely to find that this treads too close to the line of disregarding personhood of the individual and certainly conflicts with a long line of clearly decided case law.

Another argument used to justify this approach is that depriving a person of their liberty without offering them a way to regain their independence is also unacceptable, whether morally or legally. The line is crossed when the opportunity of treatment and support becomes a requirement. The state must have a very compelling interest to impose action on an unwilling person in the name of the person’s liberty. Certainly this approach has

---

479 This term is used here generally, in the most paternalistic sense of the word, in contrast to the way it is defined in the HCCA to specifically include an individual’s prior capable wishes, if any.
480 See chapter one of this Report.
481 John E Gray, Margaret A Shone, Peter F Liddle, Canadian Mental Health Law & Policy, 2 ed (Canada: LexisNexis Canada, 2008).
482 John E Gray, Margaret A Shone, Peter F Liddle, Canadian Mental Health Law & Policy, 2 ed (Canada: LexisNexis Canada, 2008).
been found to violate the *Charter* where probation or parole orders or conditional sentences have required a convicted person to have psychiatric or substance abuse treatment.483

In B.C., a person who is involuntarily committed is assumed to be incompetent to make decisions regarding treatment; treatment competence is not considered separately from committal, as it is in Ontario. It is unlikely that such an approach would survive legal scrutiny in Ontario, given the strong emphasis in Ontario case law on maximizing individual autonomy in decision-making.484 The separation of committal and competence in treatment decision-making was first introduced into Ontario law in 1978, when the MHA provided that treatment could not be given without consent of the patient or the nearest relative of the patient if he or she was mentally incompetent.485

It is anticipated that if it were law, the substitute decision-making scheme for involuntarily committed patients in B.C. would also be subject to serious legal challenge in Ontario. In B.C., the substitute decision is made by the hospital director, based on the physician’s recommendation, and in practice, this decision is delegated, sometimes to the physician making the recommendation.486 This approach would be unlikely to be accepted in Ontario where, in the leading case, *Malette v. Shulman*, the court distinguished between the medical judgment model and the patient autonomy model. The court clearly stated that the medical judgment model is not the law for treatment decisions when a person has made a clear and knowable advance directive not to accept blood transfusions even where such a transfusion is life-saving.487

Ontario’s policy is to restrict involuntary detention to situations involving or potentially involving serious harm to self or others, to protect the decision-making rights of capable patients and to provide substitute decision-making tied to the individual’s values and preferences. Any change to the law will be interpreted to reflect a change in these values and policy frameworks, and will lead to strong reaction from well-informed stakeholders who have been involved in the development of the current law over many years.

Ontario has a very well-organized, well-informed, and active mental health bar that monitors and actively litigates patients’ rights issues. It is certain that the law would be

---

483 *R v Rogers* (1990), 61 CCC (3d) 481 (BCCA); *R v L (JJ)*, 2001 MBCA 21.
484 *Fleming v Reid* [1991] OJ No 1083, 4 OR (3d) 74 (CA) at 40; *Malette v Shulman* [1990] OJ No 450, 72 O.R. (2d) 417 (CA) at 25 and 41.
485 Mental Health Act, SO 1978, c.2, s 35.
487 *Malette v Shulman* [1990] OJ No 450, 72 OR (2d) 417 (CA).
in flux for several years until the meaning and interpretation of any changes are made clear through development of a new body of case law. The government would have to defend its values and policy choices, as encompassed by the legal provisions. Legal costs would increase as hospitals, other health practitioners and review boards engage in almost certain protracted litigation.

Other anticipated consequences of Ontario adopting a ‘best interests’ approach are that while some individuals who have been in hospital untreated for some time may ultimately be treated and in due course could leave hospital, resources would be required in order to support individuals in the community with treatment compliance. Costs of medications covered in hospital global budgets and provided to hospital in-patients would also increase because more would be administered to those who are involuntarily detained.

In order to allow seriously ill persons to be treated against their will, Ontario’s legislation would need to be significantly changed. The following approaches have been used in other jurisdictions’ legislation:

1. Treatment and recovery are included in legislation as explicit elements of the Statement of Purposes:

Treatment and/or recovery to enable release from hospital are explicit and primary purposes of the legislation in B.C., Saskatchewan, Newfoundland, and New Brunswick. Including such a statement of purpose establishes the *parens patriae* rationale and can assist with defending the legislation against a *Charter* challenge. Ontario currently includes a statement of rationale in the MHA with respect to community treatment orders.488

2. Committal for the purpose of treatment, recovery or discharge, is included in the legislation together with dangerousness, lack of self-care, and deterioration as criterion for committal:

As described in Chapter 5, New Brunswick is the only jurisdiction in Canada where the ultimate decision-making for involuntary committal lies with a tribunal rather than health professionals. The most salient feature of that statutory regime is the fact that an application to the tribunal for involuntary detention may also be accompanied by a request for an order authorizing “routine clinical medical treatment,” and the treatment may be administered even before the application is decided.

488 MHA, s 33.1(3).
In the course of deciding whether to authorize the giving of routine clinical medical treatment to a person who has reached the age of 16 years and who is capable of giving or withholding consent, but who refuses to do so, the tribunal can make the order if:

(a) it also makes an order to admit the person as an involuntary patient,

(b) it is of the opinion that the refusal does not constitute reliable and informed instructions based on the person’s knowledge of the effect of the treatment on the person,

(c) it is of the opinion that the treatment is in the best interests of the person, and

(d) it is of the opinion that, without the treatment, the person would continue to be detained as an involuntary patient with no reasonable prospect of discharge. (emphasis added)

A provision worded very much like this was deleted and changed to the current standards in Ontario’s MHA in 1978.

“The possibility of cure or considerable improvement will be lost” is one of two grounds for committal and treatment in Norway’s legislation, but information in English about Norway’s law is limited.

3. Combine criteria for involuntary admission and incapacity.

Capacity and admission could be combined so that there is only one criterion for both, as in Newfoundland and Nova Scotia’s legislation. A similar approach is to require that the person be incapable to be admitted as an involuntary patient, as in Saskatchewan. This approach is incorporated into the Box B criteria in Ontario, although a substitute decision is required to provide consent.

This conflation of committal and capacity was rejected in Ontario in the 1978 amendments to the MHA. A policy change along these lines would change the definition of incapacity and arguably would lower the threshold. It could result in persons who

---

489 Mental Health Care and Treatment Act, SNL 2006, c M-9.1, s 17; Involuntary Psychiatric Treatment Act, SNS 2005, c 42, s 17(e).
491 MHA, s 10(1.1)(e).
would otherwise be found capable being deprived of their decision-making capacity because they require committal on account of dangerousness.

4. The test for capacity could be modified

A possible consideration is to frame the requirements for capacity in terms of actual understanding and/or appreciation rather than the “ability to” understand the information and the “ability to” appreciate the consequences of a decision. Manitoba has removed “ability” from the understanding branch of its parallel test, but maintains it in the “appreciation” branch. In addition, some statutes use terms such as “fully capable” or “fully comprehend” (i.e., Newfoundland, Nova Scotia). This approach may make it more likely that a person will be found incapable of providing consent, although this would most certainly be tested through litigation.

5. Permit deemed consent

The B.C. legislation provides for “deemed” consent to treatment that is recommended or proposed by a physician and authorized by an official of the hospital where the person is detained. This approach is not likely to be upheld in Ontario’s courts, as it represents a radical departure from Ontario’s established case law as well as legislation.

6. Allow psychiatric treatment without consent if certain prescribed criteria are met:

This is explicitly allowed under the legislation in Newfoundland and in New Brunswick for incapable patients “where there is no reasonable prospect of discharge” without treatment. The prospects for discharge are evaluated by the physician proposing the treatment, but recall that this evidence is heard by a tribunal before the order for committal or treatment is made (although treatment can begin before the board hearing). In addition, in Newfoundland, the patient’s prior capable wishes, if any, and current views are to be considered.

Second medical opinions and applications for review by a specialized tribunal may be allowed as safeguards. However, this is the very approach that was explicitly rejected by the Ontario Court of Appeal in Fleming v. Reid in 1991 on section 7 Charter grounds.

In Manitoba and Prince Edward Island, treatment without consent is permitted where treatment is required to prevent harm to the patient or another person. In Manitoba this is allowed only if consent or an order is pending. In PEI it is allowed in conjunction with Board approval. This bears some similarity to section 19 under Ontario’s HCCA, wherein by way of court application, treatment may be permitted pending the final disposition of an appeal, based on criteria relating to the patient’s condition. However, the Manitoba
and PEI provisions do not involve the lengthy process of applying to court for a decision. As well, Ontario’s order authorizing treatment pending appeal does not include harm to others.

7. Allow SDM to make decision based on “best interests” without consideration of prior capable wishes

The provisions regarding substitute consent could allow the SDM to make decisions in the best interests of the patient, with no obligation to respect prior capable wishes as the HCCA is currently drafted. Alternatively, a review board would be allowed to authorize the treatment even over the refusal of the capable patient or the SDM for an incapable patient (Alberta, PEI, and New Brunswick). It is certain that such provisions would be challenged in Ontario on the basis of the Charter arguments which succeeded in Fleming v. Reid, and it seems likely such a challenge would succeed.

8. Allow hospitalization based on mental disorder alone

Physicians are allowed to make the treatment decisions, and the sole grounds for compulsory treatment are that a person is assessed as having a mental disorder (New Zealand). This approach is radically different from the history and intent of Ontario’s legislation since the pre-1960s statute.

Implications for strategy

Changes to the law and to policy are time-consuming and can be very divisive among stakeholder communities. This section addresses actions that can be taken within the existing law to enable people with serious mental illness to receive the help they need sooner, and to better prepare families and others for their supportive roles.

1. Information and education for patients and families

Patients improve faster when they can be actively involved in understanding their illness and making choices about their treatment and where they have some measure of personal control. They are more likely to accept and benefit from treatment when they know what to expect in the course of their illness, and what is likely to happen if they are treated, or are not treated.492

Similarly, families can be better decision-makers and provide better support to their loved ones if they receive education about the nature of their relative’s illness, the treatment and the likely impact on the lives of the patient and the family.

Innovative approaches such as videos, interactive computer programs and other web-based applications and live role-playing are being used in health care settings generally to inform patients and families about treatment and follow-up care for serious illnesses. This needs to be translated increasingly into the mental health context.

Notices that are required by legislation to be given to patients and families about changes in status, treatment capacity or the rights to review and representation by counsel under the Act can also provide important information and an opportunity for dialogue between the physician, other clinical staff, the patient and family about the illness and treatment. Very often, mental health providers, recognizing their patients’ rights to privacy, neglect to also provide supportive, if general, information to families who feel powerless to know where to start.

2. Education of physicians and other practitioners about how to communicate with persons with mental illness, SDMs and families about treatment options

Case law sometimes describes situations where the patient, the family or the SDM clearly has not understood the nature or course of treatment that the physician recommends, or conversely, the physician has not understood the patient’s or family member’s concerns or questions. Physicians and other health care providers may use technical language to explain both the illness and the proposed treatment in ways that simply do not allow lay people to understand their situation or what might happen to them. Patients and family members are in a vulnerable position and may not ask the questions they should ask to fully understand the situation. The emotionally charged nature of the situation (which may be the culmination of a long journey to seek help for the illness) may make everyone less able to comprehend and be empowered by the information.

Training in communication between patients, families, SDMs and physicians and other health care providers would be helpful to all concerned.

3. Comprehensive range of community services and supports

In communities that have good supports and services, patients and families are able to find help sooner and avoid or minimize the need for hospitalization. However, they may be confused by the system and find it difficult to access the right services in the right place at the right time. The provincial government has made, over many years,
significant investments in a range of community services and supports. Yet many communities still do not have sufficient community services or housing options to adequately support persons with mental illness, despite the strong evidence that such services and supports can prevent hospitalization and prevent or delay return to hospital after successful treatment. Implementation of the comprehensive provincial mental health and addictions strategy, *Open Minds, Healthy Minds*, is important to continue to provide resources that can keep people out of hospital. There is also more emphasis today on linkage of services, including resource matching and referral, to maximize the person’s chances of recovery, and to link them to meaningful resources such as income, housing and other supports. Linkages between children/youth mental health services and adult mental health services are also critical to a reasonable transition at key points in that person’s life.

4. More choices about medications

Cases such as *Starson* and *N.M. v. Klukach* demonstrate that the adverse side effects of many neuroleptic and anti-psychotic medications still create barriers to treatment acceptance for some persons with mental illness. To the extent that medications can be developed that restore patients to more normal functioning, treatment will become more accepted and the adverse consequences of treatment refusals will be avoided. And to the extent that health practitioners can be cognizant and respectful of the patient’s negative experiences with medications, and search for better solutions, patients will more readily comply with the recommended treatments. Research in this area would be very helpful and needs to be supported.

5. Education about the law and its interpretation and application

As described in Chapters 1-5, there are some widespread misunderstandings among health practitioners, patients and families about the law and its application in practice. A multi-pronged ongoing educational program to provide information in terms that can be readily understood and applied, and to dispel myths and false beliefs about the law is essential and has been recommended in previous reports.

---


Implications for Research

It would be very useful for both policy-makers and those who work with the law every day to have empirical evidence about how the law is interpreted and applied by patients, family members, concerned friends, service providers, physicians and other practitioners, lawyers, judges and review board members. A great deal in this area of law depends on clinical judgment and on clinicians having sound knowledge of the law and being accurate and complete in its practical application. Communication sometimes seems to fail at critical junctures. The literature on consent addresses deficiencies in what patients remember about what they have been told when asked for consent in the medical or psychiatric contexts.\(^{496}\) It is also evident from many legislative and parliamentary hearings and anecdotes that have been told in public forums that family members have misconceptions about the law, sometimes perpetuated by health practitioners.

The reported case law and tribunal decisions can present a distorted view of the everyday application of the law because reported cases are generally those which decide a new point of law with more general application to a broader audience beyond the immediate parties. Lawyers who advise both patients and health practitioners will work to ensure that errors made in applying the Act are corrected if possible without going to a tribunal or court for a decision. If a physician misapprehends the law and informs patients or family members incorrectly that the law is the reason that someone cannot be committed, in most cases, there is no way to know or correct that. The result is that everyone carries on with the wrong impression based on misinformation.

It would be helpful to policy-makers and stakeholders who are required to interpret and apply the law to know what some of the common misconceptions are, how they are communicated – both in delivery and receipt – and what can be done to improve both knowledge of the law and skills in interpreting, applying and communicating it, and with whom. Some specific areas of inquiry might include:

1. How well is the test for capacity understood by health practitioners (including all members of multi-disciplinary teams involved with the person in a health care setting) and how is it applied?

2. What kind of behaviour and evidence, from whom, is likely to lead to a decision to commit on grounds of danger to self or others? What is the threshold? Does it differ from hospital to hospital or from physician to physician? How can it be standardized without infringing unduly on independent clinical judgment?

\(^{496}\) See Dr. Paul Applebaum’s research on informed consent.
3. What are the relative rates of committal on Box A and Box B criteria? Are there differences in length of stay or frequency of admission for Box A or B patients? Is one group more likely to receive treatment than the other?

4. How well do SDMs understand their roles and responsibilities, and what support is in place for them to fulfill these roles well?

5. Are children treated differently in different kinds of institutions to which the CFSA applies? Is the HCCA aligned with the CFSA, and if not, what are the steps to bridge that gap?

6. Are there leading practices in assessment, admission, capacity assessment, and support for good substitute decision-making that can be adopted and disseminated throughout the system to improve the standard of care?

Considerations regarding CTOs have not been included here as a separate mandated review of CTOs was recently completed.
CONCLUSION

Mental health law in Ontario continues to evolve. This Report has traced the history of the different statutes that make up the regime and has made recommendations to address some of the issues raised by the Select Committee. These recommendations include improving access to information and educational opportunities for all system stakeholders – patients, families, SDMs, physicians and other health practitioners, and police. In order for the current system to work better, at a minimum, everyone has to know what resources are available and how the law applies. This is especially true for those who decide if a person meets the relevant criteria to access services.

A broader more intransigent issue identified by the Select Committee was the increasing number of people accessing care through contact with the criminal justice system, one path that sometimes leads that person to being admitted to a psychiatric facility. These individuals, along with other users of the system who enter through the mechanisms described in the MHA, may be first time users of the system or people who suffer from a recurring mental disorder. In many cases, they are individuals who do not recognize that they have a mental disorder; stop taking prescribed medication or otherwise refuse to be assessed and treated. Compounding this issue is the fact that families may not know how to access the appropriate resources or health providers do not know how to apply the proper legal tests (impacting access). This inevitably contributes to the “stories of distress” described by the Select Committee.497

One way that has been suggested to deal with this problem is to diminish the deference to personal autonomy as a value animating treatment decision-making provisions in the HCCA. Other Canadian jurisdictions, such as B.C. have gone this route. However, in Ontario, mental health, consent and substitute decision-making legislation demonstrates a strong and entrenched commitment to respecting personal autonomy. Provisions such as the requirement to take “prior capable wishes” into account make that clear. Were there to be a fundamental shift away from that principle (for arguably legitimate reasons), Chapter 6 outlines the significant challenges this would create.

There are no right answers. However, the commitment to continue to reduce stigmatization, and to support persons with mental illness, engage with stakeholders and develop resources for all concerned can only benefit those in need.

497 Select Committee Report, at p. 2. The Committee stated: “In sum, the Select Committee heard so many stories of distress that we unanimously decided we had to do better.”
APPENDIX 1

History of the Mental Health Act in Ontario

This appendix provides a somewhat detailed description of the changes to mental health and consent law from 1954 to the present. For a brief descriptive overview of changes to mental health law over the years in Ontario, see the OHA’s Practical Guide to Mental Health and the Law in Ontario, 2010, pages 2-5.

1954 – The Mental Health Act (MHA) is first enacted by c. 50.

1960 – 1960 consolidation of the statutes of Ontario. There are no changes to the 1954 Act (now MHA, RSO 1960 c 235)

1966 – 1966, c 37 mental health legislation never proclaimed into force. Therefore, the 1954 version of the Act as it appeared in RSO 1960 c 235 remains the current version of the legislation.

1967 – SO 1967, c 51 is enacted that significantly revises the MHA. For the first time, MHA outlines the processes for admissions and review of such admissions. Some of the key new provisions include:

- **New Definitions**: “mental disorder” is defined as any disease or disability of the mind. A “psychiatric facility” is now defined. The definition of “patient” is changed from “… a person who is receiving and lodged in mental health accommodations for the purpose of receiving treatment” to “… a person who is under observation, care and treatment in a psychiatric facility”.

- **Application of the Act**: The Act now is applicable to all psychiatric facilities. In the previous version of the Act, the scope of application of the legislation had not been defined.

- **Hospitalization**: A new Part II of the Act is added. The Act now outlines the process for the informal and involuntary admission of a patient to a psychiatric facility. However, section 6 under this part allows for the refusal of admission where “… the immediate needs in the case of the proposed patient are such that the hospitalization is not urgent or necessary.”

- **Criteria for Involuntary Admission**: For a person to be admitted involuntarily, the person must be:
  a. suffering from a mental disorder of a nature of degrees so as to require hospitalization in the interests of his own safety or the safety of others; and
  b. is not suitable for admission as an informal patient.

  Admission is upon application signed by a single physician who, after examining the patient and having made due inquiry into all the facts, is satisfied and is of the opinion that the admission criteria have been met.

- **New Parts III (Estates)**
a. This newly added Part III of the Act establishes a scheme for the management of the property (or estate as stated in the Act) of all patients admitted to psychiatric facilities who are deemed to be incompetent to do so. Where so found, a certificate of incompetence is issued.

b. Among other provisions, Part III allows the Public Trustee to assume the management of that patient’s estate upon receipt of a certificate of incompetence.

c. The person can appoint the Public Trustee as committee of estate even though a certificate of incompetence may have been issued under this section. The person can also revoke the Public Trustee’s appointment as committee at any time in writing and under seal.

d. When the Public Trustee becomes committee of the estate of any person under this Act, every power of attorney of such person becomes void.

- New Part IV (Veterans)

1970 – 1970 consolidation of the statutes of Ontario. Since there have been no changes to the 1967 version of the Act, that is the version that appears in the consolidated statute.

1978 – As appears in RSO 1980, c 262. Here again there were significant revisions to the Act.

- Definitions: For the first time, “mentally competent” is defined as “… having the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent.” The Act also introduces and defines the term “nearest relative” (which looks very similarly the hierarchy of SDMs and “restrain”. The meaning of mental disorder is unchanged.

- Assessment versus Admission: The Act introduces involuntary admission as a two-step process – an assessment for observation followed by a separate process for admission. In the previous version of the Act, assessment was not a distinct process from admission with explicit criteria to be met.

- Criteria for Assessment (s 9(1)): The application for assessment criteria requires that the examining physician have a reasonable belief that the person

  a. has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

  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

  c. has shown or is showing a lack of competence to care for himself

AND the physician is of the opinion that the person is apparently suffering from a 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,
f. imminent and serious physical impairment of the person

- **Criteria for Admission (s 14(1)(c)):** The admitting physician has to be of the opinion that the person is not suitable for admission as an informal patient AND that the patient was suffering from a mental disorder of a nature and quality that likely will result in,
  i. serious bodily harm to the person,
  ii. serious bodily harm to another person,
  iii. imminent and serious physical impairment of the person

- **Length of detention under initial certificate for involuntary admission (s. 14(4)(a)):** This Act decreases the initial detention period from one month to two weeks (though the period can be extended pursuant to certificates of renewal using the same criteria)
  i. N.B. The 1978 Act also decreases the increments for which detention can be prolonged:
    - First certificate → one month max (as opposed to two months in older Act)
    - Second certificate → two month max (as opposed to three months in older Act)
    - Third and subsequent certificates → three months (as opposed to six months and then one year in the older Act)

- **New disclosure provisions relating to clinical records (s 29):** The Act introduces new provisions for the disclosure of clinical records i.e. the clinical record compiled in a psychiatric facility in respect of a patient (former patient, out-patient and former out-patient) and includes part of clinical record. There is a general prohibition on disclosure, transmission or examination of a clinical record except:
  i. with the consent of the patient or his or her nearest relative by the officer in charge or the attending physician
  ii. without consent where delay in obtaining consent would endanger the life, limb or a vital organ of the patient by a person currently involved in the direct care of the patient
  iii. by staff for the purpose of assessing and/or treating the patient
  iv. pursuant to the written request of the CEO of the officer in charge to the CEO of the health facility currently involved in direct care of the patient
    - Where the record is used for research or statistical purposes, the record must be de-identified
    - Could be used in court proceedings in certain circumstances and conditions

- **New right of review for initial involuntary admission (s 31(2)(a)):** In the 1970 Act, an application for review could only be made in two circumstances: when a certificate of renewal came into force and when an involuntary patient had been admitted and his or her detention continued. This meant that the earliest an involuntary admission could be reviewed was two weeks after the
admission. Under the new Act, the right of review is afforded as soon as the certificate of involuntary admission comes into force.

- **New provisions relating to psychosurgery (s 35):** The new Act defines psychosurgery to include electrical stimulation for the purpose of altering behavior or treating psychiatric illness. Psychosurgery excludes neurological procedures used to diagnose or treat organic brain conditions or to diagnose or treat intractable physical pain or epilepsy...The Act provides that this kind of treatment can only be given to involuntary patients with their consent or with the consent of their nearest relative. It further clarifies that a patient’s or nearest relative’s consent to treatment shall not be deemed to include psychosurgery.

- **New provision allowing competent, involuntary patients to be treated without consent (s35(4)):** This gets proclaimed into force in 1986. The Act outlines a process where involuntary, competent patients could be treated without their consent by order of a regional review board (also applies to involuntary patients who have no nearest relative from whom consent could be obtained). When a competent, involuntary patient refuses to consent to a specific psychiatric treatment or a specific course of psychiatric treatment AND an attending physician and two psychiatrists (one member and one non-member of the medical staff) has examined the patient and is of the opinion that mental condition of the patient will be or is likely to be substantially improved by the specific treatment and the patient’s mental condition will not or is not likely to improve without the specific treatment, the attending physician on notice to the patient or nearest relative, may apply to a regional review board for an order authorizing the provision of the treatment
  1. The board can authorize the treatment where it is satisfied that a) the mental condition of the patient will be or is likely to be substantially improved by the specific treatment and b) the mental condition of the patient will not or is not likely to improve without the specific psychiatric treatment.
  2. However, the Board has no authority to authorize the provision of psychosurgery as a specific treatment.

- **New provisions under Part III – Estates**
  1. The provisions under this part now generally apply to out-patients. As defined by the Act, an out-patient is a person who is registered in 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.
  2. An attending physician can examine out-patients, in addition to admissions to a psychiatric facility to determine competency to manage their estate (s 36(2))
  3. A physician’s determination on a person’s competency and related reasons must be documented in the clinical record (s 36(3))
  4. Where a patient or out-patient who has a certificate of incompetence in force has been discharged from a psychiatric facility, there is a requirement to send the notice of discharge to the Public Trustee
The Public Trustee can apply to the courts for directions in certain circumstances

1981 – No major changes to the Act. In Part III of the Act, section 56, references to Divisional Court are changed to the Supreme Court.

1983 – Provisions under Part III of the Act, Estates, are amended and/or repealed. Specifically, donees of a power of attorney by a patient under the Act are now permitted, with the proper notice to the Public Trustee to exercise that power (though the Public Trustee’s power could be re-established by the Supreme Court). Also, the provision that allowed to Public Trustee’s committeeship under the Act to trump a valid power or attorney is repealed.

1984 – The requirement for documents to be served on the Public Trustee where there was an action or proceeding against the estate of a patient or outpatient was repealed.

1986 – Changes were made as part of the Equality Rights Statute Law Amendment Act, S.O. 1986, c. 64, to bring the Ontario statutes into compliance with section 15 of The Charter (the Equality Rights section); other significant changes were made to the MHA at this time.

- **Definitions:** meaning of “spouse” was made consistent with other Acts; “age of majority” was defined to mean 16 years.
- **Restraint:** clarify that restraint may be used to prevent harm and not simply because of the person’s mental condition; section is added requiring documentation of use of restraint, with special attention to chemical restraint.
- **Informal and Voluntary status:** The concept of voluntary status is added for the first time to distinguish between “informal” and “voluntary” status of the patient; “informal” is not defined, but it is clear from other provisions that it applies to children or adults who are mentally incompetent and are admitted under the authority of a parent, guardian or committee. Children aged 12 to 16 who are admitted as informal patients are given the right to apply for review of their admission. The Act does not authorize the detention or restraint of an informal or voluntary patient.
- **Time for Psychiatric Assessment** is reduced from 5 to 3 days (120 hours to 72).
- “Assessment” distinguished from “examination” to clarify that the person who may have a mental disorder will be examined by a physician when brought to a psychiatric facility under an order of the justice of the peace, or by police, to determine if a psychiatric assessment will be authorized by a Form 1.
- **Clinical records** – How access to the record is to be given to the patient is clarified and a right of review is granted if access is denied.
- **Review Board & Procedures** – Appointment of a provincial review board is made mandatory, eliminating the discretion of the LGIC to appoint regional review boards; the concept of “advisory review boards” is eliminated.
Procedural provisions had previously been added in the 1978 amendments, but were never proclaimed. The following changes were made to these sections (30a to 33f, in R.S.O. 1980, c. 262, sections 66 & 67) and they were proclaimed in 1986.

Additional requirements are imposed on physicians and officers in charge of psychiatric facilities to notify patients of their rights to review of competency to consent to treatment, examine a clinical record, or manage their estate, and to children aged 12 to under 16 of their rights to review of informal admission, and to notify Legal Aid to provide assistance to patients and children to exercise their rights. (Section 31)

Certificates of involuntary admission or renewal may be extended upon notice to the review board where the hearing has not been held before the expiry of the certificate; (Section 32)

Hearings and decisions were speeded up by addition of requirements that the hearing begin within 7 days of the review board receiving the notice requesting a hearing, and that the Board issue its decision within one day after the end of the hearing. (Sections 33b & c)

The patient who is a party in a proceeding, his counsel or agent is entitled to examine and copy the clinical record, unless the attending physician objects on the basis that such access may cause harm to the patient or a third party, subject to a court review and order (subsections 29(6) & (7)).

Appeal rights and procedures were clarified. 

The right of review of determination of mental incompetency is added (section 35).

Sections 35(4) & (5) permit an application to the board to authorize treatment for a refusing incompetent involuntary patient. However, such a treatment order may be appealed and treatment may not be given pending the outcome of the appeal unless authorized by a judge.

1987 – Pursuant to S.O. 1987, c. 37, further procedural and equality rights amendments are made, and the more detailed substitute decision-making scheme is introduced.

- **Definitions** “informal patient” is defined as a patient admitted by authority of a parent, guardian or committee of the person appointed under the *Mental Incompetency Act*.
  - “nearest relative” is deleted and replaced with the ranked list of SDMs in new section 1a.
  - “related medical treatment” is added to allow for administration of ancillary treatment for side effects of psychiatric treatment.

- **Substitute consent**: a new scheme is introduced, with a ranked list of substitutes, and requirements for the substitute to be 16 years of age or older, have a close relationship to the person, have been in contact within the previous 12 months, be willing to assume responsibility for the decision, and not aware of a competing claim. The patient’s competent wishes or, if unknown, best interests, are required to be the basis upon which the substitute makes the decision about treatment.
• **Treatment order for a person convicted or charged no longer allowed**: judge can no longer order treatment for a charged or convicted person who may have a mental disorder, although he or she can still order the person to be assessed in hospital (s. 15(3) repealed)

• **Clinical records**: Definition extended to include all clinical records for anyone who has been detained in a psychiatric facility, whether admitted or not. The age requirement of 16 years is deleted, and the concept of mental competence is made the governing consideration, allowing for a person under the age of 16 to be considered mentally competent to have access to their record, and provide consent to disclosure and transfer of the record. The substitute decision-making scheme is applied to records access and disclosure as well as treatment decisions. (section 29 & 29a)

• **Review procedures**: Notice requirements are added when a person is subject to an application for assessment (Form 1) or when a physician applies to the board for a treatment order, and the notice must specify reasons for detention and the right to retain and instruct counsel. (s. 30(1c-1e))

Extension of certificates of involuntary admission is repealed (except upon appeal, see below), and it is clarified that the review board will determine whether or not the patient meets the requirements for involuntary admission at the time of the hearing, and the decision will apply to the certificate in force at the time of the hearing. (32a)

When the board decides to discontinue a certificate, and the physician appeals the decision, the certificate remains in force for 3 days. This allows the physician to apply for an extension of the certificate to keep the patient in hospital until the appeal is decided or the patient no longer meets the criteria for involuntary admission.

• **Consent to Treatment**: The rules of consent to treatment are changed and clarified. A mentally competent patient can consent to or refuse treatment. However, treatment may be given to a mentally incompetent patient with the consent of a SDM, as set out in the ranked scheme in section 1a, by order of a review board (if the requirements are met in s. 35a), or if a physician certifies that there is imminent and serious danger to life, limb or a vital organ. Consent to psychosurgery is excluded for involuntary patients.

Best interests is defined much as it is in the current HCCA. In the definition of “mentally competent”, the phrase “having the ability to understand the subject matter in respect of which consent is requested” is defined to mean having the ability to understand the nature of the illness for which treatment is proposed and the treatment proposed.

**1992** – The Consent and Capacity Statute Law Amendment Act, 1992, introduced three new statutes: the Consent to Treatment Act (CTA), the Substitute Decisions Act (SDA), and the Advocacy Act. Provisions regarding consent to treatment previously contained in the MHA, mainly section 35, were transferred to the CTA (and used largely as the template for consent to treatment by any health practitioner), and the right to independent rights advice provided by specially
trained rights advisers was introduced. Some of the provisions regarding substitute decision-making regarding property (particularly for outpatients) that were previously included in sections 36 to 60 were transferred to the SDA. The Advocacy Act created an Advocacy Commission which would have assumed responsibility for rights advice and rights advisers, among other matters.

The CTA, SDA, and the Advocacy Act were not proclaimed until April, 1995 (except sections 35, 36, and 37 regarding the establishment of the Consent and Capacity Board, which were proclaimed in July, 1994). They were in force for less than a year. However, the CTA was the foundation for the present day HCCA, so its main provisions as they were altered from the MHA are summarized here:

- **Consent and Capacity Review Board** is established as a provincial board with executive structure and permanent employees. Its jurisdiction is given in various provisions in the Act setting out the applications which may be made to the Board.

- **Key elements of consent are codified**: A valid consent must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud. The information necessary for an informed consent is described, and the circumstances under which consent may be withdrawn are set out.

- **“Capacity” to consent replaces “mentally competent”**, and the requirements for capacity are defined to mean “if the person is able to understand the information that is relevant to making a decision concerning the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.”

- **The Act allows for fluctuating capacity**

- **Health practitioners** are given responsibility for determining the capacity to consent to the treatment they are proposing, and for advising patients of their rights to a review of the finding of incapacity when it is made

- **Age limit of 14 is set for presumption of incapacity**: if the person is over 14 years of age, the practitioner must make the capacity determination

- **Rights advice & rights advisers** are introduced and requirements for training, scope of powers, etc. of rights advisers are to be set under the Advocacy Act

- **Principles for making substitute decisions**: The concept of capable wishes is included, and the Act provides that the SDM must respect the prior capable wishes of the incapable person. In the absence of capable wishes, the best interests standard prevails, and this is defined in terms of values and beliefs of the incapable person in addition to the weighing of risks and benefits of the proposed treatment

- **Public Guardian and Trustee** given important role: The substitute decision-making scheme set out in the SDA is brought into the ranked order of substitutes and the PGT is given significant responsibilities and powers to consent to treatment for incapable persons who have no family members or others willing to assume responsibility
• **Admission**: Authority to consent to treatment includes authority to consent to hospital admission (as an informal patient), subject to a right of review by the CCRB.

• **Limited Treatment Orders**: There is no provision for the Board to order treatment for an involuntary or incapable person except in very limited circumstances pending an appeal from a decision authorizing a person to consent on behalf of an incapable person (note that the key case of *Fleming v. Reid* which successfully challenged that provision in the MHA was decided in 1991, the year prior to the CTA being introduced).

1996 – The CTA and the *Advocacy Act* are repealed and the CTA is replaced with the HCCA. The HCCA made the following changes with respect to treatment for persons with mental disorders:

- **Purposes of the Act** are included, and these provide a policy context; facilitation of treatment is included, as is protecting autonomy, promoting communication between health practitioners and clients, and ensuring a significant role for supportive family members when a person lacks capacity to make treatment, admission and personal care decisions.

- **No age for capacity**: The previous provision regarding the age of 14 is deleted and capacity if to be determined in every case according to the ability to understand and appreciate.

- **Rights advice** is retained in the MHA for psychiatric patients and the task of providing it is assigned to the Psychiatric Patient Advocate Office; for all other treatments, the health practitioner is tasked with providing the patient with information about the consequences of their finding of incapacity.

- **Prior capable wishes**: Applications to the CCB for directions with respect to an incapable person’s wishes and to depart from those wishes are allowed.

2000 – Bill 68, (known as Brian’s Law) made significant changes to the MHA including:

- **Definitions**: Many of the new or substituted definitions in this section align the MHA with the HCCA. So, for example, the MHA definitions of “health practitioner”, “plan of treatment” and “treatment” have the same meaning as found in the HCCA. Other definitions such as “physician”, “psychiatric facility” and “rights adviser” are also changed. “Community treatment plans” are defined for the first time.

  - At the same time, the definition of treatment in the HCCA is amended to read “… to include a course of treatment, plan of treatment or *community treatment plan* but does not include…”

- **Box B criteria for psychiatric assessment and involuntary admission added**: New assessment criteria for persons suffering with a recurring or ongoing mental illness are introduced. A physician or a justice of the peace can now make an application/order for assessment where he or she has 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/justice of the peace 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 SDM has been obtained.

Where involuntary admission is contemplated, criteria (a) through (e) must be met. In addition, the physician must also be of the opinion that the patient is not suitable for admission or continuation as an informal or involuntary patient.

- Removal of the requirement of “imminent” physical impairment for assessment and involuntary admission: Under a Box A application for assessment for a person suffering from a mental disorder, the Act removes “imminence” of physical impairment to the person as a consideration when assessing merits of an application.
- Limitation on who can apprehend and detain persons suffering from a mental disorder, and basis for action: Under the s. 17 police powers, only police officers (as opposed to peace officers) have the authority to take someone into custody and take that person for examination by a physician. Police action must now be based on reasonable and probable grounds (previously, the police had to have witnessed the behaviour in question before being able to act). Footnote 27 to this Report discusses police powers more fully.
- Alignment of the MHA, HCCA and Criminal Code provisions: The Act now specifies that persons who are detained in a psychiatric facility under Part XX.1 of the Criminal Code may be restrained, observed and examined under the MHA and provided with treatment in accordance with the HCCA.
- New community treatment order regime added: Sections 33.1 – 33.9, 35.1 and 39.1 outline the criteria and process for community treatment orders, supported by community treatment plan (which is “treatment” under the HCCA).

2001 – Amendments to the section 56, Part III (Estates).

2002 – The six month limitation period as set out in section 78 of the Act is repealed.
2004 – Substantive changes are made to the MHA to ensure alignment with the newly introduced PHIPA and other legislation, including:

- **Definitions**: The definition “mentally competent” is repealed with the concept of “capacity”. Definitions of “personal health information” and “record of personal health information” are added. Lastly, the definition of “substitute-decision maker” is aligned with the HCCA so that SDM is “… a person who would be authorized under the Health Care Consent Act, 1996 to give or refuse consent to a treatment on behalf of the patient, if the patient were incapable with respect to the treatment under that Act, unless the context requires otherwise.”

- **PHIPA provisions**: Subsection 29(1.1) is added to govern the transfer of patient records from one site to another; section 34.1 is added to resolve any conflicts between the MHA and PHIPA in relation to community treatment orders (the MHA prevails); repeal of the definition and disclosure and use in research provisions related to “clinical records” in the MHA and new PHIPA compliant provisions introduced; and the replacement of all references to “clinical records” replaced with “records of personal health information”.

2010 – The MHA is amended once again making the following changes:

- **Community treatment orders can be issued or renewed even where the patient or SDM has not consulted a rights adviser**: The circumstance would have to such that the rights adviser had made best efforts but was unable to locate the person who is the subject of the order; the person refused to consult with the rights adviser; or where the PGT is the SDM for the person subject to the order.

- **New rights for involuntarily admitted patients**: Involuntarily admitted patients now have a right to apply for a transfer to another psychiatric facility under section 39.2.

- **Newly added patient transfer option**: New section 39.2 allows the Board to consider and approve the transfer of a patient to another psychiatric facility where there has been a material change in circumstances; the person has completed a fourth certificate of renewal; and certain criteria are met.
APPENDIX 2

Summary of key differences in committal regimes between the MHA and the CFSA

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>AS PER MHA (HCCA IN RESPECT OF TREATMENT)</th>
<th>AS PER CFSA (SECURE TREATMENT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of mental disorder</td>
<td>“any disease or disability of the mind”\textsuperscript{498}</td>
<td>“a substantial disorder of emotional processes, thought or cognition which grossly impairs a person’s capacity to make reasoned judgments”\textsuperscript{499}</td>
</tr>
<tr>
<td>Youngest age of admission</td>
<td>Presumption that children under 12 can be admitted as either involuntary or informal patients.</td>
<td>Explicitly contemplates the admission of children under the age of 12.\textsuperscript{500}</td>
</tr>
<tr>
<td>Decision-making and admission</td>
<td>Decisions regarding informal admissions are made upon the recommendation of a physician while involuntary admissions require the additional input of a second physician who will sign the order for involuntary committal.\textsuperscript{501}</td>
<td>Admission is pursuant to a court order except in cases of emergency where admission is made by the administrator. Where a child is younger than 12 years old, his or her admission (emergency or otherwise) requires Ministerial consent.\textsuperscript{502}</td>
</tr>
<tr>
<td>Criteria</td>
<td>Criteria for the informal admission of children require a physician’s assessment that the child is in need of care but not evidence of incidences of serious bodily</td>
<td>Among other criteria, court-ordered or emergency admission under the CFSA requires consideration of whether or not the secure treatment program would be effective in preventing the risk of harm</td>
</tr>
</tbody>
</table>

\textsuperscript{498} MHA, s 1(1).
\textsuperscript{499} CFSA, s 112.
\textsuperscript{500} CFSA, s 117(2).
\textsuperscript{501} MHA, s 20.
\textsuperscript{502} CFSA, ss 17 and 24.
<table>
<thead>
<tr>
<th>ISSUE</th>
<th>AS PER MHA (HCCA IN RESPECT OF TREATMENT)</th>
<th>AS PER CFSA (SECURE TREATMENT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>harm to the child or others. It does include the child’s views or wishes, among others. When a child is admitted involuntarily, the likelihood for future serious physical impairment to him or herself is one of the key considerations.</td>
<td>to self or others. Unlike involuntary admission under the MHA, in neither case is the likelihood of future serious bodily harm or impairment a consideration.</td>
</tr>
<tr>
<td>Treatment</td>
<td>“Treatment” under the MHA has the same meaning as under the HCCA. It means 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.</td>
<td>The CFSA neither defines treatment nor incorporates the treatment definition found in the HCCA. It is therefore presumed that the use of psychotropic drugs and secure isolation rooms as detailed within the Act might be considered as “treatment” for purposes of mental disorders in children. If so, the CFSA clearly prescribes a very narrow range of treatment available to children with mental health concerns.</td>
</tr>
<tr>
<td>Detention</td>
<td>Children 16 and over who are admitted as informal patients cannot be detained for any period by the facility unless their legal status is changed to involuntary.</td>
<td>Children can be detained in locked units on the premises of secure treatment programs, even after reaching the age of 18 if the order is still in effect.</td>
</tr>
</tbody>
</table>

---

503 MHA, s 13(3).
504 MHA, s 20.
505 CFSA, s 117(1) and 124(2).
506 HCCA, s 2(1).
508 CFSA, s 118(4).
<table>
<thead>
<tr>
<th>ISSUE</th>
<th>AS PER MHA (HCCA IN RESPECT OF TREATMENT)</th>
<th>AS PER CFSA (SECURE TREATMENT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration</td>
<td>Children between the ages of 12 and 15 who are informal patients can apply to “inquire” into the ongoing necessity of their observation, care and treatment. Where a child in admitted involuntarily, time periods may vary in length as subsequent certificates are completed, but the initial commitment is for a two-week period.</td>
<td>A court may order secure treatment for an initial period not exceeding 180 days, though the period may be extended. Emergency admission can be for a maximum of 30 days.</td>
</tr>
<tr>
<td>Rights Advice and Legal Counsel</td>
<td>For involuntary patients, the attending physician who completes the certificate must give the patient notice about the reasons for the detention and about the patient’s rights to a hearing, counsel, and the opportunity to transfer to another facility. The physician must also notify a rights adviser who must promptly meet with the patient and explain his or her rights. Such formal rights advice is provided upon significant changes of legal</td>
<td>Under the CFSA, where a child is subject to an emergency admission, the child must be given written notice of his or her right to a review; the Provincial Advocate for Children and Youth and the Children’s Lawyer must also be provided notice of the admission so that the child is represented in a timely way.</td>
</tr>
</tbody>
</table>

---

509 MHA, s 20(4).
510 CFSA, ss 118 and 120. The maximum commitment is 60 days if the applicant is CAS, unless the parent consents to a longer period or the child becomes a Crown or society ward.
511 MHA, s 38.
512 CFSA, s 124(6), (7) and (8).
<table>
<thead>
<tr>
<th><strong>ISSUE</strong></th>
<th><strong>AS PER MHA (HCCA IN RESPECT OF TREATMENT)</strong></th>
<th><strong>AS PER CFSA (SECURE TREATMENT)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>status, including on involuntary admission, findings of incapacity to consent to treatment or manage property; and in a couple of instances related to the proposed issuance of a community treatment order.</td>
<td>The right to apply to a court for review of a commitment and termination of the secure order (made either under s. 117(1) or s. 120(5)) is available at any time to a child 12 years and older or his or her parent. Additionally, any person may apply to the Board to review an emergency admission.</td>
</tr>
<tr>
<td>Rights of Appeal and Review</td>
<td>An informal patient 16 or older may apply to the CCB to review the decision to admit – a child over the age of 12 but under the age of 16 does not have that right. Instead, children in this age may apply every three months to inquire into whether they need observation, care and treatment in the psychiatric facility. An involuntary patient may apply to the Board to determine whether or not the prerequisites for admission or continuation as an involuntary patient are/continue to be met.</td>
<td></td>
</tr>
<tr>
<td>Release from Program</td>
<td>A child has to be discharged when he or she is no longer in need of the observation, care and treatment provided therein.</td>
<td>Children are released from secure treatment when the administrator is satisfied that they no longer need the service and that there is an appropriate</td>
</tr>
</tbody>
</table>

---

513 MHA, s 39.
514 CFSA, s 122(1).
515 CFSA, s 124(9).
516 MHA, s 34(1).
<table>
<thead>
<tr>
<th>ISSUE</th>
<th>AS PER MHA (HCCA IN RESPECT OF TREATMENT)</th>
<th>AS PER CFSA (SECURE TREATMENT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>post-discharge care plan in place.(^{517}) In certain circumstances, the administration has the discretion to release the child earlier despite a court order.(^{518})</td>
</tr>
</tbody>
</table>

\(^{517}\) CFSA, s 121(1).  
\(^{518}\) CFSA, s 121.
## APPENDIX 3

### Summary of provincial provisions relating to capacity & treatment without consent (other than emergency situations)

<table>
<thead>
<tr>
<th>Province, Act</th>
<th>Consent</th>
<th>Test for Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ontario, Health Care Consent Act</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONSENT</td>
<td>There is no treatment without consent; if a person has been found incapable, consent is obtained from a substitute decision-maker.</td>
<td></td>
</tr>
<tr>
<td>TEST FOR CAPACITY</td>
<td>The test for capacity is based upon a person’s ability to do two things: a) understand the information relevant to making a decision and b) appreciate the consequences of making a decision or lack of a decision.</td>
<td></td>
</tr>
<tr>
<td><strong>Manitoba, Mental Health Act</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONSENT</td>
<td>Except as provided in this Act, a competent patient of a facility has the right to consent to or refuse psychiatric and other medical treatment unless in an emergency situation.</td>
<td></td>
</tr>
<tr>
<td>TEST FOR CAPACITY</td>
<td>The test for capacity is based on actual understanding, not ability to understand; however, the second branch of the test is also based on ability (like Ontario).</td>
<td></td>
</tr>
<tr>
<td><strong>Saskatchewan, Mental Health Services Act</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONSENT</td>
<td>A patient’s involuntary status means that they are incapable and therefore unable to consent to treatment.</td>
<td></td>
</tr>
<tr>
<td>TEST FOR CAPACITY</td>
<td>A person is incapable if they are unable to “fully” understand and make an informed decision regarding his or her need for treatment or care and supervision. The capacity criterion is part of the civil committal criteria.</td>
<td></td>
</tr>
</tbody>
</table>
### Alberta, *Mental Health Act*

**CONSENT**

| Section 29 | If a capable involuntary patient objects to any treatment the patient is or will be receiving, the attending physician shall not administer the treatment “unless the review panel makes an order” to treat. This situation may occur if a board or attending physician who considers it in the best interest of an involuntary patient to administer treatment.\(^{519}\) |

**TEST FOR CAPACITY**

| Section 26 | Similar to Ontario, a person is mentally competent to make treatment decisions if the person is able to understand the subject-matter relating to the decisions and able to appreciate the consequences of making the decisions. |

### Quebec, *An Act respecting the Protection of persons whose mental state presents a danger to themselves or to others and the Civil Code*

**CONSENT**

| Civil Code, Section 11 | No person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with consent. |
| An Act respecting... Schedule (3) | People are entitled to refuse treatment, unless treatment was ordered by a judge. |

**TEST FOR CAPACITY**

| N/A | There is no legislated test for capacity. |

### Newfoundland and Labrador, *Mental Health Care and Treatment Act*

**CONSENT**

| n/a | Given that a patient’s involuntary status means that he or she is incapable to make treatment decisions, the issue of consent does not arise. |

**TEST FOR CAPACITY**

| Section 17(1)(b)(ii)(B) | A person is incapable if they are unable to fully appreciate the nature and consequences of the mental disorder or to make an informed decision regarding his or her need for treatment or care and supervision. Arguably, this test for capacity may be more difficult to meet than the test in Ontario as it requires a person to be “fully” able rather than simply “able” to appreciate. |

\(^{519}\) A determination of whether treatment is in the patient’s best interests is based upon four factors set out in section 29(3)(b).
<table>
<thead>
<tr>
<th>Province</th>
<th>Act/Act (Section(s))</th>
<th>Consent to Treatment and Health Care Directives Act</th>
<th>Consent to Treatment and Health Care Directives Act</th>
</tr>
</thead>
</table>
| **Prince Edward Island, Mental Health Act and the Consent to Treatment and Health Care Directives Act** | Section 23(1), (2) and (12) | Patients at psychiatric facilities, who are capable, have the right to give or refuse consent to psychiatric or other medical treatment unless:  
  - The person is under 16 years of age; or  
  - The treatment is needed to keep the patient under control and to prevent harm to the patient or to another person and pending an order of the Review Board. |  |
| **TEST FOR CAPACITY** | Section 23(3) | A person is capable with respect to treatment if the patient is, in the health practitioner’s opinion, able (a) to understand the information that is relevant to making a decision concerning the treatment; (b) to understand that the information applies to his or her particular situation; (c) to understand that the patient has the right to make a decision; and (d) to appreciate the reasonably foreseeable consequences of a decision or lack of a decision. |  |
| **British Columbia, Mental Health Act** | Sections 1 and 31(1) | There is “deemed consent” by hospital directors where a patient is either incapable or capable and refuses treatment. |  |
| **TEST FOR CAPACITY** | n/a | The deemed consent precludes considerations of capacity. |  |
| **Nova Scotia, Involuntary Psychiatric Treatment Act** | Section 18 | In determining a patient’s capacity to make a treatment decision, the psychiatrist shall consider whether the patient fully understands and appreciates:  
  (a) the nature of the condition for which the specific treatment is proposed;  
  (b) the nature and purpose of the specific treatment;  
  (c) the risks and benefits involved in undergoing the specific treatment; and  
  (d) the risks and benefits involved in not undergoing the specific treatment. |  |
In determining a patient's capacity to make a treatment decision, the psychiatrist shall also consider whether the patient's mental disorder affects the patient's ability to fully appreciate the consequences of making the treatment decision.

The test for capacity is a higher standard than in Ontario as a result of the adverb “fully”.

### New Brunswick, *Mental Health Act*

<table>
<thead>
<tr>
<th><strong>CONSENT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>8.11(3)</td>
</tr>
</tbody>
</table>

If a capable patient refuses to consent to treatment, the patient’s psychiatrist can apply to the board, which can then order the giving of routine clinical medical treatment. Treatment can be given pending a determination of the application. When the tribunal decides it can treat a capable person, it makes a decision based on 4 factors, including that there is no reasonable prospect of discharge without treatment.

### TEST FOR CAPACITY

<table>
<thead>
<tr>
<th><strong>Sections</strong></th>
<th><strong>For the purposes of consent under the Mental Health Act, a person is mentally competent to give or refuse to give consent if the person is able to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or refusing to give consent, and, if the consent relates to a proposed treatment for the person, the subject-matter is the nature of the person’s illness and the nature of the proposed treatment.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1(2), 8.01(1), 8.11(2), and</td>
<td></td>
</tr>
</tbody>
</table>

### The Territories, *Mental Health Act*

<table>
<thead>
<tr>
<th><strong>CONSENT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 21 (in all Acts)</td>
</tr>
</tbody>
</table>

### TEST FOR CAPACITY

<table>
<thead>
<tr>
<th><strong>Yukon</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Mental Health Act</em>, Section 19</td>
</tr>
</tbody>
</table>

<p>| <strong>Northwest Territories, Mental Health Act</strong> | “Mentally competent” means having the ability to understand the subject-matter in respect of which consent is requested and the ability to appreciate the consequences of giving or withholding consent. |</p>
<table>
<thead>
<tr>
<th>section 1</th>
<th>&quot;Mentally competent&quot; means having the ability to understand the subject matter in respect of which consent is requested and the ability to appreciate the consequences of giving or withholding consent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nunavut Mental Health Act, section 1</td>
<td>&quot;Mentally competent&quot; means having the ability to understand the subject matter in respect of which consent is requested and the ability to appreciate the consequences of giving or withholding consent.</td>
</tr>
</tbody>
</table>
BIBLIOGRAPHY

Civil Committals

Legislation

An Act to amend certain Ontario Statutes to conform to section 15 of the Canadian Charter of Rights and Freedoms, SO 1986

An Act to amend the Mental Health Act, SO 1987

Bill 16, Creating the Foundation for Jobs and Growth Act, 2010

Consent to Treatment Act, 1992, SO 1992, c 31

Criminal Code of Canada, RSC, 1985, c C-46


Mental Health Act, RSO 1990 c M7

Substitute Decisions Act, 1992, SO 1992, c 30

Jurisprudence


Ahmed v Stefaniu [2005] OJ No 6203 (Sup Ct)

Ahmed v Stefaniu [2004] OJ No 3854, 72 OR (3d) 590 (Sup Ct)


Bobbie v Health Sciences Centre (1998) 56 Man R (2d) 208, 12 ACWS (3d) 278 (QB)


CD (Re), 2010 CanLII 55562 (ON CCB)

Centre for Addiction and Mental Health v. Ontario, 2012 ONCA 342 (CanLII)

CM (Re), 2012 CanLII 24927 (ON CCB)
CP (Re), 2005 CanLII 1047 (ON CCB)

Daugherty v Stall [2002] OJ No 4715, 118 ACWS (3d) 728 (Sup Ct)

E (Re) [2005] OCCBD No 127

FS (Re), 2012 CanLII 4752 (ON CCB)

G (Re), 2009 CanLII 45565 (ON CCB)

GJ (Re), 2010 CanLII 47505 (ON CCB)

JJ (Re) [2005] OCCBD No 149


LDS (Re), 2012 CanLII 20401 (ON CCB)

LQ (Re), 2012 CanLII 18304 (ON CCB)

MA (Re), 2012 CanLII 4749 (ON CCB)

MBG (Re), 2003 CanLII 14360 (ON CCB)

McCorkell v Riverview Hospital (Director) [1993] BCJ No 1518, 104 DLR (4th) 391 (BS SC)

MT (Re), 2004 CanLII 56536 (ON CCB)


NC (Re), 2012 CanLII 20396 (ON CCB)


PT (Re), 2010 CanLII 68912 (ON CCB)

JS (Re) 2004 CanLII 46818 (ON CCB)

Sevels v Cameron [1994] OJ No 2123 (Ont Ct (Gen Div))

SF (Re), 2010 CanLII 26688 (ON CCB)

SJ (Re), 2012 CanLII 18182 (ON CCB)
SR (Re), 2011 CanLII 32706 (ON CCB)

Starnaman v Penetanguishene Mental Health Centre [1995] OJ No 2130, 24 OR (3d) 701 (CA), motion to extend time to apply for leave to appeal dismissed, [1996] SCCA No 129

T(Re), 2009 CanLII 24054 (ON CCB)

Thwaites v Health Sciences Centre Psychiatric Facility [1988] MJ No 107, 48 DLR (4th) 338 (CA)

Secondary sources


Gerald B Robertson, “Civil Commitment and the “Unsuitable” Voluntary Patient” (2010) 19 Health L. Rev No 1, 5 - 9


John E Gray, Margaret A Shone, Peter F Liddle, Canadian Mental Health Law & Policy, 2 ed (Canada: LexisNexis Canada, 2008)

Katherine Brown and Erin Murphy, “Falling through the Cracks: The Quebec Mental Health System” (2000) 45 McGill LJ 1037


Government sources

Ministry of Health, Form 1 - Application by Physician for Psychiatric Assessment, online: <http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-6427-41~1/$File/6427-41_.pdf>

Ministry of Health, Form 2 – Order for Examination under Section 16, online: <http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-6428-41~1/$File/6428-41_.pdf>

Ministry of Health, Form 42 - Notice to Person under Subsection 38.1 of the Act of Application for Psychiatric Assessment under Section 15 or an Order under Section 32 of the Act, online: <http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-1787-41~1/$File/1787-41_.pdf>

Exhibits submitted to Select Committee
Memorandum from Candace Chan and Carrie Hull on Civil Commitment of Children under the Child and Family Services Act and Mental Health Act, dated July 20, 2010

Memorandum from Carrie Hull on Admission to a Psychiatric Facility in Ontario, dated December 4, 2009

Treatment
Legislation

Mental Health Act, RSO 1990 c M7

Jurisprudence
AC v Manitoba (Director of Child and Family Services), 2009 SCC 30, [2009] 2 SCR 181
AM v Benes [1999] OJ No 4236, 46 OR (3d) 271 (CA)

Ciarlariello v Schacter [1993] 2 SCR 119, SCJ No 46

Cuthbertson v. Rasoli 2013 SCC 53

D’Almeida v Barron 2010 ONCA 564, OJ 3647, leave to appeal to the SCC refused, [2010] SCCA No 511


Fleming v Reid [1991] OJ No 1083, 4 OR (3d) 74 (CA)

Gunn v Koczerginski [2001] OJ No 4479 (Sup Ct J)

H (B) v Alberta (Director of Child Welfare), 2002 ABQB 371, AJ No 518, aff’d 2002 ABCA 109, AJ No 568

Howlett v Karunaratne 1988 OJ No 591, 64 OR (2d) 418

Huisman v MacDonald, [2007] OJ No 2037, 280 DLR (4th) 1 (CA), leave to appeal refused [2007] SCCA No 428 (SCC)

Malette v Shulman [1990] OJ No 450, 72 OR (2d) 417 (CA)

Marsden v Taylor [2006] OJ No 4045, 151 ACWS (3d) 725 (Sup Ct J)

Martin v Findlay, [2008] AJ No 462, 88 Alta LR (4th) 207 (Alta CA)

MT (Re), 2004 CanLII 56536 (ON CCB)

Neto v Klukach [2004] OJ No 394, 128 ACWS (3d) 1008 (Sup Ct J)

Reibl v Hughes [1980] 2 SCR 880

Saunders v Bridgepoint Hospital [2005] OJ No 5531, OTC 1108

SMT v Dr W Abouelnasr [2008] OJ No 1298, 2008 CanLII 14550 (ON SC)

SR v Hutchinson [2009] OJ No 516, 177 ACWS (3d) 499 (Sup Ct J)


Starson v Swayze, 2001 CanLII 7651 (ON CA)

Privacy

Legislation

Mental Health Act, RSO 1990 c M7

Personal Health Information Protection Act, 2004 SO 2004, c 3 Schedule A

Jurisprudence
Ann Cavoukian, Order HO-002 (July 27, 2006), Information and Privacy Commissioner /Ontario

Jones v Tsige, 2012 ONCA 32 (CanLII)

R v Swain, [1991] 1 SCR 933

Government sources


Exhibits submitted to select committee on mental health and addictions
Memorandum from Candace Chan and Carrie Hull, Civil Commitment of Children under the Child and Family Services Act and Mental Health Act, dated July 20, 2010

Memorandum from Carrie Hull, Background Material for Mental Health Law Hearings, December 9, 2009, dated December 2, 2009

Memorandum from Carrie Hull, Family Access to Personal Health Information in British Columbia and Ontario, dated August 4, 2009

Secondary sources


Children

Legislation
Child and Family Services Act, RSO 1990, c C11


Mental Health Act, RSO 1990 c M7

Patient Restraints Minimization Act, 2001, SO 2001, c 16

Provincial Offences Act, RSO 1990, c P33

Youth Criminal Justice Act, SC 2002, c 1

Jurisprudence
AC v Manitoba (Director of Child and Family Services), 2009 SCC 30, [2009] 2 SCR 181

Children’s Aid Society of Metropolitan Toronto v SH [1996] OJ No 2578, 138 DLR (4th) 144 (Ct J)

LC v Pinhas [2002] OJ No 5309, OTC 1065 (Sup Ct)

Malette v Shulman [1990] OJ No 450, 72 OR (2d) 417 (CA)

RB v Children’s Aid Society of Metropolitan Toronto, [1995] 1 SCR 315

Syl Apps Secure Treatment Centre v BD, 2007 SCC 38, [2007] 3 SCR 83

U(C) (Next friend of) v Alberta (Director of Child Welfare) (2003), 223 DLR (4th) 662 (Alta CA)

Secondary sources

Mary Jane Dykeman, “Addressing systemic issues in women’s mental health: An inquest into the death of Cinderella Allalouf” (1999) 1:1 Journal of Women’s Health and Law

Government sources

Other Jurisdictions

Legislation
An Act respecting the Protection of persons whose mental state presents a danger to themselves or to others, RSQ, c P-38.001

Care Consent Act, SY 2003, c 21, Sch B

Civil Code of Québec, LRQ, c C-1991

Criminal Code, RSC 1985, c C-46


Health Care (Consent) and Care Facility (Admission) Act, RSBC 1996, c 181

Involuntary Psychiatric Treatment Act, SNS 2005, c 42

Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ) 2009

Mental Health Act, CCSM c M110

Mental Health Act, RSA 2000, c M-13

Mental Health Act, RSBC c 288

Mental Health Act, RSNB 1973, c M-10

Mental Health Act, RSNWT 1988, c M-10

Mental Health Act, RSNWT (Nu) 1988, c M-10

Mental Health Act, RSO 1990 c M7

Mental Health Act, RSPEI 1988, c M-6.1

Mental Health Act, RSY 2002, c 150

Mental Health Care and Treatment Act, SNL 2006, c M-9.1
Mental Health Services Act, RSNB 2011, c 190

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

Norway, Mental Health Care Act, Act No. 62 of 2 July 1999 relating to the provision and implementation of mental health care (the Mental Health Care Act), with later amendments

Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11

Jurisprudence

Fleming v Reid [1991] OJ No 1083, 4 OR (3d) 74 (CA)

H (B) v Alberta (Director of Child Welfare), 2002 ABQB 371, AJ No 518, aff’d 2002 ABCA 109, AJ No 568 (QB)

McCorkell v Riverview Hospital (Director) [1993] BCJ No 1518, 104 DLR (4th) 391 (BS SC)

R (M) (Re) [1991] PEIJ No 131, 96 Nfld & PEIR 236

R v Rogers [1990] BCJ No 2752, 61 CCC (3d) 481 (BCCA)

R v Wright [1996] MJ No 269, 110 Man R (2d) 191 (CA)

Saskatoon Regional Health Authority v AB, [2005] SJ No 187, SKQB 153 (QB)


Thwaites v Health Sciences Centre Psychiatric Facility [1988] MJ No 107, 48 DLR (4th) 338 (CA)

Walker (Litigation Guardian of) v Region 2 Hospital Corp [1994] NBJ No 242, 116 DLR (4th) 477 (NBCA)

Willis v O’Reilly [1986] SJ No 740, 32 DLR (4th) 478 (QB)

Secondary sources
Charles Pearson, “Consent to Psychiatric Treatment in Canada Specific Issues” (1993) 2 Health L Rev No 2, 3-18

Dr Muriel Groves, “Suggested Changes to BC’s Mental Health System regarding Involuntary Admission and Treatment in Non-Criminal Cases” (Adopted as a Position Paper of the BC Civil Liberties Association, February 2011)


Katherine Brown and Erin Murphy, “Falling through the Cracks: The Quebec Mental Health System” (2000) 45 McGill LJ 1037


Uniform Law Conference of Canada, online: <http://www.ulcc.ca/en/home/>


**Government sources**
Alberta Health Services, Guide to the Alberta Mental Health Act and Community Treatment Order Legislation (September 2010), online: <http://www.albertahealthservices.ca/hp/if-hp-mha-guide.pdf>

British Columbia Ministry of Health, Form 15 Mental Health Act, Nomination of Near Relative, online: <https://www.health.gov.bc.ca/exforms/mhdforms/HLTH3515.pdf>


Canada, Legislative Assembly, Standing Senate Committee on Social Affairs, Science And Technology, “Mental Health Policies and Programs in Selected Countries”, *Interim Report of The Standing Senate Committee On Social Affairs, Science And Technology*
Government of Saskatchewan, Mental Health Services, online: 
<http://www.health.gov.sk.ca/mental-health>

Manitoba, Manitoba’s Mental Health, online: <http://www.gov.mb.ca/health/mh/act.html>

Ministry of Health and Long-Term Care, Mental Health: Bill 68 (Mental Health Legislative Reform), 2000, online: 

Norwegian Ministry of Health and Care Services, “Mental Health Services in Norway” (2005), online:  

Ontario, Legislative Assembly, Select Committee on Mental Health and Addictions,  

Parliament of Canada, Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada, chapter 7, online:  
<http://www.parl.gc.ca/Content/SEN/Committee/381/soci/rep/report1/repintnov04vol1part3-e.htm>

**Exhibits submitted to select committee on mental health and addictions**

John E Gray, Presentation to the Ontario Select Committee on Mental Health and Addictions,  
Exhibit 1/01/269 A, dated December 9, 2009

Memorandum from Carrie Hull on Mental Health Initiatives around the World, dated March 24, 2009

Memorandum from Carrie Hull on Time Limits on Involuntary Treatments in Norway, dated September 25, 2009

Memorandum from Carrie Hull, Background Material for Mental Health Law Hearings,  
December 9, 2009, dated December 2, 2009
Implications

Jurisprudence

AC v Manitoba (Director of Child and Family Services), 2009 SCC 30, [2009] 2 SCR 181

E (Mrs) v Eve [1986] 2 SCR 388, SCJ No 60

Fleming v Reid [1991] OJ No 1083, 4 OR (3d) 74 (CA)

Malette v Shulman [1990] OJ No 450, 72 OR (2d) 417 (CA)

McCorkell v Riverview Hospital (Director) [1993] BCJ No 1518, 104 DLR (4th) 391 (BS SC)

Mullins v Levy [2009] BCJ No 23, 304 DLR (4th) 64 (CA) at 209, leave to appeal to SCC refused, [2009] SCCA No 106

R v L (JJ), 2001 MBCA 21

R. v Rogers [1990] BCJ No 2752, 61 CCC (3d) 481 (BCCA)

Reibl v Hughes [1980] 2 SCR 880

Secondary sources


Ontario, Open Minds, Healthy Minds (Toronto: Queen’s Printer for Ontario, 2011)