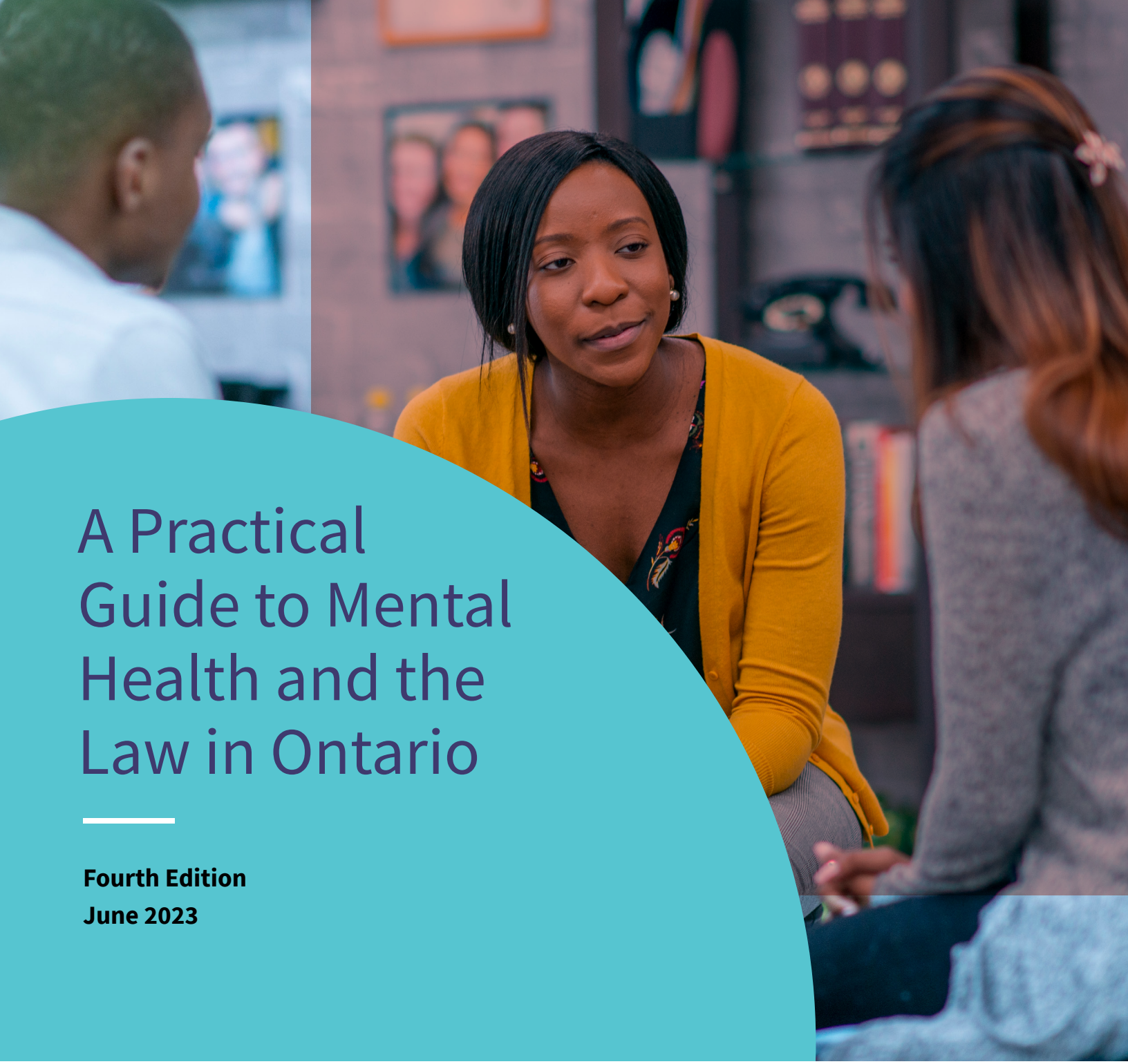

A Practical Guide to Mental Health and the Law in Ontario

Fourth Edition
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Ontario Hospital Association

Partner | Borden Ladner Gervais

Disclaimer

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

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

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

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Katharine has practiced exclusively in health law for almost 25 years.

Katharine provides strategic and practical legal advice and support to health care organizations. In addition to working closely with senior leadership teams, clinical leadership and front line staff, Katharine provides support to Hosptial Boards on a range of issues. Katharine works regularly with subject matter experts across all practice areas to provide legal services that meet the needs of all types of health care organizations.

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Barbara Walker-Renshaw

Barbara has been a co-author of the OHA's "A Practical Guide to Mental and Health and the Law" since the first edition was published in 2009. Although she retired from the practice of law on December 31, 2022, she is pleased to have taken an active role in updating this 2023 fourth edition.

Barbara practiced law, first as an associate and, subsequently, as a partner in the Health Law Practice Group of Borden Ladner Gervais LLP, where she was also a national leader of BLG's Mental Health Law Practice.

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Barbara also provided external counsel advice to public hospitals and psychiatric facilities on privacy, policy and enterprise risk management.

She is the author of the chapter on Mental Health Law in the *Canadian Health Law Practice Manual* and a contributing author to the chapter on Mental Health Law in the 3rd edition of *Law for Canadian Health Care Administrators*, both published by Lexis Nexis. For several years, she was a program director and co-chair of the Osgoode Certificate in Mental

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Barbara was selected by her peers for inclusion in the 2015 to 2022 editions of *The Best Lawyers in Canada*® (for Health Care Law, Administrative and Public Law) and in the 2022 edition (since 2021) (for Personal Injury Litigation).

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Foreword

Since 2009, the Ontario Hospital Association (OHA) has partnered with Borden Ladner Gervais LLP (BLG) to prepare a guide for frontline mental health care providers.

A Practical Guide to Mental Health and the Law aims to provide its readers with a general understanding of mental health law issues in several key areas, such as consent to treatment, involuntary admissions, community treatment orders, the detention and supervision of mentally disordered criminal offenders, along with an overview of the provincial and federal legislation that governs the provision of mental health care in Ontario.

The 2023 edition of the Guide includes legislative and case law updates, refreshed content and new resources to assist in preparing for virtual hearings and setting out comprehensive recommendations on the use of restraints. Case law considered in developing these updates includes Consent and Capacity Board (CCB) and Ontario Review Board (ORB) hearing decisions as well as appellate decisions. Other substantive updates address hospital – police interactions, the *Child, Youth and Family Services Act* (CYFSA), virtual care, medical assistance in dying for mental health patients and updates to the discharge planning section of this resource.

On behalf of the OHA and BLG, we hope that *A Practical Guide to Mental Health and the Law* will provide guidance to assist clinicians and health care organizations as they navigate ongoing and emerging challenges in mental health care and the law.

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CHAPTER

1 Overview of Legislation Relevant to Mental Health Care in Ontario

1. Introduction

In March 2007, the federal government appointed Senator Michael Kirby to chair the Mental Health Commission of Canada ("the MHCC") and charged it with the task of developing a national strategy for setting priorities and coordinating services in mental health care. In May 2012, the MHCC released a long awaited national mental health strategy: "Changing Directions, Changing Lives: A Mental Health Strategy for Canada".[1] With its ongoing mandate, the MHCC continues to work towards improving access to mental healthcare in Canada, with such initiatives as the Knowledge Exchange Centre to ensure the public dissemination of the Commission's research, programs, guidelines and tools.[2] In 2017, the federal government renewed the MHCC's mandate through 2027.

On August 8, 2022, the MHCC released its Annual Report 2021-2022, which focused on the ongoing impact of the COVID-19 pandemic on the mental health of many Canadians, including those living with serious mental illness and those living without safe housing, or in rural and remote settings. The MHCC also highlighted the growing gap in access to timely, quality and culturally appropriate mental health and substance use health care, as well as supporting innovations for accessing mental health care, such as the rapidly growing area of e-mental health programs.[3] The MHCC noted that during the pandemic, "growing numbers of people in Canada received clinical care from certified health-care practitioners via video conference, telephone, chat services and text messaging." To address concerns about data privacy, the MHCC is leading an initiative to develop an accreditation framework for mental health apps.[4]

At the provincial level, the Ontario government launched a mental health and addictions strategy, entitled "Open Minds, Healthy Minds" in June 2011.[5] The strategy focused on providing children and youth with greater access to mental health and addiction services. In November 2014, the strategy was expanded to support the transition between youth and adult services and to improve the quality of services for Ontarians of all ages, through the funding of certain initiatives.[6] While there is still much work to be done, at present, the provincial government appears committed to improving access to mental health and addiction services as a core priority. In June 2019, the Ontario provincial government created Ontario Health to "connect, coordinate and modernize the province's health care system," including the delivery and quality of mental health care.[7]

On March 3, 2020, the Ontario government published "Roadmap to wellness: a plan to build Ontario's mental health and addictions system", with the stated intention of establishing a Mental Health and Addictions Centre of Excellence and investing $3.8-billion in mental health care over the following 10 years.[8]

1 This Mental Health Commission of Canada strategy document can be found online at: http://strategy.mentalhealthcommission.ca/pdf/strategy-images-en.pdf.

2 Knowledge Exchange Centre: Interim Report (Mental Health Commission of Canada, May 2014), at p. 5; the Report may be accessed at http://www.mentalhealthcommission.ca/English/initiatives-and-projects/knowledge-exchange-centre.

3 Mental Health Commission of Canada, *Annual Report 2021-2022*, available online at https://mentalhealthcommission.ca/resource/annual-report-2021-2022/, at pp. 5 -9 (Accessed December 19, 2022)

4 *Ibid*, at p. 13.

5 Ontario, Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy (Ontario Government): https://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf

6 Ontario, "Ontario Expanding Strategy to Address Mental Health Issues", News Release, November 25, 2014, available at: https://news.ontario.ca/mohltc/en/2014/11/ontario- expanding-strategy-to-address-mental-health-issues.html.

7 *Ibid*, at p. 13.

8 See https://www.ontario.ca/page/roadmap-wellness-plan-build-ontarios-mental-health-and-addictions-system" (accessed December 19, 2022).

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

As noted in "Changing Directions, Changing Lives", in any given year, one in five people in Canada experiences a mental health problem or illness, with a cost to the economy of well in excess of $50-billion.

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

The treatment of psychiatric patients raises legal issues that ordinarily do not arise in the treatment of other illnesses. The fact that patients are often detained against their will places a high priority on the protection of individual rights within the treatment facility. Consequently, administrators and health professionals who work in the mental health field must be as sensitive to legal issues as they are to medical issues. Decisions about treatment of psychiatric patients will often receive a high degree of scrutiny from tribunals or boards charged under the provincial legislation with the review of such decisions. For courts and tribunals, the question whether treatment is authorized by law may eclipse any question about the quality of the treatment administered and whether or not it was effective. This is because courts and tribunals are concerned with process issues. If the process is inadequate, there is likely to be negative comments on the health care providers and institution regardless of the outcome for the patient.[9]

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

The purpose of this Guide is to provide health practitioners and administrators with an overview of the legislative scheme governing mental health care in Ontario that is sufficiently detailed to use as a desk-top resource.

2. Historical Development and Context

On January 26, 1850, Ontario's first provincial psychiatric asylum opened its doors on the location of what is now known as the Queen Street Site of the Centre for Addiction and Mental Health. Upper Canada, which later became Ontario, was a colony of the United Kingdom, and imported the approach set out in the *County Asylums Act*, a statute passed by the British House of Commons in the year 1813, which provided for the establishment of institutions for care of the mentally ill.[10] Following the opening of Ontario's first "asylum", other provincial public mental hospitals were opened to provide treatment and custody for the seriously mentally ill. For many years, Ontario's *Mental Hospitals Act* governed such facilities.

The courts reviewed admission and discharge decisions into designated mental hospitals until 1933, when the legislation changed to allow for any two physicians to authorize the admission of a mentally ill person, with no involvement of the judicial system. The legislation did not provide for the review of the committal decision unless the patient brought a writ of *habeas corpus* to the Court for the purpose of challenging the lawfulness of the detention and seeking a court order requiring the patient to be released.[11]

9 John J. Morris, Cynthia D. Clarke and Anna L. Marrison,, Law for Canadian Health Care Administrators, 3rd ed, (LexisNexis, 2020, Ch. 5, section 1, at 151-152.

10 Michael Bay, "1933-2003: Lessons from 70 Years of Experience with Mental Health, Capacity and Consent Legislation in Ontario" (2005) 24 Health Law in Canada 3 at 36 – 43.

11 *Ibid* at 36-37.

In the early 1960s, with the introduction of new medications for treating mental illness, it became possible to reduce or control symptoms to the extent that patients could be discharged into the community to settings such as "Homes for Special Care", or as out-patients monitored by acute care, hospital-based psychiatric teams.[12] The introduction of universal health insurance in Ontario in 1972, for example, resulted in a "fourfold increase in the utilization of psychiatric services."[13]

During the last several decades, a number of legislative developments have had a significant impact on the mental health system in Ontario.

Another significant development was the amendment in 1968 of the *Mental Health Act* ("*MHA*"), which provided for the admissions of persons to a psychiatric hospital based on criteria of "dangerousness", and where the person required hospitalization "in the interests of his/her own safety or the safety of others". The *MHA* also established a tribunal that could review the committal, if the patient requested.[14]

In 1978, the *MHA* was amended to include criteria for involuntary admission where the person was experiencing a mental disorder and was at risk of "imminent and serious physical impairment of the person." Although the "imminent" criteria only applied to the physical impairment of the patient, the view that it also applied to the dangerousness criteria was widely held and persists today, even after the removal of the word "imminent" from the legislation when it underwent further reform in 2000. As government publications have noted, "the 'imminent' requirement often prevented people who were deteriorating from getting the treatment they needed at an earlier stage."[15]

In the 1990s, the *MHA* was again amended to protect patients' legal rights by requiring that rights advice be delivered to patients in certain circumstances and by imposing obligations on hospital administrators to ensure that procedures associated with involuntary admissions were followed.[16]

Up until the 1990s, treatment decisions were not the subject of legislation. Treatment of incompetent persons was based on the directions of the family, or, on the clinical opinion of the treating physician.[17] The Crown had the ultimate responsibility for the treatment of incompetent adults as there were no principles in the common law that provided for an individual substitute decision maker to have priority over the Crown. In fact, health practitioners could be liable to patients for the common law tort of battery, if they treated incompetent adults without court authorized consent.[18]

Up until the 1990s, consent to treatment legislation introduced a more nuanced approach to capacity.

Consent to treatment legislation, which was introduced in the 1990s, represented a significant shift away from global findings of incompetency to a more nuanced approach to capacity that recognized that capacity could fluctuate with respect to both time and treatment. The legislation began as the *Consent to Treatment Act* in 1992, and later evolved into the *Health Care Consent Act* ("HCCA"). [19]

The law set out in the *HCCA* essentially codifies the common law requirement that health care practitioners obtain capable, informed and voluntary consent prior to proceeding with treatment. The *HCCA* rules on consent to treatment are applicable universally in all health care settings, including community and outpatient settings, and also apply to mentally ill patients in psychiatric facilities. Further, the *HCCA* establishes that patients may challenge findings of incapacity by applying to Ontario's Consent and Capacity Board ("CCB") for a review of findings.

12 Ontario, Ministry of Health and Long Term Care (as it then was), Dan Newman MPP, Mental Health 2000 and Beyond: Strengthening Ontario's Mental Health System: A Report on the Consultative Review of Mental Health Reform in the Province of Ontario, (June 1998). Available at: https://www.health.gov.on.ca/en/public/publications/mental/mentalreform.aspx (accessed December 15, 2022)

13 *Ibid.*

14 *Mental Health Act* Amendments, SO 1967, c 51, s. 8; see also, Michael Bay, *supra* note 6 at 38.

15 Ontario, Ministry of Health and Long Term Care (as it then was), Mental Health: Bill 68 (Mental Health Legislative Reform), 2000" online: <http://www.health.gov.on.ca/en/public/publications/mental/treatment_order.aspx>.

16 Michael Bay, *supra* note 6 at 38.

17 Ontario, Enquiry on Mental Competency, Enquiry on Mental Competency: Final Report, (Toronto: Queens Printer for Ontario, 1990) at 306 (Chairman: Professor David Weisstub).

18 John J. Morris, "Substitute Decision Makers: Who has Authority to make the Decisions?" (Conference paper, 6 June 1996) [Unpublished]; Citing Re Eve, [1986] 2 SCR 388 at 12.

19 *Health Care Consent Act*, SO 1996, c 2, Sch A., [*HCCA*].

Where a person is admitted to a psychiatric facility and found incapable with respect to treatment of a mental disorder, the person must be provided with rights advice, including notice of their right to challenge the finding.

If the CCB confirms the health professional's finding of incapacity, the patient has a right of further review or appeal to the courts.[20]

The issue of capacity to manage property arises regularly in the provision of mental health care, particularly upon admission to a psychiatric facility. For many years, Ontario had a *Mental Incompetency Act* ("*MIA*"),[21] which provided for a global finding of mental incompetency, based on evidence that a person had been diagnosed with either developmental delay or brain injury, or a mental disorder of such a nature that the person required care and supervision for his or her protection. Once such a global finding had been made, the *MIA* called for the establishment of a "committee" that would oversee the person's property. This Act was eventually repealed in 1995.

The *Substitute Decisions Act* ("SDA") came into force in 1992. It provides the procedure to assess a person's capacity to manage property or to make personal care decisions may be assessed.[22] It also provides the criteria that must be met in order for the Public Guardian and Trustee ("PGT") or someone else to become a person's guardian, in the event that the person is found incapable. Further, it sets out the legal framework for granting power to an "attorney" of the person's choosing, in the event of their incapacity to manage property and/or to make personal care decisions. The *SDA* recognizes that a person's property may be subject to a "statutory guardianship" that arises by operation of law, such as a finding of incapacity to manage property made by a psychiatrist following a person's admission to a psychiatric facility.[23]

Following the provincial government's 1998 review of Ontario's mental health related legislation,[24] amendments were made to the *MHA* to address the "revolving door syndrome". This "syndrome" saw a patient admitted to a hospital in crisis, treated under substitute consent until the crisis passed, and then discharged to the community where insufficient out-patient resources lead to the patient's eventual non-compliance, deterioration and return to hospital for a further involuntary admission. The amendments included a new ground for civil commitment: substantial mental or physical deterioration that would likely arise if the person were not treated. This ground is now known as the "Box B" criteria and may be used as the basis for a preliminary "Form 1" application for psychiatric assessment, as well as an involuntary admission.

The amendments to the *MHA* in 2000 also established Community Treatment Orders ("CTOs"), which provide a structure for the treatment of persons with mental illness in the community, rather than in a psychiatric facility, if certain criteria are met.[25] More recently in December 2015, the *MHA* was amended to provide the Consent and Capacity Board ("CCB") with the authority to order certain terms and conditions under which long-term involuntarily admitted patients are detained under what are now called certificates of continuation. The December 2015 amendments also amended the provisions dealing with CCB's power to order a long-term involuntarily admitted patient to be transferred from one psychiatric facility to another.[26]

The legislative scheme governing the provision of mental health care in Ontario continued to evolve with the introduction in 2004 of the *Personal Health Information Protection Act* ("PHIPA"). This legislation sets out

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

21 RSO 1990, Chapter M 9, repealed on April 3, 1995

22 *Substitute Decisions Act,* 1992, SO 1992, c 30.

23 *Ibid*, s. 15; see also *Mental Health Act*, RSO 1990, c M7, s 54 ("*MHA*").

24 *MHA*, *ibid*, sections, 15.1, 20.1 and 33.1; see also Dan Newman, *supra* note 8.

25 *MHA*, *ibid*, s. 33.1. We discuss the *Mental Health Act*, and the law governing as community treatment orders in Chapter 3, as well as the *MHA* provisions relating to psychiatric patient admissions, including voluntary, informal and involuntary admissions. For a discussion of the amendments which led to Community Treatment Orders, see: http://health.gov.on.ca/en/public/publications/pub_mental.aspx; accessed March, 2016 and the" Report on the Legislated Review of Community Treatment Orders", December 2005, available at https://health.gov.on.ca/en/common/ministry/publications/reports/dreezer/dreezer.aspx.

26 Bill 122, *Mental Health Statute Law Amendment Act,* 2015; online: http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=3453. The *MHA* has not been amended since 2015.

comprehensive rules for the collection, use and disclosure of personal health information in a manner that provides for the consistent protection of confidentiality of personal health information, while also facilitating the effective provision of health care. *PHIPA*, in large measure, replaced and amended some of the specific provisions that governed clinical psychiatric records in prior versions of the *MHA*.

There remain notable exceptions that allow the "privacy" provisions of the *MHA* to take precedence over the provisions of *PHIPA*.[27]

The two administrative tribunals that most frequently hear matters concerning the rights of mentally ill persons are the CCB and the Ontario Review Board ("ORB").

The CCB has jurisdiction to hear matters under a number of Ontario statutes: The *HCCA*, the *MHA*, the *SDA*, the *PHIPA*, the *Mandatory Blood Testing Act*[28] and most recently the *Child, Youth and Family Services Act.*[29]

Health Practitioners are frequently called upon to appear before the CCB and we have devoted Chapter 5 to hearings before the CCB.

The ORB is an administrative tribunal established pursuant to Part XX.I of the *Criminal Code of Canada* ("*Criminal Code*") to have jurisdiction over criminally accused persons who have been found unfit to stand trial or who have been found not criminally responsible on account of mental disorder.[30] Prior to 1992, criminally accused persons had available to them the common law defence of insanity, which was recognized in Section 16 of the *Criminal Code*. Other provisions of the *Criminal Code* allowed those found unfit to stand trial or found not guilty by reason of insanity to be automatically detained in custody at the discretion of the Lieutenant-Governor of the province. Following the enactment of the *Canadian Charter of Rights and Freedoms*[31], those provisions of the *Criminal Code* were challenged and found by the Supreme Court of Canada to be unconstitutional, leading to the reform which gave rise to the current system under Part XX.I.[32] We will address ORB hearings within Chapter 6, which deals with the forensic psychiatric system and mentally disordered offender.

3. Key Legislation

The *Mental Health Act*

The *MHA* sets out the criteria for voluntary, informal and involuntary admissions to specially designated psychiatric facilities, as well as for the management of psychiatric out-patients under CTOs. The statute also requires the assessment of psychiatric patients' capacity to manage property following their admission to a psychiatric facility. The statute protects the rights of psychiatric patients by requiring that patients receive formal rights advice in certain circumstances and providing for the review of informal and involuntary admissions, capacity to manage property and CTOs before the CCB. A discussion of the statutory provisions and case law related to involuntary admissions and CTOs is set out in Chapter 3.

The *Health Care Consent Act*

This *HCCA* sets out rules for determining capacity in three key areas: treatment decisions, admission to care facilities and personal assistance services. It also provides rules for obtaining informed, voluntary consent from a capable patient or their substitute decision maker ("SDM") and provides for the review of findings of incapacity by the CCB. The *HCCA* sets out who may take on the role of SDM for an incapable person and the principles a SDM must following when giving / refusing consent on behalf of incapable person. Other provisions of the *HCCA* provide when treatment may be administered in an emergency situation, as well as if and when treatment may be commenced pending the resolution of a patient's application to the Board to review a finding of incapacity and / or pending the resolution of an appeal from a of the CCB confirming a finding of incapacity. Chapter 2 provides an overview of law relating to findings of incapacity to consent to treatment and substitute decision-making in the context of mental health care.

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

28 *Mandatory Blood Testing Act* 2006, SO 2006, C 26.

29 *Child, Youth and Family Services Act*, 2017 SO 2017, c 14. Sched 1. See also O Reg 191/18, s 7, which expressly prescribes the CCB as a "body" for the purposes of issues set out in sections 302, 304 and 305 of the *CYFSA*.

30 *Criminal Code of Canada* RSC, 1985, c C 46 (the "*Criminal Code*").

31 Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (UK), 1982, c. 11 (the "*Charter*").

32 The case which considered and decided the constitutionality of the former regime was *R v Swain*, [1991] 1 SCR 933.

The *Substitute Decisions Act*

The *SDA* provides the legal framework for granting a power of attorney for personal care or property, which allows capable individuals to appoint someone to act on their behalf during a period of incapacity. As well, the legislation sets out the procedure for an individual to apply to the Court to be appointed as a guardian where a person has not completed a power of attorney as well as for situations in which someone wishes to challenge the validity of a particular power of attorney. This important piece of "companion" legislation to both the *MHA* and the *HCCA* is discussed in further detail in Chapter 2.

The *Personal Health Information Protection Act*

PHIPA governs the collection, use and disclosure of personal health information in Ontario. Recently, *PHIPA* was amended to provide that a person's right of access to their health records includes a right of access the record in an electronic format. In the mental health care context, it is essential for health care practitioners to understand how the unique demands of providing mental health care are impacted by a health information custodian's obligations under *PHIPA*, as well as the circumstances in which the *MHA* takes precedence over *PHIPA*, for the collection, use and disclosure of personal health information.[33] The statutory and common law governing the privacy of personal health information is discussed in further detail in Chapter 7.

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

Since 1992, this section of the *Criminal Code* has governed the assessment, detention and release of persons who have come into contact with the criminal justice system as a result of a mental disorder. Part. XX.1 provides the legal framework for provincial "Review Boards" for making and reviewing dispositions for persons who have been charged with a criminal offence and unfit to stand trial or not criminally responsible on account of mental disorder. The detention, treatment and supervision of criminally accused, forensic psychiatric patients in specially designated psychiatric facilities is a sub-speciality of mental health law with which mental health care practitioners should have some familiarity, regardless of whether they work at one of Ontario's forensic facilities. The forensic mental health system is discussed in more detail in Chapter 6.

33 See ss. 34.1 and 35 of the *MHA*, RSO 1990, c M7.

CHAPTER

2 Consent to Treatment

1. Introduction

This chapter focuses on consent issues for patients with mental illness. This requires consideration of the principles and provisions of the *Health Care Consent Act* ("HCCA")[1] which applies to all areas of health care in Ontario.

A fundamental principle of health care in Ontario is that treatment shall not be provided without consent. If a patient is capable, then that patient will decide whether to consent to, or refuse, the proposed treatment. If a patient is not capable, then a substitute decision maker ("SDM") will be asked to make the decision on their behalf.[2]

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

The stated purposes of the *HCCA* include the following:

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

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

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

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

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

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

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

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

(f) To permit intervention by the Public Guardian and Trustee ("PGT") only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to a care facility or personal assistance services.[3]

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

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

1 *Health Care Consent Act*, *1996*, SO 1996, c 2 Sched A, s 10 [*HCCA*].

2 *Ibid*, s 10.

3 *Ibid*, s 1.

What is "Treatment"?

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

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

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

A "**course of treatment**" is a "series or sequence of similar treatments administered to a person over a period of time for a particular health problem".[5]

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

1. Is developed by one or more health practitioners;
2. Deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition; and
3. Provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition".[6]

Where a plan of treatment is proposed, one health practitioner is able to represent others involved in the plan for the purposes of proposing the treatment, assessing capacity and seeking the informed consent of the capable person or from an appropriate SDM on behalf of an incapable person.[7]

A "**community treatment plan**" is "a plan that is required as part of a community treatment order"[8] and will be discussed in Chapter 3.

An individual's capacity is always considered in the context of proposed treatment for which consent is being sought. An individual may be capable with respect to some treatments and incapable with respect to others.[9] Capacity may fluctuate and an individual may be capable with respect to a proposed treatment at one time and incapable with respect to this same treatment at another.[10] If an individual becomes capable with respect to treatment that is being provided pursuant to substitute consent, their capable decision to continue or discontinue the treatment will supersede the substitute consent.[11]

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

Necessary and "**ancillary treatment**" will be covered by substitute consent when it is required as part of the treatment for which the substitute consent is given. This will be the case even if the person is capable with respect to the necessary and ancillary treatment.[12] Some examples of "ancillary" treatment issues include the use of restraints for the purpose of administering medication by injection pursuant to substitute

4 *Ibid*, s 2.

5 *Ibid*.

6 *Ibid*, s 13.

7 *Ibid*.

8 *Ibid*, s 2.

9 *Ibid*, s 15(1).

10 *Ibid*, s 15(2).

11 *Ibid*, s 16.

12 *Ibid*, s 23.

consent,[13] diagnostic testing and testing for the purpose of monitoring a condition or treatment.

2. Determining Capacity to Consent to Treatment

The Test for Capacity

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

A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[14]

An evaluation of capacity to consent to treatment involves a "two-part test" with consideration of the following:

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

and

(b) Is the person able to appreciate the reasonably foreseeable consequences of their decision, or their lack of decision.[15]

A person may be found incapable if they do not meet one part of the test, or both.

There is a presumption of capacity with respect to treatment and, absent "reasonable grounds", a health practitioner can assume that a person is capable.[16]

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

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

In the leading decision on consent to treatment, *Starson v Swayze*, the Supreme Court of Canada made the following comment about the first part of the test:

> ***The person must be capable of intellectually processing the information as it applies to his or her treatment, including its potential benefits and drawbacks.*** *Two types of information would seem to be relevant: first, information about the proposed treatment; and second, information as to how that treatment may affect the patient's particular situation. Information relevant to the treatment decision includes the person's symptoms and how the proposed treatment may affect those symptoms.[17] (emphasis added)*

An inquiry into a patient's capacity to consent to treatment "must start with some evidence as to the foreseeable benefits and risks of treatment and the expected consequences of not having treatment".[18]

Individuals who lack capacity under the first part of the test may have a cognitive condition that impedes their ability to retain and/or process the information.

Communication barriers[19] should not be an impediment to a person's ability to process relevant information. When seeking consent from an individual who has difficulty communicating, all reasonable steps should be taken to facilitate their discussion with their health practitioners for the purpose of evaluating / assessing capacity and seeking consent.

13 *T. (S.M.) v Abouelnasr*, 2008 CarswellOnt 1915 (Ont SCJ).

14 *HCCA*, *supra* note 1, s 4(1).

15 *Ibid*, s 4.

16 *Ibid*, s 4(2)(3).

17 *Starson v Swayze*, 2003 SCC 32, [2003] 1 SCR 722, 225 DLR (4th) 385 para 16.

18 *Anten v Bhalero*, 2013 ONCA 499 at para 23.

19 Examples of communication barriers include language barriers, a person with hearing loss, or a person being unable to speak. Possible solutions to remove these communication barriers may include the use of interpreters, communication through "hand squeezing" or "blinking" as well as writing, typing and other forms of communication.

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

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

> ***The patient must be able to acknowledge his or her symptoms in order to be able to understand the information relevant to a treatment decision.*** *Agreement with a medical professional's diagnosis per se, or with the "label" used to characterize the set of symptoms, is not, however, required.*[20] *(emphasis added)*

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

> *While a patient need not agree with a particular diagnosis, if it is demonstrated that he has a mental "condition", the patient must be able to acknowledge the possibility that he is affected by that condition...As a result, a patient is not required to describe his mental condition as an "illness", or to otherwise characterize the condition in negative terms...* ***Nonetheless, if the patient's condition results in him being unable to recognize that he is affected by its manifestations, he will be unable to apply the relevant information to his circumstances, and unable to appreciate the consequences of his decision.***[21] *(emphasis added)*

This is the more complicated part of the test and is often the main issue at CCB hearings.

A person will not be able to "appreciate the reasonably foreseeable consequences of a decision" if they cannot apply the information relevant to making the decision to their own situation.[22]

In making a determination of a person's ability to appreciate the consequences of a decision, or lack of decision, with respect to a proposed treatment, there must be tangible evidence consistent with and beyond mere verbalization of "understanding".

The second part of the test for capacity will not be met where it is demonstrated that a person is unable to apply the information about the proposed treatment to their own situation.[23]

Examples of Incapacity Under the Second Part of the Test

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

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

Adolescents and Children

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

20 *Starson, supra* note 16, para 16.

21 *Ibid*, at para 79.

22 In *Wright v Coleman,* 2015 ONSC 2744 the court held that finding a patient was incapable of foreseeing the consequences of a decision regarding the proposed antipsychotic medication, it was implicit in that decision that the appellant could not be capable of appreciating the consequences of a decision or lack of decision regarding the side effects of a medication he did not feel he required.

23 *Khan v St. Thomas Psychiatric Hospital* (1992), 7 OR (3d) 303 (CA) at para 314-5; *Tran v Ginsberg,* 2011 ONSC 927 at paras 34 and 38; see also *M.M. v. de Souza*, 2016 ONCA 155 at paras 19 and 22.

Age can, and should, be taken into account by a health practitioner when considering whether there are "reasonable grounds" to depart from the presumption of capacity as well as when assessing capacity. If the patient is a baby, this concept is overwhelmingly obvious – a health practitioner does need to spend more than a moment in considering whether the patient may be able to given informed consent for proposed treatment. As a child matures, this thought process should deepen.[24] While the patient's age will become decreasingly determinative, it need not be ignored completely.[25]

There is a requirement for formal rights advice to be given to any patient in a psychiatric facility who has been found incapable with respect to treatment if they are 14 years of age or older.[26]

Where there is not a formal requirement for "rights advice", health practitioners are expected to follow professional guidelines with respect to the provision of information about the consequences of a finding of incapacity, which recognize that the communication should take into account the particular circumstances of the situation, including a patient's age / maturity.

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

Geriatric Patients

For the elderly, the same presumption of capacity applies. With older patient populations, capacity may be affected by a myriad of health conditions that develop as a result of the aging process. Some geriatric patients may have significant mental health issues that need to be recognized and addressed.

Capacity in this patient population needs to be carefully and routinely evaluated. Capacity may fluctuate and there may be times when a patient's capacity depends on the stability of an underlying condition.

Example of How Capacity May Fluctuate

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

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

Consequences of a Finding of Incapacity

Under the *MHA*, patients admitted to a psychiatric facility must be given "notice" of findings of incapacity.[27] A "Form 33" notice is given to a psychiatric patient who has been found incapable of consenting to treatment.[28]

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

25 Please see *A.C. v Manitoba* at footnote 24.

26 General Regulation RRO 1990, Reg 741, *Mental Health Act.* RSO 1990 c M7, s 15.

27 *Ibid.* There is a requirement for rights advice to be given to a person who is admitted to a psychiatric facility who is 14 years of age or older on a finding of incapacity with respect to treatment.

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

The various regulatory Colleges have policies, practice guidelines and other directives that their members are expected to follow.[29] These guidelines generally require health practitioners to consider capacity and explain findings of incapacity to their patients. Each regulated health professional should be familiar with the professional obligations and expectations as set out by their College.

Once a health practitioner has made a finding of that a person is incapable, their "next step" is to identify the appropriate SDM and to seek their informed consent for the proposed treatment.

3. Substitute Decision Makers

When a person is incapable, a health practitioner proposing treatment will look to their SDM to make decisions on their behalf. To make decisions on behalf of an incapable person, someone must be "qualified" act as their SDM.

Identifying an Appropriate Substitute Decision Maker

There is a "hierarchy" for determining who may give substitute consent on behalf of an incapable person. The following is a reproduction of the hierarchy from the legislation:

1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.
3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent to the treatment.
4. The incapable person's spouse or partner.
5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.
6. A parent of the incapable person who has only a right of access.
7. A brother or sister of the incapable person.
8. Any other relative of the incapable person.[30]

Generally, the highest-ranking person in the "hierarchy" is entitled to make decisions on behalf of the incapable person.[31] An SDM who is lower in priority may give or refuse consent if they believe that a higher ranking SDM would not object to him or her making the decision as long as the higher ranking SDM is not guardian, attorney for personal care or CCB representative.[32]

In addition to being the "highest ranking" on the list, in order to be an SDM, there are additional criteria, all of which must be met.[33] These criteria include:

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

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

30 *HCCA*, *supra* note 1, s 20(1).

31 *Ibid*, s 20(3).

32 *Ibid*, s 20(4).

33 *Ibid*, s 20(2).

A potential SDM is "available" if "it is possible, within a time that is reasonable in the circumstances, to communicate with the person and obtain a consent or refusal".[34]

If an SDM is not available to health practitioners for an extended period of time, they may not meet the criteria to make decisions for the incapable person.

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

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

A "guardian of the person" is someone who has a Court Order for guardianship. The application process to be appointed as a guardian is set out in the *SDA*.[35] When appointing a guardian, the court must specify the functions over which the guardian has decision making power. These may be limited in time or by any conditions the court wishes to impose.[36] Full guardianship may be ordered when the individual is fully incapable of all functions.[37] In all other cases, the court will award a partial guardianship outlining the exact role of the guardian.[38] Where the guardian has authority to give or refuse consent to the proposed treatment, the guardian will be the SDM for the incapable person, as there is no higher ranking option.

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

- **Equally ranked SDMs disagree on a proposed treatment and one (or more) is seeking to be appointed so as to be in a position of higher rank in the determination of who is the SDM.**
- **A close friend of the patient applies to make a decision**

34 *HCCA*, *supra* note 1, s 21(11).

35 *Substitute Decisions Act*, SO 1992, c.30, ss 55-65, [SDA]. These sections in Part II of the *SDA* cover applications for Guardianship of the Person.

36 *Ibid*, ss 58(1)(2).

37 *Ibid*, s 59(1). The test for determining capacity to consent to "personal care" is in s 45 of the *SDA*.

38 *Ibid*, ss 58(3) and 60.

The court will only appoint someone to this role if it is satisfied that there is no other alternative action which does not require the person to be found incapable of personal care and which is less restrictive on the person's decision-making rights.[39] The court will also consider whether the proposed guardian is the incapable person's guardian for property under a continuing power of attorney; the incapable person's wishes, if they can be ascertained; and the closeness of the relationship between the applicant and the incapable person.[40]

The court will not appoint a person who is paid to provide health care, social, training or other support services unless this person is also a family member or there is no other suitable and available person.[41]

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

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

A "Power of Attorney for Personal Care" is a document completed in accordance with the legal requirements set out in the *SDA*.[42] The test for capacity to grant a Power of Attorney for Personal Care is not the same as the test for capacity to consent to treatment. A person is capable of granting a power of attorney if:

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

(b) The person can appreciate that the attorney may need to make decisions regarding personal care on his or her behalf.[43]

39 *Ibid*, s 55 (2).

40 *Ibid*, s 57 (3).

41 *Ibid*, s 57 (1). Unless the person is also the Guardian of Property, Power of Attorney for Personal care or Continuing Power of Attorney, as per s. 57(2).

42 *Ibid*, ss 46 – 54. These sections cover Powers of Attorney for Personal Care.

43 *Ibid*, s 47.

To be valid, the power of attorney document must be signed in front of two witnesses, and the witnesses must also sign the document.[44]

It is now possible for power of attorney documents to be witnessed virtually, provided at least one person who is acting as a witness is a licensee within the meaning of the *Law Society Act* and the signatures required are made contemporaneously.[45]

An "attorney" acting pursuant to a Power of Attorney for Personal Care may have authority to make treatment decisions for a person who has been found to be incapable under the *HCCA*.[46] Provisions may be included in a power of attorney to restrict the attorney from making any decisions until it has been formally determined that the grantor is not capable and may outline the method to be used and factors to be considered to make this determination.[47]

Several provisions which may be included in a Power of Attorney for Personal Care are considered to have such significant consequences for the grantor that additional requirements must be met before they are valid. These provisions include:

(a) Authorizing the reasonable use of force to:

  (i) Determine if the patient is incapable;

  (ii) Confirm if the patient is incapable of personal care when there is a condition that no decisions may be made by the attorney until this is confirmed; or

  (iii) Obtain an assessment for any reason the patient outlines in the power of attorney;

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

(c) Waiving the patient's right to a review by the CCB of a finding of incapacity by a health practitioner or an evaluator.[48]

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

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

(b) A statement from an assessor, on the prescribed form, dated within 30 days after the power of attorney was executed, indicating that at the time of the assessment the grantor was capable of personal care, and they understood the effect of the document and the facts upon which the assessor's opinion is based.[49]

A court has the power to validate any power of attorney that is otherwise ineffective.[50]

Where the SDM for an incapable person is appointed in a Power of Attorney for Personal Care, it is recommended that a copy of the power of attorney document be placed in the patient's chart.

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

The procedure and process for an application to the CCB to be appointed as a "representative" is set out in section 33 of the *HCCA*. This type of application can be brought by an incapable person 16 years old or older, for the appointment of someone to make decisions for them, or by another person 16 years old or older who wants to make decisions for the incapable person.[51] If the incapable person has a court appointed guardian or a power of attorney for personal care with the authority to give or refuse consent to the proposed treatment they do not have the right to apply to the CCB for a representative.[52]

44 *Ibid,* s. 48. There is a list of individuals who are excluded from acting as a witness to a power of attorney (s. 10(2) *SDA*), which includes the attorney, or the attorney's spouse/partner; the grantor's spouse/partner; a child of the grantor or a person whom the grantor has demonstrated a settled intention to treat as their child; a person whose property is under guardianship or who has a guardian of the person; and a person who is less than eighteen years old.

45 *Substitute Decisions Act, 1992,* SO 1992, c. 30 at s 3. 1.

46 *Ibid*, ss 49(1)(2).

47 *Ibid*, ss 49(1)(b), (2)(3).

48 *Ibid*, s 50(2).

49 *Ibid*, s 50(1).

50 *Ibid*, s 48(4).

51 *HCCA*, *supra* note 1, s 33(1)(2).

52 *Ibid*, s 33(3).

New treatment cannot be commenced while an application for the appointment of a representative is pending.[53]

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

4. The incapable person's spouse or partner.

Unless two people are living separate and apart as a result of a breakdown in their relationship[54], they are considered to be "spouses" if:

(a) they are married to each other; or

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

(i) have cohabited for at least one year,

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

(iii) have together entered into a cohabitation agreement under section 53 of the Family Law Act, 1996.[55]

A "partner" is "either of two persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives".[56] The definition of "spouse" in the *HCCA* includes same sex partners.

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

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

A "child" is not defined in the *HCCA*.

The birth parent of a child is the parent of the child, except in cases where the birth parent is a surrogate and there has been a relinquishment of entitlement to parentage by surrogate or a declaration by the court to that effect.[57] There is also a presumption of other biological parent in a variety of circumstances.[58]

This paragraph does not include a parent who has only a right of access.

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

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

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

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

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

7. A brother or sister of the incapable person.

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

53 *Ibid*, ss 18(2)(3).

54 *Ibid*, s 20 (8).

55 *Ibid*, s 20 (7).

56 *Ibid*, s 20 (9)(b).

57 *Children's Law Reform Act,* RSO 1990, c C 12 s 6, ss 6(2).

58 *Ibid*, s 7(2). These circumstances include: when the person is the birth parent's spouse at the time of the birth; the person was married to the child's birth parent by a marriage that was terminated by death or judgment of nullity within 300 days before the birth of the child or by divorce where the *decree nisi* was granted within 300 days before the birth of the child; when the person was living in a conjugal relationship with the child's birth parent before the child's birth and the child is born within 300 days after they cease to live in a conjugal relationship; the person has certified the child's birth, as a parent of the child under the *Vital Statistics Act* or a similar Act in another jurisdiction in Canada; and when the person has been found or recognized by a court of competent jurisdiction in Canada to be a parent of the child.

8. Any other relative of the incapable person.

A "relative" under this section is someone "related by blood marriage or adoption" to the incapable person.[59]

The composition of families can vary greatly for different patients. If a health practitioner is uncertain as to whether someone falls within one of the categories in the hierarchy, including "any other relative", they should contact the appropriate risk management representative or their organization's designated resource for accessing legal counsel.

The Role of the Public Guardian and Trustee

If there is not an SDM available, then the PGT shall make the decision to give or refuse treatment on behalf of the incapable person.[60] This is often referred to as the PGT acting as the "SDM of last resort". One of the steps taken by the PGT will be to try to locate an SDM who meets the criteria in s. 20 of the *HCCA*. For more information on the role of the PGT, please refer to their website at: www.ontario.ca/page/office-public-guardian-and-trustee.

Managing Conflict between SDMs

If SDMs, with equal authority to make the decision who meet all the requirements, disagree on whether to give or to refuse consent, then the PGT shall make the decision for them.[61]

Example of Conflict between Equally Ranked SDMs

An incapable patient is receiving treatment based on substitute consent provided by her four children. A new treatment is recommended, and only three of the four children consent.

The majority does not "rule" in this situation. If equally ranked SDMs cannot agree on a proposed treatment, then the PGT will be approached to make the decision on behalf of the incapable person

59 *HCCA*, *supra* note 1, s 20(10).

60 *Ibid*, s 20(5).

61 *Ibid*, s 20(6).

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

An SDM, on behalf of an incapable person, is required to make decisions in accordance with the principles for substitute decision-making set out in the *HCCA*.[62] In 1997, the Ontario Superior Court commented:

> *It is mental capacity and not wisdom that is the subject of the SDA and the HCCA. The right knowingly to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The State has no business meddling with either. The dignity of the individual is at stake.*[63]

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

Prior Capable Wish

An SDM who:

> knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age... shall give or refuse consent in accordance with the wish.[64]

This is generally referred to as a "prior capable wish". The key issues are determining the wish – and in particular whether it was expressed while the patient was capable and that it is applicable to the circumstances. As long as these criteria are all met, the wish should be followed with very limited exceptions.[65]

62 *Ibid*, s 21.

63 *Koch (Re)* (1997), 35 OR (3d) 71 (SC) at para 17.

64 *HCCA*, *supra* note 1, s 21(1).

65 *Conway v Jacques* (2002), 59 OR (3d) 737, 214 DLR (4th) 67, 2002 CarswellOnt 1920 (CA).

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

> *While the Board in a proper case may make a finding as to prior capable wishes that differs from the view of prior capable wishes expressed by the SDM, once the Board has found what the prior capable wishes are, it does not have a general discretion to override those wishes. That is not only, or primarily, a matter of interpretation of the statute, although it is that: it is also a matter of constitutional law. The whole of the Consent and Capacity Board should have this point brought home to it.*
>
> *With respect to prior capable wishes, there is a small amount of "wiggle room" for the Board in connection with whether the prior capable wishes are "applicable in the circumstances", but that should be approached with care and restraint because of the constitutional dimension. It is not a discretion.*[66]

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

An individual may express a wish orally or in writing, including in a Power of Attorney for Personal Care. In order for a wish to be a "prior capable wish", it must be established that it meets the criteria above.[67] When a wish is expressed in writing, and in particular, in a Power of Attorney for Personal Care, it may be presumed to be a prior capable wish which may be "displaced" by "relevant evidence".[68]

It is appropriate for a health practitioner to consider a prior capable wish, and as well as any other evidence about possible wishes to the contrary, in discussing a proposed plan of treatment with an SDM. Both an SDM and a health practitioner proposing a particular treatment can apply to the CCB for "directions" to clarify a possible prior capable wish, or to depart from a prior capable wish.[69]

66 *L. (L.) v. T. (I.),* 1998 CarswellOnt 4097 (Gen Div) at 30 – 31.

67 *Barbulov v Cirone*, 2009 ONSC 15889; *Friedberg v Korn* 2013 ONSC 960 – paras 64-65.

68 *Ibid*, *Friedberg* at para 66.

69 *HCCA*, *supra* note 1, ss 35 and 36. A Form E is an Application to the Board for Permission to Depart from Wishes.

"Best Interests"

In situations in which there is no "prior capable wish", or if it is impossible to comply with the wish, then the SDM is required to act in the incapable person's "best interests".[70] In determining what the incapable person's best interests are, an SDM is to consider:

1. The values and beliefs that the person knows the incapable person held when capable and believes they would still act on if capable;
2. Any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and
3. The following factors:
   (a) Whether the treatment is likely to
      (i) Improve the incapable person's condition or well-being;
      (ii) Prevent the incapable person's condition or well-being from deteriorating; or
      (iii) Reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
   (b) Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
   (c) Whether the benefit of the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
   (d) Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

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

70 *Ibid*, s 21(2).

Other Obligations of a Substitute Decision Maker

SDMs who are court-appointed guardians or powers of attorney have legislated duties.[71]

These "duties" include:

(a) Explaining their role to the incapable patient;

(b) Encouraging the patient's participation in the decision making process;

(c) Fostering the independence of the incapable patient;

(d) Encouraging regular contact with family and friends;

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

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

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

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

Limits on Substitute Decision Making

While an SDM can consent to an incapable person's admission to a hospital or other facility for the purpose of receiving the proposed treatment,[72] there are limitations on the ability of an SDM to consent to admission to a psychiatric facility for this purpose. This is addressed in more detail in Chapter 3.

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

Decisions Not Being Made in Accordance with these Principles

If an SDM is not making decisions in accordance with the principles for giving or refusing consent on behalf of an incapable person, a health practitioner may bring a "Form G" application to the CCB.[73] The purpose of this application is to determine whether an SDM is complying with the principles for making decisions on behalf of an incapable person.[74] These applications (Form G) do not result in the SDM being "removed" from their decision making position, but rather in the CCB directing them on the decision, in accordance with these principles.

If the SDM does not comply with the direction of the CCB within the time set out in the CCB's decision, the SDM "shall be deemed not to meet the requirements" for being an SDM.[75] In this situation, the health practitioner may seek substitute consent from the next appropriate person who meets the criteria in subsection 20(1) of the *HCCA*.

71 *SDA*, *supra* note 30, ss 66 and 67.

72 *HCCA*, *supra* note 1, s 24.

73 *Ibid*, s 37.

74 *Ibid*, s 37(1).

75 *Ibid*, s 37(6).

Examples of Cases Involving Form G Applications

The following are examples from cases in which a SDM was directed to consent to the proposed plan of treatment:

A patient with advanced dementia was awaiting discharge but the behavioural and psychological symptoms of dementia made her placement in a long-term care facility difficult. Treatment with antipsychotic medication was proposed to address these symptoms and increase the likelihood of admission to long-term care. The SDM refused to consent to the proposed treatment. The Board concluded that, while the SDM had good reason to be skeptical given that the patient had experienced terrible side effects to treatment in the past, it was not in the patient's best interest for the SDM to be closed to the possibility of a new trial of antipsychotics, and weighing all the circumstances, the treatment was in her best interests.[76]

Treatment with antipsychotic, mood stabilizing, and anxiety medications was proposed for a patient with schizoaffective disorder. The SDM refused to consent to the proposed treatment and refused to attend the Form G hearing. The SDM was found to not be acting in the patient's best interests. The Board specifically highlighted that while a capable person has the right to make foolish decisions, "a SDM does not have the right to make unwise or unreasonable decisions on behalf of an incapable person".[77]

A plan of treatment was proposed for a patient with dementia, Parkinson's, and coronary artery disease. This plan of treatment provided for comfort measures with no further dialysis, vasopressors, feeding or CPR. The SDM did not consent. In considering the best interests of the patient, the Board reviewed the medical factors for the treatment plan, the patient's quality of life, dignity and pain, prior capable wish as expressed in a power of attorney, as well as his religious and cultural beliefs.[78]

In considering the best interests of a one year old who had sustained a severe brain injury, the Board focused on preserving the dignity and well- being of the patient, concluding that they could not imagine that an objective observer would not be heartbroken not just because of the patient's drowning but "also for her complete absence of well-being and the treatment imposed upon her with no prospect of recovery".[79]

There are also cases in which the Board concluded that a patient's SDM had complied with the principles in refusing to consent to proposed treatment for an incapable person:

The SDM of a patient who had been diagnosed with autism consented to his acting as a donor for a stem cell transplant that could save his brother's life. The Board found that the SDM had educated herself about the risks facing the patient, considered them carefully and had considered the patient's relationship with his brother as well as the patient's own needs in making this decision on his behalf.[80]

The SDM of a patient who suffered from cognitive and physical impairments as a result of a head injury had been admitted to hospital multiple times as a result of increasingly intense fall related injuries. The treatment team recommended that the patient be admitted into a care facility but her SDM, who was also the patient's primary care provider, refused to entertain the idea. The Board considered whether the patient had a prior capable wish, her best interests and other factors, including that the SDM understood the patient's care needs and that they could rely on her undertaking to make all of the necessary changes and arrangements to allow her to live safely in her home.[81]

Form G cases can be quite challenging and it is strongly recommended that health practitioners get legal advice prior to commencing these applications.

76 *Re NH,* 2017 CanLII 34286 (ON CCB)

77 *PT (Re),* 2021 CanLII 63748

78 *GG (Re),* 2020 CanLII 36914

79 *KHK (Re),* 2021 CanLII 85312

80 *MU (Re),* 2022 CanLII 34907

81 *FD (Re),* 2021 CanLII 23155

5. What is a Valid Consent?

For consent to be legally "valid", it must relate to the treatment, be "informed", be given voluntarily and not be obtained through misrepresentation or fraud.[82] It is the obligation of the health practitioner who is proposing the treatment to obtain informed consent.[83]

For consent to be "informed", the capable person, or SDM for incapable person, must have received "the information ... that a reasonable person in the same circumstances would require in order to make a decision about the treatment" and "received responses to their requests for additional information about those matters."[84] This "information" should include the nature of the treatment, the expected benefits of the treatment, the material risks of the treatment, the material side effects of the treatment, alternative courses of action, and the likely consequences of not having the treatment.[85]

A material risk is "one that a reasonable person in the patient's position would want to know about before deciding whether to proceed with the proposed treatment. Risks that are rare will be material if the consequences of those risks are serious."[86] Expert evidence is relevant to determining the material risks involved in a particular treatment.[87]

Consent to a proposed treatment may be express or implied. Consent to a proposed treatment can be withdrawn by a capable patient or by an SDM for an incapable patient.[88]

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

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

Members of a regulated health profession should be aware of the policies and guidelines from their respective Colleges on informed consent.

6. Consent and Capacity Principles: Other Considerations

Emergency Treatment without Consent

An "emergency" is a situation in which the person for whom a treatment is being proposed is considered to be at risk of sustaining serious bodily harm if the treatment is not administered promptly, or if they are experiencing severe suffering.[89]

Treatment may be administered to a capable person without consent in an "emergency" situation in which there is a communication barrier (due to language or disability) and a reasonable, practical means of communication cannot be found without there being a delay that will prolong the apparent suffering of the person or put that individual at risk of sustaining serious bodily harm, and there is no reason for the health practitioner proposing the treatment to believe that the person does not want the treatment.[90]

Treatment may be administered to an incapable person without consent in an "emergency" situation in which the time required to seek the appropriate substitute consent will prolong the apparent suffering of the person or put that individual at risk of sustaining serious bodily harm.[91]

82 *Ibid*, s 11(1).

83 *Augustine v Lopez*, 1994 CarswellOnt 3969, [1994] O.J. No. 2646 at para 19-21, aff'd [1998] O.J. No. 642 (C.A.), leave to appeal ref'd [1998] S.C.C.A. No. 168; see also *Penate v St. Michael's Hospital*, 2022 ONSC 4939 at para 245.

84 *Ibid*, s 11(2).

85 *Ibid*, s 11(3).

86 *Revell v Chow*, 2010 ONCA 353 at para 42.

87 *Videto et al. v Kennedy*, 33 OR (2d) 497, 1981 CarswellOnt 580 (ONCA) at para 12, citing *Reibl v Hughes*, [1980] 2 S. C.R. 880 at 884 and *Hopp v Lepp*, [1980 2 S.C.R. 192 at 210.

88 *HCCA*, s 14.

89 *Ibid*, s 25(1).

90 *Ibid*, s 25(3).

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

A health practitioner is also permitted to perform an examination to determine whether there is an emergency, on either an incapable or a capable person, in which there is a communication barrier and there are the same concerns about a delay as set out above.[92]

The ability to provide "emergency" treatment to a capable patient is subject to the health practitioner being aware of a "prior capable wish" to the contrary.[93] For an incapable patient, if the situation is an "emergency" and the SDM is not adhering to the principles for substitute decision making, then the health practitioner can proceed with the treatment without consent.[94]

If treatment is provided without consent in an "emergency" situation, this treatment continues "only for so long as is reasonably necessary" to obtain a consent from a SDM for an incapable person[95], or until the person regains capacity and is able to make their own decision.[96] In either scenario, the opinion of the health practitioner as to why treatment was given under this section must be documented in the clinical record.[97]

Treatment pending appeal

As is discussed in more detail below, and in Chapter 5, if a patient applies, or intends to apply, to the CCB for a review of a determination of incapacity with respect to a treatment, the health practitioner is not permitted to start that treatment.[98]

Delay in the commencement of treatment is a significant concern for health practitioners and mental health facilities. There are medical, ethical and practical implications from delays in treatment as a result of the appeal process under the *HCCA* and the negative impact that this may have on a patient.

It is strongly recommended that health practitioners seek legal advice about the appropriateness of a motion to the Court for leave to treat a patient, pending disposition of the appeal. These motions are challenging and whether it is an appropriate option will depend on the situation and condition of the patient, as well as the nature and status of the appeal.

92 *Ibid*, s 25(4).

93 *Ibid*, s 26.

94 *Ibid*, s 27.

95 *Ibid*, s 25(6).

96 *Ibid*, s 25(9).

97 *Ibid*, s 25(5).

98 *HCCA*, *supra* note 1, s. 18.

Assessments of Financial Capacity

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

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

Consent Issues in Community Treatment Orders (CTO)

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

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

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

There are a few restrictions on applications to review findings of incapacity to consent to treatment. A person whose SDM is a Guardian of the Person with the authority to give or refuse consent on their behalf or a Power of Attorney for Personal Care pursuant to a Power of Attorney document that specifically waives the person's right to bring an application

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

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

101 *SDA*, *supra* note 30, s 6.

102 The Office of the Public Guardian and Trustee, which is part of the Ministry of the Attorney General, may in some circumstances assume the role of guardian of property, in cases where the criteria set out in the *SDA* are met. More information on the PGT's role in managing property on behalf of incapable persons is available online at <https://www.ontario.ca/page/office-public-guardian-and-trustee>.

103 *HCCA*, *supra* note 1, s 32(1).

104 *Ibid*, s 32(4).

for a review of capacity,[105] may not bring an application to the CCB to review their capacity.[106]

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

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

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

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

(d) If a party to the application before the CCB has informed the health practitioner that they intend to appeal the CCB's decision,

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

  (ii) Until there has been a final disposition of the appeal from the CCB's decision.[107]

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

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

105 *SDA*, *supra* note 30, s 50(1).

106 *HCCA*, *supra* note 1, s 32(2).

107 *Ibid*, s 18(1)(3).

108 *Ibid*, s 18(4).

109 *Ibid*, s 32(5); note if the reviewing Court declines to hear the appeal on the merits, then the original CCB decision is the "final disposition" date for the purpose of section 32(5); see *Conway v Darby*, 2013 ONCA 538 at para 10, citing *K.M. v. Shammi*, 2012 ONSC 1102 at para 10.

110 *Ibid*, s 32(6).

Calculating Time from "Final Disposition"

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

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

There is a further discussion of applications to the CCB, appeals from decisions of the CCB and the impact of these applications and appeals on treatment, in Chapter 5 of this Toolkit.

A complete list of the types of applications that can be made to the CCB is set out in Appendix "C".

CHAPTER

3 Assessment and Hospitalization Under the *Mental Health Act*

1. Introduction

The *Mental Health Act* ("*MHA*") provides the legal framework for the admission into specially designated psychiatric facilities of persons suffering from a mental disorder.[1] The term "mental disorder" is defined broadly in Ontario's *MHA* to mean "any disease or disability of the mind".[2]

Under the *MHA*, "psychiatric facility" is a defined term meaning a facility "for the observation, care and treatment of persons suffering from mental disorder, and designated as such by the Minister". The list of psychiatric facilities and their designations is maintained on the Ontario Ministry of Health's website.

The *MHA* provides psychiatric facilities with the power to lawfully detain persons who have been found upon examination by a physician to meet certain prescribed criteria. Although the language of the legislation suggests that this power applies to all psychiatric facilities, the *General Regulation* enacted under the *MHA* provides that certain psychiatric facilities are not required to provide in-patient services (i.e., non-Schedule 1 facilities), and are therefore, "exempt from the application" of Parts II, except sections 35 and 35.1, and Part III of the *MHA*. Parts II and III of the *MHA* provide for the involuntary admission of patients.[3]

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

The Officer in Charge ("OIC") of a psychiatric facility is defined by the *MHA* as the "officer who is responsible for the administration and management of a psychiatric facility"[4], which is generally speaking, the President and CEO. The *MHA* imposes a number of statutory obligations upon the OIC. Fulfillment of these obligations is an essential precondition to involuntary admission, continuation of involuntary or informal admissions, and in some cases, clinical decisions. Failure to comply with the OIC obligations set out in the *MHA* can result in the revocation of a patient's involuntary status. Such consequences impose a burden on psychiatric facility resources and can impact negatively on patient care by delaying therapeutic progress and in some cases, may give rise to risks associated with premature discharge. Most psychiatric facilities have policies that address the duties of the OIC, and in particular, provide for who may act as a designate or delegate of the OIC to fulfill the prescribed duties within the prescribed time limits.

The statutory duties of the OIC are discussed throughout this chapter and are set out in greater detail in a reference chart at the conclusion of this chapter.

1 *Mental Health Act*, RSO 1990, c M7 [*MHA*]. Formerly in Ontario, several provincially-run psychiatric hospitals were governed according to the provisions of the *Mental Hospitals Act*, RRO 1990, c M8, which was repealed in December 2009. Currently, all Ontario public hospitals that provide in-patient and out-patient psychiatric care are designated as psychiatric facilities by the Minister of Health, according to section 80.2 of the *MHA* and also operated as public hospitals.

2 *MHA*, *supra* note 1, s 1(1).

3 *General Regulation,* RRO 1990, Reg 741, s 7 [*General Regulation*], enacted under the *MHA.* We discuss non-Schedule 1 psychiatric facilities in further detail in Chapter 4 of this text.

4 *MHA*, *supra* note 1, s 1.

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

The term "patient" has a precise legal definition in the *MHA*: "a person who is under observation, care and treatment in a psychiatric facility."[5]

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

- **Voluntary patien**t – A person who has agreed to be admitted to the psychiatric facility for care, observation and treatment;
- **Informal patient** – A person who has been admitted pursuant to a substitute decision maker's consent under section 24 of the *Health Care Consent Act* ("HCCA")[6];
- **Involuntary patient** (person who is the subject of a Form 3, 4 or 4A) – A person who has been assessed by a psychiatrist and found to meet certain criteria set out in section 20 of the *MHA*, following which the person is admitted and detained as an involuntary patient; or
- **Patients admitted under court order** (Form 6 or 8), according to sections 21 to 25 of the *MHA*.

"**Out-patient**" is also a defined term, and means a person who is "registered in a psychiatric facility for observation or treatment or both, but who is not admitted as a patient and is not the subject of an application for assessment"[7].

A patient's status under the *MHA* can change throughout the course of a hospital admission. For example, a patient who has been involuntarily admitted may experience an improvement in their condition such that they no longer meet the criteria for an involuntary admission, even though the authorized period of detention has not expired. In that case, the attending physician may terminate the involuntary admission and authorize the patient's continued admission as a voluntary or informal patient, by executing the approved form (Form 5).[8]

Moving in the other direction, a voluntary or informal psychiatric patient's condition may change such that they are no longer suitable for continuation as a voluntary or informal patient. In that case, the attending psychiatrist must assess the patient to determine whether they meet the criteria for an involuntary admission. If so, the attending physician must complete and file a certificate of involuntary admission with the OIC of the psychiatric facility.[9]

Where a person is being assessed for admission to a psychiatric facility as the subject of either a Form 1 (application by a physician for assessment), Form 2 (order for examination issued by a justice of the peace) or Form 13 (order to admit a person coming into Ontario issued by an authorized delegate of the Minister of Health and Long Term Care ("Minister")), the person is not considered a "patient" within the meaning of the *MHA* until they have been formally admitted to a psychiatric facility by the attending physician.[10]

Psychiatric facilities are designated as such by the Minister and the designation applies to the whole facility, not just the ward designated as the in-patient psychiatric unit. Consequently, a person who is being treated for a medical condition on a medical ward of a hospital may become a psychiatric patient due to the patient's need for psychiatric treatment, even though they are on the medical ward. Similarly, when a psychiatric patient requires medical treatment on a medical ward, the patient generally remains a psychiatric patient while on a medical ward. If the psychiatric patient is involuntarily admitted, steps should be taken to ensure the patient's continued detention when on an unlocked medical ward.

Whether a person is, or is not, a patient in a psychiatric facility, and what type of patient they are, will have significant ramifications for the person's rights under the *MHA*. For example, once admitted to a psychiatric facility and regardless of the psychiatric patient's status as voluntary, informal or involuntary, the *MHA* requires a physician to examine the person to determine whether they are capable with respect to managing their property.[11] We discuss assessments of capacity to manage property in greater detail below.

5 *Ibid.*, s 1(1).

6 *Health Care Consent Act*, 1996, SO 1996, c 2, Sched. A [*HCCA*].

7 *MHA*, *supra* note 1, s 1(1).

8 *Ibid.*, s 20(7).

9 *Ibid.*, s. 19.

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

11 *MHA*, *supra* note 1, s 54.

Voluntary Patients

The meaning of "voluntary patient" is not set out expressly in the definition section of the *MHA*. The Ontario Court, in an appeal of a CCB decision, has stated that in order for a person to be a voluntary psychiatric patient, "the person must be in a position to exercise their own free will and must have made a capable decision to consent to voluntary status as a psychiatric patient."[12]

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

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

Patients admitted on a voluntary basis to a psychiatric facility are free to leave the facility if they choose, even against medical advice.

The *MHA* provides that admission may be refused where the "immediate needs in the case of the proposed patient are such that hospitalization is not urgent or necessary".[13] Similarly, the *MHA* is clear that a patient "shall be discharged" when they are no longer in need of the observation, care and treatment provided in a psychiatric facility.[14] The admission or discharge decision remains dependent on the clinical judgment of a physician. Since psychiatric facilities are also public hospitals, they are governed by the *Public Hospitals Act* ("*PHA*"),[15] and the regulations enacted under that statute. Under the *PHA*, no person shall be admitted to a hospital as a patient except on the order or under the authority of a physician who is a member of the medical staff.[16]

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

In that context, if following discharge, or admission refusal, the person subsequently harms themself, or another person, the admission and/or discharge assessment will be looked at closely.[17] Under subsection 34(1) of the *MHA*, "a patient shall be discharged from a psychiatric facility, when they are no longer in need of the observation, care and treatment provided therein". Determining whether a patient requires the kind of observation, care and treatment afforded by an in-patient admission to a psychiatric facility, is a matter of clinical judgment.

Generally, in order to meet the standard of care, mental health care professionals must exercise reasonable care and skill and take into consideration all relevant factors in arriving at a clinical judgment regarding admission or discharge

12 *Daugherty v Stall,* 2002 CanLII 2657 (ONSC) at para 21; recently cited with approval in *Alta v. Desarkar,* 2017 ONSC 4325.

13 *MHA*, *supra* note 1, s.11.

14 *Ibid*, s. 34(1).

15 *Public Hospitals Act*, RSO 1990, c P40 ("*PHA*").

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

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

decisions.[18] The law recognizes that psychiatry is an inexact science, in part because it is dependent on what patients are willing to disclose about their thoughts and feelings. However, an accepted standard of care generally requires that all reasonable steps be taken to reduce the risk of foreseeable harm. That said, not all persons who arrive on the doorstep of a psychiatric facility must be admitted[19] and not all risks associated with discharge can be mitigated.

Informal Patients

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

In practice, the informal admission process is used mostly for persons under the age of 16. Incapable adolescents who are 12 years of age or older, but less than 16, who have been admitted as informal patients, have the right to apply to the CCB to determine whether they need observation, care and treatment in a psychiatric facility.[20] Incapable persons who are older than 16 have the right to object to or refuse an informal admission to a psychiatric facility, as noted above. The patient may demonstrate their objection to being admitted informally by attempting to elope or by statements that they want to go home. The CCB has held that patients should be informed of the SDM's decision to admit them informally, so that they may exercise their right to object to the admission if they wish to do so, and further, this discussion should be noted in the patient's chart.[21]

Where the informal patient is objecting to being in hospital or where they require restraint or detention on a regular basis to safely manage their mental condition, their attending physician should consider whether the patient meets the criteria for involuntary admission, which includes a finding that the patient is not suitable for admission or continuation as an informal or voluntary patient.[22]

In weighing whether a patient could be admitted informally or involuntarily, the CCB recently noted the distinction between a safety device and restraint. In *Re BR*, the Board considered evidence that an involuntarily detained patient required the use of a wheelchair with a lap belt, for the purpose of preventing the patient from getting up independently and injuring themself. The Board was not clear on whether the lap belt was a safety device, rather than restraint, and gave greater

18 *Haines v Bellissimo* (1977), 18 OR (2d) 177 (HCJ), at 190 – 191, cited in Richard D. Schneider (as he then was), *Annotated Ontario Mental Health Statutes*, 4th ed. (Toronto: Irwin Law, 2007) at para. 7.

19 *MHA*, *supra* note 1, s. 11.

20 *MHA*, *supra* note 1, s 13 (Form 25). Such applications may be made every three months by the patient. There is a "deemed" application every six months (s. 13(2)).

21 In *Re CA, 2012 CanLII 47912 (ON CCB).* the CCB rescinded a fourth certificate of involuntary admission (Form 4) for a patient who, at the outset of her admission, had been admitted informally. The CCB held that the patient was not properly admitted as an informal patient, since she was over the age of 16 and the evidence demonstrated that she objected to being admitted to a psychiatric facility. Relying on the decision of *Daugherty v Stall*, *supra* note 8, the CCB stated that the patient should have been informed expressly of her informal admission, so that she could exercise her right to object if she wished to do so. The CCB commented that there was no notice to CA of her status as an informal. Ultimately, the CCB rescinded the fourth certificate of renewal, since the patient was neither an informal nor a voluntary patient at the time the physician changed her status to involuntary, pursuant to section 19 of the *MHA*.

22 *MHA*, *supra* note 1 ss 20(1.1)(f), 20(5)(b). See also s. 14 of the *MHA* which provides that "nothing in this Act authorizes a psychiatric facility to detain or to restrain an informal or voluntary patient." Many CCB decisions have interpreted section 14 as a prohibition on the restraint of informal or voluntary patients, necessitating the admission of a psychiatric patient on an involuntary basis where ongoing use of restraint is necessary: see for example, *Re W*, 2006 CarswellOnt 9390 at 44-45, *Re B,* 2009 CanLII 7422 (ON CCB) and *Re JO,* 2022 CanLII 106507 (ON CCB). However, see *S.M.T. v Abouelnasr,* 2008 CanLII 14550 (ONSC), where the court concluded that restraint, for the purpose of administering treatment, may be considered a treatment, as it is done for a health-related purpose. The Court concluded that the provisions of the *HCCA* that allow for an incapable patient to be treated pursuant to substitute consent, and where necessary, to be restrained in order to do so, did not violate the Charter, due to the procedural safeguards built into the *HCCA*.

weight to the fact that the patient could not be discharged safely to the community. The CCB found that if informally or voluntarily admitted, the patient was likely to attempt to leave the hospital and in doing so, would inadvertently suffer physical impairment as a result.[23] That said, other CCB decisions have interpreted section 14 of the *MHA* as a prohibition on the restraint of informal or voluntary patients, necessitating the admission of a psychiatric patient on an involuntary basis where ongoing use of restraint is necessary.[24]

3. Form 1: Criteria for Application for Psychiatric Assessment

In most cases, the path to an involuntary admission begins with an Application for Psychiatric Assessment ("Form 1"). The physician who makes such an application need not be a psychiatrist; however, the physician must have personally examined the person within the past seven days prior to completing the application.[25] In addition to their own observations, the physician is entitled to rely on the reports of others about the person, but the physician must distinguish between the two and document accordingly. There is no requirement that the examination take place in hospital. In practice, such examinations often take place in emergency departments and may take place in a physician's office in the community, or via videoconference or telephone.[26]

The statutory authority for a Form 1 assessment is found in section 15 of the *MHA*. The sections set out the criteria that must be met before a Form 1 may be completed. These tests, which are addressed in more detail below, have come to be known as "Box A" and "Box B" criteria as that is how they are set out on the approved Form 1.

"Box A"

Box A is known as the "serious harm test" and is derived from the language of subsection 15(1). Where a physician examines a person and has reasonable cause to believe that the person,

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

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

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

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

(a) Serious bodily harm to the person;

(b) Serious bodily harm to another person; **or**

(c) Serious physical impairment of the person,

the physician may apply in the prescribed form for a psychiatric assessment of the person.

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

23 *Re BR*, 2022 CanLII 7534 (ON CCB)

24 *Re B*, 2009 CanLII 7422 (ON CCB)

25 *MHA*, *supra* note 1, s 15(2).

26 For more on privacy issues related to telehealth and virtual care, please see Chapter 7, at page 7-12.

"Box B"

Box B is known as the "future harm test" and is derived from the language of subsection 15(1.1). Like Box A criteria, the Box B criteria require the physician to have personally examined the person, and formed a reasonable belief that the person:

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

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

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

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

(b) 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**

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

the physician may make application in the prescribed form for a psychiatric assessment of the person.[27]

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

A Form 1 takes effect on the date that it is signed by the physician, and that must be within seven days of the physician's last examination of the person who is subject of the application.[28] Once signed, the Form 1 is effective for seven days and provides authority for any person to take the person to a psychiatric facility where they may be detained, restrained, observed and examined for no more than 72 hours.[29]

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

The *MHA* imposes an obligation on the attending physician of the person who is subject of a Form 1 assessment to provide the person with written notice that sets out the reason for the detention and the fact that the person has the right to retain and instruct counsel without delay.[30] This written notice is typically given in a Form 42. Recent CCB case law suggests that the attending physician is required to provide 'notice', by way of a Form 42, once the patient's detention begins at the psychiatric facility. The physician who issues the Form 1, if not in a psychiatric facility, is not required to deliver a Form 42. Consideration may be given to whether the physician should advise the patient that they have executed a Form 1, depending on the circumstances. When detention begins at the psychiatric facility, the attending physician is required to deliver a Form 42 at that time.[31]

Courts and CCB panels have held that where a patient has not been provided with a Form 42, or other written notice of their detention, the statutory requirements of the *MHA* have not been met and the person's detention is unlawful.[32]

Given that a patient may challenge the validity of the Form 1 to undermine a subsequent certificate of involuntary admission if

27 *MHA*, *supra* note 1, s. 15(1.1).

28 *Ibid*, s 15(4).

29 *Ibid*, s 15(5).

30 *Ibid*, ss 38.1(1), 38.1(2).

31 *H.A.(Re)*, 2020 CanLII 88250 (ON CCB), where the CCB panel clarified that a Form 42 must be delivered promptly upon the commencement of detention, but not necessarily promptly upon the Form 1 being signed.

32 *R v Webers*, [1994] OJ No 2767 (Ont Ct Gen Div); followed in *SSR (Re)*, 2008 CanLII 15889 (ON CCB).

the written notice is not delivered to the patient, it is prudent practice to ensure that the date and time notice is delivered to the patient is noted by the physician on the Form 1, in the space provided for that purpose. Many hospitals also retain a copy of the notice that was delivered to the patient and file it with the Form 1 on the clinical chart. Most hospitals continue to use the Form 42 to provide notice.[33]

4. Other Routes to Assess Persons at Risk of Harm

Form 2

In addition to a physician's application for psychiatric assessment (Form 1), any person can appear before a justice of the peace and provide sworn information that there is a person within the jurisdiction of the justice, who meets either the Box A or Box B criteria outlined above. After considering that information, the justice of the peace may issue an order in the prescribed form for the examination of the person by a physician.[34]

This section gives rise to a "Form 2" application. It is sometimes used by concerned family members but may also be resorted to by other persons who have come into contact with a person who they believe requires mental health care. The *General Regulation* enacted under the *MHA* states that for the purposes of this type of order, the "information on oath" that is brought before the justice of the peace may be oral or written information, and may include documents and other materials relevant to the justice's determination as to whether the criteria are met.[35]

The Form 2 order is directed to the police in the same locality where the justice has jurisdiction and provides authority to the police to take the person named in the order into custody "forthwith" to an "appropriate place" where the person may be detained for examination by a physician.[36] For the purposes of this section and also section 17 discussed below, the place to which people are most often taken is a hospital emergency department.[37] However, the *MHA* terminology of "appropriate place" confers discretion to have the person examined in a physician's office or other facility, if need be. It is common for the physician's Form 2 examination to result in a Form 1 application for psychiatric assessment.

Police Apprehension

Section 17 of the *MHA* provides police officers with authority, under certain circumstances, to take a person to an appropriate place for examination by a physician, where it would be "dangerous" to proceed to obtain a Form 2. In other words, the police officer may apprehend a person, without a Form or order, if the circumstances set out in section 17 are met. Section 17 provides that the police officer must have reasonable and probable grounds to believe that a person is acting or has acted in a "disorderly manner" and that the person meets the Box A criteria discussed above.[38]

Where a police officer takes a person in custody to a designated psychiatric facility for the purpose of a psychiatric assessment under the authority of the *MHA*, the police officer must remain at the facility and retain custody of the person until the psychiatric facility takes custody of them.[39] Pursuant to the *MHA*'s *General Regulation*, a decision by the facility to take custody of the person must be made as soon as is "reasonably possible". The *Regulation* also contemplates consultation between the police and the staff of the psychiatric facility who are responsible for deciding as to whether the facility will take custody of the person; it also requires the staff to promptly inform the police when the decision is made.

33 See for example, *C.B. v Sawadsky*, [2005] OJ No 3682 (SCJ) [*Sawadsky*] (confirmed on appeal 2006 CanLII 34259 (ONCA)). In this decision, the court considered a patient's claim that she had been unlawfully detained due to the physician's alleged failure to provide her with a Form 42, after he executed a Form 1. In that case, the physician had not noted on the Form 1 that the Form 42 had been delivered, nor was there a copy of the Form 42 on the chart. The trial judge ultimately accepted the physician's evidence that he had delivered the Form 42, as it was his normal practice to do so. The court preferred the physician's evidence over that of the plaintiff, who had alleged that the Form 42 had never been delivered.

34 *MHA*, *supra* note 1, s 16(1).

35 *General Regulation*, *supra* note 3, s 7.1.

36 *MHA*, *supra* note 1, ss 16(2), 16(3).

37 *Ibid*, s 18.

38 See Box A discussion above at page 3-5 regarding Form 1 Box A criteria. Note that section 17 of the MHA does not allow the police to rely on Box B criteria.

39 *MHA*, *supra* note 1, s 33 and *General Regulation*, *supra* note 3, s 7.2. Please note that section 33 simply refers to "a psychiatric facility", which is defined in the *MHA* to include all psychiatric facilities designated as such by the *MOHLTC* and arguably includes all facilities designated as Schedule 1 through 6. If police have brought a patient who appears to be suffering from a mental disorder to a hospital that is not a designated psychiatric facility, as contemplated by section 17 of the *MHA*, the hospital may wish to consider developing a practice analogous to those required under the *MHA*. See also text at footnote 43.

"Forthwith"

Section 18 of the *MHA* requires that where a physician is conducting an examination under section 16 (Form 2) or section 17 (police action), the examination "shall be conducted forthwith after receipt of the person at the place of examination".[40] The question of what is meant by "forthwith" often arises. In a 2005 decision, the Ontario Superior Court considered whether an examination conducted by a physician pursuant to a Form 2 was conducted "forthwith" when the physician completed the examination some two and a half hours after the person had been brought to the hospital by police.[41] The judge held that "it is difficult to determine precisely when an examination is conducted forthwith". In the circumstances of the case – a busy emergency room during the SARS outbreak where reasonable efforts were made to prioritize persons brought in under the *MHA* – the trial judge held that the patient had been examined forthwith.[42] We take that to mean in more general terms that "forthwith" means as soon as is reasonably possible.[43]

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

In certain circumstances, patients may also be taken to a psychiatric facility by judge's order. For example, where a person appears before a judge charged with or convicted of an offence, and the judge has reason to believe that the person suffers from a mental disorder, the judge may order the person to attend a psychiatric facility for examination.[44] The order is issued as a Form 6. Or, if the person is already in custody and appears before a judge charged with an offence, and the judge has reason to believe the person suffers from a mental disorder, the judge may order that the person be admitted as a patient to a psychiatric facility for a period of not more than two months.[45] That order may be issued as a Form 8.

When relying on either section 21 (out of custody accused) or section 22 (in custody accused), the judge must confirm with the "senior physician" of the psychiatric facility – defined as the physician responsible for clinical services in the psychiatric facility, otherwise known as the Psychiatrist in Chief – that the services of the psychiatric facility are available to the person named in the order.[46] Also, in each of these circumstances, the "senior physician" in the facility has the responsibility of writing a report to the judge as to the mental condition of the person ordered examined or admitted.

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

The criteria for Involuntary Admission are set out in subsection 20(5) (Box A) and subsection 20(1.1) (Box B). These criteria are also set out on the face of the Form 3. The attending physician[47] must have observed and examined the person who is either the subject of an application for assessment under section 15 (Form 1), or the subject of an order under section 32 (Form 13 Order to admit a person coming into Ontario), in order to make one of the following decisions:

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

(b) To admit the person as an informal or voluntary patient if the attending physician is of the opinion that the person is suffering from mental disorder of such a nature or quality that the person is in need of

40 *MHA*, *ibid.*, s 18.

41 *Sawadsky*, *supra* note 33 at paras 41–42.

42 *Ibid*.

43 Police officers have expressed frustration at waiting times in busy emergency rooms, where there is a delay in medical staff availability to examine a person brought in on a Form 2 or under section 17, prior to determining whether or not the person will become the subject of a Form 1. Police officers are required to maintain custody of the person until the psychiatric facility is willing to assume custody of the patient, under section 33 of the *MHA*, as noted above. Depending upon the person's willingness to remain at the facility and cooperate with the examination, the transfer of custody from the police to the facility may take place prior to a Form 1 being executed. However, the Form 1 once executed does provide a psychiatric facility with the authority to detain the patient for up to 72 hours. Psychiatric facilities should have practices and procedures to help facilitate communication between police and staff on this issue, as required by s. 7.2 of the *General Regulation* under the *MHA*, *supra* note 3. Facilities such as community hospitals should also address this issue. See Chapter 8 for further comments.

44 *MHA*, *supra* note 1.

45 *Ibid*, s 22(1).

46 *Ibid*, s 23.

47 *Ibid*, s 1 – "attending physician" means a "physician to whom responsibility for the observation, care and treatment of a patient has been assigned".

the treatment provided in a psychiatric facility and suitable for admission as an informal or voluntary patient; or

(c) To admit the person as an involuntary patient by completing and filing with the OIC a certificate of involuntary admission if the attending physician is of the opinion that the conditions set out in the subsection 20(1.1) or 20(5) are met.[48]

The attending physician may also change the status of an informal or voluntary patient to that of an involuntary patient if the "Box A" or "Box B" criteria, discussed below are met.[49]

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

The physician, under **Box A criteria**, is required to admit the patient on an involuntary basis if they form the opinion that:

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

  (i) Serious bodily harm to the patient,

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

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

(b) The patient is not suitable for admission or continuation as an informal or voluntary patient.[50]

Essentially, the criteria require that the symptoms of the mental disorder from which the person is suffering are such that there is a likelihood that serious bodily harm will result either to the patient or to another person, or that the patient will experience serious physical impairment, unless the patient is detained in a psychiatric facility. The CCB, in matters where the patient has challenged their involuntary admission under this criteria, has emphasized that "likelihood" means probability, and that a mere "possibility is not sufficient".[51] In other words, it must be demonstrated to the CCB that it is more likely than not that the person's mental disorder will result in one of the enumerated harms.

The term "serious bodily harm" is not defined in the *MHA*. CCB panels have interpreted this phrase on various occasions. For example, several panels have defined serious bodily harm as that which is "more than merely trifling".[52] This definition echoes the *Criminal Code of Canada* ("*Criminal Code*"), definition of bodily harm: "any hurt or injury that interferes with the health or comfort of a person that is more than merely transient or trifling."[53]

In the criminal law context, the Supreme Court of Canada has defined "serious bodily harm" to mean "any hurt or injury, whether physical or psychological, that interferes in a substantial way with the physical or psychological integrity, health or well-being of the complainant".[54] Several CCB panels have adopted the Supreme Court of Canada's definition of serious bodily harm as fitting for the criteria for involuntary admission, including the fact that serious psychological harm may amount to serious bodily harm.[55]

In considering whether the criteria for involuntary admission is made out at the time of the hearing, evidence of past harm to the patient or to other persons may be relevant. Examples of past harm, inflicted while the patient was suffering from a mental disorder, that the CCB has found to constitute "serious bodily harm" include throwing a cosmetic jar at a nurse resulting in the nurse's nose being broken,[56] or assaulting a stranger when the stranger refused to provide a cigarette.[57]

48 *Ibid*, s 22(1).

49 *Ibid*, s 19.

50 *Ibid*, s 20(5).

51 See for example, *Re W.J.K.*, 2007 CanLII 32896 (ON CCB) ; see also *Re RO*, 2017 CanLII 72314 (ON CCB).

52 See for example, *Re WS*, 2020 CanLII 83866 (ON CCB); citing *Re A.B.*, 2003 CanLII 54969 (ON CCB), citing *Dayday v MacEwan* (1987), 62 OR (2nd) 588 (Ont Dist Ct); see also *Re A.J.*, 2016 CanLII 31949 (ON CCB).

53 *Criminal Code of Canada*, RSC, 1985, c C 46 [CC], s 2.

54 *R v McCraw*, [1991] 3 SCR 72 at 81.

55 *Re J.S.*, 2004 CanLII 46818 (ON CCB); see also *Baig v Maldeniya*, 2019 ONSC 2045, a decision of the Ontario Superior Court where the court dismissed an appeal and upheld the CCB panel's decision wherein they found that the patient had caused serious bodily harm to his sister in the form of psychological harm.

56 *Re A*, 2005 CanLII 12686 (ON CCB).

57 *Re J.H.*, 2007 CanLII 49468 (ON CCB) ; see also *Re AG*, 2016 CanLII 31931 (ON CCB) where the CCB confirmed a risk of serious bodily harm to others based on evidence of the patient's multiple altercations with family members and hospital staff since becoming psychotic. For example, the patient had lunged at her sister and had to be held back at that time; the patient pushed her brother to the ground resulting in a shoulder injury that required medical treatment; on admission, the patient was in possession of a knife and told her nurse she would use the knife to defend herself, if needed; and finally, two months prior to the hearing, the patient kicked at staff while wearing hiking boots.

However, the criterion is whether serious bodily harm is likely to occur in the future if the person is not involuntarily admitted. It is arguable that this does not necessarily require evidence of past actual harm.[58]

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

> Serious physical impairment refers to unintentional harm to the patient that includes the outcome of a range of potential risky activities that the patient would likely undertake. These risky activities must occur as a result of the mental disorder and arise after discharge. The range of risky activities that could result in serious physical impairment to the patient might include the outcome of failing to take medication where such conduct is predictable and physically harmful. Socially inappropriate conduct that would create hostility and violence in others towards the patient might also be connected with the mental disorder and create serious physical impairment through fights or other unreasonably risky behaviour.[59]

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

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

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

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

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

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

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

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

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

58 In *D.S. v. Youssoufian*, 2021 ONSC 5929, an appeal of a CCB decision, the Ontario Superior Court weighed past evidence of harm as against more current evidence showing harm to the patient was not likely. The court held that the panel of the CCB relied on insufficient evidence to conclude that involuntary status due to the patient's mental disorder was necessary to protect the patient from likely serious physical impairment. The court ordered the patient's release from hospital.

59 *Re M.T.*, 2004 CanLII 56536 (ON CCB). See also *Re J.S., supra* note 47, where the CCB found that the patient's delusions incorporated symptoms that arose from physical illnesses including basal cell carcinoma. The CCB found that due to the patient's delusional belief that the basal cell carcinoma lesion was caused by snake eggs, he was unable to arrange and consent to appropriate medical care and was thus likely to suffer serious physical impairment if he did not remain in the custody of a psychiatric facility. See also *Re AH*, 2016 CanLII 32104 (ON CCB), where the CCB found that a patient was at risk of serious physical impairment where their mental disorder would cause them to engage in sexually provocative, intrusive, and impulsive behaviour which would put them at risk of retaliation from others, thereby putting their physical health at risk. In *Alta v. Desarkar* (2017 ONSC 4325) the court accepted the risk of retaliation as a relevant consideration to the issue of whether the patient will suffer "serious physical impairment" if the patient does not remain in hospital.

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

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

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

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

In terms of the type of harms that will likely result from the patient's untreated mental disorder, we have discussed serious bodily harm and serious physical impairment above in relation to Box A criteria. How have CCBs interpreted "substantial" mental or physical deterioration? Many panels of the CCB have considered "substantial" to have its plain dictionary meaning, that is, "considerable, consequential, ample, significant, and sizeable".[60] When considering whether a patient is likely to suffer substantial mental deterioration if not detained in a psychiatric facility, the CCB has accepted evidence of non-compliance with treatment, resulting in a re-emergence of symptoms that disrupt the person's ability to function in the community. For example, in one case before the CCB, the patient had become non-compliant with treatment in the community and had started to exhibit grandiose behaviours and signs of thought disorder; the CCB accepted that the patient was at risk of substantial mental deterioration. The patient was also at risk of physical deterioration as she suffered from a number of medical conditions, such as diabetes and hypertension, which would worsen when her mental disorder interfered with her ability to manage treatment of those physical conditions.[61]

In another case, the CCB did not accept the attending physician's conclusion, that the re-emergence of symptoms of the patient's chronic paranoid schizophrenia would lead to substantial physical deterioration of the patient, once discharged and living in the community, in the absence of evidence of this having happened in the past. In part, the CCB relied on evidence that the patient was part of a large family, with siblings who lived within close proximity and who would intervene to prevent physical deterioration. However, the CCB accepted that the patient would suffer substantial mental deterioration if not in the custody of psychiatric facility and so confirmed the certificate on that ground.[62]

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

In cases before the CCB that have considered both criteria, it appears that the CCB considers that deterioration implies a process of decline that becomes more serious as time goes on; whereas impairment suggests harm where the cause is more temporally finite – injuries, for example, that arise as a result of a physical assault linked to the patient's mental

60 See for example, , *NM (Re),* 2022 CanLII 7517 (ON CCB);see also *Re C.P.,* 2003 CanLII 15613 (ON CCB); which was cited with approval by the court in the case of *T. S. v. O'Dea*, 2004 CanLII 12720 (ON SC), and more recently in *Thompson and Empowerment Council v. Ontario*, 2013 ONSC 5392 (CanLII)

61 *Re K.S.*, 2008 CanLII 32289 (ON CCB) ["*Re. K.S.*"]; see also *Re D.M.*, 2011 CanLII 70531, where the CCB found that there was evidence that the patient would suffer both substantial physical deterioration and serious physical impairment if not admitted as an involuntary patient. DM suffered from both schizophrenia and end stage Huntington's disease, a neurological condition that affected the patient's mental and physical status. See also *Re CE*, 2016 CanLII 26077 (ON CCB), where the CCB found that the patient's mental disorder, when untreated, resulted in her becoming disorganized which made her unable to use good judgment to avoid risky behaviour such as threatening behaviour, resisting arrest, going outside in extremely cold weather without coat and boots and abusing substances in the company of people who would leave her helpless and unable to fend for herself. Accordingly, her mental disorder put the patient at risk of substantial physical deterioration.

62 *Re M.R.*, 2008 CanLII 28422 (ON CCB).

disorder.[63] For instance, serious physical impairment could arise out of medication non-compliance, which results in socially inappropriate conduct that creates hostility and violence in others towards the patient, leading to fights and other unreasonably risky behaviours.[64] Wandering in traffic might be another example.[65] At the same time, medication noncompliance can also lead to substantial mental or physical deterioration, the symptoms of which increase in significance over time.

It is clear from the CCB decisions that the impairment or deterioration must be linked to the mental disorder. It is often a matter of judgment and argument whether physical harm is characterized as serious physical impairment or substantial physical or mental deterioration. The results experienced by the patient could potentially meet any one or all three of the criteria. In one case recently before the CCB, the patient suffered from alcoholic amnestic disorder and psychogenic polydipsia. Unless closely supervised, the patient would consume excessive amounts of fluid which would lead to electrolyte imbalance and serious cardiac problems. The patient also suffered from high blood pressure and diabetes, and could not remember to take medications for these illnesses. In this case, the CCB confirmed the certificate on the ground that the patient would likely suffer serious physical impairment if not detained in a psychiatric facility.[66] However, it is arguable that this patient's outcomes might also have satisfied the criteria of substantial physical or mental deterioration.

Box A versus Box B: What's the difference?

The essential differences between Box A and Box B criteria are the Box B requirements that:

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

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

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

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

63 *Re J.J.*, 2005 CanLII 57872 (ON CCB).

64 *Re M.T.*, 2004 CanLII 56536 (ON CCB); see also: *SS (Re),* 2022 CanLII 1067537 (ON CCB), where the CCB considered serious physical impairment to be unintentional self-harm often through an inability to care for oneself, adopting the definition in *Re M.T.*

65 *Re K.S.*, *supra* note 62.

66 *Re R.K.*, 2008 CanLII 8769 (ON CCB).

Procedural Aspects of Involuntary Admission

Regardless of the criteria under which a patient is involuntarily admitted, the physician's decision to involuntarily admit a patient triggers certain further events designed to safeguard the patient's liberty interests and ensure that the involuntary admission is in compliance with the *MHA*. For example, it is essential that the physician, who completes the Form 1 assessment leading to a Form 3, is a different physician than the one who applied for the Form 1 assessment. This builds in a second medical opinion, as it were, into the process. Further, the attending physician must file the certificate with the OIC, and the OIC or their delegate, must review the certificate for compliance with the *MHA*.[67]

If the OIC or delegate finds that the certificate has not been completed in accordance with the criteria set out in the *MHA*, the attending physician **must** be informed and **must** re-examine the patient to either release or admit the patient according to the criteria. If this is not done in a timely fashion, the OIC or delegate is required to release the patient.[68] Accordingly, many psychiatric facilities address this statutory obligation in their OIC policy to ensure that any deficiencies in a Form can be addressed after hours and over the weekend, where necessary. The pending expiry of the period of detention of the prior certificate creates some urgency to address any deficiency in the certificate of involuntary admission.

A patient's involuntary admission may be renewed or continued if the patient continues to meet the criteria when assessed prior to the expiry of a certificate. The criteria relied on at the time of a renewal or continuation of depend on the patient's condition at that time; they do not have to be the same criteria as when the patient was first admitted.

In December 2015, the *MHA* was amended to provide for certificates of continuation to be used following the expiry of a third certificate of renewal, provided that the patient still meets the criteria for involuntary admission. A first and any subsequent certificate of continuation is also valid for a period of three months.[69]

The authority of certificates of involuntary admission are time limited. [70]

Form 3	Certificate of Involuntary Admission	For not more than two (2) weeks
1st Form 4	Certificate of Renewal	For not more than one (1) additional month
2nd Form 4	Certificate of Renewal	For not more than two (2) additional months
3rd Form 4	Certificate of Renewal	For not more than three (3) additional months
Form 4A	Certificate of Continuation	For not more than three (3) additional months for a first or subsequent certificate of continuation

67 *MHA*, *supra* note 1, s 20(8).

68 *Ibid*. See for example, *RJ v. Zalan* 2016 ONSC 2337, at paras 49-53, 73 and 93-99 ("*RJ v. Zalan*"), where the patient appealed a decision by a panel of the CCB confirming their involuntary status on three grounds, including that the physician failed to file a "properly" completed first Certificate of Involuntary Admission with the OIC. The physician was asked to correct the form, following its review by the OIC, but filed the completed form after the 72-hour period of the Form 1 had elapsed. The Ontario Superior Court upheld the CCB panel's finding that the error on the form was trifling and the error did not affect the substance of the form as it was clear that the physician was satisfied the criteria for involuntary admission were met. The patient was provided timely rights advice and her rights were protected despite the initial minor error on the form.

69 *Ibid,* s. 20 (4)(iv); Bill 122 amended the *MHA* to provide for certificates of continuation and to provide the CCB with expanded authority on the review of Form 4As to make certain prescribed orders in section 41.1 of the *MHA*. These amendments responded to the Ontario Court of Appeal finding that the ability to indefinitely renew a Form 4, without the CCB having the authority to more actively supervise the conditions under which long term involuntary patients were detained, violated the section 7 of the Canadian *Charter of Rights and Freedoms*: *P.S. v. Ontario,* 2014 ONCA 900. Panels of the CCB continue to rely upon the decision of *P.S. v. Ontario*, 2014 ONCA 900 to interpret the Board's powers to make orders pursuant to section 41.1(1); see for example *Re BT*, 2022 CanLII 88726 (ON CCB). See Chapter 5 for further discussion on the expanded powers of the CCB at Form 4A hearings and the implications of those powers for psychiatric facilities.

70 *MHA*, *supra* note 1, s 20(4).

As with the first certificate of involuntary admission, all certificates of renewal or continuation must be filed with, and reviewed by the OIC.[71]

The patient has the right to apply to the CCB for a review of whether the criteria for issuing, renewing or continuing a certificate of involuntary admission are met. Even if the patient chooses not to apply to the CCB, the *MHA* provides that on the completion of the first certificate of continuation and on the completion of every fourth certificate of continuation thereafter, the CCB must convene a hearing to determine whether the criteria for involuntary admission continue to be met.[72] At a hearing to review a certificate of continuation, the 2015 *MHA* amendments provided the CCB with authority to make certain orders regarding how the patient is to be managed, if it also confirms the certificate of continuation.[73] A patient is entitled to apply to the CCB for section 41.1 orders on the completion of a first Form 4A and on the completion of any subsequent Form 4A, provided that it has been 12 months since the most recent application for section 41.1 orders, unless there has been a material change in circumstances. These section 41.1 orders are discussed below.

Where the CCB is reviewing a patient's involuntary status and is advised that a physician has completed a notice of intention to issue a Community Treatment Order (CTO) for a patient, the CCB has the discretion to take this into consideration when reviewing the patient's status. When the CCB is reviewing a certificate of continuation, it must take the intention to issue a CTO into account and may make an order to rescind a certificate of continuation effective on the issuance of a CTO.[74]

If the period of detention on the certificate has expired, the involuntary patient who was the subject of the expired certificate is deemed to be an informal or voluntary patient.[75] If prior to the expiry of the certificate, the patient's condition has improved such that the criteria of involuntary admission are no longer met, the patient may be continued as an informal or voluntary patient upon the completion of the appropriate form (Form 5) by the attending physician.[76]

The attending physician should discuss the prospect of becoming a voluntary patient with the patient, and document the discussion indicating the patient's willingness to remain at the facility on a voluntary basis in the patient's chart.

Applications for orders from the CCB in context of Form 4A reviews

When the CCB convenes a hearing to review a certificate of continuation, the 2015 amendments to the *MHA* provide the CCB with the authority to make the following orders only if it confirms a certificate of continuation:

- transfer a patient to another psychiatric facility (as discussed below in the following section, the Form 19 application for transfer to another psychiatric facility has been revoked and replaced with the power to order a transfer within the context of a review of a certificate of continuation),
- place the patient on a leave of absence on the advice of a physician[77] (this is in the context of a certificate of continuation review hearing; section 27, which deals with the authority of the OIC to place patients on a leave of absence at any time on the recommendation of the patient's attending physician, remains unchanged),
- direct the OIC to provide to the patient:
  - a different security level;
  - different privileges within or outside of the psychiatric facility;
  - supervised or unsupervised access to the community; or

71 *Ibid*, s 20(8).

72 *Ibid*, s 39(4).

73 *Ibid*, s. 41.1(1).

74 *Ibid*, s 41(2.1)(2.2) and (3.1).

75 *Ibid*, s 20(6).

76 *Ibid*, s 20(7).

77 In *Re K.T.*, 2016 CanLII 46420, the CCB conducted a Form 4A review hearing where the patient requested an order for leaves of absence. The CCB found that since no physician had made a recommendation for the leave of absence, the CCB was precluded from making the order. In other words, the patient cannot succeed in obtaining an order for a leave of absence without the recommendation of a physician.

– certain vocational, interpretive, or rehabilitative services.[78]

In making an order under section 41.1 of the *MHA*, the CCB is required to take into account the following factors:

- the safety of the public;
- the ability of the psychiatric facility or facilities to manage and provide care for the patient and others;
- the mental condition of the patient;
- the re-integration of the patient in to society;
- the other needs of the patient; and
- any limitations on the patient's liberty should be the least restrictive limitations that are commensurate with the circumstances requiring the patient's involuntary detention.[79]

In addition to taking into account the above factors when making any section 41.1 orders, the CCB is also required to take into account the following additional factors when considering whether to order the patient transferred to another psychiatric facility:

- whether the transfer is in the patient's best interests;
- whether the transfer is likely to improve the patient's condition or well-being; and
- an attempt has been made to transfer the patient under section 29 of the *MHA* (where so advised by the attending physician, the OIC may make arrangements with the OIC of another psychiatric facility to transfer the patient there).[80]

The CCB is not permitted to make an order directing or requiring a physician to provide any psychiatric or other treatment to the patient; or to direct or require that the patient submit to such treatment. Treatment decisions therefore remain subject to the independent clinical opinion of the treating psychiatrist, subject to the patient's capacity to consent to or refuse treatment, and subject to the law governing substitute consent where the patient is found incapable with respect to treatment decisions, as provided for in the *HCCA*.

A patient is entitled to apply to the CCB for section 41.1 orders upon the completion of a first Form 4A and on the completion of any subsequent Form 4A, provided that the patient, or someone acting on the patient's behalf, has not made another application in the previous 12 months, unless there has been a material change in circumstance.[81]

Where it has confirmed a certificate of continuation, the CCB may make any section 41.1 orders on its own motion or in response to an application for orders brought by a patient, or in response to an application for transfer brought by the Minister, the OIC of the psychiatric facility where the patient is currently detained, or the patient. Where the CCB is contemplating making an order on its own motion, it must provide notice to the statutory parties to a certificate of continuation hearing, namely:

78 *MHA, supra* note 1, s 41.1(2); see also *Re K.T., supra* note 77, where the patient requested an order for vocational training in construction, or if that was not available, other vocational training, if the facility could accommodate it. The CCB declined to make the order, finding the specific program requested unavailable, there were no specifics with respect to other programs, and the patient's attending physician was not recommending any program. The CCB specifically held that their ruling at the time of the hearing did not preclude the patient from advancing a similar request in the future if certain factors changed: i.e., the doctor recommended it, the nature of the request was more specific and the patient became more engaged. The patient also requested a different security level plus supervised and unsupervised access to the community. The Board applied the factors and granted an order that would allow the patient to have a specified amount of supervised access to the community at the discretion of the OIC. See also BV (Re), 2022 CanLII 87774 (ON CCB), for a recent example of how the Board will apply the s. 41.1(3) factors to the evidence. In this case, the patient sought four different types of section 41.1 orders, including: (1) unsupervised leave of absence; (2) increase in off-ward passes; (3) vocational support to pursue various courses; and (4) a transfer to another facility (in the alternative, if Orders 1 through 3 were not granted). The Board declined to make any of the requested Orders.

79 *Ibid*, s. 41.1(3). See also *Re AS* 2016 CanLII 68761 (ON CCB) where the CCB held that it should not make a s. 41.1 order unless it is satisfied that the substance of the proposed order would not be made in the course of normal practice. In other words, the panel should not intervene unless it is satisfied that the clinical team would not otherwise take steps to restrict a patient's liberty as little as the patient's condition permits. This is an important practical point which should be addressed by the representative of the patient's current facility in evidence at the hearing.

80 *Ibid*, s 41.1(10). See *Re PR*, 2016 CanLII 58681 (ON CCB), where the CCB confirmed the factors specific to a request for a transfer order are to be considered in addition to the general factors set out in s. 41.1(3); in other words both sets of factors are to be considered.

81 *Ibid*., s 39(6).

- the patient;
- the attending physician;
- the OIC of the psychiatric facility where the patient is currently detained; and
- if the order involves the transfer of the patient to another psychiatric facility, the OIC of that facility, the Minister (if the Minister has informed the CCB that they intend to participate as a party), and such other persons as the CCB may specify.

The CCB may also order an independent assessment of the patient, if that is necessary to determine whether any section 41.1 order is appropriate.[82]

Section 41.1 orders may be made subject to the discretion of the OIC of the psychiatric facility (section 41.1(9)), much like the discretion that may be exercised by the person in charge under Ontario Review Board ("ORB") dispositions regarding forensic patients detained or supervised under Part XX.1 of the *Criminal Code*. Section 41.1 orders are considered binding. However, the amendments also contemplate that clinical circumstances may change such that the OIC cannot safely follow an order. For example, **if** after having received an order from the CCB to assign the patient a specific security level within a hospital, the OIC does not follow that order, but instead takes "temporary action" contrary to the order, **then** the OIC must apply to the CCB to vary or cancel the order, if the temporary action exceeds a period of seven days.

Review of "temporary action" to depart from a CCB order

Section 41.2 of *MHA* contemplates that such "temporary action" may be taken where the patient poses a serious risk of bodily harm to the patient or others, such that it is not feasible to carry out the order. This is akin to a Restriction of Liberties hearing which is required for forensic patients detained or supervised under Review Board dispositions, where the person in charge of the forensic psychiatric facility "significantly restricts" the liberties of the patient for a period greater than seven days. In the CCB context, there are notice requirements to the patient and to the Board, which again are similar to the notice requirements for restriction of liberties for forensic patients under the ORB.

82 *Ibid*., s 41.1(8).

Applications for Transfer of an Involuntary Patient from one hospital to another (Forms 51 or 52)

In 2010, the *MHA* was amended to provide the CCB with jurisdiction to conduct "transfer hearings", which consider applications for the transfer of an involuntary patient from one psychiatric facility to another. As noted above, in December 2015, the *MHA* was again amended to provide the CCB with the authority to consider an application for transfer in the context of a Form 4A review hearing. The previous section of the *MHA* that dealt with the CCB's authority to hear a transfer application was repealed.

The 2015 *MHA* amendments provide the CCB with the authority to make certain orders when it reviews an involuntary patient's first certificate of continuation, including an order for the transfer of the patient to another psychiatric facility (*MHA*, ss 41.1(1) and 41(2)(para 1)).[83] An application for transfer of an involuntary patient may be brought by:

- the involuntary patient or someone acting on the patient's behalf (*MHA*, s 39(6), Form 51), or
- the OIC of the psychiatric facility where the patient is currently detained (*MHA*, s. 39(8), Form 52), or,
- the Minister or Deputy Minister of Health (*MHA*, s 39(8), Form 52).

Regardless of who brings the application, notice must be given to the OIC of the potential receiving facility named in the application. Where an application for transfer is brought by a party other than the patient, a transfer order cannot be made over the patient's objection.

After the first application for transfer is finally disposed of, an involuntary patient or someone acting on the patient's behalf may not bring a second application sooner than 12 months later, unless the CCB is satisfied that there has been a material change in circumstances.[84] The same "material change in circumstances" criteria governs whether the CCB will hear a patient's application for review of a finding of incapacity with respect to the same or similar treatment sooner than six months after the final disposition of an earlier application.[85]

83 We discuss the 2015 *MHA* amendments and the case law interpreting them in the paragraphs that follow.

84 *MHA*, *supra* note 1, s 39(7).

85 *HCCA*, *supra* note 6, s 32(5) and (6).

As set out in subsection 42(2) of the *MHA*, the parties to a certificate of continuation hearing where a transfer application is in issue include:

- the patient who is the subject of the transfer application;
- the attending physician;
- the OIC of the current facility where the patient is involuntarily detained; and
- the OIC of the proposed receiving facility (the facility named in the application).

The Minister of Health is entitled to notice of the application and to be heard at the hearing; the Minister may also apply for party status at the hearing.[86] The CCB will convene a pre-hearing conference where a Form 51 or 52 application for transfer has been made, in order to set a date for the hearing and to canvas the likely issues and position of the parties in advance, and to make orders, if necessary, for the disclosure of documents. The proposed receiving facility should obtain clinical notes and records on the patient, and seek an opportunity to speak with members of the patient's current clinical team, in order to gain as much information as possible to evaluate whether the receiving facility can safely provide care and treatment for the patient.

All of the parties to the hearing have an opportunity to present evidence for, or against, the potential transfer.

The CCB also applies the balance of probabilities[87] standard to the evidence presented at a hearing about a potential transfer. When the OIC of a psychiatric facility receives notice that an involuntary patient at another facility has applied to the CCB for a transfer to that facility, they will also be notified of a pre-hearing teleconference. At the pre-hearing conference, the parties will be asked to set out the issues that are expected to arise at the hearing, including whether or not there has been an attempt to transfer the patient under s. 29 of the *MHA*.

In order to prepare for the hearing itself, staff at the potential receiving or transferee facility, will need to have access to the patient's clinical records in order to determine whether or not the patient can be safely managed at the proposed receiving hospital. Examples of records that may be helpful to forming an opinion about the transfer include: recent physician progress notes; recent nursing and allied health professional notes; any critical or notable incident reports for the last three to four months; any CCB clinical summaries prepared for recent CCB hearings or for the transfer hearing by the patient's attending physician. This can be canvassed at the pre-hearing teleconference, where the patient's lawyer should be in a position to confirm whether their client intends to proceed with the transfer application.

If the patient does not object to the proposed transfer, the CCB may order the patient transferred to the psychiatric facility named in the application. In determining whether to grant a transfer, the CCB is required to consider certain factors, along with the other factors it must consider when making any order under section 41.1 generally. We address the general factors first (as set out in section 41.1(3)), followed by the factors specific to transfer orders (s. 41.1(10)).

(A) General factors for section 41.1 orders and how they may apply to transfer orders

(a) the safety of the public;[88]

The CCB will consider the risks posed by the patient and whether the receiving facility is equipped to manage these risks.[89]

86 *MHA*, *supra* note 1, ss 42(2) and (3).

87 The "balance of probabilities" refers to a standard of proof that requires the trier of fact to weigh the evidence before it and decide whether it is more likely than not a certain proposition has been established – i.e., whether a patient is incapable with respect to treatment decisions or meets the criteria for involuntary admission, or should be transferred to another psychiatric facility.

88 *MHA*, *supra* note 1, s 41.1(3) para 1; as noted above at note 78, this is one of the factors the CCB shall consider when making any order under s 41.1 s.

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

(b) the ability of the psychiatric facility or facilities to manage and provide care for patient and others;[90]

In transfer application cases under section 39.2 of the MHA before it was repealed, the CCB considered whether the potential receiving facility offers the particular type of care and treatment required by the patient. For example, where a patient requires a highly secure setting, the CCB will consider whether the potential receiving facility can provide the required level of security.[91] *The CCB has not considered bed availability at this stage of the hearing, preferring instead to take bed availability into account when addressing the timing of the transfer, if it is ultimately granted.*[92]

(c) the mental condition of the patient and the other needs of the patient;[93]

(d) the transfer is likely to foster the patient's reintegration into society;[94]

This factor requires a comparative analysis as to which facility is more likely to offer the patient opportunities to reintegrate into the community, based on, for example, evidence relating to accessibility to community placement services and supports.[95] *The CCB will consider the patient's readiness for community reintegration in deciding how heavily to weigh this factor.*[96]

(e) the other needs of the patient;[97]

(f) any limitations on the patient's liberty should be the least restrictive limitations that are commensurate with the circumstances requiring the patient's involuntary detention;[98]

(B) Factors specific to transfer requests

(a) the transfer is in the patient's best interests;[99]

The CCB will consider all of the factors that would advance the patient's interests and will balance competing interests, some of which may be better addressed at the current facility, while others may be better addressed at the potential receiving facility.

Examples of such interests include: access to family and support networks and the likelihood that access will actually increase or decrease at a new facility; the facility which provides the best

90 *MHA, supra* note 1, s 41.1(3), para 2. Although the factors to be considered on a transfer hearing have been abbreviated in section 41.1(10), because an order for transfer is an order made under section 41.1, the CCB should arguably take into account the other factors it is required to consider on s. 41.1 orders generally, as set out in section 41.1(3). In *Re M.H.,* 2016 CanLII 58686 (ON CCB), the CCB considered a request for transfer and a request for an order for certain privileges. On the transfer, the CCB expressly considered the three factors set out in s. 41.1(10), but then went on to consider the other factors set out in s. 41.1(3). Although it is difficult to discern, it appears that the CCB considered the general factors only in relation to the request for certain privileges. In the result the CCB did not order the transfer or the requested privileges.

91 *Re GJ*, *supra* note 89. In this case, the patient, G.J., requested a transfer from a secure facility to a less secure facility. G.J. gave evidence at the hearing and admitted that he did not have any concrete information about the less secure facility, but believed that it was a "better place" than his current facility. At the time of the hearing, the patient was untreated and had recently assaulted a co-patient. The more secure facility had a secure perimeter within which patients could walk, whereas the evidence demonstrated that at the less secure facility, the patient would likely be confined to a five bed unit for intense observation and treatment. The CCB determined that the less secure facility could not provide for the patient's care and treatment as it lacked a maximum secure unit. The CCB considered other factors as well, and ultimately, the patient's application was denied.

92 *Nyranne Martin and Kendra Naidoo, "Consent and Capacity Board Transfer Hearings: What Can Psychiatrists Expect?" OBA newsletter, Health Matters, 20: 1 (December 2010)*, citing *Re A.H.*, 2010 CanLII 51099 (ON CCB), *Re G.J.*, *supra* note 89 and *Re B.M.*, 2010 CanLII 59640 (ON CCB).

93 *MHA supra* note1, s 41.1(3) paras 3 and 5 respectively; these are new factors that the CCB is required to consider when making any order under s. 41.1; along with considering the safety of the public and the reintegration of the patient into society, these two factors are identical to the factors that the ORB must consider when making a disposition concerning a not criminally responsible or unfit to stand trial, mentally-disordered offender.

94 *MHA*, *supra* note 1, s 41.1(3), para 4.

95 *Re S.R.*, 2011 CanLII 32706 (ON CCB).

96 *Re G.J.*, *supra* note 89.

97 *MHA*, *supra* note 1, s. 41.1(3) para 5. This factor echoes the requirement imposed on the ORB to consider the other needs of the patient when crafting the least onerous and least restrictive disposition. The "other needs" in that context can include proximity to family or required medical treatment, for example. See *Re BT*, 2022 CAnLII 88726 (ON CCB), where the Board ordered the patient's requested transfer, over the objection of the receiving psychiatric facility, given that the receiving facility was located where family access, cultural access, community access and community supports were more likely available to the patient. This finding was aligned with both the patient's reintegration and the other needs of the patient.

98 The least restrictive factor echoes the requirement imposed on the ORB to fashion the necessary and appropriate, or least onerous and least restrictive disposition for forensic psychiatric patients.

99 *MHA*, *supra* note 1, s 41.1(10)(a).

access to specialized treatment, or programming specific to the patient's needs; active therapeutic engagement with current hospital staff as compared to the effect of new therapeutic relationships at the potential receiving hospital.[100]

(b) the transfer is likely to improve the patient's condition or well-being;[101]

Evidence of the patient's clinical condition will be considered, including how well the patient adapts to change and whether the transfer would likely precipitate a setback or improvement in the patient's mental condition. Often evidence on this factor will be similar to evidence considered under item c above.[102]

(c) and, an attempt has been made to transfer the patient under section 29 of the *MHA* (a transfer on the consent of the OIC of each facility).

The CCB will want to hear evidence of what efforts have been made to effect a transfer on a voluntary basis, pursuant to section 29 of the MHA.

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

If the CCB were to grant the application and order the patient transferred, the CCB may specify a period of time within which the transfer must be made. The receiving hospital is required to admit the patient within the specified period of time.[103] In the past, if a transfer order was appealed, a party to the appeal could bring a motion to the Court to have the transfer ordered stayed pending the appeal; the section providing for that motion has since been repealed.[104]

When the CCB orders the transfer of an involuntary patient to another psychiatric facility, the authority to detain the patient continues in force at the receiving psychiatric facility (*MHA*, section 41.1(11)). The certificate of continuation in force at the time of the transfer, together with any supporting Forms regarding rights advice and notice to the patient, the CCB decision confirming the criteria for involuntary admission and ordering the transfer, should be sent to the receiving facility while maintaining copies for the patient's health record at the sending facility. The *MHA* provides that the OIC may send a copy of the transferred patient's record of PHI to the OIC of the receiving facility (section 41.1(12)).

6. Leaves of Absence

The attending physician or the OIC (upon the advice of the attending physician) may place a patient on a leave of absence from the psychiatric facility for a designated period of not more than three months.[105] The OIC may specify terms and conditions with which both the attending physician and patient must comply during the leave of absence.[106]

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

As noted above, at a Form 4A review hearing where a certificate of continuation is confirmed, the 2015 *MHA* amendments provide the CCB with the authority to place a patient on a leave of absence for a designated period on the advice of a physician and may specify terms and conditions for the leave of absence. The physician and the patient must comply with the specified terms.[107]

100 *Re S.R.*, 2011 CanLII 32706 (ON CCB).

101 *MHA*, *supra* note 1, s 41.1(10(b).

102 *Re S.R.*, *supra* note 100. See also *Re S.W.*, 2010 CanLII 80303 (ON CCB).

103 *MHA*, *supra* note 1, s 41.1(14).

104 *Ibid*, former s. 48(13) was repealed by the Bill 122 amendments. While section 48(1) allows for a party to appeal a decision or order of the CCB, there is no provision allowing for the suspension of an order pending the determination of the appeal.

105 *Ibid*, ss. 27(1)-27(2).

106 *Ibid*, s. 27(3).

107 *Ibid*, s 41.1(2), para 2 and s 41.1(13).

Absences without Authorization

If an involuntary patient or patient who is otherwise detained in the psychiatric facility (i.e., the forensic patient subject to detention under a ORB disposition) is absent from the facility without permission, the OIC may issue an order for the return of the patient to the facility.[108] The order is authority for a police officer, or any other person to whom it is issued, to apprehend the patient and return them either to the psychiatric facility from which the patient left; or to the facility nearest to where the patient was apprehended. This order is a Form 9 and is valid for one month after the absence becomes known to the OIC.[109]

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

7. Community Treatment Orders

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

As set out in the legislation itself, the purpose of CTOs is to get patients out of hospital and into the community where they may be provided with community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility.[110] The legislation goes on to provide that CTOs are directed at developing a comprehensive community treatment plan ("CTP") for the person who, "as a result of his or her serious mental disorder", experiences the following pattern:

> *The person is admitted to a psychiatric facility where his or her condition is usually stabilized; after being released from the facility, the person often stops the treatment or care and supervision; the person's condition changes and, as a result, the person must be re-admitted to a psychiatric facility.*[111]

Criteria for Issuing a CTO

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

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

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

(c) The physician has examined the person in the 72 hours prior to entering into the CTP,[112] and the physician has formed the opinion, based on the examination, and any other relevant facts communicated to the physician that:

108 *Ibid*, s 28.

109 *Ibid.*

110 *Ibid*, s 33.1(3).

111 *Ibid*.

112 In *S.S. v. Kantor*, 2016 ONSC 1444, the court held that a CTP is entered into when the persons who are signatories to the CTP have signed or executed the CTP, such that they are legally bound by the CTP. The 72 hour limitation between the issuing physician examining the patient and entering into the CTP is to ensure that "the medical findings are fresh and that the treatment plan is relevant to the condition of the patient" (citing *Singh v. DeSouza* [2009] O.J. No. 3490 at para 26). In *Kantor*, several service providers and the SDM signed the CTP more than 72 hours after the physician examined the patient and the court held that the CTO was invalid. This last aspect of the court's decision was overturned on appeal. In *S.S. v. Kantor*, 2017 ONCA 828, the Ontario Court of Appeal held that to impose a 72 hour limitation on participants to the CTP other than the physician may well frustrate the purpose of this procedural requirement, which is to ensure that the physician's medical findings are fresh, as cited above.

(i) The person is suffering from mental disorder such that they need continuing treatment or care and continuing supervision while living in the community,

(ii) The person meets the criteria for completion of a Form 1 application for psychiatric assessment on either Box A or Box B criteria if the person is not currently a patient in a psychiatric facility,

(iii) If the person does not receive continuing treatment or care and continuing supervision while living in the community, they are likely because of mental disorder to cause serious bodily harm to himself or herself, or to another person or to suffer substantial mental or physical deterioration of the person or to suffer serious physical impairment of the person,

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

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

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

(e) The physician is satisfied that the person subject to the CTO and their SDM if any, have consulted with a rights adviser and have been advised of their legal rights; and

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

Note that under criterion (e), in order for the CTO to be valid, the issuing physician must be satisfied that the person and their SDM have consulted with a rights adviser and been advised of their legal rights. This particular criterion may be waived if the person subject to the CTO refuses to consult with a rights adviser, and the rights adviser so informs the physician.[113] There are two other exceptions to the requirement to provide rights advice to an SDM or the person subject to the CTO:

- if, on the renewal of a CTO, the SDM for the person is the Public Guardian and Trustee ("PGT"), rights advice need not be provided to the PGT; and
- if a rights adviser has made best efforts[114] to locate the person subject to the CTO and the person cannot be located, then rights advice need not be provided.[115]

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

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

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

113 *MHA*, *supra* note 1, s 33.1 (5)

114 In Re LB, 2016 CanLII 26068 (ON CCB), the CCB revoked a CTO where there was a 19-day delay in providing rights advice to the patient subject to the CTO. The CCB held: "The failure to comply with section 33.1 (10) *MHA* and Regulation 741 was prejudicial to LB, who was left in an uncertain position. The imposition of a CTO on a person constitutes a significant curtailment of his or her freedom. The procedural requirements in the *MHA* are important safeguards for the protection of vulnerable persons and must be applied rigorously. LB had the right to receive timely notice that his CTO had been implemented…the failure to provide prompt rights advice to LB justified the revocation of the community treatment order." In another case, the CCB held that a 15-day delay in delivering Rights Advice was prompt (Re RD, 2018 CanLII 64014 (ON CCB). In Re DM, 2023 CanLII 16624 (ON CCB), the CCB commented that the issue of what constituted prompt rights advice in CTO cases had been considered in at least 67 reported CCB decisions, with inconsistent results. In *Salem v Kantor*, 2016 ONSC 7130 (CanLII), the Court considered whether a 17-day delay in the provision of Rights Advice was "prompt." In *Salem*, there was considerable evidence offered by the physician as to why Rights Advice was delayed and Court did not revoke the CTO on that ground. In practice, where there has been a delay in providing rights advice, health practitioners should be prepared to offer evidence as to the reasons for the delay.

115 *MHA*, *supra* note 1, s 33.1(5)

with the physician who issued or renewed the CTO or with any other health practitioner or person named in the CTP, at the times and places as scheduled.[116]

Similar to the Form 1 application, a person who is being considered for, or who is subject to a CTO, and the SDM, if any, have a right to retain and instruct counsel, and to be informed of that right.[117] The issuing physician must provide the person with a Notice of Intention to Issue or Renew a CTO (Form 49).

The Form 49 also contains a notice to the patient that they have the right to retain and instruct counsel and to receive rights advice.

When do CTOs Expire?

Generally, a CTO expires six months after it is made, unless it is renewed or terminated early at the person's or SDM's request, in which case the physician who issued or renewed the order shall review the person's condition to see if they are able to continue to live in the community without the CTO.[118]

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

The former CTO provisions could be interpreted to mean that the return of the patient under an Order of Examination automatically terminated the CTO, which required the physician to issue another CTO "from scratch". CCB policy in the past stated that a CTO was not automatically terminated when an order for examination was issued. The 2010 amendments to the *MHA* clarify this situation and provides that a CTO is not terminated by the issuance of an Order for Examination [119]

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

The remaining ground for early termination of a CTO is withdrawal of consent. As noted above, the criteria for issuing the CTO, and specifically clause (f) of this criteria, require that the CTP be consented to by the patient or their SDM, in accordance with the principles governing consent to treatment in the *HCCA*. It is a foundational principle in consent and capacity law that consent to treatment may be withdrawn at any time. Thus, the person or the SDM may withdraw their consent to the CTP at any time, but must provide the physician who issued or renewed the order with notice of intention to withdraw the consent.120 Upon receipt of the notice of intention, the physician is required to review the person's condition within 72 hours to determine whether the person is able to live in the community without being subject to the CTO.[121] If the person refuses to submit to the examination, the physician may issue an order for examination, provided that the physician has reasonable cause to believe that the person is suffering from a mental disorder such that they need continuing treatment or care and continuing supervision while living in the community.[122]

CCB Review of CTOs

Similar to an involuntary admission, the person who is the subject of a CTO has the right to apply to the CCB to review whether or not the criteria for issuing or renewing the CTO are met as at the time of the hearing.[123] Persons subject to a CTO are entitled to apply to the CCB when the CTO is issued and when it is renewed. If the person chooses not to apply for a review, there is an automatic, mandatory review of the CTO by the CCB when it is renewed for the second time and upon every second renewal after that.[124] The issuing physician has an obligation to notify the CCB upon the second renewal. The patient does not have the right to waive that review.[125]

116 *Ibid.*, s 33.1 (6)

117 *Ibid*, s 33.1(8).

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

119 *Ibid.*, s 33.3(1.1)

120 *Ibid*, s 33.4.

121 *Ibid*, s 33.4(2).

122 *Ibid.*, s 33.4(3)

123 *Ibid*, ss 39.1(1), 39.1(6).

124 *Ibid*, s 39.1(3).

125 *Ibid*, s 39.1(5).

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

In a January 2011 decision, the CCB revoked a CTO where the physician was unable to satisfy the requirement that he had examined the patient within the 72-hour period before entering into the CTP. The evidence demonstrated that the physician had examined the patient at 1:30 p.m. on December 17, 2010, and the CTP was entered into at 3:00 p.m. on December 20, 2010: 1.5 hours outside of the 72-hour period prescribed by s. 33.1(4)(c). The CCB ruled that time requirement must be strictly construed; it had no discretion to "ignore a statutory requirement" on the basis that the requirement had almost been met.[126]

In October 2022, the CCB upheld a CTO for a patient with a history of schizoaffective disorder-bipolar subtype, substance-induced psychosis and polysubstance dependence. In the five years preceding the CTO, the patient had been admitted to hospital on eleven occasions for extreme agitation, aggression, paranoia, grandiosity and poor impulse control. In confirming that the patient met all the criteria, the panel of the CCB reiterated the purpose of a CTO as set out in section 33.1 of the *MHA*, stating that "[the patient] unfortunately experienced the "revolving door" pattern described [sic] for a number of years. In the panel's view, the prevention of this pattern by the use of a CTO in this case, exemplified the purpose of this legislative scheme." The CCB declined to exercise its discretion to revoke the CTO for vagueness, on the grounds that there was no evidence that the patient suffered any prejudice as a result of the typographical and other alleged errors on the CTP.[127]

A patient appealed an April 2020 decision of the CCB that confirmed the patient's CTO. On appeal, the patient argued that they were unable, due to the COVID-19 pandemic, to meet with the ACT team up to three times per week. The patient submitted that this treatment exposed them to a "heightened risk of contracting the virus by use of public transportation to attend appointments." While the patient had not led evidence before the CCB with respect to the impacts of the pandemic, the court considered the issue. The court held that it would have dismissed this ground of appeal on the basis that there was no evidence that "the ability of the health professionals to attend to the patient's care and treatment under the 2020 CTO and the 2020 CTP has been compromised by the public health requirements needed to address the pandemic, or that the Appellant was not able safely to be treated under the 2020 CTP because of the pandemic." The patient appealed the decision to the Court of Appeal. The Court of Appeal found no reason to interfere with the lower court's decision on this, and other grounds of appeal and the appeal was dismissed.[128]

Following the 2015 *MHA* amendments, when the CCB meets to review a Form 4A, the panel is required to take into account a physician's intention to issue a CTO if a notice of intention has been completed by the physician and may maintain the Form 4A but provide for it to be rescinded Form 4A upon the issuance of the CTO.[129]

8. Assessment of Capacity to Manage Property

The right to manage one's own property is considered a fundamental right of autonomous individuals that can only be removed by operation of law. Usually, this happens according to the provisions of the *Substitute Decisions Act* ("SDA"),[130] which may result in an order of a judge, after a finding of incapacity by an assessor, or where the person has provided for the management of their property during a period of incapacity by granting a Power of Attorney for Property.[131] The right to manage one's property can also be removed pursuant to the *MHA*. The *MHA* applies where a patient is an inpatient in a psychiatric facility and a physician has assessed the patient and found them incapable of making decisions with respect to property.

126 *Re P*, 2011, CCB File Nos: OT-10-3804 and OT 10-3805 (ON CCB). See also *S.S. v. Kantor*, 2016 ONSC 1444, *supra* note 102. There are exceptions to this general principle. The decision in S.S. v. Kantor, 2016 ONSC 1444 was further appealed. On appeal, the Court of Appeal allowed the appeal on the grounds that the date on which any person other than the examining physician signed the CTP is irrelevant. The Court of Appeal considered the purpose served by the procedural requirement and determined that the approach taken by the lower court to strictly interpret the requirement that all persons involved in the CTP including the physician sign the CTP within 72 hours would not further the purpose of the 72 hour requirement but rather, would frustrate this purpose. The appeal was allowed.

127 *Re AS*, 2022 CanLII 106536 (ON CCB).

128 *Re KM*, 2020 CanLII 33314 (ON CCB); see also *KM v. Banik*, 2020 ONSC 4829 and *K.M. v. Banik*, 2021 ONCA 481.

129 *MHA*, *supra* note 1, ss 41(2.1)(2.2) and (3.1).

130 *Substitute Decisions Act*, 1992, SO 1992 c 30.

131 *Re A.*, 2002 CanLII 6475 (ON CCB).

For persons who are patients in a psychiatric facility, the *MHA* requires that a physician must conduct a capacity assessment with regard to a patient's ability to manage their property, "forthwith upon the patient's admission to a psychiatric facility".[132] The mandatory language of the *MHA* indicates that the patient lacks the right to object to the assessment.

The *MHA* provides two exceptions that relieve a physician from the obligation to assess capacity to manage property: (1) where the physician has reasonable grounds to believe that a psychiatric patient has a continuing power of attorney with respect to the management of the patient's property, or (2) the patient's property is under guardianship under the *SDA*.[133]

Where a physician is required to assess the patient's capacity to manage property and determines that the patient is not capable of managing property, the physician is required to issue a certificate of incapacity (Form 21), and also to note the determination, with reasons, in the patient's record.[134] The OIC is required to transmit the certificate of incapacity to the PGT. Where there are circumstances such that the PGT should immediately assume management of the person's property, the OIC is required to notify the PGT as quickly as possible. If the OIC is absent, this duty of notification falls to the attending physician.[135] Further, the OIC has a duty to transmit "forthwith" a financial statement in the approved form to the PGT(Form 22).[136]

If the patient's capacity improves with treatment, the attending physician may, after examining the patient for the purpose of assessing capacity, cancel the certificate, in which case the OIC is required to transmit a notice of cancellation to the PGT, using Form 23.[137]

As the patient is approaching discharge from the psychiatric facility, the attending physician is required to examine him or her to determine whether the patient continues to be incapable, or has regained capacity, with respect to managing property. This examination must take place within the 21 days prior to discharge and, if the physician determines that the patient is not capable, the physician shall issue a notice of continuance in a Form 24, which the OIC must transmit to the PGT.[138]

A physician who issues a certificate of incapacity or notice of continuance must promptly advise both the patient and a rights advisor.[139] A physician can provide the patient verbal and written notice by handing them copies of the Form 21 and Form 22 along with a Form 33 (Notice to Patient). Patients have the right to challenge the attending physician's finding that they are incapable with respect to property by applying to the CCB. However, there are certain restrictions on the frequency of these applications - they cannot be made more frequently than once every six months.[140] When a patient applies to the CCB for such a review, the physician bears the burden of proving that the patient is incapable. The statutory test for capacity to manage property is set out in section 6 of the *SDA*: "A person is incapable of managing property if the person is not able to understand information that is relevant to making a decision in the management of their property, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."[141] Some CCB decisions have referred to a list of six questions that can assist in determining whether to uphold a physician's finding that the patient is incapable with respect to managing property.

132 *MHA*, *supra* note 1, s 54(1).

133 *Ibid*, s 54(6). See *JB v De Souza*, 2018 ONSC 4061, where the court held that the CCB has no jurisdiction to review the validity of a power of attorney document ("POA", as this can only be done through courts. This case also stands for the proposition that the physician should take the POA at face value. The court noted that a person may have legal capacity notwithstanding a mental illness, and that there are different legal tests of capacity in different contexts.

134 *Ibid*, ss 54(3)-54(4).

135 *Ibid*, s 54(5).

136 *MHA*, *supra* note 1, s 55.

137 *MHA, supra* note 1, s 56.

138 *Ibid*, ss 57, 58

139 *MHA*, *supra* note 1, s 59(1); See also *JS v. Gelber, supra note* 138, at paras 25 to 47: A delay in providing rights advice following the issuance of a Notice of Continuance just prior to discharge may be a breach of procedural fairness as it may adversely affect a patient's ability to commence an application to the CCB about the finding.

140 *MHA*, *supra* note 1, s 60(1)-(2)

141 See *Re R.H.*, 2007 CanLII 42448 (ON CCB); see also *JS v Gelber*, 2022 ONSC 2088, where the court found that a patient was denied procedural fairness when the CCB declined to take jurisdiction to hear his appeal of a Notice of Continuance because the patient had initiated the appeal during a subsequent admission to hospital instead of at the time it was initially issued (on discharge); the patient had left the hospital following the discharge order and prior to the rights advisor being able to contact him.

Questions to Consider for the Capacity to Manage Property

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

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

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

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

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

(f) Does the patient possess or have the capacity to learn the skills necessary to make the sort of decisions required in an estate of the size, nature and complexity that they possess?[142]

Note: it is improper to ground a finding of incapacity with respect to property on an assessment of what is in the best interests of the patient. Capable patients are entitled to make bad decisions.[143]

142 See *Re J.T.*, 2008 CanLII 5623 (ON CCB); see also Re EV, 2016 CanLII 31918 (ON CCB), where the CCB found that the symptoms of the patient's mental condition interfered with her ability to prioritize and appreciate what money was used for or should be used for and not appreciate the consequences for herself if she continued to spend excessively or impulsively or gave away her money. Accordingly, she was unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision about managing her property. See also:

143 *W.S. v. Dr. Bismil*, 2020 ONSC 17 at paras 25-27. The Court set aside the CCB's finding that a patient was incapable of managing her property on the basis of the physician's evidence that she was spending her money on alcohol. The court concluded that it was an error of law for the Board to characterize W.S.'s decision to "acquire alcohol" as "a decision in the management of her property" when there was no other evidence of issues with respect to property management. While W.S. may spend money to acquire alcohol, there was no corroborating evidence that this expenditure dissipated her property."

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

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

Where the patient's psychiatric condition requires the patient to remain in hospital after the medical problems have been resolved, or where the psychiatric condition becomes a substantial reason for admission, it may be necessary to consider whether the patient should be "admitted" as a psychiatric patient, as opposed to simply continuing as a medical patient with a psychiatric consult. In this case, the patient's category of admission – voluntary, informal or involuntary – will need to be considered.[144] It is only when the medical patient also becomes a psychiatric patient that the obligation to conduct an assessment of the patient's capacity to manage property is triggered.

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

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

In cases where patients have challenged their involuntary admission or a physician's finding that they are incapable with respect to managing property, the CCB and appeals courts have held that it is not enough to consider that a person is a voluntary psychiatric patient, simply because the person is in a public hospital, which is also designated as a psychiatric facility, and is being treated for various conditions, including mental health conditions.[145]

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

Finally, in some circumstances, consulting psychiatrists may be asked to conduct a financial capacity assessment by concerned family members. **There is no authority under the *MHA* for a consulting psychiatrist or attending physician to conduct a financial capacity assessment for anyone other than a "psychiatric patient" under the *MHA*.** Concerned family members may want to consider planning for an assessment under the *SDA*.

10. Duties of the "Officer in Charge"

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

The *MHA* imposes various duties on the OIC, and sometimes expressly allows for that duty to be delegated to another member of the psychiatric facility. Where the *MHA* does not expressly provide for the delegation of an OIC duty, it is permissible at law for the OIC to designate certain officers or members of the management staff to act in the shoes of the OIC, with the authority given to the OIC by the statute. Many hospitals have policies that address the duties of the OIC and who may act as their delegate or designate, as the case may be, and in what circumstances. It is important to ensure that duties are delegated appropriately and in a manner that complies with the *MHA*. Failure to discharge the duties imposed on the OIC, particularly in relation to the filing and review of certificates of involuntary admission, renewal or continuation, can result in the CCB exercising its discretion to rescind certificates, even though the substantive criteria for involuntary admission are met at the time of the hearing. Psychiatric facilities should therefore consider the nature of each OIC responsibility and how it can be effectively carried out.

145 See, for example, the foundational case on what is required before a patient can be considered to be a voluntary psychiatric patient: *Daugherty v Stall*, 2002 CanLII 2657 (ONSC), at paras. 21-23.

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

MHA Section	General Area	Duty of the Officer in Charge ("OIC")
s 19	Involuntary Admission Filing	Receipt of certificate of involuntary admission by the OIC or their designate; filed by the attending physician who changes the status of an informal or voluntary patient to involuntary.
s 20(1)(c)	Involuntary Admission Filing	Receipt of certificate of involuntary admission (Form 3) by the OIC or designate, to be filed by the attending physician who has completed Form an initial psychiatric assessment for involuntary admission (Form 1).
s 20(3)	Form 1 Expiry Release of Patient	When 72 hours has elapsed from the initiation of a Form 1 (or a Form 13), the OIC or their designate is required to release the person, unless the attending physician has already acted on the Form 1 (or 13) assessment by releasing the person, or admitting the person as either a voluntary, informal or involuntary patient. In the last case, the physician must have completed and filed the Form 3 with the OIC.
s 20(4)(b)(iii) and (iv) Reg 741, section 9	Involuntary Admission Renewal	Receipt of the certificates of renewal (Form 4) or continuation (Form 4A) at the mandated intervals. The OIC or their designate shall complete and transmit to the CCB a notice in Form 17 of the filing of a first certificate of continuation or subsequent fourth certificate of continuation respecting a patient. The Form 17 notifies the CCB of the need for a mandatory review.
s 20(8)	Involuntary Admission Review for Compliance with *MHA*	Following the filing of a certificate of involuntary admission, renewal or continuation (Forms 3, 4, or 4A), the OIC or delegate shall review the certification documents to ensure they have been completed in compliance with the criteria outlined in the *MHA*, and *if not*, the OIC shall inform the attending physician and unless the person is re-examined and released or admitted in accordance with section 20, the OIC shall release the person.
ss 26(2) and (3)	Withholding Communications To and From Patients	Where the OIC or delegate has reasonable cause to believe that the contents of a communication written by, or sent to, a patient meets certain criteria; the OIC or delegate may open and examine the contents of the communication and if the contents meet the criteria, may withhold it from delivery, unless the communication appears to be sent to or by, a lawyer, a member of the CCB, an elected member of the legislature, or the Ombudsman of Ontario.[146]
s 27	Leave of Absence	The OIC or their designate may, upon the advice of the attending physician, place a patient on a leave of absence from the psychiatric facility for a designated period of not more than three months, and prescribe terms and conditions for the leave. This section applies to patients admitted under the *MHA* and does not apply to forensic patients. LOAs for forensic patients must be authorized by the Review Board and included in the forensic patient's Review Board disposition.[147]

146 For more on privacy expectations regarding communications to and from a patient admitted to a psychiatric facility, please see Chapter 7, at page 7-7.

147 For more on types of dispositions by the ORB, please see Chapter 6, at page 6-13.

MHA Section	General Area	Duty of the Officer in Charge ("OIC")
s 28	Unauthorized Absence	Where a person who is subject to detention (i.e., under the *MHA* or *Criminal Code*) is absent without leave from a psychiatric facility, the OIC or their designate may issue an order to a police officer or any other person for the return of the person to the psychiatric facility where they were detained, or to the psychiatric facility nearest to the place where the person is apprehended.
Reg. 741, section 8	Unauthorized Absence Form 9	Under the *MHA* regulations, as soon as the OIC becomes aware of the unauthorized absence, the OIC or their delegate, is required to issue a Form 9 "forthwith" and notify the appropriate police service or law enforcement authority. Similarly, the OIC shall notify the authorities "forthwith" when the patient has returned, or the patient has not returned within one month, such that the patient is deemed to have been discharged.
s 29	OIC to OIC Inter-Facility Patient Transfer Form 10	The OIC or their designate, upon the advice of the attending physician, may transfer a patient to another psychiatric facility, if otherwise permitted by law and subject to arrangements being made with the OIC of the potential receiving facility. A Form 10 should be filled out where the patient is transferred. Where an involuntary patient is transferred under this section, the authority to detain the patient continues in force at the receiving psychiatric facility to which the patient is transferred. The OIC also has the authority under this section to transfer the patient's record of PHI to the OIC of the receiving hospital.
s 30	Transfer to Public Hospital	Upon the advice of the attending physician, the OIC or their designate, may transfer the patient to a public hospital for treatment that cannot be provided in the psychiatric facility. Where the patient is an involuntary patient, the period of involuntary detention continues and the administrator of the public hospital assumes the authority of the OIC under the *MHA* in respect of custody and control of the patient.
s 33.1(10)	Community Treatment Orders	The physician who issues or renews a CTO must ensure that a copy of the order, together with the community treatment plan (CTP), is given to the OIC, or their designate, where applicable.
s 35(2)	PHI Exceptions to the *Personal Health Information Protection Act* (PHIPA)	The OIC or their designate, may collect, use and disclose PHI about a patient, with or without the patient's consent, for the purposes of: • Examining, assessing, observing or detaining the patient in accordance with the *MHA* or; • Complying with Part XX.I of the *Criminal Code*, or an order or disposition made by the ORB with respect to forensic psychiatric patients.[148]

148 Where this section conflicts with the provisions of the *Personal Health Information Protection Act, the Mental Health A*ct prevails: section 34.1, *MHA*, *supra* Note 1. See Chapter 7 for further discussion.

MHA Section	General Area	Duty of the Officer in Charge ("OIC")
ss 35(3), (4.1), (5) and (6)	Mandatory Disclosures as Set Out in *MHA*	The OIC, or their designate, has a mandatory obligation to disclose a patient's record of PHI in certain circumstances: • To the CCB in relation to a proceeding before the CCB regarding the patient; • To a person who is entitled to have access to the record under section 83 of the *SDA*;[149] • Pursuant to a summons, order, direction, notice or similar requirement in respect of matter that may be in issue in a court of competent jurisdiction or under any Act, except where the attending physician states in writing that they are of the opinion that the disclosure is likely to result in harm to the treatment or recovery of the patient or is likely to result in injury to the mental condition of a third person, or bodily harm to a third person.
s 35 (4)	PHI Permissive Disclosures as Set Out in *MHA*	The OIC or their designate may disclose PHI to: • A physician who is considering issuing or renewing, or who has issued or renewed, a CTO; • A physician appointed to act as a substitute of the CTO's issuing physician; • Where requested by the issuing physician or a person named in the CTP, to another person named in a person's CTP; and • A prescribed person who is providing advocacy services to patients in prescribed circumstances, i.e., a rights adviser.
s 38(4)	Form 4A hearings	The OIC or their designate, must promptly give an involuntary patient a copy of the application and shall also promptly notify a rights advisor when • the OIC, or the Minister or Deputy Minister applies to the CCB to transfer the patient to another psychiatric facility under section 39(8) (Form 52), or • the OIC or their delegate, applies to the CCB to vary or cancel an order made under section 41.1 (Form 53).
s 38(6)	Notice to Informal Patient Who is between 12 – 16 of right of review	The OIC, or their designate, must promptly give an informal patient who is between the ages of 12 and 16 written notice of their entitlement to a hearing before the CCB. (First review possible after three months' admission; review mandatory upon the completion of six months from the date of the child's admission or last review before the CCB: section 13, *MHA*.)
s 39(3)	OIC right to review Form 3, 4 or 4A	The OIC may apply to the Board at any time to review a certificate of involuntary admission, renewal or continuation.
s 39(8)	OIC right to apply for transfer	The OIC may apply to the CCB, using a Form 52, to request that the Board make an order, under section 41.1(2), to transfer the patient to another psychiatric facility.

149 Section 83 of the *Substitute Decisions Act*, *supra* note 109, permits the PGT to have access to the clinical record for the purpose of an investigation into whether a person is experiencing serious adverse effects as a result of being incapable with respect to property (s 27, *SDA*) or personal care (s 62, *SDA*).

MHA Section	General Area	Duty of the Officer in Charge ("OIC")
s 39(9)	OIC right to apply to vary or cancel s 41.1 order	An OIC or their delegate, may apply to the CCB, using a Form 53, to vary or cancel an order made under section 41.1, if there has been a material change in circumstances, or if there has been a risk of serious bodily harm to the patient or another person, under section 41.2.
s 39(12)	OIC receipt of notice of application for transfer	Where there is an application to transfer the patient to another psychiatric facility, the CCB shall promptly notify the OIC, or their designate, of the potential receiving facility named in the application.
s 41.1(12)	Transfer of PHI records	When the CCB orders the patient transferred to another facility, the OIC of the facility from which the patient is transferred, may transfer the patient's record of PHI to the OIC of the receiving facility.
s 41.1(14)	Orders made by the CCB at a Form 4A hearing	If the CCB makes a section 41.1 order that directs the OIC to take certain actions with respect to an involuntary patient, the OIC has the responsibility to ensure that the orders are complied with, within the time frame and in the manner provided for in the order, unless the Board has expressly made the implementation of the order subject to the discretion of the OIC or their designate (section 41.1(9)).
s 41.2	Temporary action to depart from s 41.1 order	Despite the obligation to comply with section 41.1 order, the OIC or their delegate, may take a temporary action contrary to the order, if there is a risk of serious bodily harm to the patient or another person. Where such temporary action is taken, the OIC or their delegate must ensure that: • the action is clearly documented in the patient's record of PHI, • written notice of the temporary action is promptly delivered to the patient, and • if the temporary action exceeds a period of seven days, the OIC or delegate must promptly apply to the Board to vary or cancel the order (Form 53).
s 42(2)	Party to a Form 4A hearing	The OIC, or their designate, is automatically a party to a Form 4A hearing involving a patient subject to a Form 4A at their facility. The OIC is also a party to a Form 4A hearing that involves an application that an involuntary patient be transferred to their facility.
s 48(12)	Involuntary Admissions Under Appeal	The OIC, or their designate, receives a statement in writing (Form 7) from the attending physician that a patient who has appealed a decision of the CCB confirming their involuntary status, continues to meet the criteria, at the time period that would have applied for the renewal of the certificate under section 20(4). The OIC or designate, should also receive a Form 7, at the appropriate intervals, where the physician who was a party to the hearing, appeals a decision of the Board rescinding a certificate of involuntary admission and has obtained a court order extending the effectiveness of the appealed from certificate, pending the outcome of the appeal.

MHA Section	General Area	Duty of the Officer in Charge ("OIC")
s 50	Communication with CCB on patient's behalf	If a patient or another person on the patient's behalf provides to the OIC an application to the CCB under the *MHA* or any other Act, the OIC, or their designate, must transmit the application promptly to the CCB.
ss 54-58	Incapacity to Manage Property	Under this section, where a physician has determined that a patient is incapable with respect to managing their property, the OIC, or their designate, has certain obligations: • To transmit the Form 21, certificate of incapacity, to the PGT (s 54(4)); • To notify the PGT if there are circumstances requiring the PGT to immediately assume management of the person's property (s 54(5)); • To transmit a Form 22, financial statement, to the PGT (s 55); • To transmit the Form 23, notice of cancellation, to the PGT (s 56); • To transmit the Form 24, notice of continuance, to the PGT prior to discharge (s 57(2)); and • To transmit notice of the incapable patient's discharge to the PGT (s 58).
Reg. 741, s 7.2	Transfer of Custody from Police to Psychiatric Facility	When a person is taken to the psychiatric facility pursuant to a Form 2 or, under the police power of apprehension (section 17, *MHA*), the OIC, or their delegate, must ensure that a decision is made as soon as possible as to whether the facility will take custody of the person.

11. Rights Advice

While the *MHA* is recognized as remedial legislation aimed at facilitating the care and treatment of persons whose mental disorder has put them at risk of harm, it is still legislation that has the effect of removing or compromising rights which are considered fundamental in a free and democratic society.[150] Consequently, the *MHA* provides for the **mandatory delivery of rights advice in the following situations**:

- The attending physician has determined that a person meets the criteria for involuntary admission and has issued a certificate of involuntary admission, or a certificate of renewal or continuation, in respect of that person; or has determined that a voluntary or informal patient meets the criteria for an involuntary admission and changes the patient's status to that of an involuntary patient (Forms 3, 4 or 4A);[151]
- An adolescent who is 12 years of age or older but less than 16 years of age is admitted as an informal patient and has the right to apply to the CCB for a review of their status (every three months) (Form 27);[152]
- The attending physician has determined that a patient over the age of 14 in a psychiatric facility is incapable with respect to psychiatric treatment (Form 33);[153]
- The OIC, or their delegate, has determined that a patient who is over the age of 14 is incapable with respect to the collection, use of disclosure of their PHI (Form 33),154 unless certain exceptions apply;[155]

150 *P.S. v. Ontario*, 2014 ONCA 900 (CanLII), at paras 78 - 92.

151 *MHA*, *supra* note 1, ss 38(1), 38(3).

152 *Ibid*, ss. 38(6)-38(7).

153 *General Regulation*, *supra* note 3, s 15.

154 *Ibid*, s 15.1.

155 *Ibid*, s 15.1(5) – if the person has a guardian of the person or property, under the *Substitute Decisions Act*, 1992, who has authority to do so on the person's behalf; or the person as an attorney under a Power of Attorney for personal care, that waives the person's right to apply to the CCB to review a determination of incapacity in this respect; the person is in a coma, is unconscious or otherwise unable to communicate, despite reasonable efforts to understand the person; or the attending physician determines there is an emergency.

- The attending physician has determined that the patient is incapable with respect to managing their property, including finances, and has issued a certificate of incapacity to manage property (Form 21), or a certificate of continuation (Form 24);[156] and
- A physician is considering issuing or renewing a CTO (Form 49).[157]

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

Under the *General Regulation* of the *MHA*, only certain persons may be designated to perform the functions of a rights adviser. The person must be knowledgeable about the legislation and the rights of the patient to apply to the CCB under the *MHA*, and also under the other relevant legislation – the *HCCA* and the *PHIPA*. The rights adviser must also be knowledgeable about the CCB, and about how to obtain legal services and have the necessary communications skills to function effectively as a rights adviser. Finally, the person must obtain certification that they have successfully completed a Ministry-approved training course for rights advisers.[158] In many Ontario hospitals, members of the Psychiatric Patient Advocate Office ("PPAO") provide rights advice.[159]

Rights advisers are deemed to have met their obligations under the *MHA* and the *General Regulation* if they have done their best to explain the matter at issue in a manner that addresses the special needs of the person whose rights are in issue, even if the person ultimately does not understand the explanation.[160] The rights adviser is required to confirm that rights advice has been given by completing and filing a Form 50.[161]

There are boxes on the Form 50 that the rights advisor will check to indicate that an application has been made to the CCB. Health practitioners should not rely exclusively on this information – particularly if a box is not "ticked" and a patient indicates an intention to apply to the CCB. For more information about the various applications to the CCB, please see Appendix C.

156 *MHA*, *supra* note 1, s 59(2).

157 *Ibid*, s 33.1(4)(e); see also *General Regulation*, *supra* note 3, s 14.3 (in this case, both the patient and the substitute decision maker, if any, must be provided with rights advice see discussion above under section of this chapter discussing CTOs).

158 *General Regulation*, *supra* note 3, s. 14.2.

159 For more information on this organization, see Psychiatric Patient Advocate Office | ontario.ca

160 *General Regulation*, *supra* note 3, s 16(1).

161 *Ibid*, s 16(2).

CHAPTER

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

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

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

Sources of Authority to Detain and Restrain Patients at Risk of Harm to Themselves or Others

Generally, there are three sources of lawful authority under which a person may be detained in a hospital: the statutory authority provided to psychiatric facilities which is set out in the *Mental Health Act*[2] ("*MHA*"); the statutory authority provided in the *Health Care Consent Act*[3] ("*HCCA*") that allows a substitute decision maker ("SDM") to authorize the admission to hospital of an incapable person on whose behalf the SDM is consenting to treatment; and the common law.

In non-Schedule 1 facilities, the *Patient Restraint Minimization Act*[4], the common law and the use of restraint as part of, or ancillary to, treatment under the *HCCA* provide the legal framework for these policies. The related issue of "restraint" is addressed in more detail in Chapter 8.

Under the *Mental Health Act*

The authority to detain patients in psychiatric facilities is reviewed in detail in Chapter 3. Although the language of the *MHA* suggests that the powers of detention apply to all psychiatric facilities, those that are not required to provide in-patient services (i.e., non-Schedule 1 facilities) are "exempt from the application" of the parts of the *MHA* that provide psychiatric facilities with the authority to involuntarily detain patients.[5]

A physician at a non-Schedule 1 psychiatric facility or a community hospital who has assessed a patient and is of the opinion that the person meets the criteria for a psychiatric assessment as set out in section 15 of the *MHA* can issue a Form 1.[6] Issues with respect to the transfer of patients on a Form 1 will be addressed later in this chapter.

Under the *Health Care Consent Act*

A patient who is incapable with respect to treatment may be admitted to hospital as an "informal patient" if the admission is consented to by the patient's SDM and section 24 of the *HCCA* applies.[7] This section of the *HCCA* provides that:

1. Subject to subsection (2), an SDM who consents to a treatment on an incapable person's behalf may consent to the incapable person's admission to a hospital or psychiatric facility or to another health facility prescribed by the regulations, for the purpose of the treatment;
2. If the incapable person is 16 years of age or older and objects to being admitted to a psychiatric facility for treatment of a mental disorder, consent to their admission may be given only by,

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

2 *Mental Health Act*, RSO 1990 c M7 [*MHA*].

3 *Health Care Consent Act*, 1996, SO 1996, c2, Sched A [*HCCA*].

4 *Patient Restraints Minimization Act*, 2001 SO 2001 c 16.

5 General Regulation, RRO 1990, Reg 741, under *MHA*, s 7.

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

7 See *MHA*, *supra* note 2 at s 1. For examples of cases that involve informal admission under section 24 of the *HCCA* see: *Daugherty v Stall*, 2002 CanLII 2657 (ON SC) and *Re XN*, 2018 CanLII 141898 (ON CCB).

(a) their guardian of the person, if the guardian has authority to consent to the admission; or

(b) their attorney for personal care, if the power of attorney contains a provision authorizing the attorney to use force that is necessary and reasonable in the circumstances to admit the incapable person to the psychiatric facility and the provision is effective under subsection 50(1) of the *Substitute Decisions Act*, 1992.[8]

This allows a lawfully designated SDM consenting to a treatment on behalf of an incapable patient to also consent to their admission for the purpose of that specific treatment. The SDM can consent to the admission over the patient's objection, unless the admission is for treatment of a mental illness in a psychiatric facility and the patient is over 16 years of age. The SDM's authority in these circumstances includes the authority to detain and restrain the patient as may be necessary for the admission and treatment.

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

Common Law Duty

There is a common law duty of a health practitioner "to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others" that is acknowledged in section 7 of the *HCCA.*[9].

Caregivers have a common law duty to restrain or confine in emergency circumstances. The statutory criteria for a Form 1 requires consideration of factors similar to those that give rise to the common law duty.[10]

It is often suggested that the common law duty is confined in time to an immediate situation / emergency and that it cannot be extended indefinitely. Depending on the circumstances, it may be that the need to use restraint continues so long as the patient continues to meet the required level of risk to self or others.[11]

Scenario: A patient arrives at the emergency department of a non-Schedule 1 facility. The patient is triaged and awaiting assessment by the physician, who is not immediately available as they are attending to an emergency situation. The patient starts to act in a verbally and physically aggressive manner to both other patients and staff. The nurse immediately calls for security and other staff members. Together, they restrain the patient physically and take steps to have the physician attend as soon as possible. The physician orders medication as a chemical restraint. The patient remains in physical restraints for an hour, at which time he expresses a desire to leave the Hospital, as well as an intention to commit suicide. The physician assesses the patient and completes a Form 1, and steps are taken to arrange for a transfer to a Schedule 1 facility for psychiatric assessment. As a bed is not immediately available, the patient is waiting in the emergency department for 36 hours prior to transfer.

The Restraints: The hospital, heath care team and security guards were relying on the common law authority to restrain and detain the patient for the purpose of his transfer to a Schedule 1 facility for psychiatric assessment, treatment and care. In their clinical judgment, the level of risk to the patient, as well as to those around him, was such that this was a necessary step. They fulfilled their duty of care to their patient, and met their responsibilities to the others in the department and the community.

8 *HCCA*, *supra* note 3, s 24.

9 *HCCA*, *supra* note 3, s 7.

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

11 In *Re CD*, 2015 CanLII 94621 (ON CCB), the CCB explained the limitations of this common law duty as it relates to admission to a hospital: "The common law duty to restrain or confine a person who is unwilling to stay in the hospital is restricted to the circumstances set out in section 7 of the *HCCA*. Thus section 7 of the *HCCA* did not allow a person who suffered from mental disorder and was unwilling to stay in the hospital to be suitable for admission or continuation as an informal or involuntary patient."

2. Transferring Patients to a Schedule 1 Psychiatric Facility

Patients may be transferred to a Schedule 1 psychiatric facility for psychiatric assessment on a Form 1 or on a referral from a physician at the sending facility, if clinically appropriate.

Transferring Patients "Forthwith"

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

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

There are no hard and fast rules to determine what is meant by "as soon as reasonably possible". What a reviewing court will find "reasonable" will derive from its examination of all of the circumstances of the transfer in a particular case.

Consequently, it is important that the efforts to arrange a transfer to a Schedule 1 psychiatric facility, the care provided pending transfer, and the ongoing monitoring and assessment of the patient to determine that they continue to meet the criteria for a Form 1, and therefore for transfer to a psychiatric facility, be documented.

The time of acceptance by the receiving Schedule 1 psychiatric facility should also be documented, as well as the efforts made to transfer as soon as reasonably possible thereafter, again depending on whether the patient continues to require the psychiatric assessment and meets the Form 1 criteria. The documentation of these steps is important for determining whether the person was transferred as soon as reasonably possible, or "forthwith".

Detention While Awaiting Transfer

Where circumstances require that a person be detained pending transfer to a Schedule 1 psychiatric facility, it is appropriate for health practitioners to rely on the common law duty to detain patients where immediate action is necessary to restrain or confine the person in order to prevent serious bodily harm to them or others. In certain situations, non-Schedule 1 psychiatric facilities may admit patients pursuant with consent of their SDM, in accordance with section 24 of the *HCCA*.

When it is not possible to arrange a timely and appropriate transfer of to a Schedule 1 facility, and where the facility has an in-patient mental health unit, a patient's rights are arguably better respected if they are detained at the non-Schedule 1 facility and provided with both written notice of the detention with a Form 3 and rights advice,[12] including their right to counsel and the ability to challenge the detention with the usual review mechanisms.

This is a challenging area in which consideration must be given to balancing the risks of detaining or discharging a patient who does not want to stay in hospital for treatment and care, including psychiatric assessment. Non-Schedule 1 psychiatric facilities and community hospitals are advised to seek specific legal advice if they are in this situation.

Patient Transfers to Schedule 1 Facilities

Non-emergent transfers of patients are an issue in all areas of health care. Those working to facilitate the transfer of a patient from a non-Schedule 1 facility to a Schedule 1 facility for assessment need to consider the appropriate mode of transportation of the patient.

The security of the patient and others must be considered when determining the appropriate mode of transportation. This is determined case-by-case based on the clinical presentation and care needs of the patient. These decisions must take into account the reasonably foreseeable consequences of the decision.

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

If there is an issue in the course of transportation, one of the questions that will be asked in any review of the event is whether the outcome may have been avoided by using a different mode of transportation.

The physician completing a Form 1 should consider how the individual can be safely transferred given their physical and mental condition. The physician's determination of the appropriate mode of patient transport, as well as the basis for this decision, should be documented in the clinical record.

Please see Chapter 8 for more information on Patient Transfers.

CHAPTER

5 Consent and Capacity Board Hearings

1. Introduction to the Consent and Capacity Board and its Role

The Consent and Capacity Board ("CCB") is an independent provincial tribunal that has been established to provide "fair and accessible adjudication of consent and capacity issues, balancing the rights of vulnerable individuals with public safety."[1]

The CCB holds hearings under the *Health Care Consent Act* ("HCCA"), *Mental Health Act (*"MHA"), *Personal Health Information Protection Act* ("PHIPA"), *Substitute Decisions Act* ("SDA"), *Child Youth and Family Services Act* ("CYFSA"), and the *Mandatory Blood Testing Act* ("MBTA"). A complete list of the types of applications that may be made to the CCB can be found on the CCB website at http://www.ccboard.on.ca/scripts/english/forms/index.asp.

While the CCB has jurisdiction to hear applications under a range of legislation, health practitioners in mental health are most likely to be involved in those relating to capacity to consent to treatment (Form A), capacity to manage property (Form 18), involuntary admission (Form 16) and Community Treatment Orders (Form 48).[2] Appendix "C" sets out the applications that may be made to the CCB under the *HCCA* and *MHA*.

The CCB cannot give legal advice to health practitioners, patients or families. The CCB staff try to be helpful to those with whom they interact, but the provision of legal advice is beyond the scope of the assistance that they can provide.

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

2 According to the CCB's 2020 – 2021 annual report, the CCB received a total of 9917 applications, the majority of which related to review of involuntary status (43%), review of finding of incapacity (for treatment, admission or personal assistance services) (27%), and review of a Community Treatment Order (25%). The CCB convened over 6300 hearings province wide in the 2020/2021 fiscal year. http://www.ccboard.on.ca/english/publications/documents/CCB_Annual_Report_2020-21_FINAL_FINAL-s_%20SECURED.pdf

The Statutory Framework

When an application is received, the CCB will convene a hearing within seven days to review the issue.[3] This is a statutory requirement. On the consent of the parties, this timeline can be extended.[4]

The Board is scheduling all hearings to convene by either teleconference or videoconference (Zoom) and plans to increase the use of videoconference for hearings.[5]

At the hearing, a "panel" of the CCB will hear the evidence relevant to the application. The panel will be comprised of 1, 3 or 5 members of the Board.[6] A single member panel will be a lawyer member.[7] A three member panel will include a lawyer, a psychiatrist, physician or registered nurse, and a third person who is neither a lawyer nor a psychiatrist, physician or registered nurse.[8] A five-member panel will include the members who would sit on a three member panel, with an additional two members from within these categories.[9]

Following a hearing, the CCB will render a decision within one day.[10] The "decision" is a concise statement of the result, with no reasons. Any party can request written reasons for the decision within 30 days of the decision. If so, the written

3 *Health Care Consent Act*, SO 1996 c 2 Sch A at s 75 (1)(2) [*HCCA*].

4 *Ibid* at s 75(2).

5 The CCB has an Information Sheet on Videoconferencing Hearings, effective from April 11, 2022 <http://www.ccboard.on.ca/scripts/english/publications/videoconferenceinfosheet.asp>

6 *Ibid* at s 73(1); *Mental Health Act*, RSO 1990 c M7 at s 39 (13) [*MHA*].

7 *Ibid* at s 73(2). A single panel member hearing an application under the *Mandatory Blood Testing Act*, 2006, SO 2006 c 26, may have different qualifications.

8 *MHA*, *supra* note 5, s 39 (14)(1)(2). The composition of the panel is more specific for three and five member panels when the hearing relates to a 'Certificate of Continuation" (Form 4A). For these hearings, a lawyer, psychiatrist and a third person who is neither of these is required.

9 *Ibid* at s 39 (14)(3)(4). For a hearing relating to a Certificate of Continuation, the other two members must be a combination of a lawyer, psychiatrist or third person who is neither of these.

10 *HCCA*, *supra* note 3 at s 75(3).

reasons are to be provided within four business days of the request.[11] The CCB will also prepare written reasons in response to requests received more than 30 days after the decision, as long as the request is made within 12 months. Written reasons prepared in response to requests received outside of the 30 day window will be delivered in a timely manner but not necessarily within four business days.

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

Decisions available on CanLII use initials instead of full names for the names of patients, family members and other witnesses / companies that may identify the patient. Witnesses appearing in their professional capacity (health practitioners, physicians and capacity assessors) are referenced in posted decisions by their full names.[12]

CCB Rules of Practice

As an administrative tribunal, the CCB has established Rules of Practice and Policy Guidelines to govern its practice.[13] The purpose of these Rules is:

> ... to provide a just, fair, accessible and understandable process for parties to hearings before the Board. The Rules attempt to facilitate access to the Board; to promote respectful hearings; to promote consistency of process; to make hearings less adversarial, where appropriate; to make hearings as cost effective as possible for all those involved in Board hearings by ensuring their efficiency and timeliness; to avoid unnecessary length and delay of hearings; to assist the Board in fulfilling its statutory mandate; and in delivering a just and fair determination of the matters which come before it.[14]

A copy of the CCB's Rules can be found on its website at: http://www.ccboard.on.ca/english/legal/documents/CCB_Rules_of_Practice_June_19_2019__FINAL-S.pdf

CCB Policy Guidelines[15]

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

> ...identify guiding principles for adjudicating and managing care. While not binding on Board members, these Policies provide guidance to Board members and to the personnel supporting adjudicative functions with regard to the procedures that should be followed in particular situations before the Board.[16]

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

Policy Guideline No. 1 - Right to Apply When Certificate of Involuntary Status or Renewal is Renewed before the Board Renders a Decision.[17]

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

11 *Ibid* at s 75(4).

12 See 'Board's Reasons for Decisions' published on the CCB's website <http://www.ccboard.on.ca/scripts/english/legal/reasonsfordecisions.asp>

13 *Statutory Powers Procedure Act*, RSO 1990, c S 22, [*SPPA*].

14 CCB Rules of Practice, Rule 1.1, online: <http://www.ccboard.on.ca/english/legal/documents/CCB_Rules_of_Practice_June_19_2019__FINAL-S.pdf>

15 In the 2009 edition of this Toolkit, there was reference to a Policy #3 – Effect of a Form 47 (Order for Examination) on a CTO. This is no longer in effect.

16 CCB Policy Guidelines, online: <http://www.ccboard.on.ca/scripts/english/legal/policyguidelines.asp>.

17 *Ibid*. This policy is effective from March 31, 2022. <http://www.ccboard.on.ca/scripts/english/legal/policyguidelineno1.asp>

Policy Guideline No. 2 - Arranging Legal Counsel for a Person who is the subject of an application.[18]

This policy guideline sets out the principles and procedures to be followed when a person who is the subject of an application before the Board does not have legal counsel. These include, but are not limited to, directing Legal Aid Ontario to arrange for legal representation for the person, the person representing themselves, appointing *amicus curiae* (a friend of the Board)[19] and when to allow a lawyer to withdraw from representing a patient before the Board.

This policy guideline does not address situations in which a health practitioner or other party may require representation. It is strongly recommended that a health practitioner contact risk management within their organization and / or review legal resources that may be available to them if they have questions about representation relating to CCB applications.[20]

Policy Guideline No. 3 - Disclosure of An Applicant's Personal Information For Hearings Under The *Mandatory Blood Testing Act*.[21]

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

Policy Guideline No. 4 - Policy for Delivery of Documents to the Board and to Other Parties for CCB Hearings.[22]

This policy guideline deals with the delivery of documents in advance of a CCB hearing in order to make sure that documents are received in a manner that supports the conduct of fair, timely, cost effective and efficient hearings. The policy guideline provides:

- The party with the onus at the hearing (usually the health practitioner / assessor) must send the materials they intend to rely on to the Board by email or fax[23] not later than 10:00 am on the business day prior to the hearing.
- There is also an expectation that a party intending to bring a motion at a hearing will provide written notice of the motion to the Board and all other parties no later than 10 a.m. the day before the scheduled hearing date.[24]
- The other parties must provide the materials they intend to rely on by 2:00 pm on the business day prior to the hearing.
- Materials being delivered to the Board must be provided to all parties at the same time or earlier by the party delivering the materials.
- If materials are not delivered by the required time, they may be accepted by the Board, at the discretion of the panel.[25]
- The format for communicating document packages to the Board is described in detail in paragraph 2.2 of this Policy Guideline.
- Documents submitted to the Board must be relevant to the hearing.
- There is an expectation that the documents submitted will not exceed 50 pages. It will be up to the panel to decide if it is appropriate to accept relevant documents exceeding 50 pages, if appropriate in the circumstances.

This policy guideline applies notwithstanding Rule 30.2 of the CCB's Rule of Practice and confirms that the CCB, on its own motion, or any other party, may raise an objection to the materials submitted by another party at the outset of the hearing on the grounds of relevance or other issue.

18 *Ibid*. This policy is effective from March 31, 2022. <http://www.ccboard.on.ca/scripts/english/legal/policyguidelineno2.asp> In *CM (Re)*, 2022 CanLII 106518 (ON CCB), the patient wanted to proceed without counsel and, after following the process set out in this policy, the CCB decided that the patient's decision to self-represent was informed, and that the patient presented as an intelligent and articulate man who was comfortable with the hearing process. The CCB decided to proceed with the hearing without counsel for the patient or *amicus curiae*. See also *Re: A.F.*, 2010 CanLII 77954 (ON CCB), which dealt with a prior version of Policy Guideline No. 2.

19 *HCCA*, *supra* note 3 at s 81(1).

20 Physicians may also wish to contact the Canadian Medical Protective Association with questions about applications to the CCB.

21 *Ibid.* This Policy Guideline is effective from December 15, 2010 <http://www.ccboard.on.ca/scripts/english/legal/policyguidelineno3.asp>

22 *Ibid*. This Policy Guideline is effective from October 1, 2020. <http://www.ccboard.on.ca/scripts/english/legal/policyguidelineno4.asp>

23 Although Practice Direction 4 permits delivery of materials to the CCB by fax, the Board's preference is to receive materials by email (ccb@ontario.ca). As the CCB increases its use of electronic hearings, delivery of documents via email will continue to be best practice.

24 See Rule 18 of the CCB Rules.

25 The criteria to be considered by the panel in deciding whether to accept the documents are set out in Policy Guideline No. 4 at paragraph 2.1.1.

If questions arise about the interpretation of these Policy Guidelines or their application, consider consulting with risk management and legal resources as may be available.[26]

Parties to Hearing and Appointment of Counsel

The "parties", or required participants to an application, are set out in the legislation.[27] An overview of the usual parties to each of the applications under the *MHA* and *HCCA* is listed in Appendix "C".

The CCB has the discretion of adding other parties to an application. This is usually done on a motion by the person seeking to be added as a party to an application. The factors to be considered and process to be followed by the CCB in considering a motion with respect to whether someone should be specified as a party to an application are set out in Rule 6 of the CCB's Rules of Practice.[28]

There is no legal requirement for parties to be represented by legal counsel. As set out above, Policy Guideline No. 2 deals with the policy and procedure for the Board to arrange counsel for the person who is the subject of the hearing. This may involve the PGT, or the Children's Lawyer where the subject of the hearing is a minor. The policy guideline also addresses the use of *amicus curiae* ("friend of the Court") to assist the Board in making that that the hearing is procedurally fair for a potentially vulnerable party.

A patient may request or deny the assistance of counsel. The CCB is likely to grant a "reasonable" request for an adjournment of a hearing based on a patient's request for counsel.[29] What is "reasonable" will be determined on the facts of a particular situation.

A health practitioner may wish to seek legal advice or support if they are advised of a contentious issue and / or a procedural or legal argument to be advanced at a hearing or case conference. Legal counsel may be able to assist with addressing preliminary issues or preparing for the hearing and may not be required for the hearing itself.

Most health care organizations in Ontario will have formal or informal polices / practices to assist health practitioners in accessing legal counsel.[30]

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

Access to Health Records for Patient's Counsel

The need to deliver documents for CCB hearings is separate and distinct from a lawyer's statutory right to access their client's health records under the *Health Care Consent Act*.

Patient's counsel is entitled to access and copy their client's health records as maintained by the health practitioner and by an organization where their patient was admitted at the relevant time.[31] This legal right applies irrespective of whether a Notice of Hearing has been issued by the CCB.

26 The CCB has also published an assortment of information sheets addressing common topics and issues that come before the Board (http://www.ccboard.on.ca/scripts/english/publications/infosheets.asp#generalinfo) as well as applications involving questions of end of life care and common cases relied on in such applications (http://www.ccboard.on.ca/scripts/english/legal/practicedirection.asp).

27 For example, for applications relating to consent to treatment see s 32(3) of the *HCCA*, for applications relating to admission to a psychiatric facility see s 41 of the *MHA*, and for applications relating to Community Treatment Orders see s 39.1(9) of the MHA.

28 *Supra* note 12, Rule 6.

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

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

31 *HCCA*, *supra* note 3 at s 76. See also CCB's guideline on s 76 of the *HCCA*: http://www.ccboard.on.ca/english/legal/documents/Obligation%20re%20Disclosure%20of%20Medical%20or%20Health%20Record%20under%20s%2076%20of%20the%20HCCA.pdf

There is an expectation that health practitioners and organizations will take reasonable steps to facilitate counsel's access to their client's health records, even where a signed consent form has not been provided.

Please see Chapter 7 for more information about Privacy and Mental Health Care.

The Burden of Proof on Health Practitioners

The person who made the finding that is the subject of the hearing bears the burden of proof. The standard of proof on applications dealing with consent issues is a "balance of probabilities", which is also referred to as the civil standard of proof.[32]

The standard of proof is an "enhanced balance of probabilities" when issues of involuntary admission are being considered. This has been described as "something more than the simple enhanced balance of probabilities required in civil litigation, but much less than proof beyond a reasonable doubt, as required by criminal law".[33]

The onus is on the party making the finding to present clear, cogent and compelling evidence that supports the finding.[34] There is no obligation on the patient to prove that they are capable. Please see Chapter 2 for more information about the presumption of capacity.

The "usual" party on an application before the CCB is the health practitioner who made the finding that is the subject of the review. The physician who is most responsible for the patient's care at the time of the hearing is often the most appropriate "party" to the hearing. The physician may present information from other prior evaluations, from a review of the chart, from collateral sources, and from their own examination of the patient. The physician may determine that another individual, including a health practitioner, should also attend and give their own evidence on an issue to which the physician cannot speak directly.[35]

Bringing witnesses to a Board hearing is discussed further below.

2. Preparation for Hearings

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

Once a health practitioner becomes aware that an application has been made to the CCB,[36] steps should be taken to ensure that the necessary forms are complete and available. These forms are the underpinning of the finding to be reviewed, and a preliminary issue will be whether the procedural processes, as required in the legislation, were followed.

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

32 *Starson* v *Swayze*, 2003 SCC 32, [2003] 1 SCR 722, 225 DLR (4th) 385 [*Starson*].

33 *M (Re)*, 2005 CanLII 56677 (Ont CCB).

34 *Starson*, *supra* note 23.

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

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

Health practitioners should also provide patient's counsel with copies of any documents to be relied upon, prior to the hearing, including the clinical summary.[37] This communication in advance of the hearing may assist with identifying any preliminary or substantive issues that may require consultation with a lawyer, or an adjournment.

When preparing for the presentation of evidence at a hearing, review the legal test(s) that are to be addressed.

If a health practitioner is uncertain about the legal framework for the issue(s) that are the subject matter of the hearing, or how to apply the facts of a particular patient case to that framework, it is strongly recommended that they seek legal advice or support prior to the commencement of the hearing.

Case conferences may be requested by the parties or suggested by the CCB. Case conferences are an appropriate forum to discuss issues with respect to scheduling, document production, or if a health practitioner requires direction from the Board. It is best practice to request a case conference by emailing the request and the reason for the case conference to the Board. Consent is not required from the other party(ies) to request or schedule a case conference.[38]

In preparing for a CCB hearing, a health practitioner should prepare to make submissions on the issue(s) before the Board, to ask questions of the patient and any other witnesses and to make a "closing argument"[39] at the end of the proceeding. These preparations will be addressed in more detail below. If the person making the application to the CCB decides not to proceed with the hearing, this needs to be communicated by them, or someone acting on their behalf, to the CCB, in writing as soon as possible. The preferred form for this communication is the CCB's "Notice of Withdrawal".[40]

37 The CCB's Policy Guideline No. 4 addresses the procedure for the delivery of parties' materials to the Board and other parties, as well as the length and formatting of those materials.

38 See Rule 19 of the CCB's Rules regarding Case Conferences.

39 A closing argument is the final 'pitch' to the panel on why a position on the issue(s) in dispute should be accepted. It is not an opportunity to introduce new evidence.

40 A PDF version of the "Notice of Withdrawal" may be found on the CCB website http://www.ccboard.on.ca/scripts/english/forms/index.asp. The use of this form is **not** mandatory.

The Use of Clinical Summaries and Documentation from the Chart

It is strongly recommended that a clinical summary be prepared for use at a hearing. **A clinical summary outlines the issue(s) before the CCB and the applicable legal test(s), as well as the facts and opinions that the health practitioner is relying on to support the finding.** These summaries streamline the issues for the CCB and assist the health practitioner in preparing their evidence. The clinical summary should be "marked as an exhibit" at the hearing, so that it forms part of the record for the hearing. As an "exhibit", the clinical summary may be referenced by the CCB in preparing any reasons for decision and in the event of an appeal it will be part of the materials submitted to the Court.

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

The documents that are marked as exhibits become documentary evidence and form part of the record that the CCB relies upon when making its decision. The exhibits will also form part of the 'record of proceeding' that the Court will consider if there is an appeal of the CCB's decision.

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

"Evidence" when a person is incapable

Health practitioners are often asked to express their clinical opinion and judgment with reference to "evidence". The Ontario Court of Appeal has confirmed that in order for the CCB to uphold the respondent's finding of incapacity, the respondent's evidence needs to be "corroborated".[41] This legal rule of "evidence" is applicable to any "a verdict, judgment or decision" as against an individual who is:[42]

1. A person who has been found,
    (i) incapable of managing property under the *Substitute Decisions Act*, 1992 or under the *Mental Health Act*,
    (ii) incapable of personal care under the *Substitute Decisions Act*, 1992, or
    (iii) incapable by a court in Canada or elsewhere.
2. A patient in a psychiatric facility.
3. A person who, because of a mental disorder within the meaning of the *Mental Health Act*, is incapable of giving evidence.

This would apply to most patients bringing an application to the CCB.

In a proceeding before the CCB, the evidence of a health practitioner may be "corroborated" by the patient's evidence, although it is recommended that evidence of the clinical opinion and judgment of another health practitioner be provided, where possible, to further support the finding. "Corroboration" does not require the healthcare practitioner to prove their case through independent evidence. The rule only requires that the "evidence" of the person seeking the decision about the incapable person have "other material evidence" to "support" their position.[43]

In preparing for a hearing, one option is to consider incorporating "corroborating evidence" into the clinical summary, and having any clinical notes and records confirming the clinical opinion and judgment being relied upon marked as an exhibit.

Some examples of "evidence" that may support the case being presented to the CCB include:

- Excerpts from the clinical notes and records prepared by other health practitioners.
- Clinical notes and records from other attendances and admissions.
- Letters from, and notes summarizing discussions with other care practitioners and family members about events which have contributed to the clinician developing the opinion being reviewed.
- Other information that is from someone other than the person who made the finding before the CCB.

Identification of Possible Witnesses

In preparing for a CCB hearing, a health practitioner should also consider whether it is appropriate, in the circumstances of the particular hearing, to call "witnesses". Typically, a witness might be called if they have evidence that is relevant to the issue(s) in dispute, and that evidence is not otherwise found in the documents one intends to rely upon and submit to the CCB.

A witness may be a service provider, another member of the health care team, a family member of the patient, a friend, or someone who is involved with the patient in the community. If other members of the health care team, family members or anyone else is going to be asked to give evidence at the hearing, make sure they are aware of the date, time and location, as well as the virtual hearing details.

Generally, those who have been involved with the patient will be prepared to attend voluntarily at the hearing as a witness. If, for some reason, a potential witness is not prepared to attend voluntarily, then a "summons" can be requested from the CCB.[44]

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

41 *Anten v Bhalero*, 2013 ONCA 499, para 28.

42 *Evidence Act*, RSO 1990, c E 23, s 14.

43 *Ibid*. See also, *Anten v Bhalero*, 2013 ONCA 499, paras. 28-30; *Gajewski v. Wilkie*, 2014 ONCA 897 (CanLII) at paras. 35-38, 40; *Christoforou v Liu,* 2015 ONSC 1278 at para 38. *Farquhar-Lockett v Jones*, 2016 ONSC 346 (CanLII) at paras. 66-72; and *J.C. v Maldeniya*, 2021 ONSC 8540 (CanLII) at paras. 10-11.

44 Rule 32 of the CCB's Rules of Practice.

Case Conferences

At the request of the parties, and in some cases on its own initiative, the CCB may direct that there be a case conference "to consider any or all of the following":[45]

- the identification, simplification and / or resolution of some of all of the issues;
- identifying facts or evidence that may be agreed upon by the parties;
- identifying all parties to the hearing;
- the estimated duration of the hearing;
- identifying the witnesses; or
- any other matter that may assist the just and most expeditious disposition of the proceeding.

Case conferences are common when a more complicated hearing is anticipated and provide an opportunity for the statutory parties to an application to have a meaningful discussion and narrow, or resolve, some of the issues.[46]

A case conference is a good opportunity to address any issues that may impact a hearing. It is best to clarify, seek direction on, or resolve any issues at a case conference rather than waiting until the hearing. Case conferences help avoid unnecessary delays and adjournments.

A case conference may result in the presiding member making "any order considered necessary or advisable with respect to the conduct of the hearing, including an order adding parties". An Order made at a case conference will be available to the panel who ultimately conducts the hearing.[47]

The CCB has the ability to request materials from the parties for the purpose of the case conference.[48] This is separate from the hearing process and the only information from a case conference available to the panel at the hearing is a resulting Order or Endorsement.[49]

45 *Supra* note 10, Rule 19.1

46 Please see Appendix "C" for more information on the statutory parties to a particular Application to the CCB.

47 *Ibid*, Rule 19.8.

48 *Ibid*, Rules 19.2, 19.6, 19.7

49 *Ibid*, Rules 19.9

Motions

The CCB's Rules of Practice also provide for "motions". A "motion" is a request for a decision on issue at any stage in the hearing, at the request of one party.[50] A motion may be considered at any stage of a proceeding; however, they are most commonly brought at the outset of the hearing to address "preliminary" and procedural issues.

It is strongly recommended that potential motions be canvassed at a case conference at which the presiding member is asked to set a timeline for the delivery of materials / submissions prior to the hearing of the motion, or through correspondence with patient's counsel well in advance of the hearing.

Setting a timeline for the delivery of materials for a motion at a case conference is an effective way to streamline the hearing process and avoid unnecessary delays and adjournments.

Mediations

The CCB's Rules of Practice provide for "mediations".[51] Practically, these are not a common CCB process.

Parties always have the option of agreeing to participate in a formal or informal mediation process to resolve, narrow or simplify some or all the issues in dispute. Any agreement reached between the parties should be communicated to the CCB, in writing, and may result in a streamlined and more focussed hearing process.

Changes in Patient Status Following an Application to the CCB

If there is a change in the patient's clinical status that impacts the issues on a hearing before the Board, the health practitioner should notify the other parties to the proceeding and provide copies of any Forms and relevant clinical notes and records as soon as possible.

50 *Supra* note 12, Rule 18.

51 *Ibid*, Rule 20. A "mediation" is a process in which there is an effort by the parties, on consent, to resolve or simplify some or all of the issues that will be before the CCB at a hearing.

Examples of Clinical Changes that May Impact a CCB Hearing

Form A – if the patient regains capacity to consent to the proposed treatment

If it is determined that the patient is capable to make a decision about the proposed treatment, the patient should be advised of the change and it should be documented in the clinical notes and records.

The health practitioner should also communicate the change in the patient's condition to their lawyer / *amicus*, any other parties and to the Board.

The CCB has developed a "Cancellation of Incapacity Finding" Form[52] that is available on its website. The use of this form is NOT required and documentation in the clinical notes and records is an appropriate for way to confirm that the patient will be making their own decision with respect to the proposed treatment.

Form A – the treatment in question is no longer proposed for the patient

If there is a change in the treatment plan such that the proposed treatment that is the subject of the finding of incapacity is not longer being recommended for the patient, this should be documented and communicated to the patient and substitute-decision maker.

The health practitioner should also communicate that there is a change in the proposed plan of treatment to the patient's lawyer / *amicus*, any other parties and to the Board.

There is a section on the CCB's "Cancellation of Incapacity Finding" Form that addresses this situation. Again, the use of this form is NOT required and documentation in the clinical notes and records is an appropriate for way to confirm that there has been a change in the proposed plan of treatment for a patient.

Form 16 – if the patient no longer meets criteria for involuntary admission

If it is determined that a patient no longer meets the criteria for involuntary admission, a Form 5 should be completed, changing the patient's status to informal or voluntary.[53]

The health practitioner should communicate the change in the patient's status to the patient's lawyer / *amicus*, any other parties and to the Board.

52 http://www.ccboard.on.ca/scripts/english/forms/index.asp

53 Please see Chapter 3 for more information about changes in a patient's status.

If a patient indicates to a member of the clinical team that they do not wish to proceed with an application to the CCB, they should be encouraged to speak with their lawyer or *amicus*, if either is in place, or further rights advice should be requested.[54]

If a patient decides to withdraw an application to the CCB, this should be promptly communicated to the Board by patient's counsel, *amicus* or a rights advisor.

CCB Hearings

The hearing will open with introductory comments from the Presiding Member of the panel of the CCB that will include an overview of the process. More often than not, the patient is present, as they are usually the subject of the hearing. In some cases, the patient may choose not to attend the hearing. If the patient is not there, the Presiding Member will likely enquire as to why they are not in attendance.

A patient who is the subject of an application to the CCB may be represented by counsel. If the patient does not have counsel, the Presiding Member will likely enquire as to whether the patient would like to have counsel present, and in some cases may take steps to order counsel.[55]

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

The Presiding Member may also take the opportunity to mark the materials submitted to the Board[56] as "Exhibits". **If a document is not marked as an exhibit, that document will not form part of the record before the Board**, and the Board cannot rely on that document, or its contents, in reaching a decision.

If a witness reads from a document that is <u>not</u> marked as an exhibit, only the information that is read will form part of the evidence. The panel members cannot review the document in their deliberations and the document will not be in the "Record of Proceedings" proceedings that will be prepared in the event of an appeal.

Once the substantive part of the hearing begins, the health practitioner, or the person who made the finding that is the subject of the hearing, will be asked to present "the evidence" they are relying on to support their findings. The health practitioner can and should rely on and reference the clinical summary and supporting document while giving their evidence, with a focus on key information that is relevant to the finding.

In most hearings, the health practitioner, or the person who made the finding that is the subject of the hearing, with the burden of proof at the hearing, will present first. There are situations in which the party with the burden of proof may choose to call another witness first, to provide a factual foundation for their evidence. If a health practitioner has questions about how and when to call witnesses, it is recommended that they seek legal advice through the resources available.

Following the presentation of a witness' evidence, the other parties will have an opportunity to ask questions or "cross-examine" them. When this is complete, the members of the panel will have the opportunity to ask the witnesses questions. If there are questions from the panel, the parties will have an opportunity to comment or ask questions arising from those posed by the CCB.

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

54 Please see Chapter 3 for more information about rights advice.

55 Please see notes above with respect to Policy Guideline No. 2.

56 Please see notes above with respect to Policy Guideline No. 4.

Dealing with "Procedural Issues" Before the CCB

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

- A copy of the Form 42 is not in the chart;
- Form 1 and Form 3 completed by the same physician;
- Form 3 or Form 4 completed outside of the prescribed time;
- Errors in the completion of forms (for example, boxes missed, descriptions indecipherable or too brief);
- Improper (or absent) OIC review of Forms 3 and 4;
- Incomplete (or absent) notes of consent or other discussions;
- Lack of, or alleged delay, in rights advice;
- Allegation of a lack of procedural fairness, including that notice of a capacity assessment was not provided;
- Issuing/renewing physician did not examine the patient within 72 hours of entering into a community treatment plan;
- Allegation that a Community Treatment Plan is vague and overbroad, or that it includes treatments in respect of which the patient has not been found incapable;
- An application is brought following the patient's discharge from Hospital;
- A Form 4 was completed when the attending physician was unaware of an outstanding appeal with respect to the patient's involuntary status; and
- Applications contrary to s. 39(7) of the *MHA* and contrary s. 32(5) of the *HCCA*.

A party who intends to raise a procedural issue should give notice to the other parties as soon as possible, and at a minimum by 10:00 am the day before the hearing.[57] It may be appropriate to address a procedural issue at a case conference and set a time line for the delivery of materials relevant to the adjudication of the issue. Health practitioners who are notified about procedural issues may wish to seek legal advice and support to assist in preparing to respond to an issue at a hearing and / or to determine if additional steps need to be taken to address the issue.

If a procedural issue is raised for the first time at the hearing, the health practitioner can object to lack of notice and, if they are unprepared to deal with the issue "then and there", may request an adjournment to consult counsel.[58]

If a health practitioner wants to deal with a procedural issue without legal representation or consultation, it is recommended that they carefully read the applicable sections of the legislation and confirm that their position, based on the specific facts of the situation, are consistent with the legal framework applicable to the issue(s) in dispute. It is also recommended that health practitioners ask patient's counsel if they are aware of any cases in which the CCB and the Court have considered the issue, either for or against their position. Counsel have a duty to bring both favourable and unfavourable decisions to the attention of the CCB.

If a health practitioner "loses" a hearing on procedural grounds without consideration of the substantive issue on the application, then the health practitioner should consider whether further clinical assessment is required. For example, if a Form 3 or 4 is invalid on procedural grounds, a Form 1 may be completed if the patient meets the criteria at that time and then there may be a subsequent assessment of whether the patient meets the criteria for a Form 3.

57 Rule 18.3 of the CCB's Rules of Practice requires a party or person to give written notice to the Board and the parties of any motion they intend to bring at the earliest possible date, and in any event, no later than 10 a.m. the day before the scheduled hearing date.

58 Rule 28 of the CCB's Rules of Practice deals with adjournments.

Procedural Invalidity of Forms

One example of when the CCB may be asked to declare a Form invalid on "procedural grounds" is a situation in which the patient argues that the Form 3 was improperly completed, and therefore the subsequent Form 4 was invalid.

The Ontario Superior Court of Justice considered this situation on an appeal from a decision of the CCB in 2004. The judge hearing the case commented that:

"..., *In the Matter of P.L.H.*, the Board addresses the Forms used under the *HCCA*. There at p.16, the Board agreed with an earlier finding in *In the Matter of M.S.*, where the Chair stated that it is the Board's view

of the law when a Form 1 expires, the law does not contemplate that its expiry means 'the person must be turned loose even though he or she might cause harm to himself or others serious bodily harm.' The Board in *P.L.H.*, supra, said this reasoning also applies if an improper form is mistakenly used. It said, '**as long as hospital staff are human, mistakes will be made**.' This reasoning applies to the Appeal before me and the issue of the Form 3." (emphasis added)

This decision of Madam Justice Greer may be found at *T.S. v. O'Dea*, [2004] O.J. No.36.

3. After the Hearing

Decisions by the CCB

The CCB is able to make decisions within the scope of the decision making authority set out in the *HCCA*, *MHA*, *PHIPA*, *SDA*, *MBTA* and *CYFSA*. It is not able to make decisions that fall outside of the powers granted. As indicated at the beginning of this Chapter, the Board is required to deliver a "decision" within one day of the hearing.[59]

Amending and Reviewing a Decision

The CCB may correct errors in its decisions or reasons that are typographical, technical, calculation, or clerical in nature at any time.[60]

The CCB may also choose to review all or part of its own decision or Order, on its own initiative or at a party's request made within 5 days of the decision or Order.[61] Upon review, it may confirm, vary, suspend or cancel the decision or Order.[62] Importantly, the CCB will not ordinarily consider a request to review its decision or Order if the issue is properly the subject of an appeal.[63]

Rights of Appeal

A party before the CCB has a statutory right of appeal to the Superior Court of Justice from a decision of the CCB on questions of law or fact or both.[64] On appeal, the Superior Court of Justice can do any of the following things:

1. Exercise any powers that the CCB had when it made its decision;
2. Substitute its opinion in the place of an opinion that was made by a health practitioner, evaluator, substitute decision-maker or the CCB; or,
3. Direct that the matter be re-heard by the CCB under specific parameters.[65]

Legal counsel is required for appeals, and it is strongly recommended that legal advice be sought on receipt of a Notice of Appeal, or when considering taking steps to issue a Notice of Appeal. Depending on the nature of the appeal, steps may need to be taken urgently. **It is prudent to have counsel involved in any appeal from the outset.**

A health practitioner who would like to appeal a decision of the CCB should seek immediate legal advice. An appeal must be "taken" within seven days of the decision,[66] and depending

59 *HCCA*, *supra* note 3 at s 75(3); Rule 35.1 of the CCB Rules of Practice.

60 Rule 36.1 of the CCB Rules of Practice.

61 *Ibid* at Rule 36.2-36.5.

62 *Ibid* at Rule 36.2.

63 *Ibid* at Rule 36.6.

64 *HCCA*, *supra* note 3 at s 80(1).

65 *HCCA*, *supra* note 3 at s 80(10).

66 *HCCA*, *supra* at s 80(2).

on the nature of the application that was before the CCB, there may be other considerations.

The Practical Aspects of an Appeal

Once a Notice of Appeal is issued, there will be an open court file until the appeal is abandoned, or quashed or dismissed by the Court.

A health practitioner who is served with a Notice of Appeal should contact the appropriate risk management representative or their organization's designated resource for accessing legal counsel. A health practitioner will require legal counsel to respond to an appeal.

When the CCB receives a Notice of Appeal that has been issued by the Ontario Superior Court, it will prepare a "Record of Proceedings" and transcripts. The Record of Proceedings will include the Notice of Appeal, Reasons for Decision, the Decision(s) of the Board, Notice(s) of Hearing, the application(s) filed with the Board, the exhibit list from the hearing and copies of the documents filed with the Board and marked as exhibits at the hearing.

When the Record of Proceedings and transcripts are ready, copies are delivered to the parties and filed with the Court. These materials form the basis for the appeal, and additional materials cannot be relied upon without "leave", or permission of the Court.

There is a formal process for the delivery of written submissions for the Court to review as part of the appeal.[67] These include a "factum", which is a statement of facts and law, as well as the position being taken by the party and the law to be referenced at the hearing of the appeal.

It is expected that counsel for the parties will collaborate to establish a timetable for the delivery of materials and on setting dates for the hearing of an appeal.

Impact of Appeal on Treatment

As discussed in Chapter 2, treatment is not to be commenced pending an application to the CCB or an appeal to the Superior Court.[68] If a course of treatment was in place prior to the commencement of the appeal, it can continue, but a "new" treatment cannot start. The process of getting an appeal heard by the Superior Court can take time, and the practices for getting a hearing of an appeal from a decision of the CCB varies in different regions of Ontario. The Court of Appeal commented in *Conway v. Jacques*:

> *Finally, I must express my concern regarding the unacceptable delay flowing from the protracted nature of these proceedings. Over five years have passed since Dr. Jacques first raised the issue of the patient's psychiatric treatment with SDM. I urge all concerned to do what is required to have the issue of the patient's treatment resolved as soon as possible.*[69]

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

Hospitals should have a policy or plan to deal with situations in which a patient appeals from a decision of the CCB, particularly when the appeal relates to treatment.[70] While there is a timeline for appeals in the *HCCA*, this is very rarely realistic. The consequences of delay in moving appeals forward, particularly with respect to treatment, can be significant and may include considerable delays in the commencement of treatment that result in the patient's prolonged detention[71] and/or limit the treatment options available to subsequent health practitioners.[72]

67 *HCCA*, *supra* at s 80.

68 *Ibid* at s 18(3)(d); please see Chapter 2.

69 *Conway v. Jacques* (2002), 59 OR (3d) 737, 214 D.L.R. (4th) 67, 2002 CarswellOnt 1920 (C.A.) at para. 41.

70 In *Szeman v. Legault*, 2010 ONSC 1060 at para. 42, the Court commented: "It is inconsistent with the legislation and the findings of the Supreme Court of Canada, to delay an appellant's attendance at court to have the appeal heard in an expeditious manner. I accept Ms. Roy's submission that the hospital has addressed this issue and that if a similar situation occurs in the future that the hospital or the physician's counsel will contact the Trial Coordinator and arrange for a convenient date for a court appearance forthwith." The process of dealing with an appeal from a decision of the CCB may vary, depending on how these appeals are managed in the various regions of the province.

71 This was discussed in the decision of Brown J. *in Cavalier v Ramshaw*, *supra* at para. 5.

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

Hospitals should have a policy in place to make sure that the appropriate members of the treatment team are aware of any outstanding appeals and the impact they have on patient care.

It is possible to bring a motion to the Court for an Order allowing for treatment pending an appeal.[73] Applications for treatment pending appeal have become more common in recent years, with more guidance from the court on the interpretation and application of this section of the *HCCA*. These applications will not be granted lightly. A decision as to whether an application for treatment pending appeal is appropriate in any given situation is one that should be made on a case-by-case basis, in consultation with legal counsel.

It is also possible for steps to be taken to expedite an appeal to the Superior Court. This is also an issue that can be discussed with legal counsel.

Treatment Pending Appeal Example

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

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

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

Appeals from Decisions relating to Involuntary Status

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

Appeals arising from decisions relating to involuntary admissions are rare. In part, this is due to the tension between the time it can take to have an appeal decided and the automatic right of a patient to review their involuntary admission on the issuance of each subsequent certificate. For example, if a patient were to appeal a confirmed second certificate of renewal, which is in force for two months from its date of issuance, the appealed-from certificate would likely expire long before an appeal could be perfected and decided.

The provisions in the *Mental Health Act* that govern the effect of an appeal on a certificate of involuntary admission can vary depending on whether the CCB has confirmed or discontinued the certificate.

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

1. It is confirmed or rescinded by the court;
2. It is rescinded by the attending physician;
3. 48 hours after notice is given to the attending physician that the party appealing has withdrawn the appeal; or
4. The attending physician confirms under subsection 48(12) that the patient does not meet the criteria set out in subsection 20(1.1) or (5).[74]

73 See *HCCA*, *supra* at s 19 and *Starson, supra* note 23. A few cases that set out how the CCB, and the Court, has applied the interim treatment provisions of the *HCCA* may be found at: *Ducharme v Hudson*, 2021 ONCA 151; *Almeida v Morgan*, 2020 ONSC 2192; and *Elder v Klukach*, 2017 ONSC 677.

74 *MHA*, *supra* note 5, s 48(11). Please see Chapter 3 for more information about the criteria for involuntary admission in ss. 20(1.1) and (5) of the *MHA*.

During the period in which the certificate is continued pending the appeal, "the attending physician shall examine the patient at the intervals that would have applied under section 20 and shall complete and file with the Officer in Charge a statement in writing as to whether or not the patient meets the criteria set out in subsection 20(1.1) or (5)".[75]

This requirement for reassessment of the patient confirms that there is ongoing evaluation of whether the criteria for involuntary admission continue to be met, although the patient is not entitled to further review of their status by the CCB. The physician is required to complete and file with the officer in charge, following each examination, a statement in writing (Form 7) as to whether the patient meets the criteria for involuntary admission as of that date.[76] If the patient continues to meet the criteria, they will remain involuntarily admitted to hospital.

If the physician determines that the patient no longer meets the criteria, the appealed from certificate may be rescinded and a Form 5 may be completed.

If the patient decides to withdraw an appeal of a confirmed certificate of involuntary admission, a physician may complete and file a renewal of the certificate that was under appeal.[77]

Generally, where a patient has initiated an appeal of the Board's decision to confirm a certificate of involuntary admission, the Board lacks jurisdiction to hear an application brought by the same patient to review a Form 7 or other statement in writing by the attending physician that the patient continues to meet the criteria for involuntary admission.[78]

If the CCB **rescinds** the certificate, the physician may wish to consider an appeal. Where an appeal is "taken"[79] from a decision of the CCB dealing with involuntary admission, the certificate is extended for three days.[80] During this time, a motion may be brought seeking an Order from the Superior Court extending the effectiveness of the certificate beyond the three-day period.[81]

The criteria that must be met for this extension, as well as the process and options available to the Court, are set out in section 48 of the *MHA*. Due to the nature and complexity of these motions, it is strongly recommended that immediate legal advice be sought if consideration is being given to an appeal to a CCB decision revoking a patient's involuntary status.

75 *Ibid* at s 48(12).

76 *MHA*, *supra* note 5, s 48(12); see also *R.J. v. Zalan,* 2016 ONSC 2337 (CanLII)

77 *MHA*, *supra* note 5, s. 48(8) and (9).

78 In *JJ (Re),* 2022 CanLII 100366 (ON CCB), the Board concluded that the patient could bring no application to the Board to review a Form 4 certificate of renewal, where the patient had filed an appeal of the Board's earlier decision confirming the patient's involuntary status under a Form 3. The Form 4 was issued prior to the patient serving and filing his appeal of the Board's decision. "The practical application of [s. 48(11) of the MHA]is that when a party appeals a Board Decision confirming involuntary status, there is no further application to the Board of that involuntary status, until the appeal resolves (by withdrawal or decision)." (at para 6). Further the Board noted that "the "certificate" in place at the time that the appeal was filed, remains in place in accordance with *MHA* subsection 48(12)." (at para. 9).

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

80 *MHA*, *supra*, note 35 at s 48(5).

81 *Ibid* at s 48(6).

CHAPTER

6 Forensic Psychiatric Patients and the Criminal Law

1. Introduction and Historical Developments

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

> *In every society there are those who commit criminal acts because of mental illness. The criminal law must find a way to deal with these people fairly, while protecting the public against further harms. The task is not an easy one.*[1]

Indeed, some authors suggest that "the reason the very first mental health legislation was established in Ontario in 1839, over 180 years ago was that the legal/judicial/correctional system could not cope with the problems of the mentally ill".[2] The criminal justice system has attempted for many years to address the needs of the mentally ill who, due to their illness, have behaved in ways that bring them into contact with law enforcement agencies, the criminal courts and "forensic" psychiatric facilities.[3]

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

> The vast majority of people living with mental health problems and illnesses are not involved with the criminal justice system. In fact, they are more likely to be victims of violence than perpetrators. Nevertheless, they are over-represented in the criminal justice system; that is, there is a much higher proportion of people living with mental health problems and illnesses in the criminal justice system than in the general population. The reasons for this over-representation are complex. Clearly, people are involved in the criminal justice system because of criminal behaviour. However, lack of access to appropriate services, treatments and supports have also had a powerful influence on this situation. This over-representation has increased as the process of de-institutionalization of people living with mental health problems and illnesses, coupled with inadequate re-investment in community based services, has unfolded. Estimates suggest that rates of serious mental health problems among federal offenders upon admission have increased by 60 to 70 percent since 1997.[4]

In 1992, there was significant legislative reform following a decision of the Supreme Court of Canada, *R v Swain*.[5] In the *Swain* case, the Supreme Court held that the provisions of the *Criminal Code* dealing with those found unfit to stand trial or found not guilty by reason of insanity were unconstitutional, as they violated the accused's *Charter* guaranteed rights to procedural fairness and to be free from arbitrary detention, as guaranteed by the *Charter of Rights and Freedoms* ("*Charter*").

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

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

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

4 Mental Health Commission of Canada, *Changing Directions, Changing Lives: The mental health strategy for Canada* (Calgary, AB, 2012) at 48. Online at: https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/MHStrategy_Strategy_ENG.pdf

5 *R v Swain*, [1991] 1 SCR 933 [*Swain*].

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

> *Part XX.I reflected an entirely new approach to the problem of the mentally ill offender, based on a growing appreciation that treating mentally ill offenders like other offenders failed to address properly the interests of either the offenders or the public. The mentally ill offender who is imprisoned and denied treatment is ill-served by being punished for an offence for which he or she should not in fairness be held morally responsible. At the same time, the public facing the unconditional release of the untreated mentally ill offender was equally ill-served. To achieve the twin goals of fair treatment and public safety, a new approach was required.*[6]

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

- Orders for an accused's mental condition to be assessed, in certain circumstances;
- Orders for the treatment of an accused who has been found unfit to stand trial, if certain criteria are met;
- Dispositions and orders in relation to a person who has been accused of a criminal offence, and who has been found by a court or a review board to be either not criminally responsible on account of mental disorder ("NCRMD"), or, unfit to stand trial due to mental disorder ("Unfit");[7]
- The establishment of provincial review boards to make or review dispositions concerning any NCRMD or Unfit accused; and
- The membership, jurisdiction and procedure of a Review Board in making or reviewing dispositions or assessment orders.

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

6 *Winko*, *supra* note 1, at para 20.

7 A person who has been found Unfit has not yet had their criminal charges disposed of, since they have been found to suffer from a mental disorder that would impair their ability to participate meaningfully in their own defence at trial (see *CC, supra* note 8, s. 2, which defines "unfit to stand trial" to mean "unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and in particular, unable on account of mental disorder to: (a) understand the nature or object of the proceedings, (b) understand the possible consequences of the proceedings, or (c) communicate with counsel." See Section 3 below for further detail). A person found NCRMD has been found neither guilty nor acquitted of a criminal offence. The NCRMD verdict confirms that the person has committed an offence but has been absolved of criminal responsibility due to their mental disorder (see Section 4 below at page 6-9 for further detail on the defence of NCRMD). Section s.672.1(1) defines an "accused" to include a person who has received a verdict of NCRMD. Accordingly, the NCRMD offender is often referred to as "the accused" in the legislation and case law. In forensic mental health clinical settings, they are referred to by their health practitioners as clients or patients. In this chapter, given the legal perspective of this resource, we use the term "accused".

2. When Mental Disorder is an Issue: Assessment Orders

Types of Assessments

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

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

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

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

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

(e) Whether a stay of proceedings should be ordered, in certain circumstances, where an accused has been found unfit to stand trial.[8]

The court may order an assessment at any stage of proceedings against the accused of its own motion, on application of the accused, or on application of the Crown, the latter being subject to certain limitations.[9]

What would allow the court to form "a reasonable belief" that an assessment of the mental condition of the accused is necessary?

Commentators have suggested that reports of the accused's behaviour or the accused's actual observed behaviour in the court room indicative of active mental illness could be sufficient basis for a "reasonable belief" on which to order an assessment of fitness to stand trial.[10]

Where the accused is fit to stand trial,[11] the court's ability to order an assessment of criminal responsibility will be limited at the outset of the trial by whether the accused has put their mental condition in issue by raising the NCRMD defence. Once the court has found that the evidence establishes that the accused has committed the offence in question, the Crown may make an application to have the issue of criminal responsibility determined.

In 1991, the Supreme Court of Canada held that a common law rule that allowed the Crown prosecutor to enter evidence of the accused's insanity, where the accused did not intend to enter a defence of insanity, violated the accused's right to control their own defence, and thus violated section 7 of the *Charter*.[12] As a result, the Supreme Court articulated a new common law rule to conform with the *Charter*, which allowed the Crown to raise independently the issue of insanity **only after** the trier of fact had concluded that the accused was otherwise guilty of the offence charged. This principle continues to apply to the NCRMD regime currently in force and is recognized by the limitations on the Crown's ability to raise the issue that are articulated in Part XX.I.[13]

8 *Criminal Code of Canada*, RSC 1985, c C46, s 672.11 [CC].

9 *Ibid*, s 672.12.

10 Richard D Schneider, *Annotated Ontario Mental Health Statutes*, 5th ed. (Toronto: Irwin Law, 2022) at 433 [*Schneider*]. Schneider's text includes a very helpful chart setting out the various circumstances in which a judge may order Assessments at pp. 434.

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

12 *Swain*, *supra* note 5.

13 *CC*, *supra* note 8, s 672.12(2) and s. 672.12(3). In other words, the Crown may only apply for an assessment order in respect of an accused's fitness or criminal responsibility where there are reasonable grounds to doubt that the accused is fit or that the accused is criminally responsible, on account of mental disorder.

Once an accused has been found unfit to stand trial or NCRMD,[14] the ORB may only order an assessment of the accused on its motion, or on the application of the Crown or the accused, where the Board has reasonable grounds to believe that such evidence is necessary to:

(a) Make a recommendation to the court under subsection 672.851(1);[15] or

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

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

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

(iii) The accused has been transferred from another province under section 672.86.[16]

The circumstances set out in subsection (b) generally arise when the accused is before the ORB for the first time. However, the ORB also has authority to direct that assessments of an accused be carried out as part of its statutory mandate to gather relevant information in order to craft an appropriate disposition and to supervise the progress of the accused's rehabilitation and treatment.[17] In 2014, the *Criminal Code* was amended to provide the ORB with the authority to order an assessment for the purpose of determining whether to refer a high risk accused ("HRA") to the court for a review of the HRA designation.[18]

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

15 *CC*, *supra* note 8, s 672.851(1) provides for the ORB to make a recommendation to the court with jurisdiction over the offence that the accused has been charged with, to hold an inquiry as to whether the charges should be stayed, where the ORB has determined that the accused is permanently unfit and no longer poses a significant threat to the safety of the public. Note that s 672.851 is drafted such that the Board may make a recommendation for a stay of proceedings only where the accused is before the ORB pursuant to s. 672.81 (annual, early or restriction of liberty review) or s. 672.82 (discretionary review), but not where the accused is before the Board at an initial hearing pursuant to s. 672.47 and s 672.48.

16 *CC*, *supra* note 8, s. 672.121(a) and (b).

17 *Mazzei v British Columbia (Director of Adult Forensic Psychiatric Services)*, [2006] 1 SCR 326, at paras 59-60.See also: *Ontario (Attorney General) v Taylor* [2008] OJ 2744 (SCJ).

18 *CC*, *supra* note 8, section 672.121(c).

Procedure Associated with Assessments

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

- Who is to conduct the assessment or the hospital where it is to take place;
- Whether the accused is to be detained in custody while the order is in force;[19] and
- The period of time during which the order is to be in force (including time for the accused to travel to and from the place of assessment).[20]

With regard to specifying the hospital where the assessment is to take place, Part XX.I of the Criminal Code defines "hospital" to mean a facility designated by the provincial Minister of Health for the "custody, treatment or assessment of an accused in respect of whom an assessment order, a disposition or a placement decision is made".[21]

Time Limits specified in the *Criminal Code* for Assessments	
Assessment order	Generally shall not be in force for more than 30 days.[22]
Assessment for fitness to stand trial	Generally to take place within five days. Accused and Crown prosecutor may agree to longer period, up to 30 days.[23]
"Compelling circumstances" exception	In these circumstances (which are not defined), the court or ORB may continue the assessment order in force for up to 60 days.[24]
Extension	Order may be extended for further period of up to 30 days, provided that total period (initial + extension) does not exceed 60 days.[25]

19 See s. 672.16(1), which creates a presumption against the accused being detained in custody, unless certain criteria are met.

20 *CC*, *supra* note 8, s 672.13

21 *Ibid*, s 672.1(1).

22 *Ibid*, s 672.14(1).

23 *Ibid*, s 672.14(2).

24 *Ibid*, s 672.14(3).

25 *Ibid*, s 672.15.

During the period that an assessment order is in force, no bail order or other order to hold the accused in custody may be made; the court-ordered assessment takes precedence over other designated orders.[26]

The Assessment order may be in a Form 48 (court ordered assessment) or a Form 48.1 (ORB ordered assessment). Once the assessment is completed, the accused must be brought back before the court or ORB that made the order "as soon as practicable". Thus, assessment orders provide for the early return of the accused to detention, and hence to court, should the assessment be completed before the order expires.[27]

Treatment of the Accused during Assessment

An assessment order may not direct that psychiatric or any other treatment of the accused be carried out and the order cannot direct the accused to submit to such treatment.[28]

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

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

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

Section 25 of the *Mental Health Act* ("*MHA*") provides that any person who is detained in a psychiatric facility under Part XX.I of the *Criminal Code* may be restrained, observed and examined under the MHA and provided with treatment under the *Health Care Consent Act* ("HCCA").[29] Therefore, so long as the assessment order requires that the accused be detained in a psychiatric facility, the attending psychiatrist could resort to the provisions of the *HCCA* to provide the accused with treatment. However, practically speaking, given that an assessment order may not exceed 60 days, the process for determining incapacity may not be concluded until after the assessment order expires, if the accused person challenges the finding, by way of a review before the CCB and any subsequent appeals of the CCB's decision.[30]

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

If the patient is being assessed for fitness to stand trial, the physician may wish to consider that, once a verdict of unfit to stand trial is made, the court may order that the accused submit to treatment, without the consent of the accused, where there is a medical opinion before the court that the accused would likely become fit within a period of not more than 60 days and that any risk of harm associated with the treatment is not disproportionate to the anticipated benefit.[31]

Assessment Reports

An assessment order usually requires the person who makes the assessment to submit a written assessment report on the mental condition of the accused. The report is to be filed with the court or the ORB that ordered it, within the period required. This means that the assessing physician, together with the facility where the accused has been ordered detained, should arrange to have it delivered to the registrar's office of

26 *Ibid*, s 672.17.

27 *Ibid*, s 672.191.

28 *Ibid*, s 672.19.

29 *Mental Health Act*, RSO 1990, c M7, s 25 [*MHA*]; *Health Care Consent Act, 1996*, SO 1996, C 2, Sched. A ("HCCA").

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

31 *CC*, *supra* note 8, s 672.58. This is the only circumstance in which a court may compel the accused to submit to treatment without the accused's consent.

the court that ordered it and have it delivered to the attention of the justice who ordered the assessment. The court staff will make arrangements for copies of the assessment report to be provided to the Crown, the accused and any counsel representing the accused.[32]

3. Fitness to Stand Trial

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

The requirement that an accused be 'fit to stand trial' stems from the ancient notion that an accused must be present to respond to accusations of the state. That basic requirement developed into a more refined view that the accused must not only be physically present but mentally present as well.[33]

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

> "unfit to stand trial" means unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, **and** in particular, unable on account of mental disorder to:
>
> (a) Understand the nature or object of the proceedings,
>
> (b) Understand the possible consequences of the proceedings, or
>
> (c) Communicate with counsel.34 (emphasis added)

An accused is presumed to be fit to stand trial unless the court is satisfied on the balance of probabilities that the accused is unfit.[35]

To be found fit to stand trial, the accused must be able to understand the process and concepts involved in a criminal trial. The Ontario Court of Appeal in *R v Taylor* held that the test is one of "limited cognitive capacity," such that the accused need only possess sufficient mental capacity to have a basic understanding of the charges and court process. While the "**fit**" accused should be able to meaningfully participate in the proceedings; the accused does not have to act in their best interests.[36] Bloom and Schneider have suggested that the Taylor test focuses too exclusively on cognitive ability and therefore may miss the accused who may be unfit but whose fitness issues relate to mental disorders other than cognitive impairment or overt psychosis, such as depression, paranoia or mania.[37]

The issue of fitness to stand trial may be determined at any point prior to a verdict being rendered, where there are reasonable grounds to believe that the accused is unfit. The court, of its own motion or on the application of the accused or the Crown, may order that the issue of the fitness be tried.[38] Where the issue will be tried and the accused is not represented by counsel, the court shall order that the accused have counsel.[39] If after the trial of the issue, the verdict is that the accused is fit to stand trial, the remaining stages of the proceeding continue as if the issue of fitness of the accused had never arisen.[40]

32 *Ibid*, s 672.2.

33 Hy Bloom & Richard D Schneider *Mental Disorder and the Law: A Primer for Legal and Mental Health Professionals* (Toronto: Irwin Law, 2nd Edition, 2017) at 76 [*Bloom & Schneider*].

34 *CC*, *supra* note 8, s 2.

35 *Ibid*, s 672.22; the "balance of probabilities" refers to a standard of proof that requires the trier of fact to weigh the evidence before it and decide whether it is more likely than not a certain proposition has been established, in this case, fitness to stand trial. More likely than not means a probability that is a greater than a 50% chance.

36 *R v Taylor* (1992), 17 CR (4th) 371 (ONCA).

37 See *Bloom & Schneider*, *supra* note 33 at 98-101 for further discussion of this issue.

38 *CC*, *supra* note 8, s 672.23(1).

39 *Ibid*, s 672.24(1).

40 *Ibid*, s 672.28.

Examples of Common Fitness-Related Issues	
Keep fit orders	Where the accused is detained in custody on delivery of a verdict that the accused is fit to stand trial, the court **may order the accused to be detained in a designated psychiatric facility until the completion of the trial**, if the court has reasonable grounds to believe that the accused would become unfit to stand trial if released.[41] This is often referred to as a **"keep fit" order**.
Court ordered treatment following a finding of unfit to stand trial	Where an accused is found unfit to stand trial and the court has not made a disposition with regard to the accused, the court may order the treatment of the accused to be carried out, regardless of whether the accused person consents, for a period not exceeding 60 days and subject to any conditions that the court considers appropriate, including the detention of the accused at a designated psychiatric facility for the purposes of the treatment.[42] While the court has discretion to order the treatment, based on expert medical evidence that certain criteria are met,[43] the court is prohibited from ordering psychosurgery or electro-convulsive therapy.[44] Courts may not order that treatment is to take place while the patient is detained in hospital, the Court **must** seek the consent of the person in charge of the hospital where the accused is to be treated.[45]
After the accused is found unfit	Where a verdict of unfit to stand trial is rendered, the court may choose on its own motion, but must, on the application of either the accused or the Crown, hold a disposition hearing. At a disposition hearing, the court shall make a disposition if the court is satisfied that it can do so **and** it considers that a disposition should be made without delay.[46] If these two conditions are not present, the Court will generally refer the matter to the ORB for an initial hearing, which must generally take place no later than 45 days after the Court renders the verdict of unfit to stand trial. Even where the Court does make an initial disposition, provided that it is for the accused's detention or discharge subject to conditions, the ORB is still required to hold a hearing within 90 days of the Court rendering a disposition.[47] In other words, the ORB will eventually see the unfit accused for an initial hearing following the unfit verdict; either within 45 days if the court makes no disposition, or within 90 days to review the initial disposition made by the Court.

41 *Ibid*, s 672.29.

42 *Ibid*, s 672.58.

43 *Ibid*, s 672.59.

44 *Ibid*, s 672.61.

45 *Ibid*, s 672.62(1). See *Centre for Addiction and Mental Health v Al-Sherewadi*, 2011 ONSC 2272 at para 17. The Court quashed a forthwith warrant of committal, which a lower court judge had issued without regard to the evidence that a bed was not available at the hospital to which the court had ordered the accused be detained. The reviewing Court held that where courts issue a treatment order, there is nothing in the wording of s. 672.61 that imposes a time limit on the consent of the hospital or that requires that the consent be immediate and unqualified. Consequently, treatment orders may be issued to take effect from a certain date, pending the availability of a bed at the proposed receiving hospital. See also *R v Conception*, 2014 SCC 60, which dealt with a similar situation involving an unfit accused. This decision is discussed at the text associated with footnote 49.

46 *Ibid*, s 672.45(1)-(2).

47 *Ibid*, s 672.47.

As noted above, the authority of a court to order an unfit accused to submit to treatment, without the person's, or incapable person's substitute decision maker's consent, is an exceptional authority. In any other circumstance, treatment of an accused, who is subject to the jurisdiction of the ORB, may only proceed with the accused's or their substitute decision maker's consent, in accordance with the provisions of Ontario's *HCCA*. When making a treatment order in respect of an unfit accused, the court must first obtain the consent of the person-in-charge of the hospital where the accused is to be detained and treated.[48]

In 2014, the Supreme Court of Canada considered a case where the lower court had made a treatment order effective forthwith, and had refused to delay the effective start date of the treatment order.[49] There was evidence before the lower court that a bed would be available within six days, however, the court ordered that the treatment order commence forthwith and that the accused be taken to the designated hospital nonetheless. The hospital appealed the order. In particular, the Court of Appeal allowed the appeal and held that the lower court had not obtained the consent of the person in charge, as required by s. 672.62. In particular, the Court of Appeal held that implicit in a consent to accept patients subject to a treatment order, is an understanding that:

> **...hospitals will have the necessary facilities, personnel, and in-patient beds available at the time the order becomes operative, to enable them to provide the treatment required in a manner that is effective and ensures the safety of the patient, the medical and hospital staff, and the other patients at the hospital.**[50]

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

> **The purpose of the treatment order regime in the *Criminal Code* is to restore an unfit accused's fitness to stand trial as expeditiously as possible, thus enabling the trial process to proceed in a timely fashion and, in turn, enhancing both the accused's fair trial and other Charter rights and society's interest is seeing that criminal matters are disposed of on their merits.** Experience shows that the majority of accused who are the subject of treatment orders suffer from a serious psychotic illness, such as schizophrenia, schizo-affective disorder, or bipolar disorder. Experience also shows they can often achieve a return to fitness for trial through the administration of anti-psychotic drug treatment for a period of 30-60 days: hence, the 60-day limit on a s. 672.58 order.[51] (Emphasis added)

The unfit accused appealed the Court of Appeal's decision to the Supreme Court of Canada. The majority of the judges of that Court dismissed the appeal, as follows:

> When an accused person has been found unfit to stand trial and the other statutory requirements have been met, the court may make a disposition order directing that treatment be carried out for a specified period not exceeding 60 days and on such conditions as the judge considers appropriate for the purpose of making the accused fit to stand trial. The disposition order may not be made, however, without the consent of either the person in charge of the hospital where the accused is to be treated or the person to whom responsibility for the treatment of the accused has been assigned.
>
> …
>
> In our view, the meaning of the relevant provisions, supported by an understanding of their full context, leads to the conclusion that the hospital or person in charge of treatment must consent to all the terms of a disposition ordering treatment and, if there is no consent, the order cannot be made. The terms of the order include when it is to be carried out and therefore consent relates to timing.[52]

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

48 *Ibid*, s 672.62 (emphasis added).

49 *R v Conception*, 2014 SCC 60 ["*Conception*"], affirming *Centre for Addiction and Mental Health v Ontario*, 2012 ONCA 342.

50 *Centre for Addiction and Mental Health v Ontario, ibid* at para 29.

51 *Ibid*, at para 39.

52 *Conception, supra* note 49, at paras 1 and 13.

While the decision is helpful in general to forensic hospitals, the Supreme Court of Canada cautioned that, although it would be "exceedingly rare", a refusal of consent, and thus a delay in admitting a patient, may have the effect of unconstitutionally limiting an unfit accused's rights to life, liberty or security of the person, as guaranteed by section 7 of the Canadian *Charter of Rights and Freedoms*, in a fashion that does not accord with the principles of fundamental justice. In that case, a judge would be able to order an immediate admission, as a remedy for the breach of the accused's *Charter* rights.[53]

The nature of the ORB hearing for an unfit accused is discussed in further detail below; however, by way of summary, the ORB is required to determine whether the accused is fit to stand trial as at the time of the ORB hearing.[54]

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

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

> *No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.*[55]

"Mental disorder" is defined by the *Criminal Code* to mean "a disease of the mind". The Supreme Court of Canada has interpreted "disease of the mind" to be any illness, disorder or abnormal condition that impairs the human mind and its functioning, but generally, it does not include a self-induced state caused by alcohol or drugs or transitory mental states such as hysteria or concussion,[56] although sometimes a substance-induced psychosis may be found to be a disease of the mind.[57] However, the Supreme Court of Canada has held that in order for a substance-induced psychosis to form the basis of an NCRMD defence, the accused must have had an underlying mental disorder at the time of the index offence that was made worse by the intoxication to the point of psychosis; to simply be suffering from intoxication is not sufficient to ground an NCR defence.[58] A personality disorder may also be a disease of the mind for the purposes of subsection 16(1).[59]

The *Criminal Code* sets out two branches of the NCRMD defense test: first, the mental disorder must be causally related to the person being incapable of appreciating the nature and quality of the act or omission which is the subject of the criminal offence; or second, the disorder makes the person incapable of knowing that the act or omission was wrong.

The two branches of the NCRMD defense test are alternatives; if the accused suffers from a mental disorder such that the test set out in either branch is met, the accused may be excused from criminal responsibility.[60]

53 *Ibid*, para 43.

54 *CC*, *supra*, note 8, s 672.48(1).

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

56 *R v Cooper,*[1980] 1 S.C.R. 1149 [*Cooper*], as summarized by David Watt and Michele Fuerst, *The 2023 Tremeear's Annotated Criminal Code*, Part XX.I (Ontario ORB Edition, Thomson Carswell, 2023 at 65 [*Watt & Fuerst*].

57 *R v Mailloux* (1985), 25 CCC (3d) 171 (ONCA); aff'd (1988), 45 CCC (3d) 193 (SCC) [*Mailloux*]; as summarized in *Watt & Fuerst*, *ibid*, at 65. Note that in *Mailloux*, the accused already suffered from active symptoms of a paranoid personality disorder at the time the drugs were taken. For a more thorough discussion of the contextual approach courts are required to take in determining whether a s 16 defence will be available to an accused suffering from a substance-induced psychosis at the time of the index offence, see: *R v Bouchard-Lebrun* 2011 SCC 58. Essentially, the SCC makes clear in *Bouchard-Lebrun* that voluntary self-intoxication by a person who does not suffer from an underlying mental disorder will not afford a s. 16 defence.

58 *Bouchard-Lebrun, ibid* at para 41.

59 *Cooper*, *supra* note 56 as summarized in *Watt & Fuerst*, *supra* note 56, at 65.

60 *Watt & Fuerst*, *supra* note 56, at 63.

The first branch of the test requires evidence that the accused, by reason of a disease of the mind, was deprived of the mental capacity to appreciate the nature and quality of the act, or in other words, to foresee and measure the physical consequences of the act.[61]

The second branch of the test is not only about the intellectual ability to know right from wrong in an abstract sense but also the ability to apply that knowledge in a rational way to the alleged criminal act. In other words, the NCRMD defence will be available to the accused who is deprived by mental disorder of the capacity for rationally choosing between rightness or wrongness of the act at the time it was committed[62] and deprived of knowing that the act committed was something the accused ought not to have done.[63]

Subsection 16(2) presumes that the accused does not suffer from a mental disorder, unless proven otherwise on a balance of probabilities. The burden of proving that the accused suffers from a mental disorder rests on the party who raises it.[64] While the Crown may raise the issue of mental disorder, for the purpose of querying whether the accused has a defence of not criminally responsible open to them, the Crown may only do so after the trier of fact has concluded that the accused is otherwise guilty of the offence charged. The Crown may raise the issue of whether the accused suffers from a mental disorder prior to a positive finding that the accused committed the offence, only if the accused first puts their mental capacity for intent at issue during their defence.[65]

Where the trier of fact, either a jury or a judge, "finds that an accused committed the act or made the omission that formed the basis of the offence charged, but was at the time suffering from mental disorder so as to be exempt from criminal responsibility by virtue of subsection 16(1), the jury or the judge shall render a verdict that the accused committed the act or made the omission but is not criminally responsible on account of mental disorder".[66] The jury or judge must first be satisfied that the evidence establishes beyond a reasonable doubt that the accused committed the act or made the omission, before going on to consider whether, at the time of the offence, the accused was suffering from a mental disorder that rendered the accused incapable of appreciating the nature or quality of the act or omission, or of knowing that it was wrong.[67]

Generally, in determining whether to reach a verdict of NCRMD, the court will look to the expert evidence of a forensic psychiatrist, usually by way of a written assessment report, which may assist the court in determining whether or not the accused suffered from a mental disorder at the time of the offence such that the NCRMD defence is available to them. Bloom and Schneider in their text, *Mental Disorder and the Law*, thoroughly review the component parts of the psychiatric assessment for criminal responsibility. In their view, a forensic psychiatrist should not conclude that the mere presence of a serious mental disorder or psychosis signals that the accused was not criminally responsible at the time of the index offence. More important, in their view, is whether "the symptoms of the mental disorder have expressed themselves robustly enough at the critical time [such that] a clinician can reasonably say that the symptoms of the mental disorder were instrumental in bringing about the behaviour" giving rise to the charges.[68]

In July 2014, Part XX.1 of the *Criminal Code* was amended by parliament in Bill C-14, the *Not Criminally Responsible Reform Act*.

The amendments included a provision allowing for the designation of "high risk accused" if certain criteria are met. The Crown may bring an application to the court "before any disposition to discharge an accused absolutely," and the court may find the accused to be a "high risk accused" if the following criteria are met:

- The accused has been found NCRMD of a serious personal injury offence; and
- The accused was 18 years of age or older at the time of the commission of the offence; and

61 *Cooper*, *supra* note 56, at 65; see also *R v Landry* (1991), 62 CCC (3d) 117 (SCC); as summarized in *Watt & Fuerst, supra* note 56 at 67.

62 *R v Oommen* [1994], 2 SCR 507; as summarized in *Watt & Fuerst, supra* note 56 at 67.

63 *R v Chaulk* [1990], 2 SCR 1303; as summarized in *Watt & Fuerst*, *supra* note 56 at 67.

64 *CC*, *supra* note 8, ss 16(2)-16(3).

65 *Swain*, *supra* note 5 at 939-940, 948.

66 *CC*, *supra* note 8, s 672.34.

67 *R v David* (2002), 2002 CanLII 45049 (ON CA); ; as summarized in *Watt & Fuerst*, *supra* note 56 at 66. The approach taken by the Court of Appeal in *R v David* was recently followed in *R v Prendergast,* 2022 ONSCV 6567(CanLII) at paras. 10-13

68 *Bloom & Schneider*, *supra* note 33 at 172, and more generally at 170-187.

- The court is satisfied that there is a substantial likelihood that the accused will use violence that could endanger the life or safety of another person; or
- The court is of the opinion that the acts that constitute the offence were of such a brutal nature as to indicate a risk of grave physical or psychological harm to another person.[69]

Where a verdict of NCRMD has been reached, a court could at that point receive an application from the Crown attorney to have the accused designated as a high risk accused before the accused's situation is first considered by an ORB. When a court decides to designate an accused as a high risk accused, it is the court, not the ORB that must issue a disposition under s 672.54(c), namely a detention order. Further, the detention order must not contain any condition that would permit the accused to be "absent from the hospital" unless:

- It is appropriate, in the opinion of the person in charge of the hospital, for the accused to be absent from the hospital for medical reasons or for a purpose that is necessary for the accused's treatment, if the accused is escorted by a person who is authorized by the person in charge of the hospital; and
- A structured plan has been prepared to address any risk related to the accused's absence and as a result, that absence will not present an undue risk to the public.[70]

Since coming into force in 2014, the new high risk accused provisions have received judicial consideration across Canada.

In the first reported decision to consider the new high risk accused scheme, *R v Schoenborn*,[71] the British Columbia Supreme Court noted that the purpose of this new regime is to ensure the protection of the public against NCRMD accused who are considered dangerous and present an unacceptable risk to the public, requiring a further reduction in their liberty in the form of mandatory custodial detention and other restrictions.

The court in *Schoenborn* also noted that the threat posed by high risk accused must be greater than that which is necessary to make one of the dispositions that are already in place in s. 672.54(b) and (c) for accused who present a "significant threat to the safety of the public." In considering the meaning of the "substantial likelihood" test under 672.64, the court in *Schoenborn* found that it requires a "high degree of probability the accused will use violence that will result in grave physical or psychological harm, in the sense of substantial interference with physical or psychological integrity, health, or well-being.[72] This language was subsequently adopted and applied by the Ontario Superior Court in *R v Hadfield*.[73] To designate an NCRMD accused a high risk accused requires that the court must be satisfied to a high degree of probability on all relevant evidence and factors noted under s. 672.64(2).[74]

Once an NCRMD accused has been designated as a high risk accused, only a court can revoke the designation, when the matter is referred back to it a provincial review board.[75]

Conversely, where a verdict of NCRMD is rendered in respect of an accused who is not designated as high risk accused, the court that reached the verdict may hold a disposition hearing, on its own motion, or refer the matter to a Review Board for an initial hearing. Where the Crown prosecutor or the accused applies to the court to hold a disposition hearing, the court is required to conduct one.[76] However, as with findings that the accused is unfit to stand trial, the court will only make a disposition if the court is satisfied that it can do so and it considers that a disposition should be made without delay.[77]

If the court makes a disposition, the ORB is still required to hold an initial hearing to review that disposition (if it is other than an absolute discharge), and make a new disposition within 90 days after the court's disposition was made.[78] If the court makes no disposition in respect of an accused, the ORB

69 *CC, supra* note 8, s. 672.64(1).

70 *CC, supra* note 8, s. 672.64(3). Note that in *Re (Coussineau)* 2021 ONCA, the Court of Appeal declined to make a general ruling on the meaning of "hospital" for the purpose of considering the prohibition against a high-risk accused being "absent from the Hospital" in the context of s. 672.64. The court noted that even if "hospital" is broad enough to include hospital grounds, the court or Board making the disposition is not compelled to include unescorted grounds privileges in the disposition it makes. The limits imposed on available dispositions for high-risk accused pursuant to s. 672.64(3) set out the maximum community privileges that can be provided, not the minimum.

71 2017 BCSC 1556 ["*Schoenborn"]*

72 *Ibid* at para 35.

73 2022 ONSC 2047, at paras 28 - 31.

74 *Ibid* at para 31.

75 *CC, supra* note 8, s. 672.84(1)

76 *Ibid*, s 672.45(1).

77 *Ibid*, s 672.45(2).

78 *Ibid*, s 672.47(3).

is required to hold a hearing and make a disposition within 45 days after the verdict of NCRMD was rendered, although in exceptional circumstances, the court may extend the time for holding the initial ORB hearing to no later than 90 days from the time the verdict is rendered.[79]

In NCRMD cases, other than those involving a high risk accused, it is rare for a court to make an initial disposition regarding a new NCRMD accused.

In practice, it is rare that a court makes a disposition regarding a new NCRMD accused. Where the court issues a disposition that detains an accused in hospital or places the accused on a conditional discharge under the general authority of a designated facility, that order has immediate effect.

Alternatively, the court has the authority, where it does not make a disposition, to nonetheless make an order for the interim release or detention of the accused that the court considers to be appropriate in the circumstances, including an order directing that the accused be detained in custody in a hospital pending a disposition by the ORB.[80]

5. An Overview of ORB Hearings

General Introduction to ORBs

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

Review Boards are established by section 672.38 of the *Criminal Code* for the purpose of making or reviewing dispositions concerning "any accused in respect of whom a verdict of [NCRMD] or unfit to stand trial is rendered. Review Boards shall consist of not fewer than five members appointed by the Lieutenant Governor in Council of the province".[81] A Review Board must have at least one member who is a duly qualified psychiatrist and where only one member is so qualified, there must be at least one other member who has training and experience in the field of mental health and qualified to practice either medicine or psychology.[82]

The Chairperson of a Review Board shall be a judge, a retired judge or a person who is qualified for appointment to a judicial office (i.e., a lawyer who has been called to the Bar for 10 or more years).[83] When a Review Board meets, quorum is constituted by the chairperson, a psychiatrist member and any other member.[84] While a Review Board panel generally meets in panels of five, there may be occasions, such as inclement weather, where not all members can convene, and this provision allows the Review Board to conduct a hearing with a minimum of three members, two of whom must be the chairperson and a psychiatrist.

When the ORB holds a hearing to review or make a disposition and there is a split in the views of the panel as to the appropriate disposition, the decision of the majority of the members prevails and is treated as a decision of the ORB.[85]

Who is a "Party"?

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

(a) The accused;

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

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

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

(e) Where the disposition is to be made by a court, the prosecutor of the charge against the accused.[86]

In terms of "interested parties", Review Boards have sometimes made parents of the accused "interested parties" where they have requested standing, and more rarely, the

79 *Ibid*, ss 672.47(1)-672.47(2).

80 *Ibid*, s 672.46(2).

81 *Ibid*, s 672.38(1).

82 *Ibid*, s 672.39.

83 *Ibid*, s 672.4(1).

84 *Ibid*, s 672.41(1).

85 *Ibid*, s 672.42.

86 *Ibid*, s 672.1.

person in charge of the designated forensic psychiatric hospital to which the accused may be detained or required to report in the future.

A victim of the index offence is not considered a party to a hearing. However, the *Code* provides victims with the right to be notified of upcoming hearings, certain proposed changes to dispositions and the right to prepare and file a written statement with the court or Review Board, describing the physical or emotional harm, property damage or economic loss suffered as a result of the commission of the offence and the impact of the offence on them**.** [87]

Types of Dispositions

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

- The safety of the public, which is the paramount consideration;[88]
- The mental condition of the accused;
- The reintegration of the accused in to society; and
- The other needs of the accused.

Taking those four factors into account, the legislation requires the ORB to make the disposition that is "necessary and appropriate in the circumstances."[89] An Ontario Court of Appeal decision has held that the phrase "necessary and appropriate" continues to mean the "least onerous and least restrictive" disposition for the accused, and that the prevailing jurisprudence on that standard continues to apply.[90] In making such a disposition, the ORB must consider not only the general type of disposition (absolute discharge, conditional discharge or detention order), but must also consider the effect of the conditions of the disposition, so that the disposition taken as a whole imposes the least onerous and least restrictive conditions.[91] Further, where the ORB makes a detention order, the court or ORB must consider the totality of the circumstances in which the accused is detained to determine which of the available options for detention is the least restrictive and least onerous, or, in other words, necessary and appropriate.[92]

The ORB is required to gather and review all available evidence pertaining to all four factors set out in s. 672.54. If the parties do not present sufficient information, it is up to the ORB to seek out the information it requires.

The ORB must consider the "mental condition of the accused" at the time of the disposition hearing and not at the time of the index offence.[93] The words "mental condition" connotes a broader appreciation of the accused's condition involving the accused's overall mental state, rather than the more restrictive "mental disorder" which was considered when the verdict of unfit or NCRMD was originally made.[94]

The ORB's obligation to consider all four factors in making a disposition has been considered by the Ontario Court of Appeal. For example, where the ORB has failed to consider the other needs of the accused, the Court of Appeal has ordered a new hearing. In *R v Aghdasi*, the ORB's Reasons for Disposition had failed to address the role that the accused's cultural and linguistic isolation might play in preventing his successful reintegration into the community. Further, the Court held that

87 CC, *supra* note 8 at ss 672.5(5), (5.1), (13.3) (14), (15), (15.1), (15.2) and (15.3). See also *Gajewski* (Re), 2020 ONCA 4 at para 32 [*Gajewski*].

88 *CC, supra* note 8 at s 672.54, as amended in July 2015, by Bill C-14, 2014, c.5, s 9. Note that the case law prior to Bill C-14 had already established that the need to protect the safety of the public was the paramount consideration: see *Pinet v St Thomas Psychiatric Hospital*, 2004 SCC 21 at para 19: "The principles of fundamental justice require that the liberty interest of individuals … who have been found not criminally responsible ("NCR") for a criminal offence on account of mental disorder be taken into account at all stages of a Review Board's consideration. The objective is to reconcile the twin goals of public safety and treatment. In this process of reconciliation, public safety is paramount."

89 *CC*, *supra* note 8, s 672.54, as amended by Bill C-14, *supra* note 88.

90 *Ranieri (Re)*, 2015 ONCA 444, at paras 20-21; affirmed in *Campbell (Re)*, 2018 ONCA 140, at para 3 [*Campbell*]. Prior to the July 2015 amendments, s 672.54 required Review Boards to issue dispositions that were "the least onerous and least restrictive in the circumstances".

91 *Mental Health Centre Penetanguishene v Ontario (Attorney General)*, 2004 SCC 20at paras 44, 51-56 [*Penetanguishene*].

92 *Mental Health Centre Penetanguishene v Magee*, 2006 CanLII 16077 (ONCA) at paras 59-60 and 64 [*Magee*].

93 *Peckham v Ontario (Attorney General)* (1994), 19 OR (3d) 766 at 775 (CA), leave to appeal refused [1995] 1 SCR ix.

94 *Ibid.*

the ORB in that case had failed to seek out information about the resources that would address those needs. Accordingly, the Court of Appeal found the ORB's reasons deficient and ordered a new hearing.[95]

In *R v Conway*, the Supreme Court of Canada held that Review Boards have the jurisdiction to consider and grant remedies under s. 24(1) of the *Charter*.[96] This means that where a forensic patient alleges that their *Charter* rights have been infringed, the ORB may hear and decide that issue and award an appropriate remedy. However, the Court also held that the ORB must consider whether the *Charter* remedy sought is consistent with its statutory mandate. For example, as was the case in *Conway*, if the patient seeks an absolute discharge, granting that remedy will not be available to the ORB if it has concluded that patient continues to pose a significant threat to public safety.[97] The Court also directed the ORB to consider whether the remedy can be granted without resort to the *Charter*, by simply addressing the patient's complaint through the exercise of the ORB's statutory mandate and discretion in accordance with *Charter* values.[98]

More recently, the Ontario Court of Appeal has considered what remedies would be available where the ORB has found that an accused's *Charter* rights have been infringed by hospital conduct and has held that the ORB lacked the jurisdiction to grant costs, damages and declaratory relief as *Charter* remedies.[99] The Court held that the available remedies that the ORB could award for a *Charter* breach include:

- conditions in a disposition that are flexible, individualized and creative, in order to supervise the NCRMD accused in a responsive, *Charter*-compliant fashion;
- guidance to hospitals on their obligations under the *Criminal Code* and *Charter*; and
- certain orders of the ORB, such as holding review hearings within a period of time less than the 12 months mandated for annual reviews.[100]

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

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

> *Section 672.54 does not create a presumption of [the accused's] dangerousness. There must be evidence of a significant risk to the public before the court or ORB can restrict the NCR accused's liberty.*[101]

A "significant threat to the safety of the public" has been considered by the Supreme Court of Canada to mean a "real risk of physical or psychological harm to members of the public... [that goes] beyond the merely trivial or annoying. The conduct giving rise to the harm must be criminal in nature".[102] In July 2014, Part XX.1 of the *Criminal Code* was amended by parliament in Bill C-14, the *Not Criminally Responsible Reform Act*. The amendments included the addition of a statutory definition of significant threat to the

95 *R v Aghdasi*, 2011 ONCA 57 at para 19, citing *Winko*, *supra* note 1 at paras 24-26, 55, and 62.

96 *R v Conway*, 2010 SCC 22.

97 *Ibid* at para 101.

98 *Ibid* at para 103.

99 *Re Starz*, 2015 ONCA 318, leave to appeal refused [2016] SCCA No 459 at paras 90 – 111[*Starz*] and *Re Chaudry*, 2015 ONCA 317, at para 96 [*Chaudry*].

100 *Starz, ibid*, at paras 112 – 115, and *Chaudry*, *ibid* , at paras 97 - 103. See also *Shortt (Re)*, 2020 ONCA 651 (CanLII), where the Court of Appeal held that the Board should have exercised its inquisitorial powers to hear the accused's Charter application and craft a remedy. The accused alleged that his right to liberty had been infringed by a repeated failure to implement a condition in his ORB disposition allowing him to live in the community in accommodation approved by the person in charge. The accused's disposition had contained this term for several years prior to the hearing of the appeal, without the accused being discharged to the community. There was evidence that the accused was ready to live in the community but there was a lack of funding to provide suitable supportive housing. The Court held that the accused's Charter protected right to liberty had been infringed and ordered the Board to require a representative of the provincial government to attend the next annual review to respond to allegations regarding the inordinate delay in obtaining suitable housing and to provide an implementation plan for providing the accused with such housing.

101 *Winko*, *supra* note 1, at para 49; *CC*, *supra* note 8, s 672.54(a).

102 *Winko, ibid* at para 57.

safety of the public, which essentially codified the prior case law interpreting significant threat.

For the purposes of section 672.54, a significant threat to the safety of the public means a risk of serious physical or psychological harm to members of the public – including any victim of or witness to the offence, or any person under the age of 18 years – resulting from conduct that is criminal in nature but not necessarily violent.[103]

In the leading decision of *R v Winko*, the Supreme Court also wrote that:

> *There is no presumption that [an NCRMD] accused poses a significant threat to the safety of the public. Restrictions on his or her liberty can only be justified if, at the time of the hearing, the evidence before the court or ORB shows that the [NCRMD] accused actually constitutes such a threat.... If [the court or Board] cannot come to a decision with any certainty, then it has not found that the [NCRMD] accused poses a significant threat to the safety of the public.*[104]

Because there is no presumption that the accused continues to pose a significant threat to public safety, the accused is not required to disprove their dangerousness. It is well established that proceedings before the ORB are inquisitorial: "the ORB has an obligation to gather and review available evidence pertaining to the four factors set out in section 672.54 of the *Criminal Code*".[105] To discharge this obligation, the ORB has the power to subpoena records and witnesses and to order assessments where necessary to assist it in making a disposition.

In this regard, the ORB will look to the hospital where the accused has been detained, or has to report, for evidence on the accused's current mental condition, their progress towards reintegration into the community and the accused's other needs. The hospital's evidence will also be germane to the issue of significant threat, particularly in the form of any actuarial or clinical risk assessments that speak to the likelihood of future criminal recidivism and any recent incidents of violent, assaultive, threatening or harassing behaviour, for example. While relying principally on the evidence adduced by the person in charge of the forensic hospital, the Crown will likely emphasize evidence that relates to the index offence, the accused's insight into the relationship between his or her mental disorder and the offence, the accused's criminal history or past history of violent conduct, insofar as this evidence relates to the Crown's obligation and interest in protecting public safety.

The ORB will look to the hospital where the accused has been detained, or has to report, for evidence on the four factors set out in section 672.54: the accused's current mental condition, his or her progress towards reintegration into the community and the accused's other needs , and most importantly, the accused's current risk to the safety of the public.

In making the determination as to whether the accused poses a significant threat to the safety of the public, the Board or court may consider a broad range of evidence including, but not limited to evidence of:

- The past and expected course of treatment for the accused, including adherence to medication requirements;
- The accused's present mental condition at the time of the hearing, including the presence or absence of symptoms of mental disorder and, importantly, the accused's insight into the relationship between their mental disorder and the index offence and their insight into the need for medication (as the case may be), as well as willingness to seek assistance if decompensating, and the effect of these issues, on the accused's risk;
- The accused's plans for the future, and their feasibility;
- Available community support for the accused;
- The accused's criminal history and the gravity of the index offence;
- Any ongoing substance use on the part of the accused, in conjunction with any evidence that the substance use leads to a deterioration in the accused's mental condition and to an increase in the accused's risk to public safety;
- Recent incidents of violent or threatening behaviour, or lack thereof on the part of the accused;

103 *CC*, *supra* note 8, s 672.5401, as amended by Bill C-14, *The Not Criminally Responsible Reform Act*, S.C. 2014, c. 6, s. 10.

104 *Winko, supra* note 1, at para 62, item 3.

105 *Ibid* at para. 55.

- The health care teams' assessment of the accused; including the clinical risk assessment of the likelihood that the accused will engage in violent or otherwise criminal conduct in the future;
- The amount of time that the accused has lived successfully in the community; and
- The application of *Gladue* principles, which consider the unique circumstances and experiences of indigenous peoples, when the Board is determining the threshold question of whether an NCRMD accused poses a significant threat to the safety of the public.[106]

The Court of Appeal has commented recently on the meaning of the test for significant threat and scrutinized the ORB's application of the test in several recent cases, emphasizing the following points:

- The Board is required to consider both the likelihood of the risk materializing and the seriousness of the harm that might occur.[107]
- The correct test is of real, foreseeable risk.[108]
- In terms of likelihood, the risk must be probable, not possible.[109]
- The risk must not be speculative.[110]
- The standard for significant threat has been described as an onerous one.[111]
- The ongoing presence of mental health issues and a lack of insight into the need for medication, does not by itself establish a significant threat to the safety of the public.[112]

In *Kassa (Re)*,[113] the Court of Appeal clarified that *Winko* requires the Board to assess the likelihood of serious physical or psychological harm occurring as a result of criminal conduct that would occur if the appellant is granted an absolute discharge, and to weigh the seriousness of the potential harm in combination with the likelihood of that harm materializing. In other words, "[t]he likelihood of a risk materializing and the seriousness of the harm that might occur must be considered together".[114]

In *R v Stanley*, the Court of Appeal considered the use of a community treatment order ("CTO") to mitigate an accused's risk to the public, such that the Court found that he no longer posed a significant threat to the safety of the public and ordered an absolute discharge for the accused.[115] The Court of Appeal stated:

> *[based on] the record before the Board and the reasons underpinning its decision, it is clear that the justification for denying the appellant an absolute discharge rested upon the concern that absent a legal compulsion requiring him to do so, he would not take his medication and that he was not integrated with the non-forensic case management system. The appellant had demonstrated a record of consistent compliance for the past several years. Moreover the CTO implements a legal mechanism that requires the appellant to continue taking his medication. [The patient's attending physician] is satisfied that the appellant will adhere to the CTO. The fresh evidence is the vital link missing at the time of the hearing. The fresh evidence also indicates that the appellant has been linked with the community mental health care network to the satisfaction of his treating physician.... the only reasonable outcome in light of the fresh evidence is to grant the appellant an absolute discharge.*[116]

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

106 *Winko, supra* note 1, at para 62, items 5 and 6; we have also included other items which we regularly see ORBs consider, and referred to Ontario Court of Appeal decisions that have commented on these issues. See for example: *Gibson(Re)*, 2022 ONCA 527, paras 18 – 22 [*Gibson*]; *Faichney (Re)*, 2022 ONCA 300 at para 25, regarding the application of *Gladue* principles to the threshold question of significant threat.

107 *Sim (Re),* 2020 ONCA 563 at paras 64 - 65.

108 *Nagash (Re),* 2021 ONCA 280 at para 11.

109 *Ibid* at para 12.

110 *Winko*, *supra* note 1, at para 57; see also *Negash (Re)*, 2021 ONCA 280 (CanLII), at para 12.

111 *Carrick (Re)*, 2015 ONCA 866, at para 17.

112 *Gibson*, *supra* at note 106 at paras 21-22.

113 *Kassa (Re)*, 2019 ONCA 313, at para 34-35.

114 *Ibid* at para 33, citing *Wall (Re)*, 2017 ONCA 713 at para 13.

115 *R v Stanley*, 2010 ONCA 324.

116 *Ibid*, at paras 27 – 29.

resulting in an absolute discharge. In 2021, in *Wightman (Re)*, the Court of Appeal limited the approach taken in *Stanley* to the particular facts of that case, where the appellant's treating physician had testified at the hearing, and also provided affidavit evidence on the hearing of the appeal, as noted above. The Court cautioned against granting an absolute discharge to an appellant NCR accused, in the absence of a full evidentiary picture. While an appellate court must be vigilant in protecting the liberty of the NCRMD accused, that vigilance "must be tempered with recognition of the inherent difficulty of the subject matter and the expertise of the medical reviewers."[117]

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

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

The Supreme Court of Canada, in *R* v *Demers*, ruled that by making an absolute discharge available only to NCRMD accused and not to the unfit accused, Parliament had infringed the *Charter* rights of the unfit accused. The infringement arose due to the risk of an indeterminate detention, where the accused was unlikely to ever become fit to stand trial and no longer posed a significant threat to the safety of the public.[118]

As a result of the Supreme Court's ruling in *Demers*, Parliament introduced new provisions to Part XX.I, requiring the ORB or court to consider whether the accused is permanently unfit. If the evidence demonstrates that the accused's capacity to stand trial will never be regained or acquired, and that the accused does not pose a significant threat to public safety, then the ORB may recommend that the court with jurisdiction over the accused's offence should hold a hearing to inquire into whether a stay of proceedings should be ordered.[119] The court may also take this step on its own motion whenever the accused appears before it.[120]

When holding the hearing to determine whether a stay of proceedings is appropriate, the court must consider not only whether the accused is permanently unfit to stand trial and no longer poses a significant threat, but also whether the stay is in the interests of the proper administration of justice.[121]

The court with jurisdiction over the unfit accused, is the court in which the accused's criminal offence charge is pending. In a 2022 case, the Ontario Superior Court of Justice considered whether to stay charges of sexual assault and sexual interference, as recommended by the Review Board following the Unfit Accused's review hearing. The court held that where the accused still posed a significant threat to the safety of the public, despite the passage of time from the index offence, there could be no stay of proceedings, as it would undermine the public's confidence in the administration of justice, due to the seriousness of the alleged offences.[122]

If the court orders a stay of proceedings, any disposition in respect of the accused ceases to have effect,[123] similar to the effect of an absolute discharge for the NCRMD accused.

It should also be noted that the Mental Disorder provisions of the *Criminal Code* also afford some protection from indeterminate detention to the unfit accused by requiring that the Crown hold a "*prima facie* hearing" every two years once the accused has been found unfit. The purpose of this hearing is to require the Crown to demonstrate to the court with jurisdiction over the offence that there is still sufficient evidence to put the accused on trial.[124] In other words, the Crown must show that it has evidence, which on its face may prove that the accused committed the offence in question. If there is not sufficient evidence at the time of the *prima facie* hearing, the court must acquit the accused.

117 *Wightman (Re),* 2021 ONCA 429, at paras 27-33.

118 *R v Demers*, [2004] 2 SCR 489 at 513-515.

119 *CC*, *supra* note 8 at s 672.851(1)-(3).

120 *Ibid,* at 672.851(4).

121 *Ibid* at ss 672.851(7)-(8).

122 *R v. LeBlanc*, 2022 ONSC 2922, paras 49 – 54.

123 *CC*, *supra* note 8 at s 672.851(9).

124 *Ibid*, s 672.33.

Discharge Subject to Conditions, or "Conditional Discharge"

Where the court (initially) or the ORB finds that the accused poses a significant threat to the safety of the public, there are two possible types of dispositions that may be made: a discharge subject to conditions or a detention order.

The discharge subject to conditions[125] is a "discharge" in that the accused may no longer be detained in hospital under the terms of the ORB's order. Consequently, the ORB cannot conditionally discharge an accused and also provide a term in the disposition that the accused be detained in hospital, or a term that the accused reside in the community in accommodation approved by the person in charge.[126] If the person in charge were to have discretion to approve the accused's accommodation in the community, under the terms of a conditional discharge, this would effectively give the person in charge veto power over the discharge from hospital, contrary to the discharge order of the ORB. In a recent appeal of an ORB detention disposition, the Court of Appeal held that where a hospital wishes to retain the continued authority to alter the accused's community living arrangements or to compel their return to the hospital, should either option become necessary due to deterioration in the accused's condition, a detention disposition is required.[127]

In crafting terms for the conditional discharge, the ORB will look to whether the evidence supports the inclusion of the terms.

While not exhaustive, the following list includes common terms of a conditional discharge, that may require that the accused to:

- Report to the person in charge of the hospital, or their designate, at certain intervals;
- On the accused's consent, comply with treatment, or take medications, as prescribed by their attending physician, pursuant to subsection 672.55(1);
- Keep the peace and be of good behaviour;
- Refrain from possessing any weapons;
- Refrain from taking any non-prescription drugs, or illicit substances and alcohol and to participate in random drug screens;
- Refrain from contact or communication, direct or indirect with any victims of the index offence, except with their written revocable consent;
- Refrain from attending at a specified place, generally related to places of residence, education or employment of victims of the index offence;
- Reside at a certain address in the community or with a certain person;
- Advise the ORB and the hospital of any change of address or telephone number in advance of such a change; and
- Attend before the ORB, as required.

To impose an "abstinence" provision that requires the accused to refrain from consumption of non-prescribed substances, there must be sufficient evidence to demonstrate a connection between substance use and a significant risk to public safety. In *Re Davies*,[128] the Court of Appeal considered an appeal of an ORB disposition that prohibited an accused from using cannabis. The Court of Appeal found that the ORB had improperly relied upon evidence that cannabis use "may" create a risk of psychosis in the accused, and concluded there was insufficient evidence that cannabis use in a controlled hospital environment for a medicated and compliant patient, such as the appellant, "would" create a risk rising to the level of a significant risk to public safety.

125 *Ibid*, s 672.54(b).

126 *Brockville Psychiatric Hospital v McGillis* (1996), 93 OAC 266 (CA). If the person in charge were to have discretion to approve, or not approve, the accused's accommodation in the community, under the terms of a conditional discharge, this would effectively give the person in charge veto power over the discharge disposition of the Board.

127 *R v Capano*, [2008] OJ No 1712 (CA) at para 8; see also *R v Runnalls*, 2014 ONCA 264 at 8, and *Fotiou (Re)*, 2020 ONCA 153 at para 13: the delegation of the Board's power to require the hospital's approval of the accused's accommodation in the community is only possible under a detention order.

128 *Davies (Re)*, 2022 ONCA 716, at paras 14 – 17.

The Ontario Court of Appeal has held that it is permissible under a conditional discharge to set conditions that require the accused to:

- Upon notice by the person in charge of the hospital, immediately submit to attendance and for readmission to hospital; and
- Upon the request of the hospital, attend for psychiatric assessment.[129]

Such terms cannot be used to forcibly return an accused to the hospital, and keep the accused there against his or her will. Rather, these terms give a hospital the power to require the accused to re-attend, and require the accused to comply with a hospital's direction. If the accused then does not comply, he or she is in breach of a term of their disposition and the mechanisms under s. 672.91, 672.92 and 672.93 (discussed in further detail below) would be available for the return of the accused to hospital.[130]

On the issue of whether conditional discharges should include a term, on the consent of the accused, requiring the accused to comply with prescribed treatment, the Ontario Court of Appeal has held that:

> *... where an NCR accused seeks a conditional discharge from a mental health facility and such a disposition is a potentially realistic option based on the evidence adduced before the Board, the Board should consider whether the NCR accused might consent to any treatment conditions thought by the Board to be reasonable and necessary in the interests of the NCR accused. This type of inquiry would position the Board to impose treatment conditions, where appropriate, as provided for under s. 672.55(1) of the Code. It would also further the Board's full consideration of the least onerous and least restrictive disposition for the NCR accused, as mandated by s. 672.54 of the Code.*[131]

In other words, where the ORB is considering whether an accused should be either discharged subject to conditions, or maintained on a detention order with provision for community living, the ORB should explore the accused's willingness to consent to a condition requiring them to comply with prescribed treatment. Although the hospital may explore that with the accused prior to the hearing, the ORB will often look to the accused's legal counsel for confirmation that the accused has consented to such a condition at the time of the hearing. The ORB will also be interested to know whether the accused has a history of medication non-compliance in evaluating the necessity of such a condition.

In 2018, the Court of Appeal clarified that accused who are incapable of consenting to their own treatment under the *Health Care Consent Act* may still fulfill the consent requirement for a treatment term pursuant to s 672.55(1) of the *Criminal Code*. In *Kalra (Re)* and *Ohenhen (Re)*[132], the Court clarified that the capacity required for a treatment condition to be imposed is different than the capacity required to consent to treatment at large. To consent to a condition requiring compliance with treatment, an accused must understand all information relevant to the operation of the condition, and appreciate the reasonably foreseeable consequences of complying (or not) with the condition. Although it is ideal to consider this test for capacity in advance of a hearing, the ORB has also imposed treatment conditions where counsel for the accused advised the ORB mid-hearing that their client understands the information regarding the treatment condition and understands the consequence of complying with the condition and consequences of a breach of the condition.[133]

The Court of Appeal has held that if there is an "air of reality" as to whether an accused may be managed in the community on a conditional discharge (meaning that such a disposition is a realistic option based on the evidence adduced before the ORB), the ORB must consider two things:

- Whether the accused will consent to a condition requiring the accused to take medications as prescribed under section 672.55; and
- The potential mechanisms for accomplishing the accused's return to hospital.

129 *Re Young*, 2011 ONCA 432 [*Young*]; *see also Gajewski (Re)*, 2021 ONCA 244 [*Gajewski 2*].

130 *R v Coles*, 2007 ONCA 806 at para 4; see also *Collins (Re)*, 2018 ONCA 563 [*Collins*].

131 *R v Breitwieser*, 2009 ONCA 784; see also *Collins*, *supra* note 130.

132 *Kalra (Re)* and *Ohenhen (Re)*, 2018 ONCA 65 [*Kalra (Re)* and *Ohenhen (Re)*].

133 *Torangeau (Re)*, 2018 CarswellOnt 17565.

The Court held that the ORB is required to explore these two issues even where none of the parties to the hearing have recommended a conditional discharge.[134]

One of the challenges posed by a conditional discharge, often cited by hospitals and their clinical staff, is the difficulty of returning the accused to hospital if there are warning signs of medication non-compliance and deterioration in the mental condition of the accused.

Provisions in Part XX.I of the *Criminal Code* provide authority for the police to arrest an accused without a warrant at any place in Canada if the police have reasonable grounds to believe that the accused has contravened or wilfully failed to comply with a disposition or any of its terms, or an assessment order, or is about to do so.[135] Consequently, if the accused has breached a condition of their disposition, the arresting officer may release the accused from custody and deliver them to the hospital named in the disposition or assessment order.[136]

The arresting officer may also detain the accused in custody, if necessary, to determine the accused's identity and to establish the terms and conditions of a disposition in respect of the accused.[137]

The legislative scheme for the return of the conditionally discharged accused to their supervising hospital is helpful but not without its inherent limitations. It functions only in so far as the accused has breached, or there is an anticipated breach of, conditions of the disposition.

Section 672.91 would not be helpful where an accused has discontinued or reduced their medications if compliance with treatment is not a term of the disposition. In that circumstance, if the non-compliance has led to a deterioration, hospital staff would have to resort to the involuntary assessment provisions of the *Mental Health Act* ("*MHA*") (i.e., Form 1 or Form 2), in order to return the conditionally discharged accused to hospital.

Section 672.92 provides for the return of a conditionally discharged accused, who has breached or is about to breach a term of their disposition, to their supervising hospital. However, the conditional discharge itself, provides no inherent authority for the hospital to detain the accused once he or she has been returned to the facility. There is no warrant of committal associated with a conditional discharge, as there is with a detention order. Therefore, the attending psychiatrist will need to assess the conditionally discharged accused and determine if the accused is willing to be admitted voluntarily, or, meets the criteria for an involuntary or informal admission under the *MHA*. If the accused is detained involuntarily under the authority of the *MHA*, the Court of Appeal for Ontario has found that this would not trigger the notice requirements for a restriction of liberty hearing, where the accused is detained in hospital for longer than seven days.

In some cases where an accused has been residing in the community, and has been returned to and admitted to hospital, under the authority of sections 672.93(2) of the *Criminal Code*, the person in charge may be of the view that the conditional discharge should be replaced with a detention order. In addition to seeking an Early Review to seek a change in the disposition, the person in charge should consider whether notice to both the accused and the ORB of a "significant increase"[138] in restriction of the accused's liberty is required. If so, a mandatory Restriction of Liberty hearing may be convened, to be heard at the same time as the Early Review (see discussion of Early Review and Restriction of Liberty hearings below at pp. 6-36 to 6-38).

Detention Orders

The other type of disposition for either an unfit accused, or the NCRMD accused, who has been found to pose a significant threat to the safety of the public, is a custodial disposition requiring the accused to be detained at a specific hospital.[139] In Ontario, there are 11 hospitals that have been designated by the Minister of Health and Long-Term Care as places for the custody, treatment or assessment of an accused who is subject to an assessment order or disposition under Part XX.I of the *Criminal Code*.[140]

134 *R v Breitwieser*, 2009 ONCA 784; see also *Collins*, *supra* note 130.

135 *CC*, *supra* note 8, ss 672.91, 672.92 and 672.93.

136 *Ibid*, s 672.92(1).

137 *Ibid*, s 672.92(2).

138 *Ibid*, s 672.56(2)(b).

139 *Ibid,* s 672.54(c).

140 See https://www.health.gov.on.ca/en/common/system/services/psych/designated_cc.aspx for a list of Ontario hospitals that have been designated by the Minister of Health as forensic psychiatric facilities with in-patient and out-patient programs for mentally disordered offenders.

Where the ORB or court (initially) directs that the accused be detained in custody in a hospital, the detention order, like the conditional discharge, will contain certain conditions that the ORB will determine based on the evidence before it.

One of the fundamental conditions to be determined is the level of security under which the accused shall be detained. Where a Review Board has made a disposition that detains an NCRMD accused in hospital, "the choice of the type of hospital, the level of security and the conditions of detention will have a vital impact on the liberty interest of the detainee."[141]

There is one maximum or high secure forensic psychiatric facility in Ontario at the Waypoint Centre for Mental Health Care (formerly the Mental Health Centre Penetanguishene). The other forensic facilities in the province generally provide both "Secure Forensic" and "General Forensic" units. Previously, these units have been described as medium secure ("Secure Forensic") and minimum ("General Forensic"). More recently, a number of forensic facilities have ceased the practice of identifying each forensic unit by its security level, and instead, have requested a detention order to the "Forensic Service", without specifying either a minimum or medium security level. In order to determine the least onerous and least restrictive disposition, the ORB may require a hospital to describe the structure and security of the unit on which the accused may be detained, so that the Board can identify the unit by name or location in their detention order.[142]

In determining what level of security is appropriate for a particular accused, the ORB will consider the following factors:

- **The recommendation of the clinical team and person in charge of the hospital where the accused is detained;**
- **The nature and circumstances of the index offence(s), including the accused's potential for serious personal injury offences and lethal acts;**
- **The accused's insight into their mental condition and its relationship to their actions at the time of the index offence;**
- **The different treatments and programs available in different levels of security; and**
- **The need to protect the public from dangerous persons.**[143]

In *R v Magee*, the Ontario Court of Appeal held that the ORB panel must consider all of the factors in section 672.54 when determining the least onerous and least restrictive disposition for the accused. The Court held that it was an error of law for the ORB to focus solely on the level of security as indicative of whether a disposition would be less restrictive to the accused.

The ORB's reasons had focused on whether Mr. Magee's risk could be managed on a medium secure unit, without considering how the move from a maximum secure facility where certain recreational, education and vocational programs were offered (and which were not necessarily available at the medium secure facility) would negatively affect his mental condition, thereby increasing his risk to public safety. Further, there was evidence before the ORB that the accused's request for a transfer to a medium secure unit in part related to a desire for increased access to women, which in the context of the accused's history of violent sexual offences, the appeal court ruled should have been taken into account.[144]

In the result, the Court held that the ORB should consider not only the level of security in determining what is least onerous and least restrictive but should also look to the conditions of detention viewed in their entirety.[145]

141 *Penetanguishene, supra* note 91 at para 31; *Vasanthkumar (Re)*, 2022 CaswellOnt 4009 (Ontario Review Board), at para 25.

142 *Roberts (Re)*, 2021 ONCA 869, at paras 26 – 27.

143 *Beauchamp v Mental Health Centre Penetanguishene* (1999), 138 CCC (3d) 172 at 181 (ONCA), as summarized in *Watt & Fuerst*, *supra* note 56 at 1362.

144 *Magee*, *supra* note 92 at paras 59, 63 – 65; see also *McAnuff (Re)*, 2016 ONCA 280 and *Tompkins (Re)*, 2018 ONCA 654, para 24.

145 *Magee, supra* note 92at para 93, citing *Penetanguishene, supra* note 91at para 3 (also known as the *Tulikorpi* decision).

It is common for an accused subject to a detention order, at a minimum-security level, to be granted a term providing for community living subject to the approval of the person in charge.

It is common for an NCRMD accused subject to a detention order, at a minimum secure level, to be granted a term providing for community living subject to the approval of the person in charge. This allows for the gradual transition of the accused to community living, with trial placements at a group home, for example, before moving to the community on a more long-term basis. It also allows the person in charge to revoke the community living privilege if the accused deteriorates and requires prompt readmission and detention in hospital, thus ensuring public safety should the accused's risk of dangerousness increase.[146]

The terms of a detention order will also specify the level of control over the accused and may include terms that provide for the accused's access to hospital grounds, whether accompanied or "indirectly supervised", meaning that the accused may enter hospital grounds unaccompanied but with requirements to check in with hospital staff at regular intervals. Similarly, there may be terms governing access to the community, either in the company of staff or an "approved person", or indirectly supervised; geographical limits may be imposed. Similar to the conditions discussed above in relation to conditional discharges, a detention order may have terms requiring the accused to refrain from ingesting alcohol, non-prescription drugs or illicit substances and to submit to random testing for such substances.

In drafting the necessary and appropriate disposition, the Ontario Court of Appeal has held that the ORB is under a positive duty to ensure that the unique factors associated with an indigenous NCRMD accused be considered. Further, the Board should apply *Gladue* principles, when considering the appropriate placement, reintegration into society and the other needs of the accused when determining the necessary and appropriate disposition.[147]

146 Joan Barrett & Riun Shandler, *Mental Disorder in Canadian Criminal Law* (Toronto: Thomson Reuters) (Loose-leaf revision, Release No 4, November, 2022), § 9:9 (Thomson Reuters eLooseleaf Library).

147 *R v Sim*, 2005 CanLII 37586 (ON CA), at paras 19 – 22. See also *R v Gladue*, 1999 CanLII 679 (SCC); *Summers (Re)*, 2022 ONCA 758 at para 35,

At one time, there were published guidelines for the terms of detention dispositions. These have not been updated since 1995[148] and there is some variation in practice in drafting the terms of ORB dispositions and in the interpretation of terms.

Transfers between Facilities

The ORB's Rules of Practice require that where any party will recommend that a forensic patient be transferred to another facility, notice must be given to the potential receiving facility.[149] At hearings where a transfer is recommended, it is common practice for the proposed receiving hospital to provide documentary evidence, usually by way of a letter from the person in charge or their designate, as to its opinion on the transfer and importantly, if the transfer were ordered by the ORB, the likely wait time, if any, before a bed would become available.

Following a 2010 decision of the Court of Appeal, it is now common practice for the ORB to grant authority for the interim or residual custody of the patient to the transferring hospital, with appropriate privileges, pending the transfer of the patient to another hospital.[150] Such interim custody and privileges allows for the continued progress and rehabilitation of the patient while awaiting transfer, and also provides the then current hospital to maintain detention and/or supervision of the patient pending transfer.

The ORB has suggested that *Gladue* principles and the collateral information found within a *Gladue* report may be considered for the purposes of determining whether an indigenous accused should be transferred to another facility.[151]

148 These guidelines are still available at the ORB's website online: http://www.orb.on.ca/scripts/en/legal/psych-hosp-guidelines.pdf (accessed December 2, 2022).>

149 ORB Rules of Practice, Rule 13; see Board's website online: <http://www.orb.on.ca/scripts/en/legal/orb-rules.pdf> (accessed on December 2, 2022); Rule 13 calls for notice to a potential receiving hospital four weeks in advance of annual hearing, and without delay in the case of other hearings.

150 *Mental Health Centre Penetanguishene v Ontario*, 2010 ONCA 197.

151 *Perrault (Re)*, 2019 ORBD No 2277; *Kokokopenace (Re)*, 2018 Carswell Ont 1731. See also: Faichney (Re), 2022 ONCA 300, where the Court of Appeal considered the Board's obligation to consider Gladue principles in determining the necessary and appropriate disposition, particularly with regard to the accused's reintegration into society and their other needs (paras 24-25).

Inter-Provincial Transfers

As noted above, when making or reviewing a disposition, the ORB must consider not only the mental condition of the accused and the need to protect the safety of the public, but also the other needs of the accused and the reintegration of the accused into society. It is not unusual for a mentally disordered offender to have had an itinerant lifestyle while ill, that may have led the accused to leave their home province resulting in loss of contact with their family. As the accused becomes better with treatment, there is sometimes reconciliation with family members who reside in a province other than where the accused is receiving treatment.

In these cases, it may serve the accused's eventual reintegration into the community to see the accused's care and treatment transferred to a forensic psychiatric facility in another province, closer to family members who will eventually provide support in the community. Sometimes the transfer occurs for treatment-related reasons. For example, accused from other provinces and territories have been transferred into Ontario for detention and treatment at the high secure Waypoint Centre for Mental Health Care, where the transferring province or territory did not have appropriate resources to meet the needs of the accused.[152]

An inter-provincial transfer is available to an accused who is subject to a detention order under section 672.54(c) or a treatment order while unfit to stand trial (under section 672.58), and allows the accused to be transferred to any other place in Canada provided that:

- The ORB of the province where the accused is detained recommends a transfer for the purpose of the reintegration of the accused into society, or the recovery, treatment or custody of the accused; and
- The Attorneys General of both the province to which the accused is being transferred and the province from which the accused is being transferred, give their consent.[153]

In considering whether to make a recommendation for transfer, the ORB may consider evidence as to whether the treatment offered in the new location would be more beneficial to the accused and whether another institution in the new location is prepared to accept the accused.[154]

As with a transfer to another facility within the province, where the hospital team is recommending an inter-provincial transfer, the transferring hospital should provide notice to the potential receiving hospital prior to the ORB hearing and obtain evidence from the receiving hospital as to whether it is willing and able to take on the custody, care and treatment of the accused.[155]

Once the ORB makes the recommendation, the Attorneys General of the transferring and receiving provinces must review the recommendation and decide whether to consent. This can, in practice, take many months.

In 2022, the Nunavut Review Board ("NRB") considered whether it had the jurisdiction to compel an Ontario forensic psychiatric hospital to accept a transfer of a patient who was detained at another Ontario forensic psychiatric hospital, in the absence of the receiving hospital's consent. Although the NRB issued a Disposition transferring the patient to yet a third Ontario forensic hospital, on its consent, without having to directly consider this issue, it nonetheless opined that given Parliament's inclusion of interprovincial transfer provisions in Part XX.1 of the Code, there was no gap in the legislation that would allow a Review Board to order transfers between hospitals in a territorial jurisdiction other than its own. The NRB opined that:

> A unilateral decision to place an NRB accused in an extra-territorial hospital bed raises the real risk of creating inter-jurisdictional conflict due to competition for limited resources and the inability of a province to prioritize their own patients. Particularly given the importance placed on consent of the receiving jurisdiction in s. 672.86 of the

152 Communication from Dr. Brian Jones, former Chief – Forensic Division, Waypoint Centre for Mental Health Care.

153 *CC*, *supra* note 8, s 672.86(1).

154 *Krueger v Ontario Criminal Code ORB* (1994), 95 CCC (3d) 88 at 92-93 (Ont CA).

155 *Rule 13*, *supra* note 149. Arguably, this Rule applies to notice of transfers within the province only; however, in our view, there should be evidence of whether there is a hospital willing to assume care and treatment of the accused in the other jurisdiction.

Code, and as s. 672.88(2) permits the original Review Board to retain jurisdiction over an accused in accordance with an agreement between the Attorneys General of the affected provinces, it is far from clear that the change proposed (extending extra-territorial jurisdiction to provincial Review Boards) is one that Parliament would have made.[156]

Types of Hearings

Initial Hearings

The ORB is required to hold initial hearings under section 672.47, where the court has rendered a verdict of NCRMD or unfit to stand trial and has made no disposition. These initial hearings are to take place as soon as practicable after the verdict but no later than 45 days after the verdict was rendered, unless the court is satisfied that there are exceptional circumstances in which case, the hearing must be held within 90 days.

An initial ORB hearing is also convened when the court makes a disposition, other than an absolute discharge. In this case, the initial ORB hearing must take place within 90 days of the date of the court's disposition.[157]

Despite the statutory timelines for holding initial hearings, in recent years, the ORB has held initial hearings beyond the timeframe required by the *Criminal Code*, where the accused is subject to terms of a Bail order that allows the accused to reside in the community, and the accused's counsel consents to an extension of time for holding the hearing. The usual purpose of the extension is to ensure the ORB has all the necessary documents in order to determine the necessary and appropriate disposition, including for example, a medical report providing a current risk assessment of the accused.

Initial Hearings to Impose the Designation of "High Risk Accused"

In July 2014, Part XX.1 of the *Criminal Code* was amended by Bill C-14, the *Not Criminally Responsible Reform Act*. The amendments included a provision allowing for the designation of "high risk accused" for an NCRMD accused, if certain criteria are met. The Crown may bring an application to the court "before any disposition to discharge an accused absolutely," or at any time following the NCRMD finding. In most cases to date, the application has been brought at the time of the NCRMD determination with respect to a criminal offence.

The court may find the accused to be a "high risk accused" if the following criteria are met:

(a) The accused has been found NCRMD of a serious personal injury offence; and

(b) The accused was 18 years of age or older at the time of the commission of the offence; and

(c) The court is satisfied that there is a substantial likelihood that the accused will use violence that could endanger the life or safety of another person; or

(d) The court is of the opinion that the acts that constitute the offence were of such a brutal nature as to indicate a risk of grave physical or psychological harm to another person.[158]

The "substantial likelihood" standard found in condition (c), above, was considered by the Court of Appeal in *Re Cousineau*. Two years after the appellant was found to be a high risk NCRMD accused, the accused asked the ORB to order an independent assessment to determine whether he still met the high risk accused criteria. The Court clarified that assessment of whether there is substantial likelihood or risk of violence should focus exclusively on the inherent or endemic risk posed by the accused, as an individual and not on the risk the accused would present if subject to externally imposed constraints on their liberty while under the ORB's jurisdiction.[159]

An accused who has been found to be a high risk accused by the court must be subject to a disposition that detains them at a forensic psychiatric facility with no provision for being absent from the facility unless it is for medical reasons or for the purposes of treatment. If that circumstance arises, the accused must be escorted when away from the hospital and there must be a structured plan in place to address the risk arising from the accused's absence from the hospital and to ensure the safety of the public.[160]

156 *In the matter of GN*, Reasons for Disposition, Nunavut Review Board, January 13 2022 (unpublished).

157 *CC, supra* note 8, at s. 672.47(3).

158 *Ibid*, s 672.64(1).

159 *Cousineau (Re),* 2021 ONCA 760, at para 47.

160 *CC*, *supra* note 8 at s 672.64(3).

Where a court had designated an NCRMD accused as a "high risk" accused, and made a disposition in respect of that accused, the ORB shall still hold an initial hearing. However, the ORB is required to issue a detention order, subject to the same restrictions noted in the preceding paragraph. In other words, while an accused is subject to the high-risk designation, the court and the ORB are limited to making a restrictive detention order, the conditions of which cannot permit the accused to be absent from the hospital except in very limited circumstances.[161]

In *R v Grant*, the Ontario Superior Court of Justice reviewed a high-risk accused designation imposed in 2018.[162] In November 2020, the ORB issued a disposition referring the NCRMD accused to court for a review of his high risk accused designation.

The Court clarified the elements of a review of a "high risk accused" designation:

1. No party bears an onus to convince the Court that the "high risk accused" designation is, or is not, appropriate;
2. The test for revocation is met "if the court is satisfied [on a balance of probabilities] that there is not a substantial likelihood that the accused will use violence that could endanger the life or safety of another person";
3. The Court is to consider a non-exhaustive list of factors used for high risk accused designations set out in section 672.64(2) of the *Criminal Code*; and
4. Evidence received at the original application that designated a high risk accused is relevant for a review hearing, along with evidence of an accused's current circumstances and possible future circumstances.

Ultimately, the Court in *Grant* declined to remove the high risk accused designation. Although there had been some minor improvement in the accused's condition over time, the Court determined that the majority of factors that had been present at the time of the original designation continued to exist and the "substantial likelihood" of violence test was met.

Annual Review Hearings

The ORB is required to hold a hearing every 12 months to review a disposition it has made, so long as the disposition remains in force (other than as an absolute discharge). Where the accused, who is represented by counsel, consents, and the Attorney General consents, the ORB may extend the time for holding an annual review hearing to a maximum of 24 months. The ORB may also extend the time for holding an annual review hearing to 24 months, in the absence of consent, if:

(a) The accused has been found NCRMD for a serious personal injury offence;

(b) The accused is subject to a detention order; and

(c) There is evidence before the ORB that satisfies it that the condition of the accused is not likely to improve during the extended period of time, during which a detention order remains necessary.[163]

Where the ORB extends the time for holding the next annual hearing to 24 months, notice must be given to the accused, the Crown and the person in charge of the hospital where the accused is detained.[164] The ORB's decision to extend the time for holding the hearing is deemed to be a disposition and may be appealed according to the provisions governing appeals of ORB dispositions.[165]

An accused is normally entitled to an annual review hearing, although the time for holding the annual review hearing may be extended to 24 months, if the accused is represented by legal counsel, and the accused and Crown consent.

161 *Ibid*, s 672.47(4); see also s 672.64(3).

162 *R v Grant*, 2021 ONSC 6618 (unpublished).

163 *Ibid*, s 672.81(1.2).

164 *Ibid*, s 672.81(1.4).

165 *Ibid*, s 672.81(1.5).

As noted above, an accused is normally entitled to an annual review hearing, although the time for holding the annual review hearing may be extended to 24 months, if the accused is represented by legal counsel, and the accused and Crown consent. Where an annual review hearing concerns a high risk accused, the time for holding a hearing may be extended to a maximum of 36 months if the accused is represented by counsel and the accused and Crown consent to the extension.[166]

Further, at either an initial or annual hearing in respect of a high-risk accused, the ORB may extend the time for holding a subsequent hearing to a maximum of 36 months, if the ORB is satisfied on the basis of disposition information and an assessment report, that the accused's condition is unlikely to improve and that detention remains necessary for the period of the extension.[167] If an ORB makes a decision to extend the time for holding the subsequent hearing in these circumstances, it shall provide notice of the extension to the accused, the Crown and the person in charge of the hospital where the accused is detained.[168]

Early Mandatory Reviews

Where an accused is subject to a detention order or a conditional discharge, and the person in charge of the place where the accused is detained or directed to attend requests a review, the ORB shall hold a hearing for that purpose as soon as practicable after receiving notice from the person in charge.[169] This creates a mandatory obligation to hold a hearing where the person in charge has requested a review. Such hearings may be requested where the accused's condition has either improved or deteriorated to the extent that the current disposition no longer meets the needs of the accused or does not include measures that are adequate for the protection of public safety. Further, the ORB may specify a term in its disposition that the ORB shall hold a hearing within a certain period of time from the date of the disposition, usually within six months.

166 *Ibid*, s 672.81(1.31).

167 *Ibid,* s 672.81(1.32).

168 *Ibid* s 672.81(1.4).

169 *Ibid*, s 672.81(2).

Restriction of Liberties

Where the ORB makes a disposition ordering that an accused be detained in a psychiatric facility or be discharged from the facility subject to certain conditions, the ORB may delegate to the person in charge of the hospital where the accused is detained, or to which the accused must report, the authority to increase or decrease the restrictions on the liberty of the accused within any limits and subject to any conditions set out in the disposition.[170] However, where the person in charge increases the restrictions on the liberty of the accused "significantly", the restriction must be recorded in the accused's file and notice of the increase must be given to the accused. If the restrictions remain in force for a period exceeding seven days, notice must also be given to the ORB.[171]

When the ORB has received such notice, it is required to hold a hearing as soon as practicable, for the purpose of reviewing the decision to significantly increase the restrictions on the liberty ("ROL") of the accused.[172] The Court of Appeal has held that the ORB's interpretation of the statutory requirement to hold a ROL hearing "as soon as practicable" means that an ROL hearing should be scheduled within 30 days. The Court simply stated that an ROL hearing should be "set, held and concluded expeditiously."[173]

The mandatory obligation to hold a restriction of liberties hearing arises from a 2005 amendment to the *Criminal Code*; prior to these amendments the accused could waive the hearing.

The *Criminal Code* is silent as to what would constitute a significant restriction on the liberty of the accused. A review of ORB decisions dealing with restrictions on the liberty of the accused indicate that these hearings are typically called where the accused has been living in the community but, due to a deterioration of their mental condition, has been returned to hospital and admitted for a period exceeding seven days.

170 *Ibid*, s 672.56(1).

171 *Ibid*, s 672.56(2); See *Saikaley (Re)*, 2012 ONCA 92, at para 65 [*Saikaley*], where the Court of Appeal commented favourably on the ORB's guidance in this case that a hospital must give detailed written notice as soon as practicable after the expiration of the seven day period and that the hospital must follow up if the Board fails to schedule a timely ROL hearing.

172 *CC*, *supra* note 8 at s 672.81(2.1).

173 *Saikaley*, *supra* note 171, at para 68.

There are of course, other circumstances that could constitute a significant restriction on the liberty of an accused. In *MLC v Ontario (Review Board)*, the Court of Appeal stated that,

> Any restrictions that the hospital places on the patient must fall within the envelope of the conditions enumerated by the Board in its disposition. As a safeguard, any decision by a hospital that significantly restricts a patient's liberty for more than seven days must be considered by the Board in a restrictions review.[174]

The test to be applied in considering whether or not there has been a significant increase in restrictions on liberty was clarified by the Court of Appeal for Ontario in *Re Campbell*.[175] In that decision, the Court proposed a two-stage analysis:

1. what is the liberty norm of the accused; and
2. how does the liberty norm compare as against the accused's liberty status following the increases in restriction?

In considering the liberty norm of the accused, there must be a "consideration of the duration and pattern of liberty the NCR accused was experiencing before the decision or decisions resulting in increased restrictions on liberty." It is not necessary to review what an accused is entitled to – the question is what the accused was actually experiencing before the increased restrictions were put in place. To consider the liberty norm, the Court clarified that hospitals should take a contextual approach that considers the individual's pattern of liberty in the recent past.

Ultimately, notice from the hospital to the Board is only required where the change in liberty status "clearly deviates" from the liberty norm. The Court of Appeal notes that "the change in liberty status must be so significant that a reasonable person, considering all of the circumstances, would think that the Board should be called on to consider whether the hospital properly applied the least onerous and least restrictive test ahead of the next annual review."

When a hospital is unclear whether or not a restriction of liberties has been sufficiently "significant" so as to require notice, the Court of Appeal clarifies that notice should be given.

Confinement under the *Mental Health Act* does not trigger a restriction of liberty review. For instance, an accused's involuntary admission to a forensic psychiatric hospital pursuant to the *Mental Health Act* would not constitute a significant increase of the accused liberties.[176] This is because the increased restriction flows from authority derived from meeting criteria for involuntary assessment or admission under the *Mental Health Act*, and not from the authority delegated to the person in charge of a forensic hospital by a Review Board disposition under the *Criminal Code*.

Where a restriction of liberties hearing is going to be held, the attending forensic psychiatrist, in conjunction with the person in charge will need to determine whether they anticipate that the restrictions in liberty of the accused will be relatively short term, such that once stabilized, the accused will be able to be maintained on their current disposition. If the deterioration requiring the restriction in liberties is more profound and likely to require a change to the current disposition, notice should be given to the ORB and the accused that the person in charge is also requesting an early review of the accused's disposition, pursuant to subsection 672.81(2).

The ORB must also review the ongoing nature and circumstances of the restriction on the patient's liberty from the date of the initial restriction up to the date of the review, if the restrictions remain in place.

In addition to reviewing the grounds on which a hospital decided to restrict the accused's liberties in the first place, the ORB must also review the ongoing nature and circumstances of the restriction on the patient's liberty from the date of the initial restriction up to the date of the review, if the restrictions remain in place. The purpose of a restriction of liberties review is to provide "a mechanism to monitor significant changes in the patient's liberty and to ensure that liberty is infringed only to the extent necessary to protect public safety in the time frame between the patient's annual dispositions."[177]

174 *MLC v Ontario (Review Board)*, 2010 ONCA 843 at para 28 [*MLC*].

175 *Campbell (Re)*, 2018 ONCA 140 [*Campbell*], at paras 65- 69,

176 See *Young*, *supra* note 129 where the Court found that the patient's involuntary committal under the MHA for a period greater than seven days did not trigger the hospitals obligation to give notice for the Board.

177 *MLC*, *supra* note 174 at para 35.

Recently, restriction of liberties hearings have considered the relatively new practice of hospitals to request that detention orders refer to detention at the "forensic service", rather than the older practice of specifying that an accused be detained on a "general forensic unit" (minimum secure) or a "secure forensic unit" (medium secure). In these cases, and particularly if an accused is transferred between units with different security levels (that nevertheless remain within the description of the "forensic service), a restriction of liberties hearing will focus upon the nature of the restriction on an accused on the unit where they were detained, and the level of restriction on the unit to which the accused is transferred. In some cases, the Board requires that the hospital describe the structure and security of each unit where the accused may ordered to be detained, and then the detention order specifies the unit by name or location.[178]

Dual Status Offender or Placement Hearings

Where an accused has been found unfit to stand trial or NCRMD in relation to what is called the index offence, he or she will come under the jurisdiction of a provincial Review Board. Subsequently, the accused may commit a further offence. If the accused is fit to stand trial on the charges related to the subsequent offence, the accused may be found guilty of that offence, if both the act or omission and criminal intent are proved. Where an accused, who has been found NCRMD and is subject to a custodial disposition requiring their detention in hospital, is subsequently found guilty of another offence and subject to a sentence of imprisonment, the accused becomes known as a "dual status offender".[179]

The legislation dictates that the sentence of imprisonment imposed by the court takes precedence over any prior custodial disposition of the ORB. Therefore, the ORB is required to hold a hearing to review the disposition as soon practicable after receiving notice of that sentence.[180]

The order of events may also be reversed. Where an offender, who is subject to a sentence of imprisonment, commits a subsequent offence for which he or she receives a mental disorder verdict (either unfit to stand trial or NCRMD) and a subsequent custodial disposition is imposed by the court, the ORB is also required to hold a hearing to make a placement decision.[181]

In either case, the most recent court order or disposition takes precedence until the ORB holds a hearing to review its disposition and make a placement decision whether the accused should be detained in hospital or in prison. In making a placement decision for a dual status offender, the ORB is required to consider:

(a) The need to protect the public from dangerous persons;

(b) The treatment needs of the offender and the availability of suitable treatment resources to address those needs;

(c) Whether the offender would consent to or is a suitable candidate for treatment;

(d) Any submissions made to the ORB by the offender or any other party to the proceedings and any assessment report submitted in writing to the ORB; and

(e) Any other factors that the ORB considers relevant.[182]

These are different factors than those that the ORB must consider in a hearing concerning the NCRMD or unfit offender under section 672.54. For example, the ORB at a placement hearing is not required to consider the accused's reintegration into the community, and, overall, the ORB is not required to fashion the least onerous, least restrictive disposition.

Further, because Corrections Services Canada is able to provide most psychiatric and related medical treatments through a network of Schedule 1 hospitals (Regional Treatment Centres), the issue of placement may be decided in relation to factor (c) listed above, that is, the accused's history of engagement and /or compliance with treatment and/or the historical effectiveness of those treatments.[183]

178 See *Roberts, supra* note 142.

179 *CC*, *supra* note 8, ss 672.1, 672.67.

180 *Ibid*, s 672.81(3).

181 *Ibid*, s 672.67(2).

182 *Ibid*, s 672.68(3).

183 Communication from Dr. Brian Jones, former Chief – Forensic Division, Waypoint Centre for Mental Health Care.

If the ORB decides that the offender should be detained in prison, either the federal Minister of Public Safety or the Minister responsible for the correctional services of the province to which the offender is to be sent assumes responsibility for the offender.[184] The Minister is required to be a party to any proceeding before the ORB relating to the placement of a dual status offender.[185] A representative of the Minister, or the dual status offender, may apply to the ORB for a review of the placement decision. A hearing will be convened where the ORB is satisfied that a "significant change in circumstances" warrants it. The ORB may also convene a hearing to review placement of its own motion, on notice to the Minister and the offender.[186]

Although the placement decision may determine that the accused will be placed in prison to serve a custodial sentence in respect of the offence for which he or she has been criminally convicted, there will always be a hospital named as a place of detention to which the accused will be transferred once the term of custody in prison, imposed by the sentence, has been completed. If the dual status offender is placed in custody in a designated psychiatric facility, as a result of a placement decision or a custodial disposition, each day in custody in the hospital is treated as a day of service of the term of imprisonment, and the offender is deemed, for all purposes, to be lawfully confined in a prison.[187]

Hearing Following Arrest for Breach of a Disposition

If an accused who is subject to a disposition of the ORB breaches any term of that order, he or she may be arrested for failure to comply with a disposition.[188] In certain circumstances, this may result in a hearing before a justice who may, in turn, detain the accused pending a hearing before the ORB, if certain criteria are met.[189] The ORB is required to hold a hearing to review the disposition as it would in other circumstances.[190]

Amendments to Part XX.1 of the *Criminal Code* were considered in 2005, including a provision for the warrantless arrest of an accused where the accused has breached an assessment order or disposition. However, the amendments did not go so far as to make failure to comply with a disposition order an offence. Although some may argue that breach of a disposition should be an offence comparable to failure to comply with a probation order, in the context of the mentally disordered offender, Parliament elected not to make such a breach a punishable offence in and of itself.[191] Rather, failure to comply with an order or disposition is evidence to be considered by the ORB when the accused is next before it and will be weighed in the ORB's determination of the necessary and appropriate disposition.

Discretionary Reviews

The ORB has the jurisdiction to hold a hearing to review any of its dispositions at any time, on its own motion, or at the request of the accused or any other party.[192] If the ORB decides to hold a review at its own instigation, the ORB must provide notice to the Crown, the accused and any other party.[193] Where any party requests a review of a disposition, the party is deemed to abandon any appeal against the disposition.[194]

Procedure and Practice Before the ORB

Procedure at an ORB hearing is governed by section 672.5 of the *Criminal Code*, which provides for various issues that may arise regularly at ORB hearings. As a general proviso, the section provides that a hearing may be conducted in as informal a manner as is appropriate in the circumstances.[195]

184 *CC*, *supra* note 8, s 672.68; see also *Re Belec*, [2015] O.R.B.C. No. 1296, in which the ORB held a placement hearing in respect of a dual status offender and decided to return the offender to the correctional system. The offender had been found not guilty of reason of insanity on a charge of first degree murder in 1972; in 1979, he was convicted of attempted murder; and, in 1990, he was convicted of forcible confinement and aggravated assault. In the 42.5 years since the index offence, the offender had spent time in both correctional facilities and forensic hospitals. The ORB applied the criteria in s. 672.68(3) and decided to place the offender in the correctional system.

185 *Ibid*, s 672.69(4).

186 *Ibid*, s 672.69(2) and (3).

187 *Ibid*, s 672.71(1).

188 *Ibid*, s 672.91.

189 *Ibid*, s 672.93(2).

190 *Ibid*, s 672.94.

191 See Barrett & Shandler, *supra* note 146 at§ 1:19.

192 *CC*, *supra* note 8, s 672.82(1).

193 *Ibid*, s 672,82(1.1).

194 *Ibid*, s 672.82(2).

195 *Ibid*, s 672.5(2).

The ORB has also made Rules of Procedure, which are available online at: http://www.orb.on.ca.

Of note to forensic psychiatric facilities, the Rules require the delivery of the Hospital Administrator's Report within three weeks of an annual hearing, and as soon as reasonably practicable in relation to other hearings (Rule 19).

Where any party is going to propose that an accused be transferred to another institution, that party shall provide notice to the potential receiving institution (Rule 13). As a matter of practice, this Rule should be read in conjunction with Rule 19, as a hospital who has received notice of a party's intention to recommend that an accused be transferred to its facility should consider obtaining a copy of the Administrator's Report at the accused's current location before being in a position to meaningfully comment on its view of the proposed transfer.

In addition, where any party is of the view that a particular hearing will be contentious and require longer than the normally allotted time, that party is required to give notice to the ORB and a pre-hearing conference will be scheduled in order to try and narrow the issues (Rules 28 and 29).

Adjournments

The legislated procedural provisions allow for the adjournment of a hearing for a period of not greater than 30 days, where necessary for the purpose of ensuring that relevant information is available to permit the ORB to make or review a disposition or for any other sufficient reason.[196] The statutory provisions on adjournment are supplemented by the ORB's Rules of Procedure which require that any party seeking an adjournment shall serve every other party with a Notice of Motion and file the Notice with the ORB, along with any supporting materials, within certain timelines, depending on when the hospital has provided its report (Rules 32 and 33).

The issue of adjournments was recently considered by the Court of Appeal in *Re McFarlane*. The Court of Appeal clarified that a review board deciding whether to grant or refuse a request for an adjournment must consider:

> … the interests of the not criminally responsible accused, especially any prejudice to the accused in denying an adjournment; the interests of the hospital; and [the Board's] own statutory mandate to hold timely hearings. Because a decision to refuse an adjournment is discretionary, it is owed significant deference from an appellate court. However, an appellate court may interfere if the Board errs in principle or exercises its discretion unreasonably. For example, an appellate court may intervene if the Board's denial of an adjournment deprives an accused of a fair hearing and thus is contrary to the interests of justice.[197]

Victim Impact Statements

Recent amendments to the *Criminal Code* require the ORB to notify every victim of the index offence that they are entitled to file a Victim Impact Statement where an "assessment report" received by the ORB indicates that there has been any change in the mental condition of the accused since the last disposition that may provide grounds for an absolute or conditional discharge.[198] Whether an "assessment report" includes the Hospital Administrator's Report to the ORB has not been judicially interpreted; however, the ORB now makes it a matter of practice to notify the victims of the index offence where the Hospital Administrator's Report is recommending an absolute or conditional discharge.

Victim Impact Statements (VIS) may include a description of the physical or emotional harm, property damage or economic loss suffered by the victim.[199] Sometimes, a VIS will go beyond these parameters and comment on the victim's view of the terms to which the accused should be subject. These additional comments are not admissible. In a recent decision, the Court of Appeal has provided guidance as to what should be done where a VIS goes beyond the prescribed parameters:

- Those taking the statements from the victims could advise on how the statements would need to be revised to comply with the *Criminal Code*.
- Counsel for the accused and the Crown could discuss redacting offending comments from the statements before they are tendered to the ORB.

196 *Ibid*, s 672.5(13.1).

197 *McFarlane (Re),* 2022 ONCA 633, at para 14, citing *Conway (Re)*, 2016 ONCA 918, at paras. 23, 25.

198 *CC*, *supra* note 8, s 672.5(13.2).

199 *Ibid*, s 672.5(14).

- It would be open to the parties to request the ORB to rule on the admissibility of comments on which counsel could not agree. In such cases, the ORB would hear submissions from the parties and decide whether to admit the statements in whole, with offending portions excised, or at all.
- The ORB could also, on its own initiative, direct counsel to meet and attempt to come to an agreement on which portions of the victim impact statements should be redacted during a break in the hearing.
- Lastly, it would be open to the ORB to admit a victim impact statement in full, while taking into consideration only those parts of the statement that comply with the *Criminal Code*. The ORB could identify its concerns with the statements and advise the parties that it will only consider the non-offending portions of the statement. This could be done on the ORB's own motion, or in response to concerns or objections raised by counsel.[200]

Joint Submissions before the ORB

It is not uncommon for the parties to an ORB to agree on a recommendation to the Board with regard to the "necessary and appropriate" disposition for the coming year. Where the accused, the Crown and the hospital all share the same view as to the recommended disposition, this is known as joint submission. The Court of Appeal has opined that, joint submissions can play an important role in proceedings before the Board. They can narrow the issues in dispute, or, as in this case, even eliminate the issues in dispute. And by doing so, they can reduce the time and costs of Board hearings. The Court of Appeal opined that the Board's procedures should encourage, not undermine, the use of joint submissions.[201]

Joint submissions can play an important role in proceedings before the ORB. They can narrow the issues in dispute or even eliminate some / all of the issues. In doing so, joint submissions can reduce the time and cost of ORB hearings. The ORB's procedures should encourage, not undermine, the use of joint submissions.

A recent line of ORB disposition appeals before the Court of Appeal has resulted in some guidance for the ORB on the issue of joint submissions and when a duty of procedural fairness gives rise to an obligation on the part of the ORB to notify the parties of its intention to depart from a joint submission.

In *Re Kachkar*, following an initial hearing, the ORB had issued a disposition that was more liberal than the disposition jointly recommended by the Crown and the accused's counsel. The Court of Appeal dismissed an appeal by the Crown and found that the ORB's decision to include a community access clause in its disposition, where it had not been requested or discussed by counsel at the hearing, was reasonable. The Court held that the condition was supported by the evidence, including fresh evidence submitted on behalf of forensic hospital where the accused was detained.[202]

The Court of Appeal held that while the Crown has certain statutory procedural rights in relation to Board hearings, a common law duty of fairness extends only to "those impacted by the administrative decision-making process in the sense that they have a right, privilege or interest that they can claim as their own that is affected, usually adversely, by the decision." The respondent's liberty interest, for example, is clearly his own and is clearly affected by the ORB's disposition.

According to the Court, in the non-adversarial process of ORB hearings, the Crown asserts the public interest, not a private interest. The Crown cannot be said to be an individual, nor to have a right, privilege or interest that is affected by the ORB's disposition. Therefore, the Crown is not owed a duty of procedural fairness in the circumstances of this case. In the alternative, even if the Crown is owed a duty of procedural fairness by the Board in this case, the Court concluded the duty was met.[203]

In *Re Osawe*,[204] the parties at an accused's annual hearing made a joint submission that provided for the continuation of the accused's previous disposition. The ORB rejected the joint submission, and issued a disposition that was more restrictive on the accused's liberty. Significantly, the ORB only permitted the accused's entry into the community accompanied by staff

200 *Re Klem*, 2016 ONCA 119 at paras 47 – 51 [*Klem*].

201 *Re Osawe*, 2015 ONCA 280 at para 47.

202 *Re Kachar*, 2014 ONCA 250.

203 *Ibid*, at paras 41-50.

204 *Re Osawe*, 2015 ONCA 280; see also *Alexander (Re)*, 2022 ONCA 237.

or an approved person, rather than the prior ability to do so unaccompanied. Further, the ORB removed the possibility of living in the community. The accused appealed the decision.

While the Court of Appeal recognized that the ORB has the authority and duty to reject joint submissions if they are of the view that a joint submission does not meet the requirements of s. 672.54 of the *Criminal Code*, the decision to do so engaged the duty of procedural fairness owed to the accused.

Where the ORB considers rejecting a joint submission and imposing a more restrictive disposition, it has a duty to give the accused notice of that intention as well as an opportunity to lead further evidence or make further submissions to address the ORB's concerns with the joint submission. The Court of Appeal noted that the ORB could fulfill its duty to give notice in different ways:

- Notice may be given by the presiding Chair expressing the Board's concerns about accepting a joint submission at the hearing itself, and asking the parties if they wish to lead more evidence, following an adjournment, if necessary;
- The questions asked by a number of the panel members during the hearing, where the questions are significantly probing about the core elements of the joint submission; and
- Where concerns arise after the Board begins its deliberations, the Board may need to notify the parties and offer the opportunity for additional submissions or evidence.[205]
- Overall, the ORB must satisfy the objective of allowing the accused a meaningful opportunity to present the evidence and argument relevant to the ORB's disposition.[206]

205 *Ibid*, at para 73.

206 *Ibid,* at para 75; for other Court of Appeal cases dealing with procedural fairness, see *Re Chaudry*, 2015 ONCA 317; *Re Thurston* , 2015 ONCA 351; Re *Benjamin*, 2016 ONCA 118; Re *Klem*, 2016 ONCA 119; and *Re Alexander*, 2022 ONCA 237 (CanLII) . In *Re Alexander*, the Court confirmed that the Ontario Review Board is not bound by joint submissions but rather owes a duty of procedural fairness to those individuals over which it exercises jurisdiction, which includes a duty to give notice when it considers rejecting a joint submission.

Other ORB Related Issues

Can the ORB or Court Order Treatment to be Part of a Disposition?

As noted above, the court with jurisdiction over an unfit accused may order treatment, in the absence of the accused's consent, in order to make the accused fit to stand trial. This represents a very narrow circumstance in which the court may compel the treatment of the accused. It may happen only when the accused has been found unfit by the court and the court is satisfied on the basis of expert medical evidence that a specific treatment should be administered to the accused for the purpose of making the accused fit to stand trial. The treatment period may be no greater than 60 days and certain criteria set out in the legislation must be met.[207]

In contrast, the ORB does not have the authority to make a disposition in which it directs the accused to submit to any treatment, in the absence of the accused's consent. However, where the accused consents to such a condition, and the ORB considers the condition to be reasonable and necessary in the interests of the accused, a condition "regarding psychiatric or other treatment" may be included in the disposition.[208] If an accused subsequently withdraws their consent to the condition, it could give rise to circumstances in which an early review of the disposition is sought.[209]

An accused who is incapable with respect to treatment may consent to a condition in their disposition that requires their compliance with prescribed treatment. The Court of Appeal for Ontario determined that s. 672.55(1) does not require an accused to have capacity to consent to the prescribed treatment under the relevant provincial law; rather the section should be interpreted as presuming that lawful consent to treatment has been, or will be, otherwise obtained. To consent to the condition, the accused must understand information relevant to the operation of the condition and appreciate the reasonably foreseeable consequences of agreeing to, and subsequently breaching, the condition. [210]

207 *CC, supra* note 8, ss 672.58-672.59.

208 *Ibid*, s 672.55(1).

209 See ORB website online: <http://www.orb.on.ca>.

210 *Ohenhen (Re)* and *Kalra (Re), supra* note 132 at paras 57-59, 92-94.

The ORB does not have the authority to make a disposition in which it directs the accused to submit to any treatment, in the absence of the accused's consent.

The Supreme Court of Canada has held that the provision of the *Criminal Code* that provides the ORB with the authority to make such a condition should be interpreted narrowly:

> *Despite the fact that Review Boards have the authority to make their orders and conditions binding on hospital authorities, this power does not extend so far as to permit Boards to actually prescribe or impose medical treatment for an NCR accused. Such authority lies exclusively within the mandate ... of the hospital where the NCR accused is detained, pursuant to various provincial laws governing the provision of medical services to persons in the custody of a hospital facility. It would be an inappropriate interference with provincial legislative authority (and with hospitals' treatment plans and practices) for Review Boards to require hospital authorities to administer particular courses of medical treatment for the benefit of an NCR accused.*[211]

In other words, the role of the ORB with respect to medical treatment is supervisory, to ensure that appropriate treatment happens in order to reduce the accused's level of risk and to allow for the accused's eventual reintegration into the community. The ORB is therefore able to make orders "regarding" treatment, under subsection 672.55(1), provided that the accused consents and the ORB considers the condition reasonable and necessary in the interests of the accused. In considering section 672.55, the Supreme Court of Canada held that the provision does not allow the ORB to prescribe treatment but rather, provides for a condition in the disposition that the accused consented to following a course of treatment for the purpose of managing the accused's threat to public safety.[212]

Further reinforcement of the principle that NCR or unfit accused's treatment is to be provided pursuant to provincial legislation may be found in section 25 of the *MHA*, which states that any person detained in a psychiatric facility under Part XX.I of the *Criminal Code* may be restrained, observed and examined under the *MHA*, and provided with treatment under the *HCCA*.[213]

Can a Forensic Hospital Limit an Accused's Access to the Internet?

In 2014, the Court of Appeal upheld a condition imposed by the ORB permitting the Hospital to monitor the accused's internet access.[214] The appellant, a dual status offender with a high risk for sexual violence, had made contact with a woman in Mexico via the internet using hospital computers. In the Hospital Report, the treatment team had identified computer use as a risk factor given the ability to access potential victims.

The Court of Appeal found that the computer condition was reasonable given the accused's index offence, his reluctance to discuss the contents of his communications, the documented concerns of the treatment team, and the Board's broad mandate to protect the public.

This decision affirms the authority of hospital staff to open and examine the contents of a forensic patient's mail in defined circumstances set out in s. 26(2) of the *MHA*. Further, the Court held that a reasonable expectation of privacy is context specific and in this case, NCR forensic detainees have a reduced expectation of privacy in online communications using hospital computers. The Court found that detention pursuant to an ORB disposition entails "surveillance, searching and scrutiny."

In this case, the "computer condition" in issue did not deny the appellant access to a computer or the internet. The condition, as framed, permitted the use of computer devices by the appellant, including internet-connected computer devices, so long as the appellant first consented to the monitoring of his use of such devices by hospital staff. If the appellant chose not to provide the consent, he was in effect, choosing not to use the internet.

211 *Mazzei v British Columbia (Director of Adult Forensic Psychiatric Services)*, [2006] 1 SCR 326 at para. 31 [*Mazzei*] [emphasis added].

212 *Ibid* at para 55; see also *Ohenhen (Re)* and *Kalra (Re)*, *supra* note 132, at paras 92-94.

213 For further discussion of the consent to treatment law that will apply to the Unfit or NCRMD accused in the normal course, please see Chapter 2.

214 *Re Everingham*, 2014 ONCA 743.

The Court of Appeal held that the computer condition was crafted by the ORB, "quite properly, with a view to fashioning the least onerous and least restrictive condition to facilitate the appellant's use of the internet while also ensuring that the public is not put at risk by such use."[215] Accordingly, the computer condition did not result in a s. 8 *Charter* violation.

Appeal Rights

Any party may appeal against a disposition made by a court or Review Board, or a placement disposition made by a Review Board, to the Court of Appeal of the province where the disposition or placement decision was made.[216]

These appeals are governed by the provisions in Part XX.I of the *Criminal Code* and, in Ontario, by the Ontario Court of Appeal's *Criminal Appeal Rules*.[217] Where an accused is detained in hospital, pursuant to the disposition being appealed from, the hospital, upon the accused's request, shall provide the accused with a form of Notice of Appeal (a Form 21).[218] The person in charge, or their designate, must transmit to the Registrar of the Court of Appeal any notice of appeal served upon him or her by the accused. Further, the person in charge or their designate, must deliver "forthwith" to the accused any documents that are transmitted to the accused by the Registrar, and subsequently report to the Registrar that this has been done.[219]

The Notice of Appeal from a disposition must be served on the other parties to the appeal and filed with the Registrar of the Court of Appeal with 15 days from the day the parties are provided with the Reasons for Disposition.[220]

Under s. 672.75, where any party appeals against an order directing that the unfit accused submit to treatment without their consent, the filing of a notice of appeal suspends the application of the disposition pending the determination of the appeal.[221] In May 2012, the Court of Appeal held that the automatic stay of the absolute discharge that used to arise from section 672.75 violates the liberty interests of the accused person, under both sections 7 and 9 of the *Charter* and was therefore unconstitutional. The Court suspended the declaration of constitutional invalidity for 12 months, in order to allow Parliament time to consider appropriate changes to the legislation.[222]

This issue was addressed in Bill C-14, the *Not Criminally Responsible Reform Act*, which revoked the provision in section 672.75 that automatically suspended an absolute discharge. Now, if a party appeals an ORB disposition to absolutely discharge an accused and wishes to suspend the absolute discharge pending the determination of the appeal, that party must bring an application to a single judge of the Court of Appeal for a stay of the disposition under appeal and for the substitution of a different disposition.[223]

Section 672.76 applies to any appeal, not just an appeal of an absolute discharge. In decisions concerning an application to suspend a disposition, the Court of Appeal has opined that the primary purpose of such an application is to suspend a disposition where changes in circumstances which may make compliance with the disposition pending appeal inappropriate.[224]

The applicant seeking to suspend the disposition bears the onus under s. 672.76 to demonstrate that there are compelling reasons to doubt the validity or soundness of the disposition made by the ORB as it relates to the mental condition of the accused. Further, the Court has held that the suspension should be granted only in extraordinary circumstances.[225]

215 *Ibid*, at para 25.

216 *CC*, *supra* note 8, s 672.72(1).

217 *Criminal Appeal Rules,* available on line at: https://www.ontariocourts.ca/coa/criminal-appeal-rules/ (accessed on December 7, 2022) ("Criminal Appeal Rules"); see "Part VI – Appeals from Orders made under Part XX.1 of the *Criminal Code* – Mental Disorder", but note that the remainder of the Criminal Appeal Rules apply to orders made under Part XX.1, unless otherwise specified or inconsistent with Part VI

218 *Criminal Appeal Rules, supra* note 217, ss 66(1) see www.ontariocourts.ca/coa/files/rules-forms/criminal-rules-en.pdf

219 *Criminal Appeal Rules*, *supra* note 217, s 66(3)(a)(i) and 66(6)-(8).

220 *CC*, *supra* note 8, s 672.72(2); see also Criminal Appeal Rules, *supra* note 217, s. 66(2)

221 *Ibid*, s 672.75(1).

222 *Re Kobzar*, 2012 ONCA 326, at paras 82, 88 and 89. In *Re Kobzar*, the fact that an absolutely discharged patient could bring an application for an order that the absolute discharge be carried out notwithstanding the automatic suspension under s. 672.76(2) (a), was not a sufficient procedural safeguard to cure the constitutional defect of the automatic stay. The Court held that "a subsequent review, especially one that places the onus on the accused, does not change the fact that the initial restriction of the NCR accused's liberty is automatic upon the completion of an administrative act [the file of a notice of appeal], without any due process." (*Re Kobzar*, at para 62).

223 *CC, supra* note 8, s.672.76(2)(a.1) .

224 *Penetanguishene Mental Health Centre (Administrator) v Ontario (Attorney General)*, 2001 CanLII 24036 (Ont CA), at para. 7.

225 *Re Furlan*, 2013 ONCA 618, at para 37.

The remedies available under s. 672.76 are not limited to cases in which a change in circumstances has occurred between the date of which the disposition under appeal was made and the time at which the application under s. 672.76 has been brought. The decision on an application under s. 672.76 is influenced by contextual considerations including all the provision of Part XX.1, the specific provisions under consideration, and the extent of the authority of the ORB.[226]

There may be circumstances where a party to an ORB appeal will need to seek a suspension of an absolute discharge, conditional discharge, or the terms of a detention order, pending the outcome of the appeal. Such circumstances most often relate to a change in the circumstances of the accused following the disposition, most notably a deterioration in the mental condition of the accused, which makes the appealed from disposition no longer appropriate.

Where a party appeals a conditional discharge or detention order, the disposition appealed from takes effect nonetheless and is not suspended. However, as noted above, any party may apply to a judge of the Court of Appeal for an order providing that the appealed from disposition should not take effect, and that the prior disposition should remain in place pending the resolution of the appeal.[227]

Where an appeal addresses the ORB's interpretation of the law, the standard of review is correctness. However, where an appeal involves the ORB's application of the law to the particular facts of a case, the Court of Appeal will apply a "reasonableness" standard of review. That means that where the ORB's Disposition and Reasons for Disposition are supported by the evidence, as demonstrated by the transcript of the hearing and the documentary evidence that has been entered as exhibits, the Court will not interfere with the Disposition, even if it might have come to a different conclusion on the same evidence.[228]

In addition to the transcript and documentary record of the appeal, the appeal may also be based on "any other evidence that the Court of Appeal finds necessary to admit in the interests of justice."[229] In some circumstances, particularly where there has been a material change in the condition or circumstances of the accused, a motion may be brought by one of the parties to the Appeal asking the Court to admit fresh or additional evidence.

Ordinarily, appeals are initiated by the accused and in some cases, by the Crown. In some circumstances, the Disposition and Reasons may deal with issues of importance to the hospital, where the accused is ordered detained or to report and consideration will need to be given as to whether the "person-in-charge" should appeal the Disposition. Where the hospital wishes to advance its own appeal, or take a position or intervene on an appeal initiated by another party, we recommend that the hospital consult with legal counsel.

The Court of Appeal for Ontario has Rules of Practice governing the delivery of materials in appeals of ORB dispositions, such that, where the accused has appealed the disposition, they must deliver their factum no later than the six weeks prior to the appeal hearing date. The respondent Crown must serve and file its factum no later than three weeks before the appeal hearing date. Where the person in charge is also a respondent and has chosen to file a factum, that factum must be served on the other parties to the appeal, including amicus curiae (if appointed), no later than two weeks before the appeal hearing date. This allows for the person in charge to serve and file their factum following receipt and filing of the Crown's factum.[230]

In general, the issue of whether the person in charge of the hospital will take a position on an NCRMD or Unfit accused's appeal is dependant on the issues raised by the appeal. The decision to take a position and submit a factum may be reviewed in consultation with Crown counsel and the hospital's legal counsel.

226 *Ibid*, at para 38-39.

227 *CC*, *supra* note 8, s 672.76(2).

228 *Tran (Re)*, 2020 ONCA 722 (CanLII), at para 38.

229 *Ibid*, s 672.73(1) and (2). The Supreme Court has held that "interests of justice" test refers not only to justice for the NCR detainee, but also justice to the public, whose protection is to be assured. Particularly where the appeal could result in the absolute discharge of the detainee, the Supreme Court held that an absolute discharge should be granted "only upon consideration of all of the reliable evidence available both at the time of the Board hearing, and, if appealed, at the time of the appellate review.": *R v Owen* (2003), 174 CCC (3d) 1 (SCC), at paras 54 and 59. .

230 Criminal Appeal Rules, *supra* note 217, s 70(6) – (9).

6. Other Criminal Law Related Issues

Interim Judicial Release: Bail

Where a person has been charged with an offence, the accused will generally be released from custody pending trial provided that the accused is not charged with murder or certain other offences, and provided that the Crown has not "shown cause" why the accused should be detained in custody or why an order authorizing release with conditions is justified .[231] This form of interim release is called bail. If the Crown is able to demonstrate to a judge that a person charged with an offence should only be released into the community to await trial subject to certain conditions, the judge will craft a bail order taking into account certain factors,[232] which is sometimes referred as a recognizance or undertaking.

The terms of the bail order are binding on the accused, and on any "surety" (other person) named in the bail order.

Where the court has made an assessment order for the evaluation of an accused's mental condition, the assessment order takes precedence and no order for judicial interim release may be made.[233]

If hospital staff know that a patient is subject to a bail order and learn that the patient is breaching terms of their bail order, the question arises as to what obligation hospital staff have to report a breach of the bail order to police. Essentially, the answer to this question is: it depends. That is, it depends on the terms of the bail order, the seriousness of the breach, the risk of harm to other persons, and the effect that reporting the breach may have on the patient's therapeutic relationship with their treating team, as well as duties of confidentiality.[234] Generally, it is recommended that the hospital consult with its risk management department, who may in turn wish to consult legal counsel.

231 *CC*, *supra* note 8, s 515(1).

232 *CC*, *supra* note 8, s 515(3).

233 *Ibid*, s 672.17. For a further discussion of the implications of bail for psychiatric patients and their clinicians, see Bloom & Schneider, *supra* note 33 at 156-157.

234 We discuss privacy issues in further detail in Chapter 7.

Probation

Where an accused person is convicted of an offence, the court may suspend the passing of sentence and direct that the offender be released on the conditions prescribed in a probation order. There are certain compulsory conditions of a probation order; for example, the offender must keep the peace and be of good behaviour.[235] However, the court may prescribe certain other conditions, including a condition requiring the offender to participate actively in a treatment program approved by the province, if the offender consents and the program director accepts the offender into the program.[236] "The agreement of the accused is a necessary pre-condition to the ordering of any such treatment."[237]

The Conditional Sentence Regime – Alternatives to Incarceration

For an accused person to be found guilty of an offence, the Crown must prove beyond a reasonable doubt that the accused committed the act or omission, and that the accused intended to do so (or for some offences, that the accused was reckless, negligent, or willfully blind to the consequences of their act or omission). It then falls to the Court to impose a sentence or fine on the accused who has been found guilty. At that stage, the fact that the offender was or is still suffering from a mental disorder may be relevant to the sentencing process and although found guilty, the presence of mental disorder may diminish the offender's culpability, even if not to the extent of being found NCRMD.[238]

The *Criminal Code* has a conditional sentencing regime, which provides for certain conditions, such as allowing the offender "to attend a treatment program approved by the province".[239] This applies where a person is convicted of an offence, provided that the offence is not subject to a mandatory minimum term of imprisonment, the court has imposed a sentence of imprisonment of less than two years, and the court is satisfied that the offender does not pose a danger to the safety of the community. In these circumstances, the

235 *CC*, *supra* note 8, s 732.1(2).

236 *Ibid*, ss 732.1(3)(g)-(g.1).

237 See Barrett & Shandler, *supra* note 146 at§ 6:31.

238 For a further discussion of this issue, see generally Chapter 9, "Disposition" and Chapter 10, "Sentencing", of Bloom & Schneider, *supra* note 33 at pp. 298-316 and pp 317-324, respectively.

239 *CC*, *supra* note 8, s. 742.3(2)(e).

court may order that the offender serve the sentence in the community, which would include attendance at an approved treatment program.[240] In *R v Knoblauch*[241] the majority of the Supreme Court of Canada held that the provisions of the conditional sentencing regime could be interpreted to allow a judge to order the accused to spend the period of the conditional sentence in a secure psychiatric treatment unit.

7. Diversion Programs and Mental Health Courts – A Brief Overview

In Ontario, since 1994, there has been a diversion program for the mentally disordered accused in the *Crown Prosecution Manual*.[242] Diversion or " community justice" programs provide a protocol for Crown counsel to use discretion on a case-by-case basis to not prosecute a mentally disordered accused, by withdrawing or staying the charges of a "divertible" (generally non-violent) offence, and arranging instead for the accused to receive some form of mental health care or rehabilitative program in the community.[243] The diversion program recognizes that a mentally ill accused is entitled to "special consideration flowing from the fact that their illness, disorder or impaired cognitive functioning may have played some role in commission of the offence."

In order to proceed with diversion as an alternative to prosecution, there are several criteria that must be met, including the nature of the underlying offence. For example, certain offences are considered presumptively ineligible for diversion, such as ones involving homicide, assault or driving offences causing death or bodily harm. For those, as well as other offences, the Crown may not divert the accused away from the criminal justice system. Further, there must be a reasonable prospect of conviction (since it would not be fair to subject the accused to an alternative if the Crown is not able to prove the offence), and the accused must appear to be suffering from discernible psychiatric symptoms that would likely respond to treatment,[244] although a purely treatment based approach is not necessary, where good housing and ongoing community support may be, alone, an effective response.[245]

Even before the accused reaches the courthouse and comes into contact with Crown counsel, there is another opportunity for diversion in the form of the discretion that may be exercised by the police officer who has first come into contact with the accused. As Bloom and Schneider have pointed out, police officers have the discretion to decide against laying a charge against a person who has been found committing a minor criminal offence and may instead choose to exercise their authority under section 17 of the *MHA* to apprehend the person and take them into custody to an appropriate place for examination by a physician. In some instances, rather than invoke that authority, the police may try to convince the person to attend at the emergency department of the local hospital on their own account, or to cooperate with concerned family members.[246]

Often, but not always, the decision to initiate diversion for a mentally disordered accused is made in a "mental health court" - a court with jurisdiction to hear criminal matters that decides to focus on the needs of the mentally ill offender at certain times.[247] In Ontario, mental health courts have developed an informally shared mandate to address the needs of people with mental health issues on their entry into the criminal justice system.[248] Usually, mental health courts have medical and mental health support staff available, in addition to the Crown, Judge, Duty Counsel and Mental Health Care Support Workers.[249] The purpose of a mental health court is to work with Crown and defence counsel to address the needs of the mentally ill accused, by offering opportunities to address the underlying reason for the commission of the offence, with the goal of reducing recidivism for the offender.[250] While proceedings at mental health courts usually address diversion, guilty pleas or sentencing hearings, many also do fitness hearings, including treatment orders arising from findings of unfit to stand trial, and initial NCRMD hearings.[251]

240 *Ibid*, s 742.1.

241 [2000] 2 SCR 780.

242 Ontario Ministry of the Attorney General, *Crown Prosecution Manual* Available online at: Crown Prosecution Manual: 26 (a): Mentally Ill Accused - Alternatives to Prosecution | Ontario.ca .

243 *Ibid*.

244 *Bloom & Schnieder, supra* note 33, at pp 158-160.

245 *Crown Prosecution Manual, supra* note 242.

246 *Bloom & Schnieder, supra* note 33, at pp 160-161.

247 *Mental Health Courts in Ontario: A Review of the Initiation and Operation of Mental Health Courts Across the Province,* Provincial Human Services and Justice Coordinating Committee (HSJCC) and Canadian Mental Health Association – Ontario Division, October 2017, at p. 15.

248 *Ibid*., p. 6.

249 *Ibid*, p. 15.

250 *Ibid*, p. 6

251 *Ibid*., p. 7

CHAPTER

7 Privacy and Mental Health Care

1. Introduction

It is well-established in law that personal information relating to the provision and receipt of health care is highly private and personal to the individual. It is considered the individual's own information, held in trust by their health practitioner for the individual's benefit, and may be disclosed or communicated to others only with the individual's permission unless the law otherwise authorizes the disclosure.[1]

Since November 2004, the main statute governing personal health information (PHI) in Ontario is the *Personal Health Information Protection Act* ("PHIPA"). *PHIPA* provides a comprehensive set of rules that apply to all parts of the health care sector, in order to protect the privacy of PHI, while at the same time, providing for the collection, use and disclosure of PHI in a manner that will facilitate the effective provision of health care.[2]

Prior to the enactment of *PHIPA* in 2004, sections 35 and 36 of the *Mental Health Act*[3] ("*MHA*") set out a code for the protection of privacy of the PHI of patients' who were admitted to, or registered as out-patients in, a psychiatric facility pursuant to the provisions of the *MHA*.

These *MHA* provisions were in addition to the provisions of the Hospital Management Regulation under the *Public Hospitals Act*[4] ("*PHA*") that generally governed the confidentiality of health records in public hospitals (at law, psychiatric facilities are now also public hospitals). In addition to *PHIPA*, other Ontario statutes recognize the confidentiality of PHI. For example, the *Regulated Health Professions Act* and its related statutes governing individual professions, recognize that it is an act of professional misconduct for the regulated health professional to provide information about a client to anyone other than the client or their authorized representative, except with the consent of the client or representative, or as required by law.[5]

Following the enactment of *PHIPA*, many, but not all, of the former provisions in both the *PHA* and *MHA* were repealed and replaced by the procedures and obligations set out in *PHIPA*. Most of sections 35 and 36 of the *MHA* were preserved, and a new section 34.1 was added to confirm that where there is a conflict between *PHIPA* and sections 35 or 35.1 of the *MHA*, then the *MHA* privacy-related provisions prevail. We discuss these specific provisions in more detail in section 3 of this chapter.

The underlying policy rationale for preserving the *MHA* provisions governing the confidentiality of psychiatric health care records recognizes special considerations that arise in the mental health care context. Ontario's Court of Appeal has recognized the *MHA*'s "special statutory regime" that "protects psychiatric records in a way that is very different from other health records" and has stated that the *MHA* provisions represent "a compelling indication that psychiatric records occupy a unique position and that the safest course for a justice of the peace in issuing a search warrant to seize psychiatric records is to provide that the records be sealed until a court is able to mediate among the various claims and the different legislative schemes."[6]

The purpose of this chapter is to review the provisions of the *MHA* that deal with the privacy of patients' PHI who are or have been admitted to, detained at, or are receiving out-

1 *McInerney v MacDonald*, [1992] 2 SCR 138.

2 *Personal Health Information Protection Act*, 2004, SO 2004, c 3, Sch A, s 1(a) [PHIPA].

3 *Mental Health Act,* RSO 1990, c M7 *[MHA].*

4 *Public Hospitals Act,* RSO 1990, c P40 *[PHA].*

5 See for example, the *Professional Misconduct Regulation*, O Reg, 856/93, section 1(1), para 10, enacted under *Medicine Act, 1991*, SO 1991, c 30; which applies to physicians.

6 *R v Serendip Physiotherapy Clinic*, [2004] OJ No 4653 (CA); application for leave to appeal to S.C.C. dismissed, March 17 2005.

patient care at a psychiatric facility. We will demonstrate how these provisions are different from the general rules under *PHIPA*. This chapter will also consider other aspects of privacy that frequently arise when dealing with mental health patients.[7]

2. Capacity to Consent to the Collection, Use and Disclosure of PHI

Under s. 21(1) of *PHIPA*, the test for capacity to consent to collection, use or disclosure of PHI is essentially the same as the test for capacity to consent to treatment:

> An individual is capable of consenting to the collection, use or disclosure of PHI if the individual is able,
>
> (a) to understand the information that is relevant to deciding whether to consent to the collection, use or disclosure, as the case may be; and
>
> (b) to appreciate the reasonably foreseeable consequences of giving, not giving, withholding or withdrawing the consent.

Similar to the provisions in the *Health Care Consent Act* ("*HCCA*") relating to capacity to consent to treatment, *PHIPA* recognizes that an individual may be capable of consenting to the collection, use or disclosure of some parts of PHI, but incapable with respect to other parts;[8] and that an individual may be capable of consenting to the collection, use or disclosure of PHI at one time, but incapable of consenting at another time.[9] An individual is presumed to be capable of consenting to the collection, use or disclosure of PHI, and a health information custodian is entitled to rely on that presumption, unless the custodian has reasonable grounds to believe that the individual is incapable of consenting to the collection, use or disclosure of PHI.[10]

The mere fact that a person suffers from a mental disorder and is receiving treatment for that disorder as an inpatient or outpatient of a psychiatric facility, is not sufficient grounds in and of itself to assume that a patient is incapable with respect to consenting to the collection, use or disclosure of PHI. However, where a health practitioner has determined that a patient is incapable with respect to treatment decisions, it is prudent to also consider, at the same time, the person's capacity with respect to the collection, use and disclosure of PHI.

Where the Consent and Capacity Board ("CCB") confirms a finding of incapacity with respect to treatment, and the health practitioner has **also** found the patient incapable with respect to PHI decisions, the patient is precluded from applying to the CCB for a review of any finding of incapacity regarding PHI:

- A substitute decision maker ("SDM") for the purposes of treatment is deemed to be an SDM for the individual in respect of the collection, use or disclosure of PHI about the individual, if the purpose of the collection, use or disclosure is necessary for, or ancillary to, a decision about a treatment.[11]
- An individual who a health information custodian determines is incapable of consenting to the collection, use or disclosure of their PHI by a health information custodian, may apply to the CCB for a review of the determination **unless there is a person who is entitled to act as the SDM of the individual** because the person has been found incapable with respect to treatment and the PHI in question is necessary and ancillary to the treatment.[12]

7 Please refer to the OHA's web based resources on privacy issues for public hospitals: https://www.oha.com/guidance-and-resources/privacy-and-freedom-of-information. See also the Information and Privacy Commissioner of Ontario's guidance document on the Collection, Use and Disclosure of Personal Health Information at https://www.ipc.on.ca/health/collection-use-and-disclosure-personal-health-information/

8 *PHIPA, supra* note 2, s 21(2).

9 *Ibid*, s 21(3).

10 *Ibid*, ss 21(4) and (5).

11 *Ibid*, s 5(2).

12 *Ibid*, s 22(3). See *JGT (Re)*, 2022 CANLII 7495 (ON CCB), where the Board confirmed the physician's finding of incapacity regarding treatment, accepted the physician's evidence that there was an SDM in place and consequently dismissed JGT's application to review his capacity to make PHI related decisions, since the PHI concerned the treatment for which the patient had been found incapable. See also *SH (Re)*, 2020 CanLII 6416 (ON CCB), in which the Board confirmed that the effect of s. 22(3) of *PHIPA* is to preclude a person from applying to the Board for a review of a finding of incapacity under *PHIPA*, where a person has been found incapable of making certain treatment decisions under *HCCA* and there is a SDM for that treatment in place, and the personal health information in question is ancillary to the treatment for which the person is incapable. Since the criteria in s. 22(3) were made out on the evidence, the Board dismissed the patient's application for review.

As noted above, it is important to evaluate a patient's capacity to consent to the collection, use or disclosure of PHI, particularly where a patient's capacity to consent to treatment is being assessed, so that all members of the circle of care can have access to PHI for the purpose of providing health care.

The issue of the patient's capacity with respect to PHI decisions may be germane to the so-called "lock box" provisions. Under *PHIPA*, individuals who are capable of making decisions with respect to their PHI may provide express instructions to health information custodians not to use or disclose their PHI for health care purposes without their consent, in certain circumstances.[13] These provisions can have the effect of preventing a health practitioner from disclosing PHI about a patient to other health practitioners for the same patient. This can be extremely challenging and will require the obligation to disclose to the other health care providers that some PHI is not being made available to them.

3. *MHA* Privacy Provisions may prevail over *PHIPA* General Rules

Information relating to a person's mental health and psychiatric care is "personal health information" as defined by and for the purposes of *PHIPA*. PHI is broadly defined by *PHIPA* as "identifying information about an individual in oral or recorded form" that "relates to the individual's physical or mental health, including family history, and relates to providing health care to the individual" (emphasis added). It includes the identity of the person's health care providers and the identity of the individual's SDM.[14]

Consent is at the heart of *PHIPA*.

The legislation provides that a health information custodian shall not collect, use or disclose PHI about an individual unless the individual has consented in accordance with the provisions of *PHIPA*, and the consent, use or disclosure, as the case may be, is necessary for a lawful purpose, or is permitted or required by *PHIPA*.[15] The consent may be express or implied, but it must be obtained from the individual; or if the person is incapable with respect to decisions about their PHI, consent must be obtained from the individual's SDM.[16]

Documenting Consent to Disclose PHI

In the past, psychiatric facilities used the *MHA*'s Form 14 to record a patient's authorization for the disclosure of PHI contained in their clinical record. Following the enactment of *PHIPA*, the Ministry of Health revoked the Form 14, and it is no longer an approved form for this purpose. Where consent for the disclosure of PHI is required under *PHIPA* or the *MHA*, and no exception to obtaining the required consent applies, health information custodians should, at a minimum, document that consent has been provided. While no particular form of consent is required by *PHIPA* or its regulations, health information custodians may use the sample consent form that the Ministry of Health has developed, which is available online at the Ministry of Health's web site.[17]

The Ministry of Health has developed a sample form, available online, to document consent to disclosure of personal health records.

Collection, Use and Disclosure without Consent: *PHIPA* and *MHA* Exceptions

Although the current regime governing the privacy of PHI focuses on obtaining consent, express or implied, for all collection, use and disclosure, there are circumstances where the consent of the capable patient, or their SDM, is not required.

For example, subsection 40(1) of *PHIPA* provides that a health information custodian "may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons".[18]

13 *PHIPA, supra* note 2, ss 37(1)(a), 38(1)(a) and 50(1)(e).

14 *Ibid*, s 4(1).

15 *Ibid*, s 29.

16 *Ibid*, s 21(1) sets out the test for determining whether an individual is capable of consenting to the collection, use or disclosure of personal health information.

17 https://www.health.gov.on.ca/english/providers/project/priv_legislation/sample_consent.html

18 *PHIPA, supra* note 2, s 40(1).

This provision may be relied on when health information custodians are considering disclosing PHI to the police. In addition, *PHIPA* permits disclosure of PHI for the purpose of facilitating an inspection, investigation or similar procedure that is authorized by warrant or under Ontario or federal legislation.[19] We discuss these exceptions in further detail below in section 7.8.

In the context of mental health care, *PHIPA* also provides that a health information custodian may disclose PHI about an individual to the head of a penal or other custodial institution in which the individual is lawfully detained or to the officer in charge ("OIC") of a psychiatric facility in which the individual is being lawfully detained, for the following purposes:

- Arrangements for the provision of the health care to the individual;
- The placement of the individual into custody, detention, release, conditional release, discharge or conditional discharge under Part IV of the *Child and Family Services Act*, the *MHA*, the *Ministry of Correctional Services Act*, the *Corrections and Conditional Release Act* (Canada), Part XX.I of the *Criminal Code* (Canada), the *Prisons and Reformatories Act* (Canada) or the *Youth Criminal Justice Act* (Canada).[20]

PHIPA also permits the disclosure of PHI for the purposes of determining, assessing or confirming capacity under the *HCCA*, *SDA* and *PHIPA*.[21]

While *PHIPA* provides for limited disclosure of PHI in circumstances related to psychiatric care, the *MHA* was amended at the time of *PHIPA*'s enactment to provide for the collection, use and disclosure of PHI, with **or without** the capable patient's or incapable patient's SDM's consent, for purposes relating to the care and custody of persons under the *MHA* and pursuant to the provisions of Part XX.I of the *Criminal Code*.[22]

Subsection 35(2) of the *MHA* provides that:

The OIC of a psychiatric facility may collect, use or disclose PHI about a patient, with or without the patient's consent, for the purposes of:

(a) Examining, assessing, observing or detaining the patient in accordance with the *MHA*; or

(b) Complying with Part XX.I of the *Criminal Code* or an order or disposition made pursuant to that Part.

Section 35 of the *MHA* defines "patient" broadly to include former patients, out-patients, former out-patients and anyone who is or has been detained in a psychiatric facility.[23] The reference to "any person who has been or is detained in a psychiatric facility" would include persons detained on a Form 1 or Form 2 application for psychiatric assessment, who have not yet been admitted to the facility for treatment, as well as patients who are detained pursuant certificates of involuntary admission under the *MHA* or pursuant to dispositions of the Ontario Review Board ("ORB").

Essentially, section 35(2) of the *MHA* means that the OIC, or their delegate, may choose to seek the patient's consent for the collection, use or disclosure of the patient's PHI. However, if consent is withheld, the collection use or disclosure may proceed **without** the patient's consent, if it falls within the purposes of subsection 35(2). The ability to deal with PHI without consent supports the underlying purposes of the *MHA* and the *Criminal Code* provisions for the mentally disordered offender; that is, to facilitate treatment and the eventual reintegration of the involuntarily detained, mentally ill patient back into the community by obtaining information relevant to that purpose.

The *MHA* makes clear that these "without consent" exceptions have been made knowing that they conflict with the general requirement for consent set out in *PHIPA*. Section 34.1 of the *MHA* provides that where there is a conflict between *PHIPA* and section 35 or 35.1 of the *MHA*, the provisions of the *MHA* apply. This allows the *MHA* privacy provisions to "trump" *PHIPA* in the event of a conflict.

19 *Ibid*, s 43(1)(g).

20 *Ibid*, ss 40(2) and 40(3).

21 *Ibid*, s 43(1)(a).

22 *MHA*, *supra* note 3, s. 35(2). See also Chapter 6, Forensic Patients and the Criminal Law, regarding persons detained in psychiatric facilities under Part XX.1 of the *Criminal Code*.

23 *MHA*, *supra* note 3, s. 35(1)

When read together, section 34.1 and subsection 35(2) of the *MHA* provide psychiatric facilities with the ability to collect PHI from other health care institutions and practitioners who have provided care to the patient in the past, as well as from the patient's family and friends, without the capable patient's or incapable patient's SDM's consent.

Recall that the definition of PHI includes anything that relates to the person's mental health, and includes family history. Although subsection 35(2) "trumps" the general consent principle of *PHIPA*, it should be noted that subsection 35(2) is permissive in nature and does not prevent a hospital from obtaining patient consent even though such consent is not required. Deciding whether to proceed without the patient's consent will depend on the clinical or legal purpose for which the information is required and the potential effect of proceeding without consent on the therapeutic relationship between the patient and the clinical team.

4. Disclosures for Proceedings

There are other circumstances where the provincial legislature has determined that the OIC may disclose PHI relating to mental health care in the context of legal proceedings, although there are also restrictions on the disclosure of PHI in the same context. The following paragraph refers to the provisions of section 35 of the *MHA* that provide for disclosure in proceedings and related investigations. Both *PHIPA* and the *MHA* contain provisions that deal with permitted disclosures of PHI for the purpose of a proceeding or contemplated proceedings.

- **Subsection 35(3)**: "In a proceeding before the Consent and Capacity Board, whether under this Act or any other Act, the OIC shall, at the request of any party to the proceeding, disclose to the Board the patient's record of personal health information."
- **Section 35(4.1)**: "The OIC shall disclose or transmit a clinical record to, or permit its examination by, [a representative of the Public Guardian and Trustee] who is entitled to have access to the record under section 83 of the *Substitute Decisions Act*, 1992", that is, for the purpose of conducting an investigation into allegations that a person is suffering serious adverse effects as a result of the person being allegedly incapable of making personal care decisions or of managing their property.
- **Subsection 35(5)**: The OIC, or their designate, subject to certain qualifications discussed below, shall disclose, transmit or permit the examination of a record of PHI where the record is subject to a summons, order, direction, notice or similar requirement in relation to a matter in issue or that may be in issue in a court or under any Act.
- We recommend that when a health practitioner is served with a summons or court order directing disclosure of PHI, the organization's legal counsel or risk management office should review the order to determine its validity in the circumstances. Even in the face of a valid court order for disclosure, where the attending physician states in writing that they are of the opinion that the disclosure is "likely to result in harm to the treatment or recovery of the patient"; or is likely to result in mental or physical harm to a third person", the clinical record may not be disclosed until the court that is hearing the matter, first holds a hearing to inquire into the physician's statement (**subsections 35(6) and 35(7)**). For example, a physician might object to the production of the clinical record where a patient has reported assaultive or abusive behavior by third parties, which if such information became known, might give rise to retaliatory behaviour toward the patient or others, or, which could disrupt the therapeutic alliance, thus harming the treatment or recovery of the patient.
- An example of "other similar requirement" mandating disclosure of the patient's health record can be found in subsection 76(3) of the *HCCA*: where a patient has applied to the CCB for a review of their capacity to consent to treatment, or involuntary admission, the patient's lawyer is entitled to examine and to copy, at their own expense, any medical or other health record prepared in respect of the party, subject to subsections 35(6) and (7) of the *MHA*. In other words, the facility should provide access to the patient's lawyer, unless the patient's attending physician has serious concerns about the lawyer's access to the record. In practice, such an exception would be rare.
- **Subsection 35(9)**: "No one shall disclose in a proceeding in any court or before any [tribunal or] body, any information in respect of a patient obtained in the course of assessing or treating a patient, or in the course of assisting in their assessment or treatment, or in the course of employment in the psychiatric facility" unless the patient is mentally capable of consenting to the disclosure as set out in *PHIPA* and has consented, or where the patient is incapable with respect to information decisions, with the consent of their

SDM; or, where consent has been withheld, there has been a judicial hearing to determine that the disclosure is essential in the interests of justice. This section applies to PHI that may be provided orally by a health practitioner who has been involved in the psychiatric care of the patient. It does not apply to hearings before the CCB, or a proceeding that has been commenced by the patient and relates to the assessment or treatment of the patient in a psychiatric facility. (see subsections 35(10) and 35(11)).

In determining whether the disclosure of the documents is in the interests of justice pursuant to subsection 35(9) of the *MHA*, the court will consider the following factors:

1. the relevance of the records to the proceedings;
2. the need to protect the right of the party about whom the complaints are brought to make full answer and defence while not permitting a fishing expedition;
3. the need to consider the privacy interests of the complainant or witness; and
4. limiting the disclosure of highly sensitive and confidential records to only certain circumstances.[24]

5. Community Treatment Orders (CTOs)

Subsection 35(4) and section 35.1 of the *MHA* provide for certain disclosures that relate to the contemplation and monitoring of CTOs. These disclosures include:

- **Subsection 35(4)**: "The officer in charge may disclose or transmit a person's record of PHI to, or permit the examination of the record by:
    1. A physician who is considering issuing or renewing, or who has issued or renewed, a CTO under s. 33.1;
    2. A physician who has been appointed by the physician who has issued or renewed a CTO, to carry out the issuing physician's duties in their absence [see *MHA*, subsection 33.5(2)];
    3. Another person named in the person's community treatment plan as being involved in the person's treatment or care and supervision, having first received a written request from the issuing physician or another named person; or
    4. [A rights adviser] providing advocacy services to patients in the prescribed circumstances."
- **Subsection 35.1(1)** allows a physician who is considering issuing or renewing a CTO with respect to a particular patient, to disclose PHI for the purpose of consulting with other regulated health care professionals, social workers and any other concerned person, to determine whether the person should be subject of a CTO.
- Once the CTO has been issued, **subsection 35.1(2)** permits health care professionals or any other person named in a CTO as participating in the treatment or care and supervision of a person who is subject to the CTO, to share information with each other relating to the person's physical and mental health, for the purpose of carrying out the community treatment plan.
- **Subsection 35.1(3)** makes clear that subsection 35.1(1) is an exception to the general rule that no person shall disclose the fact that a person is being considered for or is subject to a CTO without first obtaining the consent of the person or their SDM.
- **Subsection 35.1(4)** further provides that persons who receive PHI under subsections 35.1(1) or (2) (i.e., in the course of consultations regarding a CTO), must not further disclose that information unless the disclosure is permitted by the sections discussed for the purpose of issuing or implementing CTOs.

6. Disclosure for the Purpose of Receiving Rights Advice

The *MHA* requires that patients and their SDMs, if applicable, must be provided with rights advice in certain circumstances. Chapter 3 sets out the eight situations in which the *MHA* mandates the provision of rights advice to patients. For example, the involuntary admission of a patient to a psychiatric facility triggers the requirement for rights advice. The fact that a patient is the subject of a Form 3 or Form 4, constitutes PHI, as it is identifying information that relates to the person's mental health.

24 *Balasuriya v College of Physicians and Surgeons of Ontario*, 2018 ONSC 7743; *Fikry v College of Physicians and Surgeons of Ontario*, 2018 ONSC 7744.

Consequently, the psychiatric facility where the patient is detained is required by the provisions of the MHA to disclose PHI to a rights adviser, for the purpose of providing rights advice to the patient.[25]

Although rights advisers are not health information custodians as defined by *PHIPA*, the duties of confidentiality set out in *PHIPA* still apply to them, since they receive PHI from a health information custodian.[26]

7. The Patient's Right of Access to the Health Record and Right of Correction

Formerly, section 36 of the *MHA* provided a procedure by which patients who were examined, assessed or treated in a psychiatric facility could have access to their own clinical record and to file a statement of disagreement or correction. Part V of *PHIPA* now governs that process.[27]

In 2020, *PHIPA* was amended to provide that the right of access to personal health information includes the right to access the record in an electronic format.28 Under clause 52(1)(e) of *PHIPA*, there are circumstances in which the right of access may be refused, notably where the access could reasonably be expected to result in a risk of serious harm to the treatment or recovery of the individual, or a risk of serious bodily harm to the individual or another person. While this will not always be the case, it is a consideration which should form part of the decision-making process prior to granting access. In the mental health care context, it would be prudent to consult with the patient's attending physician prior to granting a request for access by the patient, or their SDM.

Once the patient has been granted access to their record of PHI, if the patient believes that the record is inaccurate or incomplete, the patient may request in writing, that the custodian correct the record.[27] Once a request has been made in writing, the health information custodian must reply stating whether or not the request will be granted within a certain period of time. Where a custodian refuses the request, the patient must be provided with the reasons for the refusal.

Even though *PHIPA* requires the custodian to correct a record if the individual is able to demonstrate that the record is incomplete or inaccurate, the custodian is not required to correct a record if it consists of a professional opinion or observation that has been made in good faith about the individual.[29]

8. Privacy Exceptions Regarding Communications To and From a Patient admitted to a Psychiatric Facility

The *MHA* contains provisions that govern the privacy of communications to and from patients in a psychiatric facility.

Section 26 of the *MHA* provides that the general rule is that "no communication written by a patient ... shall be opened, examined or withheld and its delivery shall not in any way be obstructed or delayed". However, there are exceptions that allow the OIC, or a person acting under their authority, to open and examine the contents of a written communication to or from a patient. If there are reasonable grounds to believe that the following conditions are met, the communication may be withheld from delivery:

25 *MHA, supra* note 3, s. 35(4)(d).

26 *PHIPA, supra* note 2, s 7(1)(b).

27 For further guidance in this area see: Information and Privacy Commission; A Guide to the *Personal Health Information Protection Act*, December 2004; https://www.ipc.on.ca/wp-content/uploads/Resources/hguide-e.pdf.

28 *PHIPA, supra* note 2, s 52(1.1); see also "Recent amendments to the *Personal Health Information Protection Act*" dated May 13, 2020, available at: https://www.blg.com/en/insights/2020/05/recent-amendments-to-phipa

29 *Ibid*, s 55(9); In *PHIPA* Decision 19, Complaint HA19-00300, the complainant sought a review of the hospital's decision to refuse her request under *PHIPA* to correct her records of PHI related to her hospital admission. In particular, the complainant sought removal of a form, signed by a physician, requiring her to undergo a psychiatric assessment and removal of references to her having schizophrenia and suicidal thoughts. The hospital relied on the exception at section 55(9)(b) of *PHIPA* – professional opinions or observations made in good faith – to refuse the correction. The adjudicator agreed.

(a) That the contents of a communication written by a patient would,

(i) Be unreasonably offensive to the addressee, or

(ii) Prejudice the best interests of the patient; or

(b) That the contents of a communication sent to a patient would,

(i) Interfere with the treatment of the patient, or

(ii) Cause the patient unnecessary distress.

Based on a reasonable belief that one of the conditions is met, the OIC or their delegate, may open and examine the contents of the communication. Upon examination of the contents, if any condition mentioned in either clause (a) or (b) exists, the communication may be withheld from delivery **unless** certain exceptions apply. If the communication appears to be written by a patient to, or is sent to a patient from, a lawyer, a member of the CCB or a Member of Parliament, or the Ombudsman of Ontario, the communication may not be withheld and must be delivered.[30]

9. Communicating with the Police

Prior to *PHIPA*, disclosure of PHI to police was guided by the common law or by other legal authority, such as a court order, warrant or subpoena. This has historically been an area of concern to health care providers, who are mindful of their obligations to maintain patient confidentiality.

With the enactment of *PHIPA*, the starting point for disclosure of PHI, including disclosures to the police, continues to be consent. In the absence of a patient's or SDM's consent, a health information custodian must look to legal authority referenced in either *PHIPA* or the *MHA*, that allows for disclosure in the absence of consent. Typically, the police approach health care providers for information obtained in the course of treatment, which the police believe may be relevant to an investigation. With reference to police requests for information, the authority to disclose PHI about an individual usually derives from a warrant, subpoena or court order issued in a criminal proceeding, which *PHIPA* recognizes as an authorized disclosure without consent.[31] These provisions must be reconciled with subsection 35(5) of the *MHA*, for any conflict, and in the event of a conflict, the *MHA* provisions will govern.[32]

It is recommended that organizations develop a procedure to facilitate responses to police requests for PHI. The procedure may include: who to contact, what questions should be asked to verify lawfulness of the requests, what documentation/ information may be required from the police to support the request, such as a warrant, summons or court order, what should be documented in the patient's chart and what, if any, information to disclose to the patient who is the subject of the police request.

Health practitioners may also want to contact the police regarding concerns about criminal activity that have come to their attention in the course of providing health care with the patient's consent, or without the patient's consent, if the concern rises to the level of a duty to warn. The duty to warn is triggered where the health practitioner believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.[33]

In situations where police are in attendance on hospital premises for the purpose of a police investigation, the police presence should not interfere with the safe and efficient operation of a hospital and the provision of patient care.

There is no general legislative authority that requires health care providers or citizens to report alleged criminal activity to the police.[34] Rather the *Criminal Code* requires citizens to not obstruct the police in the course of exercising their duties or omit, without reasonable excuse, to assist a police officer in the course of exercising their duties.[35] It is reasonable for health care providers to ensure that there is a lawful basis for disclosing PHI to the police, in the absence of the patient's consent.

30 *MHA, supra* note 3, ss 26(1), (2) and (3); see also the *Ombudsman's Act*, RSO 1990, c O 6, s 16(2). Although not expressly referred to in s. 26 of the *MHA*, it would be prudent to also ensure delivery of any communication to and from the Patient Ombudsman, who is responsible for investigating patient complaints related to healthcare organizations (*Excellent Care for All Act*, S.O. 2010, c. 14, s. 13.1)

31 *PHIPA, supra* note 2, ss 41(1)(a)(d) and 43(1)(g).

32 See section 3 re section 34.1 and also s. 35(5), re disclosures relating to proceedings and describing obligations arising from *MHA*, ss 35(5), (6) and (7) above.

33 *PHIPA, supra* note 2, s 40(1).

34 One exception to this rule is Ontario's *Mandatory Gunshot Wounds Reporting Act*, 2005, SO 2005 C 9, discussed below.

35 *Criminal Code of Canada*, RSC 1985, c C46, s 129 [*CC*].

As these situations are very fact-specific, health care providers should contact the Hospital's Risk Management department and/or legal counsel for advice.

Under *PHIPA*, certain permissible disclosures that were not previously covered by the common law have been provided for. For example, under clause 43(1)(g), a health information custodian may disclose PHI about an individual to a person carrying out an inspection, investigation or similar procedure that is authorized by a warrant or by any statute of Ontario or Canada, for the purpose of complying with the warrant **or for the purpose of facilitating the inspection, investigation or similar procedure** (emphasis added).[36]

Subsection 43(1)(g) allows for disclosure of PHI to police without patient consent and in the absence of a warrant or subpoena, so long as the police are lawfully conducting an inspection or investigation that is authorized by statute. Where a patient is the subject of a police investigation for criminal activity, this section may allow disclosure of patient information to police prior to the issuance of a warrant or subpoena. This section should be considered with caution where disclosure is requested by police in the absence of a warrant, order or patient consent.[37] Given that significant legal issues are at stake, for the patient and potentially for the custodian, it is advisable for the health information custodian to seek legal advice on any questions in this area, to ensure that the disclosure, or any refusal to disclose, is permitted by law.

36 *PHIPA*, *supra* note 2, s. 43(1)(g); see also s. 43(1)(h) which provides for further permissive disclosures of PHI, "subject to the requirements and restrictions, if any, that are prescribed, if permitted or required by law or by a treaty, agreement or arrangement made under provincial or federal legislation. To date the General Regulation enacted under *PHIPA* has been amended to include some additional permissive disclosures. See for example, section 7, para 2 of the Gen. Reg, which permits an agent of a health information custodian to disclose PHI acquired during in the course of the agent's activities on behalf of the custodian for the purpose of disclosures to the PGT or a CAS under s. 43(1)(e). See also section 18(6), which allows certain entities to disclose PHI received for the purpose of planning and management of a health system, to a governmental institution of Ontario or Canada, as if the prescribed entity was a custodian.

37 See also health sector related guidance on the Information and Privacy Commissioner of Ontario Website: https://www.ipc.on.ca/wp-content/uploads/2019/02/fs-health-disspelling-myths-under-phipa.pdf from February 2019; and https://www.ipc.on.ca/wp-content/uploads/2015/11/phipa-faq.pdf from September 2015.

Some statutes require reports to authorities other than police. For example, under the *Child, Youth and Family Services Act*, a health care professional must report to a Children's Aid Society a reasonable suspicion that a child is in need of protection, where that suspicion is based on information acquired in the course of their professional duties.[38] Similarly, under the *Mandatory Gunshot Wounds Reporting Act*, a facility that treats a person for a gunshot wound is required to disclose to the local municipal or regional police force or the local Ontario Provincial Police detachment, the fact that a person is being treated for a gunshot wound, as well as the person's name, if known, and the name and location of the facility.[39] *PHIPA* preserves and recognizes these types of disclosures under the category of disclosures permitted by law (clause 43(1)(h)).

Examples of other statutes requiring mandatory reports or disclosures include:

- *Coroners Act*, R.S.O. 1990, c. C.37;
- *Regulated Health Professions Act*, 1991, S.O. 1991, c.18, including the Health Professions Procedural Code, being Sch. 2 to the Act;
- *Highway Traffic Act*, R.S.O. 1990, c. H.6; and
- *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7.

A description of each of the various legislated reporting obligations is outside of the scope of this Toolkit. Health care professionals will generally find information about their profession's mandatory reporting obligations on their health college's website.

10. The Duty to Warn

PHIPA provides for disclosure related to risk in circumstances where a health information custodian believes on reasonable grounds that disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.[40]

In its December 2004 "Guide to the *Personal Health Information Protection Act*", the Information and Privacy Commissioner ("IPC") provided an example of a situation in which a health

38 *Child, Youth and Family Services Act, 2017,* SO, c 14,, s. 125.

39 *Mandatory Gun Shot Wounds Reporting Act*, SO 2005, c. 9, s 2.

40 *PHIPA, supra* note 2, s 40(1).

information custodian could disclose PHI about an individual over their objection, as permitted by subsection 40(1) of *PHIPA*.[41] In the example, the IPC described a student who had been attending a University Health Centre for counselling. The counsellor noted that the student appeared to be severely depressed and that the student could be addicted to prescription medication. Having assessed the risk of suicide, the counsellor wanted to involve the student's family and family physician, but was instructed by the student not to disclose any information. The student subsequently contacted the Centre by telephone, speaking in a slurred voice and indicated an intention to end his own life. In this type of situation, the IPC stated that the counsellor would be permitted to disclose PHI to the student's family or family physician, if they had formed the opinion that there were reasonable grounds to believe it was necessary to do so to reduce the risk of suicide in the student.

It should be added that this is a permissive and not a mandatory disclosure under *PHIPA*. Subsection 40(1) begins "A health informative custodian may disclose…" However, where the situation is such that there are significant risks of harm, disclosure to the appropriate person or authority is recommended. The case law supports the imposition of a common law duty to warn in such circumstances, even where the statute is permissive.[42]

Where the situation is such that there are significant risks of harm, disclosure to the appropriate person or authority is recommended.

11. Limits of Confidentiality in Court-Ordered Assessments

Under the *Criminal Code,* provisions dealing with the mentally disordered offender, the court may order an assessment only where the court has reasonable grounds to believe that evidence obtained by the assessment is necessary to determine any of the enumerated matters set out in section 672.11, such as fitness to stand trial and criminal responsibility.[43] Under the *MHA*, a judge also has the authority, where a person suffers from mental disorder and is charged with or convicted of an offence, to require the person to attend a psychiatric facility for examination and assessment.[44]

Whether issued pursuant to the provisions of *Criminal Code* or the *MHA*, the assessment has been ordered for the purpose of assisting the Court or the ORB to arrive at a just outcome. The health care professional who conducts the assessment, usually a forensic psychiatrist, is subject to a Court or ORB order to provide the criminal justice system with their clinical opinion on whether the person who is before the court suffers from a mental disorder and to educate the court about the various psychiatric variables that may be at play in a case for the purpose of determining fitness to stand trial or criminal responsibility.[45]

It is important to note that the court-appointed, assessing psychiatrist is generally not in a doctor/patient relationship with the person being assessed, although in the context of providing evidence at annual hearings of the ORB, the psychiatrist witness may well be.

In these circumstances, physicians will usually explain to patients that they are under an obligation to report to the court or ORB on the outcome of the assessment such that the normal parameters of doctor/patient confidentiality do not apply.

12. Invasion of Privacy Claims: Intrusion Upon Seclusion

Prior to 2012, there was no free standing claim in negligence, or tort, for the invasion of privacy at common law. Individuals had and continue to have the right to complain about a privacy breach to the IPC.[46]

41 Ontario, Office of the Information and Privacy Commissioner, A Guide to the Personal Health Information Act, (December 2004) at 28, example 8. Available online: < https://www.ipc.on.ca/wp-content/uploads/Resources/hguide-e.pdf > (accessed December 2022).

42 *Smith v Jones*, [1999] 1 SCR 455; *Tarasoff v Regents of the University of California*, [1976] 17 Cal 3d 425.

43 *CC*, *supra* note 34, ss 672.11, 672.121 and 672.13. See Chapter 6 on forensic psychiatric patients for further discussion of these particular matters.

44 *MHA, supra* note 3, ss 21 – 24.

45 Hy Bloom & Richard D Schneider, *Mental Disorder and the Law: A Primer for Legal and Mental Health Professionals*, 2nd ed (Toronto: Irwin Law, 2017) [*Bloom & Schneider*] at 49.

46 For further information, visit the Information and Privacy Commissioner of Ontario, online: <http://www.ipc.on.ca>.

In the 2012 decision of *Jones v. Tsige*, Ontario's Court of Appeal considered an appeal of a lower court summary judgment decision that dismissed a claim for breach of privacy on the grounds that Ontario law did not recognize the tort of breach of privacy.[47] A claim had been brought against a bank employee who, contrary to bank policy, had accessed the personal banking records of the employee's partner's former wife at least 174 times over a period of four years. The former wife sued the employee for breach of privacy.

On the appeal, the Court of Appeal confirmed the existence of a right of action for "intrusion upon seclusion." Where someone intentionally or recklessly intrudes, physically or otherwise, upon the seclusion of another or their private affairs or concerns, that person will be liable to that other person for invasion of their privacy, if the invasion would be highly offensive to a reasonable person.[48]

In assessing damages, the Court of Appeal in *Jones* suggested that the following factors should be considered:

- the nature, incidence, and occasion of the defendant's wrongful act;
- the effect on plaintiff's health, welfare, social, business, or financial position;
- any relationship, domestic or otherwise, between the parties;
- any distress, annoyance, or embarrassment suffered by the plaintiff; and
- the conduct of the parties before and after, including any apology or offer of amends.[49]

In 2015, the Court of Appeal considered the case of *Hopkins v. Kay*, in which there had been an unlawful disclosure of PHI. The Court determined that the plaintiff could seek a civil remedy for damages arising from the tort of intrusion upon seclusion, notwithstanding their ability to complain to the IPC under *PHIPA*.[50]

In *Hopkins v Kay*, a representative plaintiff for a proposed class proceeding alleged that her records of PHI at a hospital were improperly accessed by a hospital employee and that she (and the other plaintiffs in the class) should recover damages caused as a result of the defendant's negligence in committing the tort of intrusion upon seclusion. It was argued by some of the defendants that *PHIPA* should be seen as a complete code for dealing with breaches of privacy involving PHI, such that a lawsuit before the court should not be allowed to proceed. The Court of Appeal disagreed and confirmed that the common law tort of intrusion upon seclusion, first recognized in *Jones v Tsige*, remains an avenue of effective redress for breaches of privacy involving inappropriate access to PHI.

The Court confirmed that tort of intrusion upon seclusion requires the plaintiff to prove three elements:

1. intentional, reckless conduct by the defendant;
2. the defendant invaded, without lawful justification, the plaintiff's private affairs or concerns; and
3. that a reasonable person would regard the invasion as highly offensive causing distress, humiliation or anguish.

The Court noted that the first and third elements represent significant hurdles that are not required to prove a breach of *PHIPA*.[51] In other words, the Court found that *PHIPA* does not create an exhaustive code in relation to PHI and that the Act expressly allows for other proceedings (including court processes) to resolve individual privacy breach claims. The Court concluded that individuals should be allowed to pursue privacy breach claims against health information custodians without first having to go through the procedures outlined in *PHIPA*.[52]

The 2022 case of *Stewart v. Demme*[53] involved a hospital employee who accessed medical information of thousands of patients after steeling opioids from an automated dispensing unit at the hospital. The representative plaintiff commenced a class proceeding against the defendants for damages stemming from, among other things, intrusion upon seclusion.

The certification judge certified the intrusion upon seclusion claim. The Defendants appealed to the Divisional Court, on the grounds that the certification judge erred in his interpretation of the third step of the test for the tort, that a reasonable

47 *Jones v Tsige*, 2012 ONCA 32.

48 *Ibid* at paras 70 – 71.

49 *Ibid* at para 87.

50 2015 ONCA 112.

51 *Ibid* at para 48.

52 *Ibid* at para 73.

53 *Stewart v Demme*, 2022 ONSC 1790.

person would regard the invasion as highly offensive causing distress, humiliation and anguish.

In setting aside the certification order, the Court summarized the required elements for intrusion upon seclusion as set out in *Jones v Tsige.* The Court focused its analysis on the third element of the test and held that "not every intrusion into private health information amounts to a basis to sue for the tort of intrusion upon seclusion. The particular intrusion must be 'highly offensive' when viewed objectively having regard to all the relevant circumstances". In summary, the tort of intrusion upon seclusion remains limited.

13. *Freedom of Information and Protection of Privacy Act*

As of January 1, 2012, Ontario hospitals are subject to the *Freedom of Information and Protection of Privacy Act* ("*FIPPA*"). Public and private hospitals are designated as "institutions" subject to *FIPPA*.[54]

The legislation applies to all records in the custody or under the control of a hospital on or after January 1, 2007. Under *FIPPA*, the general public will have a right of access to these records, unless the records are excluded from the right of access or subject to an exemption under *FIPPA*. Where a record is excluded, FIPPA does not apply to it at all; however, exempt records are still subject to *FIPPA*, except in specified circumstances where the hospital is able to justify the exemption.

This right of access applies to every person. Unlike *PHIPA*, which allows a person to access records about him or herself, *FIPPA* allows anyone to access any record held or controlled by an institution on any issue, subject to the exclusions and exemptions set out in the Act.

The legislation amends the *Quality of Care Information Protection Act*, 2004 ("*QCIPA*") so as to exclude "quality of care information" (as defined in *QCIPA*) from the application of *FIPPA*. *PHIPA* already provides that the right of access in *FIPPA* **does not** apply to records of "personal health information" (as defined in *PHIPA*) in the custody or under the control of health information custodians, unless the PHI can be reasonably severed from the record. The obligation in *FIPPA* to disclose records, where the disclosure is in the public interest and the records reveal a grave hazard to the public, does apply to public hospitals. By way of illustration, section 17 of the *MHA* provides police officers with authority to detain those who they deem to be suffering from mental health issues, when indicated.[55] The corresponding records are not considered PHI pursuant to *PHIPA* and may be requested and accessed pursuant to *FIPPA*.

For further information on *FIPPA* and it applicability to hospitals, please see the IPC's Freedom of Information at Ontario Hospitals: Frequently Asked Questions.[56]

14. Privacy Issues Related to Telehealth & Virtual Care

Virtual care can be an effective means of providing treatment to patients. Virtual care may be provided in the context of a telephone call, or may involve video-conferencing and other internet-based tools.

Section 15 of the *MHA* provides that a physician who signs an application for an involuntary psychiatric assessment must "personally examine" the person who is the subject of the application. There is, however, no express requirement in the legislation that the assessment must be done in person. Accordingly, virtual care may be used for examination to complete a Form 1.[57]

In determining whether telemedicine and/or virtual care is the appropriate method for conducting an examination for a particular person, physicians must use their professional judgment and consider the following:

- Is access to the system available?
- Is the person able to participate in the examination?

54 *Freedom of Information and Protection of Privacy Act,* RSO 1990 c F 31, s 2(1)(a.2).

55 *MHA, supra* note 13, s 17.

56 For up-to-date information on this topic, please refer to the IPC's resources on privacy issues for public hospitals: https://www.ipc.on.ca/wp-content/uploads/Resources/Hospital%20FAQ-e.pdf

57 For further information, refer to OHA's Form 1 Assessments Under the *Mental Health Act* Frequently Asked Questions. https://www.oha.com/Documents/Form%201%20Assessments%20Under%20the%20Mental%20Health%20Act.pdf

- Does the access provide a confidential environment for the examinations?
- Is the connection confidential, with information security safeguards?
- Does the person have capacity to consent to virtual care?
- Is the person alone? If not, are they aware that highly sensitive information may be heard by others?

There are, of course, inherent risks specific to providing telemedicine/virtual care in the mental health context. For instance, a physician's ability to assess the patient's mental health condition via telephone or video may be limited. Furthermore, the person's ability or desire to disclose important information may be affected by the medium of communication used. As such, it is important that physicians consider the appropriateness of providing virtual care on a case-by-case basis.[58]

58 Additional information on virtual health care visits may be found on the Information and Privacy Commissioner's Website at https://www.ipc.on.ca/wp-content/uploads/2021/02/virtual-health-care-visits.pdf

CHAPTER

8 Mental Health Law Expertise at Your Hospital

The purpose of this Chapter is to discuss issues that arise when dealing with mental health patients that are not addressed elsewhere in this Guide.

1. The Use of Restraints

What is "Restraint"?

"Restrain" means to "place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient".[1]

The use and meaning of "restraint" is distinct from "detaining" a patient, and detention is discussed elsewhere in this Guide.

Restraint may involve physically laying hands on a patient.

Mechanical restraint involves devices, including jackets, straps and bedside rails that restrict movement. Locked observation rooms may be considered a mechanical or an "environmental" restraint.

Chemical restraint is the administration of medication to control a patient's movements.

Legally, there is no distinction between the types of restraints used; however, there are issues, reviewed below, around the documentation and monitoring of patients when different types of restraints are used.

The Authority to Restrain

> The *Health Care Consent Act* ("HCCA") specifically provides that:
>
> > This Act does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others.[2]

The common law duty is:

> A right and a duty to restrain [a patient] when necessary to protect [them], other patients, or others lawfully on the premises (staff or other patients) from harm and to prevent endangerment to the safe environment of the hospital or facility.[3]

Example of the Common Law Duty to Restrain

A patient had been angry and agitated, yelling at staff in a manner that caused staff to fear for their safety. He was placed in seclusion where he continued to yell and scream and kick doors and walls for some time. There was a cause for concern about the effect the behaviour was having on other patients, as well as a concern for harm that may come to the patient.

Chemical restraint was used in addition to physical restraint.

The patient brought an action claiming damages and an alleged breach of the Charter due to the use of chemical restraints.

The Court upheld the decision to employ the chemical restraint, and in doing so, considered the factual context as well as the potential consequences of not restraining the patient.

The Court held that the plaintiff posed a threat of serious bodily harm to himself, possibly to staff, and once he was in his room there was no danger to other patients, his degree of agitation was such that he was upsetting other patients, and there was a risk of a different type of injury to himself as a result of recriminations by other patients.[4]

1 *Mental Health Act*, RSO 1990 c M7, s 1 [*MHA*].

2 *Health Care Consent Act*, 1996, SO 1996 c 2, s 7 [*HCCA*].

3 *Conway v Fleming*, [1996] OJ No 1242 at paras 278-279 (Ont Gen Div).

4 *Ibid*.

Under the *Mental Health Act* ("*MHA*"), there is an express provision that "nothing in this Act authorizes a psychiatric facility to detain or to restrain an informal or voluntary patient".[5] **This does not preclude the use of restraints in an emergency in accordance with the HCCA or the common law.**

When restraints are used on a person detained or admitted under the *MHA*, the use of restraint must be documented, including a description of the means of restraint (what and how), and the behaviour that required the patient to be restrained or continue to be restrained.[6] It is also prudent to include the time restraint was initiated and discontinued, and the frequency of observation during the restraint period (when), and describe the effect on the patient.

When chemical restraint is used, documentation must include the type of medication, the method of administration, and the dosage.[7]

Where the *MHA* does not apply[8], the *Patient Restraints Minimization Act* ("*PRMA*") must be considered. The *PRMA* permits the use of restraints, in accordance with the common law, when immediate action is necessary to prevent serious bodily harm to the person or to others[9] and in non-emergent situations only if restraints are necessary to enhance the patient's quality of life and prevent serious harm to the patient or another person.[10]

Finally, there may be situations in which restraint is used as part of, or ancillary to, treatment. If treatment is being administered in accordance with substitute consent, and restraint is necessary to administer the treatment, the restraint itself forms part of the treatment.[11]

The Use and Application of Restraints

It is expected that health care facilities, including psychiatric facilities, have policies of "least restraint". The acuteness of an individual patient's condition and the risk it may pose for both self-harm and harm to others should be assessed and documented, and the patient should be managed accordingly.

Hospitals have obligations to provide training and support to staff and physicians providing treatment and care to patients within its facility. This includes training specific to issues that may arise, or be "reasonably foreseeable" during the treatment and care of patients with mental illness, and specifically relating to the use and application of restraints, whether mechanical or chemical.

Patients may require restraint from time to time, and staff need to be trained in how to deal with restraint appropriately, having regard to managing the patient's risk of harm that gave rise to the restraint, and the safe use of the restraint in the circumstances.

5 *MHA*, *supra* note 1, s 14.

6 *Ibid*, s 53. If this is not done, there is support for the allegation that there has been a "battery" of the patient: *Illingworth Estate v. Humber River Regional Hospital* (1999), 126 OAC 332, [1999] OJ No 4217 (CA). Here, there was no record as required by s 53 of the *MHA*, describing the behaviour of the patient that required that he be restrained by handcuffs, the statutory requirement for restraint, as set out in the definition of "restrain" in s 1 of the *MHA*, was not met and a claim for battery against the hospital was allowed.

7 *MHA*, *supra* note 1, s 53(2).

8 This includes non-Schedule 1 facilities, non-Schedule 1 psychiatric facilities and when patients are in a hospital that is a Schedule 1 psychiatric facilities BUT to whom the *MHA* is not applicable (ex. medical and surgical patients).

9 *Patient Restraints Minimization Act*, 2001, SO 2001, c 16, s 6(2) [*PRMA*].

10 *Ibid*, s 5.

11 *SMT v Abouelnasr*, [2008] OJ No 1298 at para 53 (QL) suggests that "restraint" may be considered a "treatment" under the *HCCA*.

What is "Reasonably Foreseeable"?

A suicidal psychiatric patient threw himself at a glass window, shattering the window, and consequently suffering significant injuries to which he eventually succumbed.

The Ontario Court of Appeal upheld the trial judge's finding that both the attending psychiatrist and hospital were negligent.[12]

The Court confirmed that the self-destructive harm that materialized was "well within the range of harm that the defendants could reasonably foresee". Consequently, the conduct of hospital staff who failed to increase the level of observation on the patient when he posed a high suicide risk came under scrutiny, as did the hospital's failure to place the patient in a room with shatterproof glass in the windows.

The Court also found that both the hospital and medical staff failed to hold an intake conference, as required by hospital policy, to develop a plan to address the patient's increased suicidality.

The use of restraint, whether mechanical or chemical, may pose a risk to the patient by virtue of the restraint itself. Inherent risks associated with the type of restraint must be weighed and balanced with the risk of harm to the patient or others if the patient is not restrained. Having weighed the risks and benefits, the reasons for the restraint application should be documented in the clinical record. In situations in which restraints are being used and the *MHA* does not apply, there should still be documentation on the reason for, and use of, restraints.

With regard to mechanical restraints, hospitals generally have control over purchasing and maintaining the equipment employed by health practitioners on its premises for the purpose of restraining patients.

Hospitals should ensure that mechanical restraints are used according to the manufacturer's instructions and are maintained in good working order.

Further, staff should be trained in the proper use of such equipment, again in accordance with the manufacturer's instructions. A manufacturer's instructions may include not only how the restraint should be applied, but also how frequently the patient should be monitored while subject to the restraint.

Hospital policy on restraint practices may also set out general guidelines on the frequency of monitoring and there may be other applicable standards of practice to consider.

Any departure from recommended use or recommended monitoring should be undertaken only on a doctor's orders, with the clinical reasons clearly documented in the patient chart.

Regulated health professionals should also be familiar with the resources, professional standards and guidelines as set out by their respective Colleges.[13]

Coroner Inquest recommendations on the use of Restraints

Ontario's *Coroners Act* requires that if a person dies while being restrained and while detained in a psychiatric facility, either as an involuntary patient under the *MHA* or as a forensic patient under Part XX.1 of the *Criminal Code*, the officer in charge of the psychiatric facility must notify the Coroner immediately, and the Coroner is required to hold an inquest concerning the death. Coroners Inquests are addressed in more detail later in this chapter.

Recommendations about the use of restraints have been made by coroner's juries in several inquests. Many of these released prior to 2017 are available on the OHA's website: https://www.oha.com/guidance-and-resources/coroner-reports-and-documents.

In 2017, a comprehensive list of recommendations was prepared by a coroner's jury following a mandatory inquest into the death of a 65-year old patient. While the patient died from natural causes, at the time he was in mechanical restraints in the crisis area of the emergency department of a Schedule 1 facility. The recommendations from this inquest

12 *De Jong Estate v Owen Sound General and Marine Hospital*, [1999] OJ No 4369 (Ont CA).

13 For example, the College of Nurses of Ontario has an "Understanding Restraints" Education Tool that links to related CNO resources: https://www.cno.org/en/learn-about-standards-guidelines/educational-tools/restraints/.

address the use of restraints, as well as many other issues. Coroner's inquests are addressed in more detail later in this Chapter. A summary of these recommendations, including those relating to the use of restraints, is attached Appendix "F".[14]

2. Clinical Risk Management

Training and Continuing Education of Staff

Generally speaking, health practitioners are bound to exercise a degree of care and skill that could reasonably be expected of a prudent and diligent practitioner in the same field and in similar circumstances.[15] Where a practitioner hold themself out as a specialist, regardless of location, a higher degree of skill is required as compared to someone who does not claim to be so qualified.[16] Generally, specialists (whether in nursing or medicine) are held to the standards of other specialists who possess the same or similar levels of knowledge, skill and training.[17]

Health practitioners are expected to exercise their clinical judgment diligently. Determining whether this has been done includes taking into account the health practitioner's assessment of the patient and information available from other sources.[18]

What may be "reasonably expected" will be determined based on the specific circumstances in any given case.

A hospital has an obligation to meet standards "reasonably expected" by the community in the provision of competent personnel and adequate facilities and equipment, and also with respect to the competence of physicians to whom it grants privileges for providing medical treatment.

Based on case law, the hospital's size, location, and the community it serves will be relevant factors in evaluating whether it met the standard required in any given case. While these factors will not be determinative, they will be considered along with all of the other circumstances in a particular case.

Documentation and Charting

Documentation serves both a clinical and legal purpose. Clear, effective and complete documentation is an important tool of communication for the health care team. Courts have recognized that charting information relevant to a patient's presentation and treatment is an important component of intra-team communication and the chart is evidence of compliance with requirements for content, retention and disclosure of medical records.[19]

Example of the Importance of Documentation

A patient underwent a bilateral carotid arteriography following which he became a quadriplegic.

The patient claimed that he had not been warned of the risks, and that he had received minimal and inappropriate care after the surgery.

The Court held that the testimony of the plaintiff was entirely unreliable as it was inconsistent with, and contradictory to, the documentation found in the chart. The Court summarized its finding as follows:

It is necessary that I say that the testimony of the plaintiff is unreliable. Whether it was because of failing memory, because of the effluxion of time between the events and the testimony, or because of the effect of the enormity of the calamity suffered by him or because of any other reason, the fact is that the plaintiff's evidence about so many of the events during that period is entirely inconsistent with and contradicted by the documentation in the hospital record.[20]

14 Verdicts and recommendations from Coroner's inquest are available through the Office of the Chief Coroner https://www.ontario.ca/page/2022-coroners-inquests-verdicts-and-recommendation. These recommendations arise from the inquest into the death of Nokolaos Mpelos.

15 See *Crits v Sylvester* (1956), 1 DLR (2d) 502 at 508 (Ont CA), aff'd [1956] SCR 991 ["*Crits*"]. See also *Tiesmaki v Wilson*, [1974] 4 WWR 19 (Alta SC), aff'd [1975] 6 WWR 639 (Alta CA).

16 *Crits, ibid.; Wilson v. Swanson*, [1956] SCR 804, 5 DLR (2d) 113 at 119, 124.

17 *Crits, supra* note 15

18 See *Wilson v Swanson*, [1956] SCR 804 at 812-813, 5 DLR (2d) 113. See also *Fullerton (Guardian ad litem of) v Delair*, 2005 BCSC 204 at para 176, varied on other grounds in 2006 BCCA 339.

19 See *Joseph Brant Memorial Hospital et al. v Koziol et al.* (sub nom *Kolesar v Jefferies*) (1977), 77 DLR (3d) 161 at 165 (SCC); *Rose v. Dujon* (1990), 108 AR 352, 1990 CarswellAlta 464 at paras 137-142 (Alta QB).

20 *Ferguson v Hamilton Civic Hospital et al.* (1983), 40 OR (2d) 577 (HCJ) at 4.

Documentation should meet statutory, institutional and professional requirements. Documentation should be legible, objective, include all pertinent information, use specific terminology, be completed contemporaneously where feasible and avoid subjective conclusions or assumptions.

Many Ontario hospitals use a practice known as "Charting by Exception". The underlying philosophy is to chart only significant findings or exceptions to norms in narrative format. Routine care and normal interventions are documented in an abbreviated method, typically on flow sheets designed for this purpose.

The "Charting by Exception" documentation system is based on the assumption that the care was provided in accordance with written standards of care, unless otherwise noted. It is a shorthand method of documentation in which it is presumed that a normal or expected event occurred unless documented otherwise. It does not mean an absence of documentation. In particular, and contrary to a common misconception, it still requires that a health practitioner document at regular intervals when no change in the patient's condition has been observed.

The Ontario Court has supported the "Charting by Exception" practice, as long it is documented somewhere in the chart that a check or assessment of the patient had been completed.[21]

All of the same principles for documentation and charting apply to electronic charting. The expectations for documenting are the same whether the health practitioner documents on paper or electronically.

No matter what type or kind of charting is used, anyone reviewing the chart must be able to determine what transpired.

Occupational Health and Safety

Caring for the acutely mentally ill may involve the assessment and management of the risk of serious harm to both the patient and others as a result of a mental disorder.[22] The terms most often referenced when dealing with these challenges are "harassment" and "violence". Harassment is vexatious "comment" and "conduct," which ought reasonably to be known to be unwelcome. Violence is actual, attempted or threatened physical harm.

One of the recognized challenges that face staff working on an in-patient mental health unit is the risk posed by patient behaviours that may fall within the definitions of harassment or violence. While this challenge is certainly not limited to mental health units, it is a concern for staff working in this environment who may be working with patients who may meet the harm-based criteria for involuntary admission or who may be detained for assessment / following being found not criminally responsible for violent criminal offences.

The *Occupational Health and Safety Act* ("*OHSA*") requires that staff be provided with information, including personal information, related to the risk of workplace violence from a person with violent behaviour, if the staff person can be expected to encounter the person in the course of work and if the risk of physical violence is likely to expose the worker to physical injury.[23] While the legislation recognizes that this may involve the disclosure of "personal information", if required, for the identification/disclosure of risk, the legislation does not set out the type and amount of information that should be disclosed. The legislation does require that the information disclosed be "reasonably necessary" in the circumstances "to protect the worker from physical injury".[24]

Where a patient has a history of violence, information relating to this history may be contained in clinical notes and records. While this information will likely be known to the staff who have clinical interactions with the patient, the obligations set out in the *OHSA* extend to all staff who can be expected to encounter the patient – including staff who are not directly involved in the care of the patient and therefore not ordinarily accessing this information.

21 *Ibid*. The Court dismissed the allegation that monitoring of the patient was too infrequent, by pointing to the medical record, which showed frequent monitoring and assessments had been done.

22 This section is focused on some specific issues for mental health care providers that may arise as a result of this legislation. The OHA provides more detailed and specific resources relating to Health Human Resources and Healthy Work Environments.

23 *Occupational Health and Safety Act*, RSO 1990 c O1, ss 32.0.1 – 32.0.8.

24 *Ibid*, s 32.0.5(4).

Organizational policies need to include criteria to determine whether a patient is someone who has a "history of violence" such that disclosure may be required under the *OHSA*.

Policies should also consider how to identify individuals with a "history of violence" to staff members[25], as well as when a patient/substitute decision maker should be involved in, and notified of, this determination.

The steps taken to identify and disclose that a patient has a "history of violence" must balance the organization's obligations under the *OHSA* with the privacy of the patient, particularly where the information upon which the determination is being made comes from the patient's personal health information.

"Persons with a history of violence" may include patients in any unit of a hospital, not only only those on a mental health unit. Scenarios in which a staff member or visitor to the facility may have a "history of violence", including "domestic violence", must also be considered. In the case of staff members, the organization's policies will also have to address the balance between the staff member's privacy and the *OHSA* duties, and how any disclosure should be managed or made.

There are significant human resources issues which arise as a result of a situation in which there is disclosure of a staff member as having a "history of violence".

While it is possible that a visitor to a hospital may have a "history of violence", obligations to disclose this and to address the risks posed by the visitor arise where this history is known to the hospital. "A hospital has the authority to control who is on its premises and may decide to limit visitors where the risks posed by the visit outweigh the benefits to the patient." Health care organizations have a number of obligations to address and reduce incidents of workplace violence or harassment, including:

- having workplace violence and workplace harassment policies in place;
- conducting assessments of risk for workplace violence within the organization;
- developing violence and harassment programs as required for the implementation of the policies and any recommendations arising from the assessment, which must include:
  - measures for requesting immediate assistance
  - measures for reporting violence or harassment
  - measures and procedures for conducting an investigation into incidents or complaints of workplace violence.
- providing information and training to staff about associated policies and programs; and,
- posting the policies within the organization.

Creating a safe setting within which to provide mental health care services is a combination of management commitment, staff involvement, education and evaluation, all of which is consistent with the theme and requirements of the legislation.[26]

While the focus of the obligations of health care organizations is to their employees, there are legal[27] and ethical obligations to patients and visitors that also have to be considered.

In creating a safe environment, for staff, patients and visitors alike, the following are some tools that may be used on an on-going basis and to addressing specific situations or concerns:

25 Depending on the environment into which the patient is admitted, or within which interactions occur, this may include colour coded stickers on wrist bands and/or charts, beds etc.

26 The Ontario Labour Relations Board has endorsed that it may be appropriate in some situations for security personnel to assist clinical care staff with "back up and support", under the direction of the clinicians, to support a safe work environment.

27 In addition to the *Occupational Health and Safety Act*, RSO 1990 c O1, there are obligations on Hospitals to provide a safe environment, as well as treatment and care to patients, which are set out in the *Occupier's Liability Act*, RSO 1990, c O2, s 3 and the *Public Hospitals Act*, RSO 1990, c P40, s 20.

- Staff training and education, particularly with respect to policies, de-escalation techniques and incident management, including in response to harassment and violence.
- Zero tolerance policy of harassment and violence and Codes of Conduct setting out expectations.
- Provide written policies to patients, staff, and visitors.
- Clear behaviour contracts with patients and visitors, and even staff, where appropriate.
- Development of individual treatment plans for patients with a risk of harassment or violence.
- Rotational or shared care.
- Consider what other options or resources may be available for specific situations, which may include consultation with security, risk management, other hospital administration or legal counsel.

While these tools cannot guarantee a safe environment, the continuing commitment of health care organizations, management and front line staff to safely manage the risks inherent in providing health care to all individuals regardless of their history or presenting health care issues, is a significant factor to achieving this goal.

Recent high profile public demonstrations have sought to interfere with health care workers and with the public accessing health care services. In January of 2022, the *Criminal Code* was amended with a view to enhancing protections for health care workers, making it an offence to intimidate a health professional, or a person who assists a health professional, in order to impede them in the performance of their duties.[28] "Health professionals" is defined broadly to include any person who is entitled under the laws of a province to provide health services. Section 423.2 also makes it an offence to intimidate a person in order to impede them from obtaining health services from a health professional. A conviction under section 432.2 carries a maximum sentence of 10 years.

3. Patients Leaving Against Medical Advice

A capable patient may decide to leave a hospital against medical advice. If this occurs, steps should be taken to minimize the risk of allowing the patient to leave the hospital – these may include, ensuring that the patient has appropriate prescriptions, arranging appropriate follow-up care, notifying the patient's family doctor (if one exists), discussing plans for return to the hospital or otherwise accessing medical care if the patient's condition worsens. As the risks to the patient of leaving against medical advice increases, the prudence of documenting in detail the nature of conversation in the patient's chart also increases.

If a decision to leave hospital against medical advice is being made on behalf of an incapable person by a substitute decision maker ("SDM"), there are other issues to consider.

A decision to remove a patient from hospital and medically necessary treatment is a significant one that may raise a concern as to whether the SDM is acting in accordance with the principles set out in the *HCCA* for giving or refusing consent on behalf of an incapable person.[29]

If an incapable patient is a minor and there is a concern that the decision to leave against medical advice is not being made in accordance with the principles of substitute decision making as set out in the *HCCA*, then in addition to the above, there may need to be consideration of whether a report is required by law to a Children's Aid Society about a child who may be in need of protection.[30]

28 *Criminal Code of Canada*, RSC 1985, c C46, s 423.2 [CC].

29 Please see Chapter 2 for more information about the principles for giving and refusing consent on behalf of an incapable person.

30 Section 125 of the *Child, Youth, and Family Services Act, 2017* sets out the duty to report child in need of protection. This includes the reasonable grounds for reporting, and to whom this duty applies.

If an incapable patient is an adult, and there is a concern that the decision to leave against medical advice is not being made in accordance with the principles of substitute decision making as set out in the *HCCA*, then an application to the Consent and Capacity Board may be appropriate.[31]

4. Patient Transfers

Determining the clinically appropriate form of transportation for a patient being transitioned from one care setting to another can be a challenge for practitioners throughout the health care continuum.

These are primarily clinical decisions, taking into account the care needs and condition of the patient, as well as practical ones, taking into consideration the options and resources available.

What are key considerations in transferring a patient to another facility?

The most common reason for a patient to be transferred is for continued treatment and care in another facility. This may include situations in which patients require treatment and care not offered at the current facility, as well as those in which the patient no longer requires the level of care offered at a particular facility.

The decision to transfer a patient is primarily a physician decision, with input, support and assistance from the inter-professional care team.

Considerations relating to patient transition / transfer

- Clinical assessment to determine the recommendations for continuing treatment and care.
- Communication with the patient / SDM about the recommendations for continuing treatment and care.
- Obtaining consent, if needed, for the disclosure of personal health information and / or for the recommended treatment and care, as appropriate in the circumstances.
- Communication with the facility to which it is recommended or proposed that the patient be transitioned / transferred, including any application process, as may be appropriate depending on the recommendations / proposals.
- Follow-up with the receiving facility for updates and to make the necessary arrangements, as appropriate.
- Consideration of clinically appropriate options for the transportation of the patient from one facility to another, including consideration of what constitutes sufficient supervision for the patient during transportation, given their clinical presentation and care needs.
- When arrangements are in place for the transfer / transition, making clinically appropriate arrangements for transportation, including care during transfer if necessary.
- Any follow-up required to complete the transfer to care to the health practitioners at the receiving facility.

There may be several health practitioners, facilities and services involved in a transition / transfer for a patient. These may include:

- Physician and clinical care team at sending facility
- Physician and clinical care team at receiving facility
- Ambulance or other transportation service, including ORNGE[32]
- CritiCall,[33] where applicable
- Police
- Family or support person providing transportation

31 Please see Chapter 2 for more information about Form G applications to the CCB.

32 https://www.ornge.ca/healthcare/transporting-a-patient

33 https://www.criticall.org/Section/About-CritiCall-Ontario

The receiving facility should be prepared for arrival and to assume care for the patient. This will include a transfer of care from any health practitioners accompanying the patient. The timing and nature of the transfer of care will depend on the condition of the patient, as well as environment into which care is being transferred. For all health practitioners involved in a patient's transition from one care setting to another, it is expected that they will act in accordance with accepted standards, guidelines and practices.

Hospitals and other health care facilities can support patients, SDMs and family as well as members of the health care team by having policies and procedures to streamline the transfer / transition process.

What factors should be considered when determining the appropriate mode of transportation for a patient?

There are patients who are able to transport themselves from one health care facility to another, while others may require emergency transportation accompanied by one or more regulated health professionals.

The determination of an appropriate mode of transportation is both clinical and practical, and may require consultation with the receiving facility and other organizations, including paramedicine and medical transportation services. Considerations may include:

- Available options and resources.
- Can the care required during transportation be provided in the mode of transportation being considered?
- Is there an appropriate care practitioner to accompany the patient, if necessary?

There may also be considerations with respect to the cost of transportation.

Are there specific issues to consider with the transfers / transition of individuals for mental health care?

There are a variety of situations in which an individual may need to be transferred to a different hospital / facility for mental health treatment and care. In addition to those outlined above, there are issues and processes under the *Mental Health Act* that may need to be considered. These include:

- Transfers to / from schedule 1 facilities for psychiatric assessments (Form 1);
- Transfers of a "psychiatric patient" under the *Mental Health Act* from one facility to another under s. 29 of the *Mental Health Act*;
- Transfers in accordance with orders under s. 41.1 of the *Mental Health Act*; and
- Transfers in accordance with a disposition of the Ontario Review Board.

In all of these situations, as well as in situations in which a "psychiatric patient" is being transferred for medical care, consideration must be given to the safety and security of the patient, and others, depending on the condition of the patient. These are in addition to the other considerations outlined in this document and may involve the use of security and / or police personnel, as well as the possible use of restraint. Any use of restraint should be in accordance with the *Mental Health Act*, *Patient Restraint Minimization Act* and applicable policies and practices.

When do health practitioners accompany patients?

Whether it is appropriate for a particular health practitioner to accompany a patient during a transfer is a clinical decision based on the patient's care needs. The determination of the type of care practitioner (physician, nurse, respiratory therapist, non-regulated care provider or other) to accompany the patient will depend on the patient's care needs, as well as the availability of care practitioner at the time of the transfer.

It is expected that health practitioners supporting patients during transportation have the necessary knowledge, skills, training and judgment for the level of care required. These health practitioners are expected to provide care in accordance with accepted standards, as well as in accordance with the expectations and scope of practice set out by the applicable regulatory college up to the time of an appropriate transfer to care to the clinical care team at the receiving facility.

From a legal perspective, the sending facility continues to be responsible for supporting staff accompanying patient on a transfer, including with respect to any occupational health and safety considerations.

What policies, procedures and practices should be in place to support the health care team in managing patient transfers / transitions?

These decisions should always be managed in a way that takes into account the clinical needs of the patient. Hospitals may wish to develop specific policies and procedures regarding the following:

- Transfer of Patients generally – these may include an overview of the steps and considerations summarized above, with reference to other supportive hospital policies (e.g., consent).
- Transfer of Patients for test and consults – these may include situations in which a patient may need to be accompanied for a test or consult, as well as situations in which a patient may be admitted to another facility for tests / consults and then repatriated for continuing treatment and care.
- Transportation for patients who require continuous monitoring and care during the transfer – some patients may need to be accompanied by health practitioners with the training to provide care during transportation (e.g., intubated patients).

Facilities may wish to develop these policies and procedures to support patients, as well as family members and clinicians during transfers and transitions in care. These policies and procedures may address processes for sending and receiving patients, with the objective of streamlining the process for all involved. It is important for such policies and procedures to be patient-focused, and to allow for the clinical determination of care needs in any given patient care situation.

5. Coroner's Inquests

The *Coroner's Act* requires that, when a person dies while a resident or in-patient in a psychiatric facility as defined in the *MHA*, the person in charge of the facility "shall immediately give notice of the death to a coroner and the coroner shall investigate the circumstances of the death".[34] Following an investigation, the Coroner may decide to hold an inquest into the death.[35]

The primary purpose of an inquest is to "inquire into the circumstances of the death and determine:[36]

(a) Who the deceased was;

(b) How the deceased came to his or her death;

(c) When the deceased came to his or her death;

(d) Where the deceased came to his or her death; and

(e) By what means the deceased came to his or her death.

These questions are answered by the jury at an inquest.

At an inquest, the jury "shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to" in answering the above questions.[37]

The jury "may make recommendations directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest".[38]

34 *Coroner's Act*, RSO 1990, c C37, s 10(2)(3). If the patient if not on the premises of the facility at the time of their death, but is a "patient" as defined under the *Mental Health Act* at the time, this provision also applies.

35 *Ibid*, see also s (4) – There is no discretion for the Coroner regarding whether to hold an inquest if the person is "in custody" at the time of their death. In these situations, an inquest is mandatory. The Divisional Court of Ontario ruled that provisions of the *Coroner's Act* that permitted discretion in whether to hold an inquest into the death of psychiatric patients is not discriminatory: *Ontario (Attorney General) v Ontario Human Rights Commission*, 2007 CanLii 56481 (ON SCDC), leave to appeal to the Ontario Court of Appeal was subsequently denied.

36 *Coroner's Act,* RSO 1990, c C37, s 31(1).

37 *Ibid*, s 31(2).

38 *Ibid*, s 31(3).

The recommendations from the 2017 mandatory inquest into the death of a 65-year old patient who patient died from natural causes, while in mechanical restraints in the crisis area of the emergency department of a Schedule 1 facility, cover the use of restraints, treatment and care for patients with mental health issues, education and training, accountability, communication with a patient's support person, community based resources, patient advocacy and support, meaningful patient voice and staff care.

These recommendations are directed to a range of stakeholders, including Ontario Hospitals, Schedule 1 facilities, the Ministry of Health[39] compile a range of expected standards, best practices, recommendations to potentially improve practices and patient safety as well as aspirational goals with respect to the use of restraints.

A summary of these recommendations, including those relating to the use of restraints, is attached Appendix "F".

It is recommended that all organizations obtain legal advice when advised of the possibility of an inquest into a death that occurred at its facility, or when the care provided at the organization may be addressed at an inquest.

6. Discharge Planning[40]

Discharge planning for mental health patients is often quite complicated as there are not always clear paths for transition from hospital. As with all discharge planning, it is strongly recommended that this process start as soon as clinically appropriate. This process may involve several members of the multi-disciplinary team in hospital, as well as from Home and Community Care Support Services, community service providers, family members, substitute decisions makers and, of course, the patient.[41]

When a patient is no longer in need of treatment in hospital, their physician is required to make an order that they be discharged.[42] If a patient cannot be immediately discharged when they no longer require the level of care, or "the intensity of resources or services" provided at the hospital, the patient may be designated as Alternate Level of Care, or "ALC" by their "attending clinician", usually their physician.[43]

Hospitals have policies and procedures to support discharge planning for all hospital patients, including mental health patients. Some of the specific challenges in dealing with mental health patients may include:

- finding appropriate discharge destination;
- accessing appropriate supports in the community; and
- legal and clinical considerations that impact discharge, for example Ontario Review Board disposition conditions or CTO provisions.

In some cases, the Consent and Capacity Board may be involved in addressing aspects of a discharge plan, for example capacity to make decisions with respect to admission to a care facility or a review of a Community Treatment Order. Not all aspects of "discharge planning" fall within the scope of issues that may be considered by the Consent and Capacity Board, which can pose a challenge for those working to support patients in a transition from hospital to the community.

It is very important that there be collaboration and communication through the health care continuum to support and encourage discharge planning for mental health patients.[44]

For more information about discharge planning and changes to the applicable legislative framework lease see: Ontario Hospital Association More Beds, *Better Care Act*, 2022: Resources (oha.com).

39 The recommendations were addressed to the Ministry of Health and Long-Term Care and the Local Health Integration Networks, as they it then were. Other stakeholders to whom recommendations were addressed include the OHA, OMA, CPSO and CNO.

40 Please see: Katharine Byrick, "Managing Transitions: A Guidance Document", online: Ontario Hospital Association: <http://www.oha.com/CurrentIssues/Issues/eralc/Documents/ Managing%20Transitions%20-%20A%20Guidance%20Document.pdf>[Managing Transitions].

41 For a more fulsome discussion of the Role of the Hospital and the Health Care Team, the Role of the Home and Community Care Support Services (formerly CCAC / LHIN), the Role of the Patient / Client/ family and Care Providers, as well as the Role of the SDM, please see *ibid* Sections 4-7.

42 Hospital Management Regulation to the *Public Hospitals Act*, RRO 1990, Reg. 965, s 16 (1).[Hospital Management Reg].

43 *Ibid*, s 16 (4)(5).

44 Managing Transitions, *supra* note 40, Sections 10 and 11 include a more fulsome discussion of some strategies and tools to deal with challenges in discharge planning.

7. Quality of Care and Patient Relations

Every hospital in Ontario has on-going obligations with respect to improving quality of care, as well as obligations to patients and their families.[45] As a result of these obligations, hospitals have robust quality assurance programs that include policies and resources to guide staff in the follow-up process for "critical incidents".[46]

A "critical incident" is, any unintended event that occurs when a patient receives treatment in the hospital,

(a) that results in death, or serious disability, injury or harm to the patient, and

(b) does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing the treatment.[47]

It is often a challenge to determine whether an event meets the definition of a critical incident. Each organization will have its own specific framework for a review of events that may have impacted patient care. It is strongly recommended that steps be taken to follow up on any events that impact a patient's condition, care and treatment to determine whether there are processes, including a critical incident review, which may be appropriate.

In 2014, a report was released that included the following "principles to guide the investigations of critical incidents":

1. Assume good intentions from all parties
2. Be patient inclusive
3. Be transparent
4. Communicate effectively with patients and families before, during and after investigations
5. Have an obligation to share lessons
6. Be consistent and predictable[48]

These principles are not limited to the response to a "critical incident" or other event, but should be part of a robust patient relations process.

One of the key messages coming from those looking at quality of care issues is the importance of involving patients and substitute decision makers, as well as family and others supporting patients, in addressing any issues that arise.

Legislated changes came into effect in July 2017[49] to support the importance of quality assurance processes and patient relations initiatives. It is important to be aware of the policies and processes within an organization to support these, as well as the resources available when an issue arises.

8. Interactions with Police

When patients are brought to the hospital by police there are sometimes challenges in determining when the officers can leave the patient in the care and custody of the hospital.

Hospitals are strongly encouraged to work with polices services to streamline and facilitate the communication of information and transitions in the emergency department. This may include working to develop written protocols or memoranda of understanding to facilitate these transitions.

It is important for a psychiatric facility to have legal authority to assume custody of the person who has been brought to the hospital by police. Proactive discussions on how to handle these situations, as well as constructive communication with respect to each specific case, will help facilitate the transition of the person from the custody of police to the care of the clinicians at the hospital.

When a person is taken in police custody to a hospital that is not a psychiatric facility (non-Schedule 1), that hospital does not have legal authority to "take custody" of the person.

If a Form 1 is completed by a physician, the patient is to be transferred "forthwith" to a psychiatric facility for psychiatric assessment.

45 These obligations are set out in the *Public Hospitals Act*, the *Excellent Care for All Act*, the *Health Information Protection Act*, and the *Quality of Care Information Protection Act* ("*QCIPA*").

46 Additional information is available at: https://www.oha.com/guidance-and-resources/clinical-and-patient-care-issues/qcipa-review-member-resources.

47 Hospital Management RRO 1990, Reg 965, s 1; QCIPA, s 2(1).

48 QCIPA Review Committee Report at 25-26. <http://www.health.gov.on.ca/en/common/legislation/qcipa/docs/qcipa_rcr.pdf>

49 QCIPA, 2016, SO 2016, c. 6, Sched. 2.

When a person is taken in police custody to a psychiatric facility (Schedule 1), the General Regulation to the *MHA* requires that these facilities ensure that a timely decision is made to assume custody of the person from the police. Consultation and communication of relevant information is an important part of this process.

Section 33 of the *MHA* is applicable only to designated Schedule 1 psychiatric facilities and provides that:

> A police officer or other person who takes a person in custody to a psychiatric facility shall remain at the facility and retain custody of the person until the facility takes custody of him or her in the prescribed manner.

The General Regulation to the *MHA* adds the following in section 7.2:

1. Where a person is taken to a psychiatric facility under section 33 of the Act, the officer in charge or his or her delegate shall ensure that a decision is made as soon as is reasonably possible as to whether or not the facility will take custody of the person.
2. The staff member or members of the psychiatric facility responsible for making the decision shall consult with the police officer or other person who has taken the person in custody to the facility.
3. A staff member designated for this purpose shall communicate with the police officer or other person about any delays in the making of the decision.
4. Where a decision is made to take the person into custody, the designated staff member shall promptly inform the police officer or other person about the decision.

The *MHA* does not provide a specific mechanism by which designated psychiatric facilities may "take custody" of, or detain and/or restrain, a person prior to a physician examination or assessment.

A determination by the Officer in Charge, or delegate, as to when police officers may transfer custody of an individual to a psychiatric facility will depend on several factors, including the condition of the person, the type of hospital and the expertise, skill and resources available to safely manage and care for the patient at that particular time. This includes a decision as to whether police may leave before the physician has examined the person to initiate detention by the psychiatric facility under the *MHA*.

Hospitals and police services are encouraged to work together in an effort to streamline the process for the transfer from police custody. Any policies or procedures being developed for this purpose must take into account:

- the experience and expertise of the staff working in the ED,
- the availability of physicians,
- the activity, volume and patient acuity in the ED,
- other hospital resource considerations,
- the impact of prolonged wait times on the police services, and
- the "case-by-case" nature of these situations.

It is important for all health care organizations to develop lines of communication and understanding with police officers. Hospitals are encouraged work with local police departments to develop written protocols to facilitate communication. Even with such protocols or memoranda of understanding in place, it is very important for decisions to be made based on the specific facts and circumstances at the time.

The above comments do not necessarily apply to "forensic" mental health patients. Their attendance at a specially designated psychiatric facility may be the subject of a Court order or disposition of the Ontario Review Board, which may provide authority for the forensic patient to be detained at the facility.

The following is an overview of some of the situations in which police or corrections officers may be at a hospital:

A patient who is in custody (arrested, from a corrections facility) is brought for treatment and care (medical or psychiatric) – police and corrections officers will likely be staying at the hospital. If the treatment and care is medical, officers may need to maintain a presence at the hospital for some time. It is important that there be communication between the officers and the clinical team to make sure that all involved are able to exercise their professional responsibilities

in this situation. In the case of a patient on a secure psychiatric unit, specific consideration will need to be given to whether a police presence is necessary, and the impact that this may have on other patients.

A patient is brought to a non-Schedule 1 facility by police with a Form 1 or a Form 2[50] – the patient will not be a "psychiatric patient" under the *MHA*[51]. Depending on the clinical presentation of the patient and the assessment by the attending physician, it may be appropriate to leave the patient at the hospital, in the care of the clinical team. If it is determined that the patient requires transfer to a Schedule 1 facility, police may be required to facilitate this transfer.[52]

A patient is brought to a non-Schedule 1 facility by police under s. 17 of the *MHA*[53] – the authority of the police to apprehend a person in the community and bring them to hospital without a Form 1 or Form 2 is limited to situations in which it would be "dangerous" to get a Form 2. It is recommended that these patients be taken to a Schedule 1 facility, where possible.

A physician at a non-Schedule 1 facility will examine the patient and, if indicated, may complete a Form 1 and consider if a transfer to a Schedule 1 facility is appropriate[54].

A patient is brought to a Schedule 1 facility by police on a Form 1 or Form 2[55] – if a patient is brought to a Schedule 1 facility by police, either directly or via a non-Schedule 1 facility, it is expected that there will consideration given "forthwith" to whether the patient is to be admitted under the *MHA*.[56]

A clinical decision by a physician is required to admit a patient to hospital.[57] Once the decision is made to admit the patient, the facility has the legal authority under the *MHA* to detain and restrain the patient, if necessary.[58]

A patient is brought to a Schedule 1 facility by police under s. 17 of the *MHA*[59] – if a patient is brought to a Schedule 1 facility by police, it is expected that consideration will be given "forthwith" to whether the patient is to be admitted under the *MHA*.[60] A clinical decision by a physician is required to admit a patient to hospital.[61] Once the decision is made to admit the patient, the facility has the legal authority under the *MHA* to detain and restrain the patient, if necessary.[62]

A patient is brought to a Schedule 1 facility by police on a transfer from another facility[63] – if arrangements have been made for the transfer of care, and admission as a psychiatric patient, police and corrections officers will be able to leave the patient at the hospital following the processing of the admission and communication of information.

It is important for all health care organizations to develop lines of communication and understanding with police and corrections officers. This is another example of the type of situation in which it will be very important for decisions to be made based on the specific facts and circumstances at the time.

50 Please see sections 3 and 4 in Chapter 3 for more on Forms 1 and 2.

51 Please see section 2 in Chapter 3 for more on "Who is a Patient" under the *Mental Health Act*?".

52 Please see section 2 in Chapter 4 for more on "Transferring Patients to a Schedule 1 Psychiatric Facility".

53 Please see section 4 in Chapter 3 for more on "Police Apprehension"; this process was discussed in *Quartey v Peel Regional Police Services Board*, 2012 ONSC 2260 (CanLii).

54 *Ibid*, *supra* notes 45-46.

55 *Supra*, note 45.

56 *Supra*, note 46; this may be on a Form 1, or as a voluntary, involuntary or informal patient.

57 *Hospital Management*, RRO 1990, Reg 965, ss 11(1)(2); *supra* note 32 at Section 4(b). Please note this section also allows permits admission by a registered nurse in the extended class, dentist, or midwife, however, it must also be considered that provisions in the *Mental Health Act* require certain actions by a "physician".

58 Please see section 1 in this Chapter, for more on restraints.

59 *Supra*, note 46.

60 *Supra*, note 51.

61 *Supra*, note 45.

62 *Supra*, note 46.

63 In this situation, the transfer may be from either a Schedule 1 or non-Schedule 1 facility.

9. Virtual Care for Mental Health Patients

In a very short period of time, virtual care has become an important tool in the delivery of healthcare, including mental health services. The standards of care for health practitioners are the same, whether they are practicing virtually or in-person. Health practitioners who provide virtual care, including those who care for mental health patients, must:

- Be competent to provide care virtually,
- Ensure it is in a patient's best interest to receive virtual care, and
- Recognize where virtual care has its limitations in providing a patient with care.

Hospitals and health practitioners need to be aware of challenges and potential risks when providing virtual care:

- A health practitioner's ability to care for a patient may be limited by not being in-person – a patient's video transmission may be partially obscured or poor quality, or the patient may not be seen at all (in the case of telemedicine).
- A health practitioner's assessment of a patient's non-verbal feedback is limited.
- A health practitioner is more reliant on a patient's self-reporting and / or assessments by other health practitioners.
- Challenges caused by language barriers / communication challenges may be exacerbated.
- A health practitioner has a limited ability to evaluate certain aspects of a patient, eg. hygiene by way of smell or screening for substance abuse.
- A patient's ability or desire to disclose important information may change with virtual care.
- A patient's ability to consent to virtual care may need to be assessed.
- There may be concerns about the involvement of third parties, including family members, during virtual care visits and the impact that may have on a patient's autonomy.

Sensitive information is often even more sensitive in a mental health care context so proper safeguards are particularly important.

In the mental health context, virtual care may be used for consultations with other health practitioners and specialists when in-person psychiatric care is not available or accessible. Virtual care may also be used to provide greater access to care.

Using their professional judgment, a health practitioner must determine the most appropriate way to conduct an examination of a particular patient, whether virtual or in-person.

As the evolution of virtual care continues, it is strongly recommended that health practitioners using these services stay up to date with applicable policies, procedures and guidelines as well as best practices about the use of virtual care. These are likely to include:

- Having reasonable information security and privacy safeguards in place.
- Confirming that the patient has consented to using video- or teleconferencing.
- Confirming that the patient has access to the technology necessary to participate in the virtual appointment.
- Confirming that the nature of the consult and patient's condition are suitable for a virtual appointment.
- Speaking directly with the patient when possible.
- Verifying the patient's identity and location.
- Collecting adequate information about the patient.
- Maintaining detailed and up-to-date records for all virtual care encounters.
- Being familiar with emergency resources available at the patient's location and how to activate them.
- Having a back-up plan in place in the event technology fails.
- Screen health practitioners to ensure they have the education, skill and experience to engage in virtual care, and

It is strongly recommended that health practitioners also familiarize themselves with the policies and guidelines of their regulatory College.

10. Medical Assistance in Dying for Mental Health Patients

Section 241.2(1) of the *Criminal Code* outlines the eligibility requirements for person seeking medical assistance in dying (MAiD), which are as follows:

- the person is eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;
- they are least 18 years of age and capable of making decisions with respect to their health;
- they have a grievous and irremediable medical condition;
- they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
- they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

A "grievous and irremediable medical condition" is defined in section 241.2(2) to mean:

- they have a serious and incurable illness, disease or disability;
- they are in an advanced state of irreversible decline in capability; and
- that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

At the time of publication, a person is not eligible for MAiD if their sole underlying medical condition is a mental illness. It is anticipated that further legislative amendments may be enacted to remove the exclusion of persons seeking MAiD where a mental disorder is the sole underlying medical condition.

It is important that health practitioners and hospitals remain up-to-date on this topic as the legal landscape continues to evolve.[64] There is no doubt that MAiD for people with mental illness will be a key topic for health practitioners and hospitals to consider for years to come.[65]

11. Secure Treatment

Secure Treatment Programs are "programs for the treatment of children with mental disorders, in which continuous restrictions are imposed on the liberty of the children."[66] The seriousness of these programs is indicated in the use of the terminology "Extraordinary Measures" in governing legislation, the *Child, Youth and Family Services Act, 2017* ("CYFSA"), to refer to these programs.[67] No child shall be admitted to a secure treatment program except by a court order pursuant to provisions committing the child to secure treatment or under the provisions for an emergency admission.[68] The person in charge of a secure treatment program is the "administrator".[69]

Secure Treatment Programs should be considered when no less restrictive method of treatment appropriate for the child's mental disorder is appropriate in the circumstances.[70]

The provisions committing the child to secure treatment found in section 164 of the CYFSA allow for a child to remain in a secure treatment program for a longer period of time (not exceeding 180 days[71]) as compared to an emergency admission as set out in section 171 (not exceeding 30 days[72]).

The criteria for an admission under section 164 are as follows:

Commitment to secure treatment: criteria

164 (1) The court may order that a child be committed to a secure treatment program only where the court is satisfied that,

64 At the time of publication, it is anticipated that additional guidance will be available in March 2024.

65 For additional information on End-of-Life Care, including MAiD, please see: https://www.oha.com/guidance-and-resources/end-of-life-care.

66 *Child, Youth and Family Services Act, 2017*, s 158(1).

67 *Ibid,* at Part VII: Extraordinary Measures.

68 *Ibid,* at s 164 for Commitment to Secure Treatment, and s. 171 for Emergency Admission.

69 *Ibid,* s 157.

70 Note: this is also a criterion under s. 164(1)(f) and 171(2)(e).

71 *Ibid*, at s 165 (1).

72 *Ibid*, at s 171(2).

(a) the child has a mental disorder;

(b) the child has, as a result of the mental disorder, within the 45 days immediately preceding,

  (i) the application under subsection 161 (1),

  (ii) the child's detention or custody under the *Youth Criminal Justice Act* (Canada) or under the *Provincial Offences Act*, or

  (iii) the child's admission to a psychiatric facility under the *Mental Health Act* as an involuntary patient,

caused or attempted to cause serious bodily harm to themself or another person;

(c) the child has,

  (i) within the 12 months immediately preceding the application, but on another occasion than that referred to in clause (b), caused, attempted to cause or by words or conduct made a substantial threat to cause serious bodily harm to themself or another person, or

  (ii) in committing the act or attempt referred to in clause (b), caused or attempted to cause a person's death;

(d) the secure treatment program would be effective to prevent the child from causing or attempting to cause serious bodily harm to themself or another person;

(e) treatment appropriate for the child's mental disorder is available at the place of secure treatment to which the application relates; and

(f) no less restrictive method of providing treatment appropriate for the child's mental disorder is appropriate in the circumstances.

It is also possible to apply for an order extending an order committing a child to secure treatment. An application for extension must be made before the expiry of the period of commitment.[73] Where an extension application is made, the person may be kept in the secure treatment program until the application is disposed of.[74] The provisions for extension (found in section 167(5)) outline similar criteria as those found in section 164.

Who can be make an application for an order for the child's commitment to secure treatment or extension of period of commitment differs depending on the age of the child.

For an order for commitment, where the child is younger than 16, the applicant may be i) the child's parent, ii) a person other than an administrator who is caring for the child, if the child's parent consents to the application or iii) a society that has custody of the child under an order made under Part V (Child Protection) of the CYFSA.

If the child is 16 or older, the applicant may be i) the child, ii) the child's parent, if the child consents to the application, iii) the society that has custody of the child under an order made under Part V (Child Protection) of the CYFSA, if the child consents to the application, or iv) a physician.

For an extension application, any of the previously mentioned individuals may apply, with the administrator's written consent, as well as the administrator, with a parent's written consent, or where the child is in a society's lawful custody, the society's consent.

For an emergency admission, any of the following may apply to the administrator, where the child is younger than 16: i) the child's parent, ii) a person who is caring for the child with a parent's consent, iii) a child protection worker who brought the child to a place of safety under section 81, or iv) a society that has custody of the child under an order made under Part V (Child Protection).[75]

Where the child is 16 or older, any of the following may apply to the administrator: i) the child, ii) the child's parent, if the child consents to the application, iii) a society that has custody of the child under an order made under Part V (Child Protection), if the child consents to the application, or iv) a physician.

Note that there are also specific provisions within this part as to how to manage a child who attains the age of 18.[76]

73 *Ibid,* at s 167(1).

74 *Ibid,* at s 167(3).

75 *Ibid,* s 171(1).

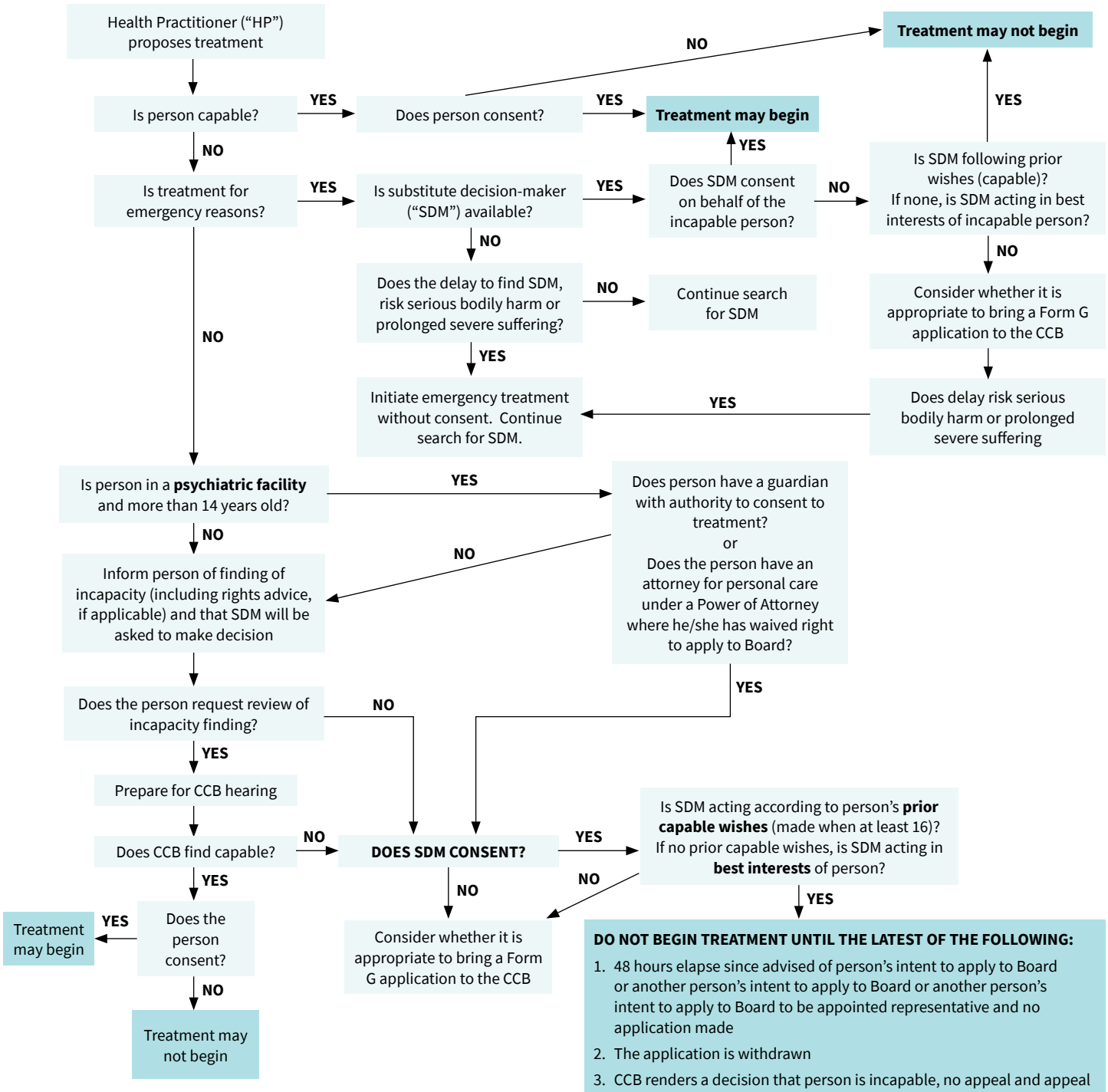
76 See, for example, s 167(2), s 165(4).

Final Comment

While it is not possible to cover all aspects of the intersection between the law and mental health in Ontario in this Guide, we have tried to provide an overview that will assist anyone trying to navigate the complex legal framework that supports the provision of mental health care in the province.

We hope that you find this 4th edition of *A Practical Guide to Mental Health and the Law* helpful and thank you to all of those who have provided feedback and support for this publication since 2009.

A Decision Tree for Obtaining Consent Under the *Health Care Consent Act*



This decision tree does not contemplate all scenarios but is intended to be a general guide to consent issues.

APPENDIX

B Acronyms

Child, Youth and Family Services Act	CYFSA
Community Treatment Plan	CTP
Community Treatment Order	CTO
Consent and Capacity Board	CCB
Criminal Code of Canada	CC
Health Care Consent Act	HCCA
High Risk Accused	HRA
Information and Privacy Commissioner of Ontario	IPC
Mental Health Act	MHA
Ministry of Health	MOH
Not Criminally Response by Reason of Mental Disorder	NCRMD
Ontario Hospital Association	OHA
Ontario Review Board	ORB
Officer in Charge of designated psychiatric facility	OIC
Patient Restraints Minimization Act	PRMA
Person in Charge of designated forensic facility	PIC
Personal Health Information Protection Act	PHIPA
Psychiatric Patient Advocate Office	PPAO
Public Guardian and Trustee	PGT
Substitute Decisions Act	SDA
Substitute Decision Maker	SDM

APPENDIX

C Quick Guide to Applications to the Consent and Capacity Board[1] Provided for in the *Mental Health Act* and the *Health Care Consent Act*[2]

Form	Title	Legislative Reference	Statutory Parties	Notes
Form 16	Application to the Board to Review a Patient's Involuntary Status	s 39(1) *MHA*	• patient • the attending physician[3]	Review of Forms 3 and 4
Form 17	Notice to the Board of the Need to Schedule a Mandatory Review of a Patient's Involuntary Status	s 39(4) *MHA*	• patient • the attending physician • OIC of the patient's current psychiatric facility • OIC of the psychiatric facility to which transfer is being sought (if transfer is in issue) • MOH, if CCB has been informed of intention to participate as party	Review of Form 4A May involve application for orders under s 41.1, including transfer to another facility
Form 18	Application to Board for Review of Finding of Incapacity to Manage Property	s 60 *MHA*	• patient • the attending physician	
Form 25	Application to the Board to Review the Status of an Informal Patient who is a Child between 12 and 15 Years of Age	s 13(1) *MHA*	• patient • the attending physician	

1 The applications listed are those that may be brought under the *Health Care Consent Act* and *Mental Health Act*. The Board also has jurisdiction to hear specific applications under the *Personal Health Information Protection Act*, the *Child Youth and Family Services Act*, and the *Substitute Decisions Act*.

2 The legislative references to the *HCCA* applications are to the treatment provisions of Part II of the *HCCA*. Please note that these forms also apply to Part III (Admission to a Care Facility) and Part IV (Personal Assistive Services).

3 Section 42(1) *MHA* provides that the attending physician, the patient or other person who has required the hearing and, such other persons as the Board may specify, are parties to proceedings before the Board. Section 42(2) provides a list of other parties specific to a Certificate of Continuation hearing, which includes the OIC of the patient's current psychiatric facility and where a transfer is being sought, the OIC of the potential receiving Hospital, as well as the MOH, if he or she informs the Board of an intention to seek party status.

Form	Title	Legislative Reference	Statutory Parties	Notes
Form 26	Notice to the Board of the Need to Schedule a Mandatory Review of the Informal Patient who is a Child between 12 and 15 Years of Age	s 13(2) *MHA*	• patient • the attending physician	
Form 48	Application to Board to Review Community Treatment Order and Notice to Board by Physician of Need to Review Community Treatment Order	s 39.1(1) *MHA* and s 39.1(4) *MHA*	• the person who is the subject of the CTO • the physician who issued the CTO • any other person who has required the hearing on the patient's behalf • such other persons as the Board may specify are parties	An application to review a CTO may be brought by the person subject to the CTO at any time while it is in effect. A mandatory review of the CTO must take place when the CTO is renewed for the 2nd time and at every 2nd renewal thereafter.
Form 51	Application by Patient to Board for s 41.1 Order	s 39(6) *MHA*	• Patient or person acting on patient's behalf • The attending physician • OIC of the patient's current psychiatric facility • OIC of the psychiatric facility to which transfer is being sought • MOH, if CCB has been informed of intention to participate as party	Forms 51 through 54 are used to seek, vary or cancel the orders that the Board may make when it confirms a Form 4A, certificate of continuation
Form 52	Application to Board by OIC or Minister /Deputy Minister for patient's transfer to another psychiatric facility	s 39(8) *MHA*	• Same as for Form 51	
Form 53	Application to Board by OIC to Vary or Cancel s 41.1 Orders	s 39(9) *MHA*	• Same as for Form 51	
Form 54	Application to Board by patient, or person acting on patient's behalf, to Vary or Cancel s 41.1 Orders	s 39(10) *MHA*	• Same as for Form 51	

Form	Title	Legislative Reference	Statutory Parties	Notes
Form A	Application to the Board to Review a Finding of Incapacity to consent to Treatment	s 32 *HCCA* s 37.1 *HCCA* when it is a "deemed" application	• the person applying for the review • the health practitioner (usually the attending physician) • any other person the Board specifies	In situations in which there is a "deemed" Form A application, this will proceed unless the person's capacity to consent to the proposed treatment has been determined by the Board in the previous 6 months.
Form B Form C	Applications to the Board to Appoint a Representative	s 33(1) *HCCA* s 33(2) *HCCA*	• the incapable person • the proposed representative • every person described in paragraphs 4, 5, 6 or 7 of s 20(1) *HCCA* • the health practitioner who proposed the treatment (usually the attending physician) • any other person the Board specifies	Form B is the application as brought by the patient Form C is the application brought by the proposed representative There is a deemed Form A application to review the capacity of the person, prior to consideration of the Form B or C.
Form D	Application to the Board for Directions	s 35(1) *HCCA*	• the substitute decision maker • the incapable person • the health practitioner who proposed the treatment (usually the attending physician) • any other person the Board specifies	There is a deemed Form A application to review the capacity of the person, prior to consideration of the Form D.
Form E	Application to the Board for Permission to Depart from Wishes	s 36(1) *HCCA*	• the substitute decision maker • the incapable person • the health practitioner who proposed the treatment (usually the attending physician) • any other person the Board specifies	May be brought by an SDM or by the health practitioner, There is a deemed Form A application to review the capacity of the person, prior to consideration of the Form E.

Form	Title	Legislative Reference	Statutory Parties	Notes
Form F	Application to the Board with Respect to Place of Treatment	s 34(1) *HCCA* or s 13(1) *MHA*	• the person who is applying for the review • the person who consented to the admission • the health practitioner who proposed the treatment (usually the attending physician) • any other person the Board specifies	May be brought by an adolescent aged 12 -16 admitted informally to a psychiatric facility. There is a deemed Form A application to review the capacity of the person, prior to consideration of the Form F.
Form G	Application to the Board to Determine Compliance with s 21	s 37(1) *HCCA*	• the health practitioner who proposed the treatment (usually the attending physician) • the incapable person • the substitute decision maker • any other person the Board specifies	There is a deemed Form A application to review the capacity of the person, prior to consideration of the Form G.
Form H	Application to the Board to Amend the Conditions of or Terminate the Appointment of a Representative	s 33(7) and s 33(8) *HCCA*	• the person bringing the application • the incapable person • the representative • the health practitioner who proposed the treatment (usually the attending physician) • any other person the Board specifies, which may include those described in paragraphs 4, 5, 6 or 7 of s 20(1) *HCCA*	There is a deemed Form A application to review the capacity of the person, prior to consideration of the Form H.

D Quick Guide to Forms under the *Mental Health Act*[1]

Form	Title	Legislative Reference	Notes
Form 1	Application By Physician for Psychiatric Assessment	s 15 *MHA*	Form 1 authorizes apprehension and detention for up to 72 hours in a psychiatric facility for purposes of psychiatric assessment. Form 42 (Notice to Person) is required.
Form 2	Order for Examination	s 13(1) of Regulation 741, to the *MHA*	Form 2 is an order from a Justice of the Peace that authorizes police officers to bring in an individual for psychiatric examination.
Form 3	Certificate of Involvement Admission	s 16 *MHA* s 13(2) of Regulation 741, to the *MHA*	Form 3 is completed on involuntary admission to a psychiatric facility and provides authority to detain the patient for up to two weeks. Form 30 (Notice to Patient) and Form 50 (Confirmation of Rights Advice) are required. Form 162 is the related application to the Board.
Form 4	Certificate of Renewal	s 20(4)(b) *MHA* s. 13(4) of Regulation 741, to the *MHA*	Form 4 renews involuntary admission to a psychiatric facility, if completed prior to expiry of Form 3, and provides authority to detain the patient for up to one, two, or three months, depending on whether it is a first, second or third renewal. Form 30 (Notice to Patient) and Form 50 (Confirmation of Rights Advice) are required with each Form 4. Form 16[2] is the related application to the Board

1 Some forms are "Ministry approved" and others set out in regulations to the *Mental Heath Act*. For a complete listing of all forms, with "fill and print" or "view and print" features, go to: http://www.health.gov.on.ca/en/public/forms/forms_cat.aspx. This Appendix does not include the forms listed in Appendix "C" which are forms used to apply to the Board for review of certain forms or orders.

2 See Appendix "C".

Form	Title	Legislative Reference	Notes
Form 4A	Certificate of Continuation	s 20(4)(b)(iv) *MHA*	Form 4A renews involuntary admission to a psychiatric facility, if completed prior to expiry of the third Form 4, and provides authority to detain the patient for an additional three months Form 30 (Notice to Patient) and Form 50 (Confirmation of Rights Advice) are required. Form 17 is the related application to the Board for a mandatory review of a first certificate of continuation, and every fourth certificate of continuation thereafter[3] Form 16 is used to apply to the Board for every other review of a certificate of continuation. Forms 51, 52, 53 and 54 are used to apply to the Board in relation to section 41.1 orders made in the context of a Form 4A review where the Board confirms the patient's involuntary status,[4] including an application for an order transferring the patient to another psychiatric facility, which replaces the now revoked Form 19. A patient is entitled to apply to the Board for section. 41.1 orders on the completion of a first Form 4A and on the completion of any subsequent Form 4A, provided that it has been 12 months since the most recent application for section 41.1 Orders, unless there has been a material change in circumstances.
Form 5	Change to Informal or Voluntary Status	s 20(7) *MHA*	Form 5 indicates a change from involuntary status to informal or voluntary status.
Form 6	Order for Attendance for Examination	s 21(1) *MHA* s 13(5) of Regulation 741, to the *MHA*	Form 6 is an Order issued by a judge for psychiatric examination, when an individual is charged with, or convicted of, a criminal offence, and is suspected of suffering from a mental disorder. Under section 23 of the MHA, the judge shall not make an order, without confirming with the "senior physician" at proposed psychiatric facility that the facility can accommodate the person. The physician must also provide a written report to the judge on the person's mental condition.

3 *Ibid.*

4 *Ibid.*

Form	Title	Legislative Reference	Notes
Form 7	Confirmation by Attending Physician of Continued Involuntary Status, pending outcome of appeal	s 48(12) *MHA*	Form 7 must be filled out by the patient's attending physician at the time(s) that a patient's involuntary status would have come up for renewal during the period that the CCB decision confirming the patient's involuntary status is under appeal to the Court; a patient may not challenge involuntary status before the Consent and Capacity Board while the appeal to the Court is pending.
Form 8	Order for Admission	s 22(1) *MHA* s 13(6) of Regulation 741, to the *MHA*	Form 8 is an Order obtained from a judge for involuntary admission to psychiatric facility, when an individual is charged with a criminal offence and is suspected of suffering from a mental disorder; valid for a maximum of 2 months. See comments on Form 6 above, on requirement for confirmation from senior physician at facility that person can be admitted, and regarding report required in writing, which also apply to Form 8 order.
Form 9	Order for Return	s 28 *MHA*	Form 9 is an Order issued by the Officer-in-Charge of a psychiatric facility when a person who is subject to detention is absent without leave. Valid for one month after the patient's absence has become known to the OIC and authorizes police officers to apprehend the person for return to the facility.
Form 10	Memorandum of Transfer	s 29 *MHA*	Form 10 is used when a patient is transferred from one psychiatric facility to another pursuant to section. 29 MHA: the OIC to OIC transfer.
Form 11	Transfer to a Public Hospital	s 30 *MHA*	Form 11 officially records the officer in charge's decision to transfer a patient to a public hospital for treatment that cannot be provided at the psychiatric facility. The patient is returned to the psychiatric facility upon completion of the treatment.
Form 13	Order to Admit a Person Coming into Ontario	s 32 *MHA* s 13(7) of Regulation 741, to the *MHA*	Form 13 is an order by the Minister for a person coming into Ontario to be taken into custody and admitted to a psychiatric facility. Form 42 (Notice to Person) is required.

Form	Title	Legislative Reference	Notes
Form 15	Statement of Attending Physician	s 35(6) *MHA*	Form 15 is a written statement from physician that disclosure, transmittal or examination of a psychiatric patient's record of personal health information is likely to result in harm to the treatment or recovery of the patient, or injury to the mental or physical condition of a third person. This issue should be considered whenever the OIC receives a summons, order, direction, notice or similar requirement that requires the production or examination of a record of personal health information belonging to a former or current psychiatric inpatient or outpatient.
Form 21	Certificate of Incapacity to Manage One's Property	s 54(4) *MHA*	Form 21 confirms a physician's finding that an admitted psychiatric patient is incapable of managing property. The physician's assessment is to take place forthwith following the patient's admission to a psychiatric facility, regardless of voluntary, informal or involuntary status. A copy of the certificate must be faxed to the PGT. Form 33 (Notice to Patient) and Rights Advice (confirmed by Form 50) are required, as well as a Form 22. Form 18 is the related application to the board.[5]
Form 22	Financial Statement	s 55 *MHA*	Form 22 is used to transmit information to the PGT when a Form 21 or a Form 24 is issued.
Form 23	Notice of Cancellation of Certificate of Incapacity to Manage One's Property	s 56 *MHA*	Form 23 is used to cancel a certificate of incapacity to manage property. A copy of this certificate must be faxed to the PGT.
Form 24	Notice of Continuance of Certificate of Incapacity to Manage One's Property	s 57(2) *MHA*	Form 24 is used to inform a patient that he or she continues to be incapable of managing property upon discharge from a psychiatric facility. Form 33 (Notice to Patient) and Form 50 (Confirmation of Rights Advice) are required, as well as a Form 22. Form 18 is the related application to the Board.[6]
Form 27	Notice by Officer-in-Charge to a Child who is between 12 and 15 Years of Age, who is an Informal Patient	s 38(6) *MHA*	Form 27 notifies the Officer-in-Charge that a child is entitled to a hearing before the Board. Form 50 (Confirmation of Rights Advice) is required. Forms 25 and 26 are the related applications to the Board.[7]

5 *Ibid.*

6 *Ibid.*

7 *Ibid.*

Form	Title	Legislative Reference	Notes
Form 30	Notice to Patient	s 38(1) *MHA*	Form 30 constitutes written notice to the patient when a certificate of involuntary admission, renewal or continuation is completed. If the certificate is a Form 4A, certificate of continuation, then a Form51 and a Form16 or 17 (first or fourth Form 4A) is attached.[8] See comments for Form 3, Form 4 and Form 4A.
Form 33	Notice to Patient	Clause 15(1)(a) of Regulation 741, to the *MHA*. s 59 *MHA* s 15.1(a) of Regulation 741, to the *MHA*.	Form 33 constitutes written notice to the patient of a finding of: • incapacity with respect to treatment of a mental disorder • incapacity to manage property, or • incapacity with respect to collection, use, or disclosure of personal health information. Form 50 (Confirmation of Rights Advice) is required. Forms A, 18 and P-1 are the related applications to the Board.[9]
Form 42	Notice to Person	s 38.1 *MHA*	Form 42 constitutes written notice to a person who has been made the subject of a Form 1 or Form 13. S. 38.1 requires that the attending physician of the person who is the subject of the forms provide the Notice. See related comments for Form 1 and Form 13.
Form 45	Community Treatment Order	s 33.1 *MHA* s 13(8) of Regulation 741, to the *MHA*	A CTO must be in a Form 45. Copy must be given to the person who is the subject of the CTO, the person's SDM if the person is incapable, the OIC if the person is an inpatient and any person or healthcare provided named in the Community Treatment Plan. Form 50 (Confirmation of Rights Advice) and Form 46 (Notice to Person) are required.
Form 46	Notice to Person of Issuance or Renewal of Community Treatment Order	s 33.1(10) *MHA*	Form 46 constitutes written notice to a person that they are subject to the CTO, and confirms right to apply to Board. See comments for Form 45.

8 *Ibid.*

9 *Ibid*., with the exception of the Form P-1, which is an application under the *Personal Health Information Protection Act*, 2004.

Form	Title	Legislative Reference	Notes
Form 47	Order for Examination	ss 33.3(1), 33.4(3) *MHA* s 13(9) of Regulation 741, to the *MHA*	Form 47 is issued for a violation of the terms of a CTO; authorizes police officers to apprehend patient and return him or her to psychiatric facility.
Form 49	Notice of Intention to Issue or Renew Community Treatment Order	ss 33.1(4), 33.1(8) *MHA*	Form 49 constitutes written notice to patient that their CTO is going to be renewed. Form 50 (Confirmation of Rights Advice) is required.
Form 50	Confirmation of Rights Advice	ss 59, 33.1(4)(e) *MHA*	Form 50 confirms patient was given rights advice. See comments for Form 3, Form 4, Form 4A, Form 21, Form 24, Form 27, Form 30[10] , Form 33, Form 45 and Form 49.

10 The Form 30 notice on a certificate of continuation is significant as it advises the patient of the right to apply to the Board for orders under s 41.1, and will attach a Form 51, and a Form 16 or 17, as applicable. Note that the patient's ability to apply for s 41.1 orders is limited to once every 12 months, subject to leave being granted by the Board to do so sooner than every 12 months, if a material change in circumstances can be demonstrated.

E Tips For Virtual Attendances

The Consent and Capacity Board (CCB) is scheduling all hearings to convene by either teleconference or videoconference (Zoom). The CCB plans to continue to increase the use of videoconference for hearings.[1]

Documents

A smooth and efficient virtual attendance starts with the preparation of materials to be submitted to the Board in advance of the hearing.

It is strongly recommended that documents be collated into a bookmarked PDF that includes the following:

1. The appropriate CCB Summary for the hearing.
2. The relevant documents to be relied on at the hearing, including forms, excerpts from the clinical notes, records and other documents.

The brief should include page numbers, to make it easy to reference specific documents and notes during the hearing. Consideration should be given to creating an index that describes each document, with page numbers and, if possible, hyperlinks each document.

In determining which documents are relevant, consider the issues before the panel and the requirements in the applicable legislation.

Read and be familiar with CCB's Policy Guideline No. 4, which is addressed in more detail in Chapter 5 and sets out how documents must be delivered to the CCB and other parties.[2]

Reminder - If documents are not marked as Exhibits at the hearing, they will not be part of the Record of Proceedings that is before the Court in the event of an appeal.[3]

1 The CCB has an Information Sheet on Videoconferencing Hearings, effective from April 11, 2022 < http://www.ccboard.on.ca/scripts/english/publications/videoconferenceinfosheet.asp>

2 There is more information on CCB Policy Guidelines in Chapter 5.

3 There is more information about CCB hearings in Chapter 5.

SAMPLE INDEX FOR A FORM A (Application to the Board to Review a Finding of Incapable to Consent to Treatment) where the patient is a psychiatric patient under the *Mental Health Act*.

CCB File # _____

Brief of Documents for CCB Hearing [insert date and time]

submitted by / on behalf of [party]

1. Clinical Summary[4]
2. Excerpt from the clinical notes and records documenting the capacity evaluation and finding that is the subject of review at the hearing.
3. Form 33
4. Form 50
5. Other excerpts clinical notes and records that are relevant the finding of incapacity. It is strongly recommended that any notes from other health professionals with similar findings be included.
6. Other collateral information that is relevant to the finding, which may include letters from the patient, SDM, documents from other admissions to hospital / health professionals / community sources.

Preparing For Virtual Attendances

Preparing for a hearing also includes making sure the teleconference or videoconference can be accessed at the designated time. Health professionals may be asked to assist patients with virtual attendances, which may require access to a telephone or a computer with Zoom, internet access and a camera.

Details for a case conference and / or hearing may be set out in a "Notice of Hearing", "Order", "Endorsement" and / or an email from the CCB, depending on the particulars of a specific situation.

Teleconference and videoconference details will differ for case conferences and videoconferences, even on the hearing.

Details of a particular virtual attendance should be reviewed to confirm that they are easily accessible well before the case conference / hearing, to avoid any scrambling for details at the designated call / log in date and time.

Preparing for a virtual attendance also includes finding a quiet location, with minimal distractions, from which to participate.

For videoconferences, it is strongly recommended that steps be taken in advance of the hearing to confirm that:

- You have access to Zoom, with reliable high-speed internet on a device (computer, laptop, tablet, mobile phone) with a camera, speakers and microphone (either built-in or a peripheral device that can be connected).
- Your equipment / set up will work for the hearing.
- Your location is suitable for participating in a case conference / hearing, including the background.
- You have access to a second monitor for accessing electronic records during the videoconference, if needed.
- You know how to change your name as it appears on the screen in a Zoom meeting.
- You know how to join a Zoom meeting and use Zoom's "Share Screen" feature if you anticipate wanting to show documents to the panel.

It is also strongly recommended that you practice navigating through and sharing pages from your Brief of Documents.[5]

4 The CCB provides templates for clinical summaries at http://www.ccboard.on.ca/scripts/english/publications/ccbtemplates.asp. These are not prescribed forms and may be modified as appropriate in the circumstances of a specific hearing. **Use of a clinical summary is strongly recommended for all hearings.**

5 For a demonstration on how to share your screen, please see this video by Zoom Support.

Participating in Virtual Attendances

Teleconferences are accessed by calling into a conference line and entering a conference code. Participants are asked to say their name, followed by the "#" sign on entering the call. The Presiding Member will confirm the participants on the call once all have joined.

Videoconferences are accessed by licking on the Zoom link provided and / or through the Zoom application with the participant pressing the "join" or "join a meeting" button and entering the ID number and the password.

The Zoom meeting will be open to participants a few minutes in advance of the start of the hearing. Participants will first be placed in to a "waiting room", then admitted when the hearing commences.

Participants in a videoconference required to identify themselves with their full name and role in the hearing, for example:

[NAME], Counsel for the [Patient]

[NAME], Observer

[NAME], Counsel for Dr. _____

[NAME], substitute-decision maker for [Patient]

Keep your microphone muted, unless you are giving evidence or speaking.

During the hearing, it is expected that only the parties and panel will appear on video. All other participants should keep their video function off unless there is a reason they are actively participating – for example, witnesses while providing evidence, interpreters.

Be mindful about not speaking over other parties or the members of the panel.

At the outset of a videoconference, the Presiding Member may provide direction as to whether they would like participants to use the 'raised hand function'.

If you anticipate wanting to use the "Share Screen" feature during an attendance, it is recommended that you raise this request with the Presiding Member as a preliminary issue. If using a "Share Screen" feature, double check that you do not have irrelevant or immaterial programs, documents or notes open on your computer as these may result in inadvertently displaying your personal notes, or worse, privileged or confidential information.

If it is appropriate for there to be private discussions during a videoconference attendance, the Presiding Member may assign participants to a "breakout room", as appropriate.

Any form of recording of a virtual attendance is prohibited, including recording by video, audio, photos and screenshots.

For further resources on participating in virtual attendances, please see:

The CCB's "Information Sheet for Videoconference Hearing":

http://www.ccboard.on.ca/scripts/english/publications/videoconferenceinfosheet.asp

Guidance on "Safe Hearings: Key Issues and Principles" from the CCB:

http://www.ccboard.on.ca/scripts/english/publications/safehearing.asp

The "Best Practices for Remote Hearings" from the Ontario Superior Court of Justice:

https://www.ontariocourts.ca/scj/notices-and-orders-covid-19/remote-hearings/8

BLG articles and insights on best practices for virtual disputes:

https://www.blg.com/en/insights/2020/05/virtual-disputes-best-practices-and-benefits

https://www.blg.com/en/insights/2020/05/covid-19-legal-perspectives-virtual-disputes-changes-options-and-best-practices

https://www.blg.com/en/insights/2020/09/coffee-break-with-blg-series-1

F Summary of Recommendations (Use of Restraints)

In November 2017 there was an inquest into the death of a 65 year old man with schizophrenia who died while in physical restraints at an Ontario hospital. At the time of his death, the patient was in the crisis area of the Emergency Department, waiting for an inpatient bed. Over the course of two days, the patient became progressively confused and agitated. He had a number of falls and spent about 10 hours in four point restraints over three separate periods of time.

The following recommendations were made by the jury and provide guidance for organizations in the review and development of restraint policies.

Use of Restraints

To All Hospitals in Ontario:

1. Ontario Hospitals should aspire to provide care without the use of restraints.
2. Ontario Hospitals should be reminded that restraint use must comply with Ontario legislation including the *Patient Restraints Minimization Act* and the provisions of the *Mental Health Act* and *Health Care Consent Act* where applicable.

To All Schedule 1 Facilities in Ontario:

1. All Schedule 1 Facilities in Ontario should have a formalized Least Restraint policy that documents at a minimum the following aspects:
   - (a) All key activities involved in the emergency and non emergency application of restraints including:
     - (iii) Assessment Alternative Solutions Consent Restraint Ordering and Application Re ordering of Restraints Ongoing Monitoring Removal Debrief and Evaluation
   - (b) All roles and responsibilities associated to the activities above
   - (c) Defined measures and metrics associated with the activities above
2. Hospital policies are to be based on applicable law and principles of least restraint. Consideration should be given to recommendations from the Jeffery James inquest as well as from this inquest. In addition least restraint policies should consider the following:
   - (a) Any order for restraint cannot be made on a "prn" or "as needed" basis;
   - (b) Mechanical or chemical restraint or seclusion should be ordered by a physician only after an assessment of the patient except in circumstances in which immediate action is necessary to prevent serious bodily harm to the patient or to another person;
   - (c) When mechanical or chemical restraint or seclusion are initiated without a physician order one should be obtained as soon as possible thereafter and the patient should be assessed by a physician within 1 hour;
   - (d) The patient should be re assessed by a physician every 2 hours thereafter during the period of mechanical restraint. The re-assessment should include consideration of whether continued mechanical restraint is required.
   - (e) If the patient is secluded they should here assessed by a physician at appropriate intervals;
   - (f) The unit manager should be notified when mechanical restraint or seclusion is initiated for a patient;
   - (g) Restraint use should be documented and this documentation should include:
     - (i) Who ordered the restraint;
     - (ii) A description of the means of restraint;
     - (iii) A description of the behaviour of the patient that required the use and or continuation of restraint;
     - (iv) A description of environmental and or relationship issues that may have been a stressor for the patient;

(v) The time that the restraint was initiated and then discontinued;

(vi) The frequency of observation during the period of restraint;

(vii) A description of the effect of the restraint on the patient;

(viii) Results of a complete physical assessment of the patient for physical injury if any associated with the use of restraints;

(ix) The manner in which the patient was observed during the period of restraint; and

(x) Cumulative totals of the number and duration of periods involving restraint over any given 24 hour period.

(h) Restraints should be considered extraordinary interventions and used only when less restrictive alternatives including engagement and de escalation have been unsuccessful;

(i) It is important for all members of the interdisciplinary care team to have a clear understanding of their roles and responsibilities with respect to the use and application of restraints;

(j) Addressing and documenting non emergency situations where the patient Substitute Decision Maker opposes the use of restraint as part of their treatment plan. Inform the Most Responsible Physician (MRP) of the opposition;

3. During periods of mechanical restraint or seclusion there should be direct uninterrupted and visual observation of a single patient. The patient under observation should be consulted about what type of interaction would be of comfort to them. Unless refused by the patient, observation should include meaningful interaction with the patient. Meaningful interaction includes:

   (a) Providing comfort and human contact;

   (b) Considerations of the safety and well being of the patient including personal care needs;

   (c) The expectation for meaningful interaction is applicable to patients with mental health issues on locked units;

4. A patient in restraint or seclusion should be advised of the reason for the restraint or seclusion including the behaviour that led to the use of restraint or seclusion as well as what would result in removal from restraint or seclusion.

5. Where available patient advocate or peer advocate support should be offered to a patient on initiation of a period of restraint or seclusion.

6. Following periods of mechanical restraint or seclusion there should be debriefs with both the patient and staff. Consider following a structured model similar to the OPEN Model as defined by St Joseph's Health Centre.

   (a) With respect to the patient debrief:

      (i) Where possible clinical staff speaking with the patient for the debrief should not be the staff involved in placing the patient in restraints;

      (ii) Where available debrief with peer advocate support should be offered to the patient;

      (iii) Comments from the patient about their experience should be documented in their own words;

      (iv) The patient debrief should be done as soon as appropriate following the end of the period of restraints and within 24-hours.

   (b) With respect to the staff debrief:

      (i) Staff directly involved in the act of restraining the patient should be rapidly surveyed for physical injury and psychological distress and provided with appropriate support;

      (ii) The team should quickly list possible antecedents to the need for restraints;

      (iii) Lessons learned and opportunities for improvement should be documented and shared with staff.

7. Patients should receive on going support specific to the psychological effects of having been in mechanical restraints or seclusion. This support should be considered as part of the patients plan of treatment. Consideration should be given to whether the plan of treatment needs to be updated following a period of restraint.

8. Only personnel who have been trained in the facility's policies and procedures pertaining to restraint use can apply restraints.

Treatment and Care for Patients with Mental Health Issues

To All Schedule 1 Facilities in Ontario:

1. There should be a clearly documented plan of treatment for each mental health patient which addresses medical and psychiatric diagnoses and takes into account the patients self identified needs.
2. Medication reconciliation should be completed as soon as possible for patients presenting with mental health issues and in particular for elderly psychiatric patients. This may be in the form of a Best Possible Medication History ("BPMH"). This should include consideration of smoking and the possible need for nicotine replacement, newly introduced medications, as well as the impact this may have on current medications.
3. Ensure that the "5 rights" of medication administration is followed:
   (a) Right patient
   (b) Right drug
   (c) Right time and frequency
   (d) Right dose
   (e) Right route
4. A "crisis plan" should be discussed and documented with the patient based on self-identified needs with consideration of the following:
   (a) Potential emotional triggers and how to address them;
   (b) Best options to help calm the patient in times of crisis;
   (c) Options that the patient identifies as the least restrictive if physical restraint becomes necessary; and
   (d) Whether the patient would like a patient advocate and or some other individual of their choice contacted if they are unable to make contact on their own.
5. All patients presenting with mental health issues should be assessed medically following in patient admission to Hospital.
6. All patient assessments should be performed in a manner to protect patient privacy and confidentiality.
7. Elderly in patients with mental health issues and multiple medical chronic conditions should whenever possible be assessed by a geriatrician or internal medicine specialist.
8. All fall risk assessments should include an assessment of the risk that may arise as a result of psychiatric medication prescribed in a patient's plan of treatment.
9. It is essential that sufficient nursing staff be assigned to care for patients in mental health units.

Education and Training

To the Ontario Hospital Association Ontario Medical Association College of Physicians and Surgeons of Ontario College of Nurses of Ontario and All Hospitals in Ontario:

1. All clinical staff providing care in mental health units should have specific education and training in providing care to mental health patients.
2. Continuing education for clinicians should include:
   (a) Emergency Department assessment of patients presenting with mental health issues should include a formal mental status exam which includes assessment and documentation of patient appearance, behaviour, speech, mood, affect, thought form, thought content, insight, judgment, and cognition;
   (b) Emergency Department physicians considering a Form 1 Application for Psychiatric Assessment should take into account information from direct assessment of the patient and corroborating information. Pre-populated forms should not be used;
   (c) Psychiatric assessment should include a full assessment with a mental status exam diagnosis and treatment plan. This assessment should be documented in the clinical notes and records;
   (d) Medical assessment during and following periods of mechanical and or chemical restraint should consider the risks of deep vein thrombosis and cardiac effects of restraints;

(e) Psychiatric assessment requires regular psychiatric follow up evaluation and should include full documentation of a mental status exam with each visit;

(f) Physicians should consider delirium as part of the differential diagnosis for any patient especially in those 65 years and older with altered cognition or altered level of consciousness;

(g) Nurses in all clinical settings should consider clinical changes in a patients condition and be alert to the need for further medical assessment;

(h) Clinicians should be aware that smoking cessation increases the impact of certain psychiatric medications. This should be considered in prescribing medications;

(i) Clinicians should consider the efficacy of nicotine replacement and should support patients to adequately use the available nicotine replacement treatment.

3. Documentation should comply with applicable College standards and guidelines as well as Hospital policies. Documentation should indicate which observations are subjective versus objective. Documentation should not include unfounded conclusions, value judgments, or labeling. Health care providers should be aware of the risk of their subjective assessments being informed by stigma or bias. Documentation should be subjected to periodic audits by the hospitals quality control.

4. Training for clinicians and security guards should be provided in house and where applicable should be provided to health care providers and security guards as a team in particular training regarding restraints.

5. Education should be provided to clinicians with respect to the recognition and management of delirium in the Emergency Department setting.

6. Clinicians should consider possible associations between psychiatric medications and cardiac issues.

To All Hospitals in Ontario

1. All front line staff working in the Emergency Department should have annual training geared towards the prevention and management of aggressive behaviours and non violent crisis intervention including training on:

   (a) Restraints including avoidance minimization of the use of restraints;

   (b) Falls;

   (c) Patient and staff safety;

   (d) Effective communications

To All Schedule 1 Facilities in Ontario:

1. Clinicians dealing with patients with mental health issues should have annual training about the care and assessment of patients with mental health issues based on a curriculum that should be informed by:

   (a) A representative patient voice;

   (b) A meaningful portion delivered by a representative patient voice; and

   (c) Principles of trauma informed care

2. Security guards who have responsibility to work in mental health units should be provided with annual training that includes the following:

   (a) Crisis Management Training:

   Crisis management training is designed to help security professionals recognize when a subject is in crisis and respond appropriately;

   (b) Effective Communication:

   The use of effective or appropriate communication is vital to lowering a person's crisis level. This training should include the skills required to respond to a crisis situation using verbal strategies intended to calm someone down so training should include:

   (i) Professionalism;

   (ii) First contact with a personal greeting and the reason for the interaction;

   (iii) The importance of verbal and non-verbal messages;

   (iv) The need to use active listening skills;

(v) The relevance of para verbal communication;

(vi) The relevance of displaying appropriate body language; and

(vii) The need for verbal strategies that include feedback.

(c) Subject Restraint / Pinel Restraint Systems

Security guards require training with respect to subject control and the principles associated with safe restraint.

3. Training should be provided to the inter professional clinical teams and security guards working with patients with mental health issues that includes trauma informed care and addresses issues of safety for patients staff and others.
4. All new clinical staff and security guards working with patients with mental health issues should complete training as per curriculum within 60 days.
5. Hospitals should provide cultural awareness and sensitivity training that includes specific training in interacting with patients experiencing mental health issues.

Accountability

To All Hospitals in Ontario:

1. All hospitals should have process and procedures in place to support employee feedback complaints and suggestions. Incorporate whistle blowing protection into the process and procedures.

To All Schedule 1 Facilities in Ontario and the Ministry of Health and Long Term Care:

2. Hospitals should monitor training and implementation application of policies to patient care including:

(a) Track training and implementation of policies;

(b) Follow up to monitor understanding and application of policies;

(c) Periodic reminders with respect to policies and best practices including examples case studies;

(d) Conduct periodic audits with respect to the application of key policies including least restraint policies;

(e) Conduct periodic case reviews of periods of restraint including chart and video review where available looking at pre restraint during restraint and post restraint care; and

(f) Review the effectiveness of the policy and updating the policy or training implementation as may be appropriate;

(g) Effective transfer of information pertaining to patients by clinical staff during shift changes and after breaks.

3. Patient satisfaction surveys should be conducted with people who receive mental health and addiction services.
4. Hospitals should track and review the number and duration of periods of mechanical restraints seclusion and chemical restraints. This should include information with respect to the event precipitating restraint use if possible.
5. Data with respect to restraint use should be reported to the Ministry of Health and Long Term Care (“MOHLTC”).
6. The MOHLTC should make data with respect to the use of mechanical restraints seclusion and chemical restraints publicly available broken down by institution.

Communication with Support Person

To All Hospitals in Ontario

1. Patients should be asked on admission and at appropriate intervals thereafter if there is a support person (including family members) that they would like to contact or have contacted. This should be documented as part of the patient record.

Community Based Resources

To the Ministry of Health and Long Term Care and the Local Health Integration Networks:

1. The MOHLTC and the Local Health Integration Networks LHINs should consider the development of intensive case management support and / or assertive community treatment teams for seniors with serious mental health issues to manage their needs in community settings whenever possible.

2. Patients should be connected with individual supports that are flexible according to need and are available in times of crisis.

Patient Advocacy and Support

To the Ministry of Health and Long Term Care and the Local Health Integration Networks:

1. Allocate resources for independent mental health peer advocates and related infrastructure to be available to Schedule 1 Facilities.
2. In its requirements for patient engagement in Ontario Hospitals MOHLTC/LHINs should set standards for engagement of mental health patients that includes the following:
   (a) Patient representatives should be accountable to other patients with association to the same facility;
   (b) Patient representatives should be elected by patients of that same facility;
   (c) Patient representatives should make decisions and take action in accordance with consultation with a broad base of patients;
   (d) Patient meetings should be organized by peer advocates where available.

To All Schedule 1 Facilities in Ontario:

1. Patient advocacy and input should be considered in the development and review of hospital policies safety and environmental factors at facilities that treat patients with mental health issues. It is recognized that where available an independent patient voice may offer additional insight to the patient experience beyond that of a volunteer patient / family advisor.
2. Where available peer advocate support should be offered to patients with mental health issues in the Emergency Department setting as well as on in patient units Patients should advocacy support provided.
3. Patients should be made aware of options and have opportunities to express concerns complaints, suggestions and compliments including hospital patients relations patient advocacy groups and other resources as may be available. Patients should also be aware of the option to contact the Office of the Patient Ombudsman.
4. Schedule 1 Facilities should consider working with representative patient advocacy groups to develop their own patient Bill of Rights specific to patients with mental health issues. The Centre for Addiction and Mental Health Client Bill of Rights may be used as a model. Information pertaining to patients rights should be readily accessible to all stakeholders.

Meaningful Patient Voice

To [the Hospital]

1. Within six months [the Hospital] will have a comprehensive plan for robust patient and family engagement to support patient identified needs and service quality improvements in the mental health program. This plan will support a process of meaningful engagement of patients with mental health issues at [the Hospital]. [The Hospital] will engage with subject matter experts including a client patient peer run advocacy organization in the realm of patient and family engagement in the development of this plan Focus of this work will include but not limited to policy training and implementation all of which would include a patient and trauma informed perspective.

Staff Care

1. All clinical staff in mental health units should have a personal alarm similar to that used by the staff at the Centre for Addiction and Mental Health.
2. Information pertaining to Employee Assistance Programs EAP should be posted in accessible locations (i.e. break rooms, staff rooms, online, etc.).

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