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**Wednesday 9 December 2009**

**Journal  
des débats  
(Hansard)**

**Mercredi 9 décembre 2009**

**Select Committee on  
Mental Health and Addictions**

Mental Health  
and Addictions Strategy

**Comité spécial de la santé  
mentale et des dépendances**

Stratégie sur la santé mentale et  
les dépendances

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LEGISLATIVE ASSEMBLY OF ONTARIO

**SELECT COMMITTEE ON  
MENTAL HEALTH AND ADDICTIONS**

Wednesday 9 December 2009

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**COMITÉ SPÉCIAL DE LA SANTÉ  
MENTALE ET DES DÉPENDANCES**

Mercredi 9 décembre 2009

*The committee met at 1603 in committee room 1.*

MENTAL HEALTH  
AND ADDICTIONS STRATEGY

**The Chair (Mr. Kevin Daniel Flynn):** Welcome to the final meeting of the year for the Select Committee on Mental Health and Addictions, or the final planned meeting.

MINISTRY OF HEALTH  
AND LONG-TERM CARE

**The Chair (Mr. Kevin Daniel Flynn):** We're hearing today for the next hour, between 4 o'clock and 5 o'clock, from the Ministry of Health and Long-Term Care. We've got Fannie, Diana and Priti. If you'd like to come forward and make yourselves comfortable.

Thank you very much for coming today. Our understanding is that you wanted to make a presentation and that we would save some time at the end for a discussion, perhaps, of some of the questions that some of the committee members have as a result of previous delegations that we've heard from, and also as a result of your presentation today.

**Ms. Diana Schell:** Mr. Flynn, I think our understanding might be a little different. If I might just briefly say, I'm Diana Schell and this is Fannie Dimitriadis. Priti Sachdeva is not coming today. After we spoke to Ms. Hull about what was anticipated for today, we decided we didn't need Priti.

Our understanding is that the committee would like some high-level information related to two issues that you've been hearing about, the first being the difficulty getting treatment for mentally ill family members and the second being the difficulty getting information about family members—so information and treatment issues. We were asked to provide a high-level statement about what the law is in this area and then make ourselves available for any questions the committee may have, and it was our understanding that most of the committee time would be taken up with your questions.

If you are okay with this, what we're proposing to do is just say what we have to say at the beginning and then leave as much time as possible for questions.

**The Chair (Mr. Kevin Daniel Flynn):** I think we're saying the same thing in different ways. Our expectation

is that most of the hour be taken up by a discussion, based on some of the things that perhaps you'll make us aware of in your statements.

**Ms. Diana Schell:** Certainly. Thank you, sir.

I'm going to talk about the treatment issues. The first thing I'd like to say is that the relevant legislation in this area in Ontario is the Health Care Consent Act, 1996. That act has been around since March 1996 and it applies to treatment provided by health practitioners. If one looks at the definition of "health practitioner" in the act, what you see is that that definition encompasses professional groups that are regulated health professions, so physicians, nurses, physiotherapists—people who are regulated under provincial regulation.

The act has a definition of "treatment." It indicates that treatment "means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose." The treatment in question is treatment provided in any setting. This is not legislation that applies exclusively to institutional settings; it's really treatment that's provided by a health practitioner. The place of treatment is not relevant for the purposes of this legislation, at least in the treatment part of the legislation.

Under the act, the issue of capacity determines who may make a treatment decision. So if an individual is capable with respect to the particular treatment decision, then that person makes a decision about whether to consent to the proposed treatment or to decline the proposed treatment. If the person is not capable, and it's the health practitioner who is supposed to make that finding, then a substitute decision-maker is supposed to make the treatment decision.

**1610**

There's a list of substitute decision-makers in the act and, for the most part, I think it's family members who would be substitutes, although there is a possibility of a guardian appointed by the court or somebody with power of attorney where the donor of the power of attorney is the person who's going to be treated.

There is a test that the substitute is supposed to apply when making a treatment decision on behalf of an incapable person. Basically what that's about is the substitute is supposed to comply with any prior capable wishes that the person expressed that apply to the circumstances and that were expressed after the individual was at least 16 years of age. If there are no prior capable wishes that the substitute knows about, the substitute is

supposed to make a decision that's in the best interests of the incapable person.

I know that you're interested in information issues, so I'll just tell you very quickly that the act says, in section 22, that a substitute decision-maker is entitled to all the same information that the person would be entitled to for the purpose of making an informed decision about the proposed treatment.

That's all I have to say for the moment, but after Fannie presents, I'll be pleased to answer any questions you may have.

**Ms. Fannie Dimitriadis:** I'll just take a few minutes to give you a brief overview of some aspects of the Personal Health Information Protection Act. I'm sort of anticipating some of the areas that might be of interest to you, so I'll focus on those.

The act received royal assent in 2004, so it's relatively new, although it has been around for a few years. The purposes of the act are set out in section 1, and they include establishing "rules for the collection, use and disclosure of personal health information about individuals that protect the confidentiality of that information and the privacy of individuals with respect to that information, while facilitating the effective provision of health care."

The act applies to health information custodians. That's a defined term that includes health care providers, such as hospitals, long-term-care homes, physicians etc. when they collect, use, and disclose personal health information. "Personal health information" is also a defined term. It means generally what you would think of as being health information when you can identify the individual to whom the information relates.

It's important to note that PHIPA is consent-based legislation, so that means that the individual's consent is required for the collection, use and disclosure of information about that individual, except where that collection, use or disclosure, as the case may be, is permitted to occur without consent. Consent can be implied in certain cases, when the personal health information is collected, used and disclosed among health information custodians who are involved in providing health care to the individual. But consent in other cases must be express, when the information is disclosed to individuals who are not custodians or where the purpose is not the provision of health care. PHIPA includes the elements of consent. It requires that consent be from the individual or an authorized substitute decision-maker, be knowledgeable, relate to the information and not be obtained through deception or coercion.

PHIPA includes a scheme governing the determination of capacity and a scheme for substitute decision-making in relation to decisions about personal health information transactions covered by the act. Largely, they parallel those that Diana just talked about in the Health Care Consent Act. They were modelled on those provisions.

Health information custodians are entitled to presume that an individual is capable of consenting to the collection, use and disclosure of their personal health information unless it is not reasonable to do so. An individual

is capable of so consenting if the individual is able to understand the information that is relevant to the decision of whether to consent, and able to appreciate the foreseeable reasonable consequences of giving, not giving, withholding or withdrawing consent. Under PHIPA, it's the custodian involved in the collection, use or disclosure, as the case may be, who determines capacity.

Where a custodian makes a determination of incapacity, unless it's not reasonable to do so, he or she is required to provide information to the individual about the consequences of the determination, such as the fact that the individual has a right to have a review of that finding and that someone else will be making information decisions on his or her behalf.

The act allows persons who are determined to be mentally incapable of making decisions to apply to the Consent and Capacity Board, which was established under the Health Care Consent Act, for a review of that determination.

PHIPA provides a framework for making decisions about the collection, use and disclosure on behalf of people who are not capable. Where an individual is not capable with respect to such a decision, the act provides a list of substitute decision-makers—again, this parallels the scheme in the Health Care Consent Act—and there's a ranking in the legislation of individuals who can take on this role.

Diana referred to one provision in the Health Care Consent Act regarding the fact that individuals who are substitute decision-makers under the Health Care Consent Act have the right to information to allow them to make those decisions, and there's sort of a parallel provision in PHIPA to allow the two acts to meet together.

In making decisions on behalf of an incapable individual, a substitute decision-maker must take into consideration a number of factors set out in the act, including the wishes, values and beliefs that the substitute knows the incapable individual held when capable.

As I mentioned, the general rule in PHIPA is that consent is required for the collection, use and disclosure of information. There are some instances when consent is not required, and I'll just highlight two for you, as they might be relevant to your work here.

Facilities that provide health care can disclose limited information about their patients' and residents' location and health status. They can let people know the fact that the individual is a patient or a resident in the facility; the individual's general health status, described as critical, poor, fair, stable or satisfactory or something along those lines; and the location of the individual in the facility. That's permitted to occur if, at the first reasonable opportunity after admission, the individual is provided with an opportunity to opt out of this kind of disclosure of their information.

There is a provision as well that provides custodians with the discretion to disclose personal health information without the consent of the individual to whom the information relates where 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. The Information and Privacy Commissioner, the body responsible for oversight of compliance with the legislation, has provided some guidance on that particular provision.

At that point, I'll turn to you, if you have any questions for Diana or myself.

**The Chair (Mr. Kevin Daniel Flynn):** I'm sure there are some questions. Thank you very much, both of you, for your presentations. Let's start on this side. Christine?

**Mrs. Christine Elliott:** Thank you very much for coming to the committee and sharing your expertise with us. We have a number of questions we'd like to ask your opinion on, as we're sort of grappling with some of these issues.

One of the things we've heard about repeatedly from family members is that their loved one—usually a son or daughter—clearly—in their view, anyway—needs to get some help. They may be taken to hospital. They may or may not be admitted on a form 1. But the key seems to be that they may get released after 72 hours with, “Okay, you're on your own,” and not much follow-up. The family members don't get notified so they often don't even know that their son or daughter has been released. So they're asking us to do something about that, both with respect to the Mental Health Act being able to keep someone on a form, either a form 1 or subsequently on a form 3, and with respect to the release of information to family members. The consent issue, of course, has to be there. But capacity seems to lie at the heart of it—whether a person has capacity or not.

1620

One of the issues that we've been talking about is: Is there an opportunity for capacity to be determined at an earlier time? Perhaps when someone initially comes in on a form 1, is there an opportunity? Have you given any thought about having an earlier capacity assessment so that a substitute decision-maker can then make decisions, if necessary, or the person can then proceed to make their own? Because what we seem to be hearing from family members is, “They don't know what they're doing and they're back out on the street, and we have no way of getting help for them.” I'd really appreciate your comments on that.

**Ms. Diana Schell:** This is, I think, really more of a question about the application of the Mental Health Act. When that act was amended in 2000, there were some criteria added that allow for a form 1, form 3 or form 4 on new grounds that it include a consideration of the person's capacity. So it's always possible that when somebody comes into hospital, a clinician—usually a physician—has already looked at the issue of capacity. I think more typically the situation is that capacity may not be assessed at an early stage because the staff at the psychiatric facility are in the process of doing an assessment and they may not have treatment that they're prepared to recommend at that point in time.

Capacity assessments are done with respect to particular proposed treatment. They don't apply to a

finding of capacity at large, if I can put it that way. The assessment of capacity is done when the clinician is prepared to make a proposal about particular treatment, so it's an assessment with respect to that treatment. I think that that may be one reason why capacity assessments are not made immediately when the person first comes into hospital.

**Mrs. Christine Elliott:** I'm just wondering how we deal with the revolving-door issues that we seem to hear about with so many people: They go into the hospital, they may or may not be kept on a form 1; if they are, then they're released after 72 hours. They get sicker, a family member brings them back in, and multiple admissions to hospital—or visits to hospital; maybe not admissions. What would be your recommendation? Is there anything that we can do in law to change the system to make it more effective so that we can actually help people more?

**Ms. Diana Schell:** The short answer is, I'm not sure that that is specifically a legal question. It might be more a question about program design, but I think that there was an attempt to deal with some of these revolving-door issues in 2000 with the enactment of the community treatment order provisions and the changes to the form 1 and the involuntary admission provisions that I mentioned just a moment ago. I'll just find those criteria for you, because that might be a helpful way to proceed.

It would be more helpful if I looked in the Mental Health Act instead of the Health Care Consent Act.

Okay. The new involuntary-admission provisions are in subsection (1.1) of section 20 of the Mental Health Act. The criteria there are lengthy. I'm not going to read them all verbatim, but they talk about the ability to continue a person as an involuntary patient where the person “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.”

So it's there that the attempt was made to address the problem you've identified, Ms. Elliott, with respect to people who have a history of repeated admission to hospitals. This addition was intended to allow a clinician to intervene at an earlier stage before there was substantial mental or physical deterioration.

That's what was done as of December 1, 2000. Whether there's more that might be done of a practical nature, I'm not sure.

**Mrs. Christine Elliott:** Thank you.

**The Chair (Mr. Kevin Daniel Flynn):** Helena?

**Ms. Helena Jaczek:** Thank you, because I want to pick up exactly on that point. Involuntary admission: On that first admission, it's required to show that there's some sort of serious bodily harm occurring, either to the individual or to someone else. What we've heard from parents of schizophrenic children is that might not necessarily be the case, this issue of serious bodily harm. It's clear that things are very wrong, but that might not necessarily be the situation, so they may not be able to have a form 1 used for that first admission.

The deterioration criteria that you're talking about requires a history, so one can see that having had previous hospitalization, subsequently the test seems to be less onerous in terms of this serious-bodily-harm piece. How would you respond, or would you think there's any way of, for that first admission, somehow, perhaps, softening this requirement for serious bodily harm?

**Ms. Diana Schell:** I appreciate that people are reporting to the committee what their understanding is of the law and they're saying what they've been told. I think that your description of the serious bodily harm requirement is actually not entirely accurate. What the act provides for is, if we're talking about a form 1, which any physician can do after examining a person in the community, the physician has to be of the opinion that the person is apparently suffering from a mental disorder of a nature or quality that likely will result in—and then there are various possible harms: There's the serious bodily harm to the person or someone else; there's also serious physical impairment of the person, which would be in the nature of unanticipated risks that the person exposes himself or herself to because they're ill and they don't appreciate the nature of the risk.

In looking at the serious-bodily-harm requirement, the courts said many years ago that what's required there to support that kind of finding by a physician is either the physician's opinion that the person is suffering from mental disorder of the sort that is likely to result in that kind of harm or a history of past harm. So there is, in fact, no requirement that the person is actually suffering serious bodily harm right now in order to detain the person as an involuntary patient or to complete a form 1. Certainly, if they were, that would satisfy the ground, but it's not a specific requirement.

**Ms. Helena Jaczek:** I think we're going to be hearing, a little bit later, from Dr. Gray from BC, and apparently they have changed some wording that softens that requirement related to this physical harm or threat of physical harm. We certainly heard from parents that they couldn't get the kind of treatment that they felt that their loved one needed.

**Ms. Diana Schell:** That's very possible. If British Columbia's considering other wording or has put in some other wording, that's something that I'd be pleased to know more about.

I think it's possible, as well, that the description that's provided to family members about how onerous these criteria are might be a little overstated. I am not saying that's deliberate, but I think that in my experience—and I've done many Consent and Capacity Board hearings, and for years I was doing almost all of the appeals involving the provincial psychiatric hospitals—certainly, it was not my experience that the courts were overly zealous in placing a very high interpretation on these provisions that made it difficult for them to apply.

**Ms. Helena Jaczek:** Thank you.

**The Chair (Mr. Kevin Daniel Flynn):** Anything, Howard?

**Mr. Howard Hampton:** No, nothing.

**The Chair (Mr. Kevin Daniel Flynn):** Any other questions? If not, thank you very much for coming today, unless you've got something, Liz?

1630

**Mrs. Liz Sandals:** What we frequently deal with is a family who very much wants to get care for a family member, and they may either not have been allowed a relationship with the patient's doctor—and I've run into that where there just simply is no relationship with the patient's doctor, so I don't think the doctor would have any way, particularly, of accurately judging their good or bad intents—or they may have had a little bit of consultation or have met, but not much interaction with the health care system that has actively been treating. Then it falls off the rails. Then they're desperately trying to figure out how to get treatment back on the rails and don't seem to be able to find any route back in.

What legal opportunities—if you look at the family, what is a family in that situation currently going to have to step through in terms of process to actually try to get some help for their family member? If that's the situation you're starting from, what would you do?

**Ms. Diana Schell:** I think part of your question is about access to services and how do family members get information about the services that may be available for their family member—

**Mrs. Liz Sandals:** No. In most cases, they have a pretty clear view of what services are available in the community. In many cases, they've already done quite extensive research. I come from a community where there's 120,000 people. You don't have to do too much research to find out the two or three things that are available in the community. So they know pretty much what it is they need. Their problem is that they've got a family member who's typically off medications, the family member is refusing treatment, they know that they need to get the family member back on medications but there doesn't seem to be a way for them to intersect with the medical community because they're not the patient.

I've had constituents who—ultimately the family member has committed suicide because the family member can't seem to get through this legal wall to say to somebody, "My family member isn't making good decisions; my family member desperately needs treatment." In that situation, they know where they need to get, but how can they get to where they need to get to try to help the family member?

**Ms. Diana Schell:** Okay. I can tell you about what's in the Mental Health Act now that can result in somebody's admission to a psychiatric facility. I don't know that it's a complete answer to your question, but I'll tell you what's here now.

Leaving aside the problem with connecting with the family member's physician, there is always a possibility of the physician arranging a voluntary admission to a psychiatric facility. If the person is incapable with respect to treatment, a substitute decision-maker can consent to that admission. The roots—

**Mrs. Liz Sandals:** But doesn't that assume that while the patient was in good shape or at least had some

capacity, they had the foresight to do that? Typically we're talking about a situation where there wasn't the foresight on the part of the patient to name a substitute decision-maker, so there is no substitute decision-maker.

**Ms. Diana Schell:** Well, if the person's incapable, there's always a substitute decision-maker identified under the act. I'm going to tell you about the ways that don't involve a co-operative response from the person who's going to be admitted.

Under section 17 of the Mental Health Act, there are criteria that may allow a police officer to take a person to a physician for an examination. There's the form 1 process that Mrs. Elliott has alluded to, and that's an examination by a physician. You have this process that starts with the physician's examination.

The route that seems to be open to family members in addition to that is something called a form 2, under section 16 of the Mental Health Act. That's an order for examination by a justice of the peace. A family member can, in fact, apply for a form 2 order. That would require that the person be examined by a physician. The physician can then do a form 1, which would lead to the person's admission to a psychiatric facility for the purpose of an assessment.

Those are the routes into hospital under this act. They all start with this idea that there has to be a process for obtaining an examination by a physician who can then do a form 1, which may or may not lead to either a voluntary or an involuntary admission to a psychiatric facility. Those are the things that the legislation provides for now.

**Mrs. Liz Sandals:** Is there any tracking of how often form 2 is successful in the case where the family and the doctor aren't already working together? I'm assuming that the family and the doctor are not co-conspiring—if I can put it that way—that you've got the family who's sitting here. The patient may not even have a current doctor because they've broken those medical connections. Do we have any tracking that shows how often these instruments are successfully used by a family member in order to access treatment?

**Ms. Diana Schell:** I have no idea. That wouldn't be something that falls within the scope of what I do, so I don't know if there's any tracking. I can tell you that a form 2 application can be made without having to have clinical evidence to support the application, but whether anybody is tracking form 2s, I have no information about that.

**Mrs. Liz Sandals:** Not the Ministry of Health, then, I think, from what you're saying.

**Ms. Diana Schell:** Well, again, I don't know. I think it's possible that data may be collected with respect to the number of individuals who come into hospital on a form 2. I don't know whether that's the case or not, but I think it's possible that the ministry collects that kind of data from the health care system. I'm just speculating in that regard; I wouldn't know for sure.

**Mrs. Liz Sandals:** Just by way of comment, my sense would be that in my community, the folks who would come into hospital, it would tend to be that they've been

picked up by the police, that the situation has deteriorated to the point that somebody is picked up by the police. Unless the family has called the police, there doesn't seem to be a way to get there without first of all involving the police, which sometimes can backfire, with people ending up in jail, which wasn't actually the intent of the family. Anyway, that helps.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Liz. Helena?

**Ms. Helena Jaczek:** Yes. On the PHIPA side of things, the privacy commissioner did make some recommendations to the Standing Committee on Social Policy. I forget—I was actually on the committee—whether it was last year or earlier this year. It related to this issue of bodily harm. She made the recommendation that PHIPA should be amended to replace “bodily harm” with “physical or psychological harm.” I'm wondering if you'd have any comment on that.

**Ms. Fannie Dimitriadis:** I can tell you that from the perspective of the lawyers who work in our branch, the legal services branch, that we interpret bodily harm as including that psychological harm. The language that was selected for the purposes of PHIPA aligns with the language in other Ontario legislation.

**Ms. Helena Jaczek:** I see. I would have thought from a lay point of view that “bodily” would somehow imply more physical?

**Ms. Fannie Dimitriadis:** That's the way we interpret it, based on case law, to that effect.

**Ms. Helena Jaczek:** You would assume psychiatrists, family doctors or anyone who might be involved in a case of mental illness would also interpret it that way?

**Ms. Fannie Dimitriadis:** I'm sorry. I can't comment on whether they would or they wouldn't. It may be that the kinds of physicians typically involved in dealing with these kinds of matters would have more knowledge than the average family doctor. I'm not sure, though. I'm just speculating.

**Ms. Helena Jaczek:** Thank you.

**The Chair (Mr. Kevin Daniel Flynn):** Are there any further speakers? Christine.

**Mrs. Christine Elliott:** I just have one further question with respect to consent and the capacity issue. Consent is presumed unless it would be unreasonable to presume under PHIPA. What kind of criteria that you know of would be applicable in that situation?

**Ms. Fannie Dimitriadis:** Well, an obvious one, not especially relevant to what we're talking about here, is if somebody's unconscious, for example. Obviously, they're not capable of making a decision themselves. Just through their discussions with the patient: How are they responding to questions? What kind of information are they providing? Does it appear as though they're understanding what's being discussed, the impact of their decisions etc.?

**Mrs. Christine Elliott:** But that seems to be the really grey area that we're dealing with.

**Ms. Fannie Dimitriadis:** Yes.

**Mrs. Christine Elliott:** It's sort of like an informal capacity assessment, really, to determine if the person is mentally capable of giving the consent. That's where I think we run into a lot of frustration with family members. They're saying, "They can't consent because they don't know what they're doing." Do you think that that's something that we could look at as an area that needs maybe some change or amendment?

**Ms. Fannie Dimitriadis:** I'm not sure because I haven't necessarily heard all the information that you've heard along the way. The scheme in PHIPA, as I mentioned before, does parallel the Health Care Consent Act scheme. It does simplify it a little bit—if that's the right word—acknowledging the fact that making decisions about treatment is different than making decisions about collection, use and disclosure of health information. That distinction was deliberate there. I'm not sure if that's helpful in response to your question.

**Mrs. Christine Elliott:** Thank you.

**The Chair (Mr. Kevin Daniel Flynn):** Okay. Any other questions? If not, I'd like to thank both of you for appearing today. Thank you very much.

**Ms. Diana Schell:** A pleasure.

**Ms. Fannie Dimitriadis:** Thank you.

**The Chair (Mr. Kevin Daniel Flynn):** For the committee members, Dr. Gray has arrived, but I understand he needs a little bit of time to set up. Maybe we'll call a brief recess. How much time do you think you'll need? Five minutes? Five minutes. Okay.

*The committee recessed from 1640 to 1657.*

#### JOHN GRAY

**The Chair (Mr. Kevin Daniel Flynn):** We can call to order again, committee. We've been joined now, as you will all have noticed, by Dr. Gray from British Columbia. Dr. Gray is going to make a presentation somewhere in the neighbourhood of 30 to 40 minutes, and then after that, he's open to questions from the committee.

Having said that, welcome to Ontario. Thank you for joining us. The floor's all yours.

**Dr. John Gray:** Thank you, Mr. Chairman, and committee members. It's a privilege to have been asked by this important select committee to share information on how other provinces and territories in Canada have dealt with the issues which witnesses before this committee have identified in the Mental Health Act, the Health Care Consent Act the Personal Health Information Protection Act.

I come to this interesting task being the lead author on a recent book called Canadian Mental Health Law and Policy—here's my prop—working in Saskatchewan and British Columbia and having ties to Ontario. These include being an adjunct professor at the University of Western Ontario and authoring or co-authoring about 14 papers relevant to the sort of issues you're talking about.

The latest paper is called Treatment Delayed—Liberty Denied. The lead author is a law professor at UWO, Robert Solomon, and co-author, Dr. Richard O'Reilly. It's been recently published in the Canadian Bar Review.

As an aside, I might just mention that this latest study examined the plight of patients who because of Ontario law could not be treated. They could not, therefore, get well enough to be released. Examples in this paper are of people being detained without treatment for five, and two at 20 and one at 25—not months, but years; detained 25 years because they couldn't be treated. At \$600 a day in hospital, or \$219,000 a year of wasted money or \$4.38 million for 20 years, that's a lot of taxpayers' money not to treat people and to deny them their liberty.

This paper that we wrote in Ontario could not have been written in British Columbia or most other provinces in this country or most other countries because they would treat people in these circumstances and they would be discharged.

Through my involvement with the Canadian Mental Health Association and also the Schizophrenia Society in BC and in Canada—I'm a past president of the Schizophrenia Society of Canada—I've heard a lot from families and consumers about problems with mental health legislation. Before I get into the detail, though, let me cover off a number of, I think, quite important points.

The first one is about the voluntary nature of treatment whenever we can manage to have it voluntary; in other words, voluntary treatment is to be preferred. Voluntary consent from the individuals themselves is always the preference, and efforts must be made to work with individuals with mental illness to encourage their acceptance of treatment.

The system also should develop services and ways of approaching people to encourage voluntary acceptance of treatment, but unfortunately some people with brain illnesses, such as schizophrenia and bipolar disorder, are unable to understand that they are ill, and this leads them to refuse treatment. So no matter how sensitive and how comprehensive your services become, you will still need a Mental Health Act.

The second point: Mental illnesses that affect insight are most likely to result in involuntary services. Unfortunately, many people with psychotic illnesses do not possess the insight that they have a treatable illness. This is caused by brain dysfunction. For example, although anxiety disorders can be very painful and very debilitating and are about 10 times as common as schizophrenia, you almost never see anyone in a psychiatric hospital as an involuntary patient with anxiety disorders—almost never. That is because anxiety disorders do not affect insight. In contrast, people with schizophrenia and bipolar disorder, where about half do not believe they are ill, make up most of the people admitted involuntarily. This lack of insight should be very important in designing mental health and information-sharing systems.

The third point: Mental health legislation provides access to treatment. Your committee has heard a lot about how more services need to be in place so people can access treatment. I absolutely support these efforts. But the people I am talking about can't access treatment because their brain illness prevents them from knowing they need it, leading them to refuse voluntary treatment.

You could have a perfect service system and people without insight would not take you up on it. In an equitable system, citizens should not be denied access to treatment because they have an illness that deprives them of understanding that they do need treatment. The illness denies the access.

The fourth issue: Consequences of not receiving needed treatment can be really quite severe. You have heard many personal stories in these hearings of what happens to people with a serious mental illness who cannot be treated because of the law. These include continued suffering, family disruption, harm to self or others, homelessness, suicide, lengthy untreated hospitalization, criminalization and stigmatization. Stigmatization of individuals can occur because of their odd untreated behaviour, but sometimes one untreated individual, such as Mr. Vince Li of Greyhound bus beheading infamy, can wipe out the positive gains made by numerous public anti-stigma campaigns very quickly. Interestingly, Mr. Li, who's a computer engineer, was released from an Ontario hospital, but he refused follow-up care. He is now doing well in treatment in Manitoba, but at what a cost to many people and what a cost to those who are trying to reduce stigma on mental illness.

The fifth point: Involuntary admission with treatment works. You've heard many accounts of people getting well once they got on the right treatment. Research bears this out and shows that the medications work and work well whether you're a voluntary or an involuntary patient, despite what some critics have told you in this committee. These involuntary treatments get people out of hospital in an average time of three weeks, and sometimes it's considerably less. Community treatment orders, which you've also heard about, have been shown to reduce readmission, reduce criminalization and reduce homelessness. Involuntary treatment is, unfortunately, essential for some people, to start them on their road to recovery.

The sixth point: Thirteen Canadian mental health acts provide many options. In my book, we compare provisions from the 13 different mental health acts in Canada. We also look at other countries. There are options in these acts for addressing the problems with Ontario legislation that you have heard, and that's what we'll get to now.

In discussing the present Ontario acts, I should mention that in the year 2000, partially in response to the tragic killing of broadcaster Brian Smith by a person with untreated delusions, the Ontario government did make significant changes to the Mental Health Act. They introduced the deterioration admission criteria and community treatment orders. These were good changes, but more needs to be done to address the problems you have been alerted to.

Now, let's look at the problems. The first one is to do with the serious bodily harm committal criteria. The problem in Ontario is this: In order to be admitted involuntarily on a first episode, a seriously mentally ill person must be likely to be physically dangerous; that is, in the

words of the act, likely to cause "serious bodily harm." And it doesn't include psychological harm, as was mentioned by the previous speaker. This leads to many people with a psychosis who are not likely to cause serious bodily harm to themselves or others, but who suffer or cause other serious harms, not being admitted.

The consequent serious harms of not being readmitted or being admitted can include, of course, homelessness, jailing, family disruption etc.

Dangerousness criteria also enhance or increase stigma, because you're linking those two things together.

Other provinces have either abandoned bodily harm criteria or they didn't take it up in the first place. It was actually an American import which not everybody bought on to—fortunately, from my perspective.

#### 1710

Ontario introduced a new deterioration criteria in 2000, which does not require the person to be likely to cause bodily harm. However, the new deterioration criteria is not helpful for a person with their first admission because of several restrictive requirements. These include to have previously been successfully treated. Well, if you're on your first break, you can't have previously been successfully treated.

So families in this situation must wait and watch the person deteriorate until the person is likely to cause serious bodily harm to the person or another person or serious physical impairment. That is not easy to predict, and tragedies, including suicide and homicide and many lesser harms, have occurred waiting for the person to become dangerous enough to be hospitalized.

Some people in easily treatable manic states—and we're pretty good at treating mania—have lost their jobs, have lost their families and have run up huge bills because of their outrageous behaviour. Because they're not physically dangerous, they cannot be helped in Ontario, but they can be helped in other provinces, including British Columbia.

For young people, in particular, unnecessary suffering, prolongation of psychosis and worsening prognosis occurs because of this physical dangerousness criteria that you have. In appendix 2, you will see a study that provides evidence that "mental health laws that require dangerousness for involuntary admission may delay the initial treatment of schizophrenia." That is a very bad thing because delay worsens prognosis, plus it exposes the young person and others to risk while the person is psychotic.

There are at least 10 additional reasons why physical dangerousness, or bodily harm, criteria should be abandoned or have not been adopted, as is the case now in seven provinces. I'm just going to zip through these—there's quite a bit of detail in the handout you've got, but we do have a time constraint.

The first one is that it is not required by the charter, and I was involved in a case in BC where the court definitively said it is not. You don't have to be physically dangerous in order to qualify, according to the charter. There are Manitoba cases as well.

People are inappropriately excluded by the bodily harm criteria. I mentioned the non-dangerous people, early psychosis, people with mania. Some people, therefore, are inappropriately forced into jails and homelessness because of the harm criteria. People are inappropriately included by the physical harm criteria, because you're taking in dangerous people who are not necessarily treatable, like psychopaths. You've got them in hospital, and what can you do with them? Nothing, because you can't treat them, but because the law says you must take them, you have to take them.

Number five: the degrading overcrowding—that was true in the States and it's true here—in hospitals, when people started to think about this dangerousness criteria as a way of reducing the number in hospitals. That has changed, because our hospitals are now not the bins that they used to be.

Dangerousness is very difficult to predict, so it becomes an arbitrary criteria, because you might think that the person is dangerous and you might think that he isn't, because there's no real way of knowing.

People are stigmatized by the law that links dangerousness and mental illness. For these reasons, the bodily harm criterion is widely ignored.

In the US, a number of the states have changed their laws, and in many other democratic countries, like New Zealand, England, Wales, Scotland, Australia and the States etc., they either never adopted it or they have changed and broadened it.

So what's the solution to the problem that you've got? My suggestion is that you examine committal criteria concerning harm and deterioration now used in British Columbia, Alberta, Saskatchewan, Manitoba, Nova Scotia and Newfoundland and Labrador. This is what it is: that the person "is likely to cause serious harm to himself or herself or to another person, or to suffer substantial mental or physical deterioration if not detained in a facility."

The above provisions have allowed a majority of Canadian provinces to solve this problem that you have in Ontario, where a person for a first admission is not eligible unless they're physically dangerous. In other provinces "harm" is not confined to "bodily harm." In the BC court case that I was involved in, the judge said, "It can include harms that relate to the social, family, vocational or financial life of the patient."

The provisions adopted by other provinces would allow for the incorporation of the current Ontario physical dangerousness/harm criteria into a broader harm criterion and would simplify your deterioration criteria.

Another way to do it legislatively would be just to replace the word "bodily" with the word "harm." So instead of serious/not serious bodily harm, we would just have "serious harm."

There will be critics in Ontario of these proposals and the law in six other provinces who will say that these are not charter-proof and are overly broad. But the Attorneys General and the Legislatures of six provinces obviously don't agree with that, and a number of courts have also

found for broad committal criteria. Moreover, the deterioration criterion that Ontario has established does not require dangerousness, so it suggests that your AG doesn't believe that dangerousness is utterly critical either.

Critics of these sorts of laws will also rail about "street cleaning," that you're going to have masses more people committed. Well, the evidence in British Columbia and the other provinces that I cited is that that is not the case. There was a formal study done in the US where they did the same thing in eight states and found that it was not the case. What in fact happens is that it makes the law more responsive to the treatment access needs of people whose harmful illness precludes them from accepting treatment voluntarily.

The next problem is the refusal of treatment necessary for the involuntary patient's release. The problem is this: Treatment is necessary to help the involuntary patient get well enough to be released. I mean, it's sort of axiomatic, isn't it? However, in Ontario a capable involuntary patient may refuse treatment, and some incapable patients may have treatment refused for them.

Where an involuntary and incapable patient has a valid wish to refuse treatment, it must be respected by the substitute decision-maker. Treatment refusal leads to unnecessary loss of liberty, continued suffering, unnecessary health care costs and harm to others, such as assaults on nurses.

In a number of provinces in Canada, including BC, where the purpose of the act is to treat, authority to admit involuntarily carries with it authority to treat involuntarily. In other words, we say there's no point in involuntarily admitting people to a hospital if you can't treat them. Treatment cannot be refused for an involuntary patient and hence they get better; they get well. However, in Ontario, where the purpose is actually to detain, the treatment needed to release the person from detention can be refused. So a capable patient has an absolute right to refuse treatment forever and consequently to be detained for the same length of time.

Even the treatment of a patient who is incapable—and by that we mean incapable of making a treatment decision—can be refused. Liberating treatment can be refused either because the substitute decision-maker does not agree with the treating doctor and says, "No, you can't treat my son," or because the patient has a previously expressed capable wish, applicable to the circumstances, not to be treated: "Before I went into hospital, I said that I never want any of that psychiatric medication stuff, so don't give it to me"—and the mother, even though she knows you need it, can't.

This wish does not have to be documented, but the substitute decision-maker, usually a family member, must refuse the treatment, even though they are convinced that great harm will befall the patient if the treatment is not administered. And it does: Treatment refusal for an involuntary patient can cause great harms and is completely different from treatment refusal for a voluntary patient. If the voluntary patient refuses treatment, they leave the hospital. If the involuntary patient

refuses, they stay detained until there is a spontaneous recovery—in other words, they get well without treatment; some people do, but not many—they accept treatment and get well enough, or they die, whichever comes first.

The harms to involuntary patients and others where the means of liberation is refused are many and serious. They're well researched, and I've got them in my book there. They include things like denial of liberty—and that article by Dr. Solomon in your package is particularly helpful on this; continued suffering; increased use of restraints and seclusion; longer stays in hospital; poorer prognosis; negative effect on other patients; increased assaults on nurses; and compromising staff ethical standards. So health staff, in essence, become jailers because they can't treat anybody. They've just got to keep them locked up. And of course, there's family disruption and increased costs.

#### 1720

Let me give you a bit more detail on one of the cases that Professor Solomon's and my paper addresses. This is about a Mr. Sevels. He was suffering from schizophrenia. He had previously responded well to treatment but he had to spend over 404 days—work that out in years and months—in seclusion, in solitary confinement, to protect him and others because the substitute decision-maker, in accordance with the Health Care Consent Act and Mr. Sevels's wish not to be treated, couldn't treat him. They took this to the court. A judge was asked to order treatment, but because of the Court of Appeal decision, he couldn't do that. The judge expressed his constitutional concern applicable to the Health Care Consent Act when he wrote this:

“It surely cannot be the intended result of the application of the Charter of Rights and Freedoms that persons who are entrapped in the cage of their mental illness ... be for prolonged periods caged and warehoused in mental health facilities where the key to their necessary and involuntary seclusion is available with relatively little likelihood of ... risk.”

Mr. Sevels finally got out of seclusion—I'm not sure how. He stayed in hospital untreated for another five years. He then attacked a male nurse, seriously injured him and was then treated; exactly how that worked, I'm not sure either. But when he was treated, he improved to the point that in 2003, he was discharged on a community treatment order. As far as we know, he's doing well now. So for all those years, he was untreated and created all those problems for himself and other people. That wouldn't happen in BC.

What are the solutions? Nova Scotia and Manitoba have solved this problem. Both provinces—and it's quite different from BC, but I'll use theirs because theirs is the most similar to your legislation—still require the substitute decision-maker to follow the incapable involuntary patient's competent wish. However, if following the wish is likely to result in significant harm, the substitute decision-maker must make the decision in the patient's best interests. Best interests is a legal standard used in

many acts. It just basically means that the benefits of the treatment outweigh any harm, taking into account the person's values and ensuring that the treatment is the least restrictive and intrusive. It surely can hardly be in any person's best interests to be detained unnecessarily, sometimes for years, nor to be secluded or restrained nor possibly assault nurses or others as a result of untreated mental illness. I'm sorry, I should have given you that slide on that one.

This is for a person who's capable now. They came into the hospital as an involuntary patient, but they're capable of making a treatment decision, like Mr. Starson, whom some of you may know, and saying, “No, I don't want to be treated.” So they just stay there and go on and on. But a number of provinces have raised the level of capability for treatment refusals while others allow a review board or a tribunal to overrule a capable refusal. Nova Scotia and Saskatchewan have raised the level of capability to what they call “fully capable.”

Another solution is to allow a review board to overcome the capable refusal when it is likely to harm the person or others. Alberta and other provinces have done this. In New Brunswick, for example, they can overcome the refusal if “it is of the opinion that, without the treatment, the person would continue to be detained as an involuntary patient with no reasonable prospect of discharge.” A similar model could be adopted in Ontario but would have to take into account—there's a famous case called Fleming versus Reid which said that you can only do these sorts of things if you give the person a hearing. It seems to me that if you follow what they suggest, you could do what's being done in those other provinces.

This is another serious issue which is alluded to in that paper that you've got: unnecessary detention, because the treatment stops when a person goes to court. This is in Ontario. Because the Health Care Consent Act requires treatment to stop when an appeal is before the courts, some people lose liberty for long periods during detention, because during the detention, they cannot be treated. For example, Professor Starson was incarcerated because he could not be treated for over five years while the court process slowly wound its way up to the Supreme Court of Canada—five years.

A study that I was involved in showed that people waiting for their court appeal from the review board spent an average of 253 days—that's eight months—in detention because they could not be treated. If it hadn't gone to the court, they probably would have been there three weeks or maybe a month, but they stayed there eight months on average. This contrasts with about a month, had they been treated. All patients' appeals were dismissed. So even though they waited for all that length of time, the court says, “Well, no, we don't agree with you,” so they got treated anyway. How can such denial of liberty and treatment be considered justice?

There is in your act a way of issuing interim treatment orders, but they're very hard to come by, it would appear.

The solution in other provinces: In a number of provinces, this problem does not arise because appeals on

capability are not permitted. However, in Nova Scotia, which has provisions most similar to yours, they have solved the problem. This is the way they do it: “Where a matter is appealed to the Nova Scotia Court of Appeal pursuant to this section, the decision of the review board takes effect immediately unless the Court of Appeal grants a stay of any order made pursuant to this act...” In other words, authorized treatment continues unless the court says it cannot. It’s the other way around here. As soon as you say, “I’m going to appeal to the court,” it doesn’t matter how ill or well you’re doing; treatment has got to stop.

Let’s then turn to community treatment orders, which are, I think, a very important innovation—well, not exactly an innovation; they’re an innovation in Ontario, but they were originally introduced in Saskatchewan, and we have a similar scheme in BC. Community treatment orders—and I’m guessing that everybody knows roughly what I’m talking about—help many people stay in the community, out of hospital, and improve their quality of life. However, in Ontario, the previous hospitalization conditions limit the number of people who can benefit from this least restrictive measure.

CTOs are the least restrictive means of providing treatment for people who meet the involuntary admission criteria. However, in Ontario, in addition to meeting the in-patient criterion of bodily harm or deterioration, a person must have had, in the last three years, two admissions or 30 in-patient days in hospital. People who have had one admission, even though they meet the admission criteria—that’s the in-patient admission criteria—cannot be put on a CTO. They may therefore stay longer in hospital and are more likely to relapse as a result.

Admission must be in Ontario. Even Mr. Arenburg—whom some of you will remember, I’m sure—who, in essence, sparked the legislation that led to CTOs after he shot sportscaster Smith, could not be put on an Ontario CTO. This is because he had a number of psychiatric admissions before that awful incident, but they were outside the province so they didn’t count.

Early psychosis programs in Ontario, if they are like those in Australia, have a small but significant number who could be released early and followed better on a CTO if the previous hospitalization precondition wasn’t there.

The Ontario CTO is for people caught, in essence, in the revolving-door syndrome of doing well in hospital on treatment, being discharged, stopping treatment and being readmitted time after time. In Australia and New Zealand, CTOs are also used to prevent people from getting into the revolving door. In those countries, CTOs can be used instead of an in-patient admission.

Let’s look at the solutions in other provinces and countries.

British Columbia, Alberta and other countries have addressed the problem. Australia and New Zealand use CTOs to avoid hospitalization; they use it on discharge as well. In BC, we have a one-admission rule. Alberta has

an equivalency series. So, for example, instead of having to be in a hospital, if you were in an institution like a prison, that would count. They still have preconditions, but if you qualify on enough of those, then you can be put on a CTO after your first admission. Critics, however, are likely to say that dropping “previous hospitalization” would drag people off the streets, like it did when CTOs were introduced previously. The experience of BC is that CTOs assist people to stay in their treatment, so they are less likely to become street people.

#### 1730

Switching gears now from the Mental Health Act and the Health Care Consent Act to the information-sharing issues: Many authorities recommend including the family in case conferences and providing necessary information to them so they can assist their relative to get better, basically. Research on early intervention shows that family involvement is critical and, obviously, appropriate information must flow between the carers—the parent in this case, or the relatives—and the clinicians, and vice versa. However, according to your presenters, this does not seem to happen in some situations because of the Personal Health Information Protection Act.

But it’s interesting that the purpose of that act is not just to guard information; it is to protect the information “while facilitating the effective provision of health care.” From what I’ve read, it would appear that some people think it’s very good at protecting information but not so good at facilitating health care.

The three areas that families—and I’m using the word “families” broadly speaking; it could be relatives or friends—usually want to be involved in are the collection, use and disclosure of information. Obviously, PHIPA prefers consumers to provide the information directly, and that’s the way it should be. But oftentimes, with mental illness, the person is not in a position to provide timely or accurate information, so there is a provision that you have in your act that allows for indirect collection, but whether everybody knows about this, I’m not sure. Education may, in fact, be in order there.

There’s apparently a problem where families want to be able to pick up the phone and report confidentially to the case worker that their daughter, for example, is not doing well, without having to seek permission from their daughter, who, let’s say, is in a psychotic state. The mother wants assurances that the clinician will not tell the daughter who provided the information or what it is. This is because the family knows that if the daughter finds out that the mother provided the information, the daughter will be become very distraught, leave home unmedicated and get into all sorts of potential problems, become psychotic and have to be readmitted.

This confidentiality problem does appear to be at least partially met in the act under section 52 where it says that if giving access to the information “could reasonably be expected to ... lead to the identification of a person who provided information in the record to the custodian explicitly or implicitly in confidence if the custodian

considers it appropriate in the circumstances that the name of the person be kept confidential....” It talks about identity and it talks about the name; it seems to me, if you keep my name confidential, my son still might guess who gave the information, and it seems to me that’s not protected, although I don’t know the act well enough to be definitive.

Access by the patient to confidential or other information provided by a family can also be blocked if “granting the access could reasonably be expected to ... result in a risk of serious harm to the treatment or recovery of the individual or a risk of serious bodily harm to the individual or another person....” It seems to me that that is an issue that may not be known well enough, that if the information is likely to disturb the treatment planning, then it could be withheld. Certainly, people know about the one where physical danger might result from it.

It’s interesting, I just caught the last of the discussion by the information people, where it was said that bodily harm is interpreted under their act as psychological harm. They actually get that from the Supreme Court of Canada, out of the Criminal Code. But in BC it’s very explicit. In BC, it says that the information can be blocked, as it were, if it threatens “anyone else’s safety or mental or physical health.” So we’re on the same wavelength, but my comment would be, from knowing about mental health people, that they do not interpret bodily harm as including psychological harm. So you’d have to be very careful to make sure that if you’re going to use the same word to mean two things in two different acts, that people understand that. Personally, I agree with their suggestion that you change it to psychological harm or mental or physical, or something like that, but distinguish it from bodily.

On the use of information: In Ontario, if clinicians want to include families in their circle of care, it cannot be done because of the law, basically. The only way you could get that is if the person gave permission or they’re found incapable and then somebody else gives permission.

I want to deal with disclosure. Disclosure of information that families consider essential to providing care to their loved one or encouraging compliance with the care plan is a big issue that families have brought to this committee’s attention. Families want to be told by the clinician not just when there is a physical danger lurking around; the family member wants to know information essential to the treatment. They don’t want to know about the kid’s private life; they want to know things that are relevant to the treatment. That could include treatment issues, safety issues, signs of relapse, side effects to watch for, recovery plans to encourage, and so on.

Families also want information that is relevant even if the person is not physically living with them. Oftentimes, even though Bill is living in an apartment, mom is going down there every day or week to see how he’s doing, and she really is the caregiver.

In the PHIPA rules on disclosure to non-clinicians involved with care without consent, there are no provi-

sions except if there’s a physical danger. While some brave clinicians may provide families with information they think is necessary to enhancing the health care of the patient, these clinicians could also face a fine up to \$50,000. That encourages, I would think, a conservative attitude to information sharing. I think our fine is \$2,000 in BC. But I shouldn’t be flippant here; it shows how seriously you take privacy.

How does BC compare? The situation is really radically different in BC. Most of the time these things are pretty similar, but this is radically different. The act there recognizes that families must have information, without consent if necessary, to serve the needs of the client and to enhance their health care. The section reads thus:

“A public body may disclose personal information...:

“(a) for the purpose for which it was obtained or compiled or for a use consistent with that purpose.”

In your packages you’ll see I’ve given you an appendix out of the Mental Health Act guide. This is how it reads. This is our how our act is interpreted: “If a client’s personal information was collected for health care purposes, public bodies”—that’s your information custodian—“may release necessary information to third parties for ‘continuity of care’. This means public bodies may disclose personal information to health care professionals, family members, or to other persons, such as friends and relatives, involved in a client’s care for the purpose of that care”—unheard of, under your act. “The release of the information must be in the best interests of the health of the client,” and must be relevant and necessary and those sorts of things.

Adopting this BC approach would, I believe, address many of the complaints you’ve heard about families being asked to be responsible for care but not being provided with the information to do the job.

Another quick point about information sharing—and I don’t have this on a slide—is the interesting irony here of the public revelation of private information at review board public hearings. Despite the strong protection of privacy legislation in Ontario, if a person goes to a review board over a sensitive issue like the reasons for their committal or their capacity, that hearing is open to the public. In theory you could have a reporter there, you could have a mom there, you could have all sorts of people there. The chair has some discretion in keeping people out, but it’s seen to be a public forum. In all the other provinces it is not; it is seen as a private forum. In other words, the review board hearings in BC and Manitoba etc. are in private. Certainly, the chair can invite other people in, but the public does not have a right of access.

#### 1740

Education and standardization: I just want to mention one of the tools that we found for helping educate people about these issues, and these are complicated issues. It’s very important to have sufficiently detailed but straightforward, ministry-blessed documents that people can relate to. Ours is called the Guide to the Mental Health

Act. Every ward has this. It's somewhat similar to yours, although yours is more complicated because you've got more acts to worry about. I think the big difference is that we have appendices in here specifically written for particular audiences. For example, we have one called, "Assistance from relatives and others in obtaining treatment." So if you're a mom or a dad, what are the sorts of things that you would look for in order to be able to convince the doctor or a judge that this person needs involuntary help? It's got one for police, physicians, and so on. I think it's fairly similar to yours, but it has those sort of personalized appendices. I think that could well be helpful.

Another idea that you might consider to help in education and standardization and also to assist consumers and families to get access to treatment when barriers such as implementation of legislation or insensitive practice prevents it is to have to have a treatment advocate. This is somebody who can help gain access to the system, basically, whether it's by overcoming legislative problems or access problems.

That's my last slide. I do have a few comments on implementation of change. If you recommend any changes, you'll find that people will oppose you, even if you say, "We just want to study them." My comment would be that all the changes that I've outlined to you, one of the concerns will be that they're not constitutional, that they would offend the charter. Each one of these ones that I've talked about has been passed by a Legislature, obviously passed by the AG of the particular government, and many of them have been approved by the courts as well.

I think what to do is what you're doing, which is, look at the problems; look at the options, including the ones that I've outlined and others; and look at what's happening in other countries. Look at the charter, because everything you do must be seen within the charter, and call it like it is. Thank you.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Dr. Gray, for a great presentation. It was very thorough. We've got about 20 minutes left for questions. There may be a vote in there somewhere, so let's move quickly to questions, starting with Christine.

**Mrs. Christine Elliott:** Thank you very much. This is enormously helpful. I think I speak for all members of the committee: You've really addressed some of the very specific issues that we've been grappling with.

I'm just wondering, Dr. Gray, if you could just comment on the first admission. If we were to recommend changes to the Mental Health Act to allow for broader criteria for people to be admitted, would you recommend any changes in the form 1 as it presently exists, the 72 hours for that determination to be made? Where would we go then? Okay, the person's in hospital. What happens after that?

**Dr. John Gray:** You're talking about how long the certificate keeps the person in hospital for their observation period?

**Mrs. Christine Elliott:** Yes.

**Dr. John Gray:** It varies across the country, from 24 hours in Saskatchewan—we have 48 hours in BC. We

used to have a week, and then we brought it down. You have the 72 hours. I read somewhere that somebody wanted a week or whatever. I think that if you stretch it out too long, in essence, you're keeping a person in hospital against their will. It seems to me that the system should be responsive. Every day you keep somebody in hospital against their will is, in essence, a bad thing—a potentially good thing. But you need enough time for observations to be made. I think 24 hours is too short, but I think 48 to 72, something like that, is not unreasonable.

**Mrs. Christine Elliott:** During that time period, should a capacity determination be made as to whether the person has the mental capability to make those decisions or not? I notice you were talking about the substitute decision-maker presuming that the person has been found incapable in the first place. In Ontario, there doesn't seem to be that mechanism in the initial 72-hour period.

**Dr. John Gray:** To be honest, we don't use a capability assessment. In fact, in that first 48 hours that we have the person, we can treat that person. We don't have to sit around for three days waiting for him to get worse; we treat him.

I'm not sure exactly when your capability decision is made. I would imagine it's when the doctor says, "Look, I want to treat somebody with something," right? Whenever he or she gets around to that, then that raises the issue of whether the person is capable or not capable of making that decision. So it could be longer than three days. But I would suggest you do it as soon as you can. Every day counts.

**Mrs. Christine Elliott:** That seems to be the problem that we're hearing from families: The person may be able to come in and be initially "formed," as they say, and then the 72-hour period runs out and maybe they don't meet those criteria anymore, so then they're just discharged onto the street with no follow-up, no family contact, no nothing. Family members say that they don't know what they're doing. If they don't meet those initial criteria anymore, then there's nothing else that can be done. The question is whether there should be a capacity assessment at that point. If the person is deemed to be incapable, then that's when the substitute decision-maker can come in and start making decisions. But we don't seem to have that mechanism built in.

**Dr. John Gray:** But the decisions would only be, wouldn't they, on whether to treat or not, not whether to keep the person in? So if the person came in today and the doctor saw them, let's say, in 72 hours or whenever and said, "I don't think you meet the criteria," you're gone. And you couldn't even put the person on a CTO, because the person has to meet the in-patient criteria to be on a CTO.

**Mrs. Christine Elliott:** And then we end up with multiple hospitalizations again—

**Dr. John Gray:** That's right.

**Mrs. Christine Elliott:** —because then they keep coming back in. Is there anything you could suggest that we could think about that would allow us to deal with that particular issue?

**Dr. John Gray:** The major one is to have broader committal criteria. If you have a physical dangerousness committal criterion, people—often you'll bring somebody in and they're physically dangerous now, right? You treat them and in two days they're not, so you've got to let them go. But if you have a broader harm criterion, or a deterioration criterion that doesn't require a previous admission, you can say, "Look, if you're not treated, you're going to deteriorate, and I'm pretty sure you're going to be back here in a couple or three weeks. Therefore, I can keep you."

You see, the problem really is your committal criteria; they're too narrow. If the person comes in on broader committal criteria, you can keep them longer. But as soon as they're not dangerous, you have to let them go.

**Mrs. Christine Elliott:** Thank you.

**The Chair (Mr. Kevin Daniel Flynn):** Okay. Without causing any offence, we have to go vote again. As I said, don't take it personally; it has nothing to do with what you've said. It has everything to do with us needing to vote. But if you'd excuse us for five or six minutes—

**Dr. John Gray:** Of course. I'm here all day tomorrow, if you want to stay.

**The Chair (Mr. Kevin Daniel Flynn):** Okay. I'm sure we'll think up some other questions on the way too.

**Dr. John Gray:** Good. Okay.

**The Chair (Mr. Kevin Daniel Flynn):** We're recessed for five minutes.

*The committee recessed from 1744 to 1755.*

**The Chair (Mr. Kevin Daniel Flynn):** Okay, if we can call it back to order.

Dr. Gray just finished answering some questions from Ms. Elliott. Are there any questions from this side? Helena.

**Ms. Helena Jaczek:** Thank you very much. In Ontario, we have a sort of two-step process. We have admission to the hospital and then we have the question of agreement to be treated. You state, in your brief to us, "In a number of provinces in Canada, where the purpose of the act is to treat, authority to admit involuntarily carries with it the authority to treat involuntarily." What would it take for us to get there?

**Dr. John Gray:** A major revolution.

**Ms. Helena Jaczek:** Yes. I was worried about that.

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**Dr. John Gray:** The provinces I was referring to are, specifically, Saskatchewan, where the person comes in, they meet the criteria and the physician authorizes the treatment—their treating physician. In Newfoundland and Labrador, it's the same thing. In British Columbia, the treating physician recommends to the director of the unit the treatment, and the director—this is where the person hasn't agreed to it themselves—authorizes the treatment.

The logic is that admission in those provinces is for the purpose of treatment; it's not just for containing dangerous behaviour. If it's for containing dangerous behaviour, that's what jails are for, and you should put people through the criminal justice system. The reason you have people in hospitals is because they're sick and

they need treatment. The Saskatchewan law commission had a beautiful comment that says that if there is no jurisdiction to treat the person in hospital, there's no jurisdiction to hold them there.

There are a number of provinces that do roughly what you do as well: They separate out admission from treatment. Australia doesn't, New Zealand doesn't and various other places as well.

How would you change it? I think you just have to argue that it is wrong to admit people just for the purpose of containing behaviour and not for the purpose of treatment. And if, like our court said, the purpose—it's clear in the BC act that the purpose is to treat people, and if you can't do it, then don't admit them.

**Ms. Helena Jaczek:** Let me just follow up. When we had the Ministry of Health legal counsel here, talking about PHIPA and consent to treatment—actually, when she was talking about consent to treatment, she made the analogy that if someone is admitted unconscious, there is an assumption that they would consent if they were conscious. And it strikes me, as I've listened to so many of the stories we've heard over the last nine months, that, essentially, someone in a psychotic state is almost like that unconscious person. I mean, they literally—they may be sitting up and walking around, but they are not consciously able to give consent. I suppose—the legal counsel immediately admitted that it was sort of obvious that they would assume if they were conscious. Well, I seem to see a very parallel situation here when someone is in an acute psychotic state. Is there any way to make that parallel?

**Dr. John Gray:** Let me make one point just before that. We are talking here about consent to treatment, and people would say, "Well, if you went to the doctor, you would have to give consent to the doctor to treat you." They analogize that to the involuntary in-patient. But in fact, you also have to give permission to be admitted. If somebody just admits you—you know, grabs you and takes you into Toronto General Hospital—that's false imprisonment and all those things. So there are two issues.

But under a mental health act, you're admitted without your consent, right? That's the reason you have a mental health act, otherwise you wouldn't need a mental health act. You're admitted without your consent. So the argument that I make is that, in the same way, you must be treated without consent in order to get you out of hospital. There's no other way of getting you out.

How do you make it parallel with the unconscious? You see, the trouble with that analogy, I think, is that if the unconscious person had in their wallet an advance directive that said, "Please do not revive me," you'd be bound by that under your laws—under everybody's laws, actually. So I'm not quite sure how you analogize those.

**The Chair (Mr. Kevin Daniel Flynn):** Okay, first Jeff, then Howard, then Liz. Jeff?

**Mr. Jeff Leal:** Dr. Gray, thank you for a most insightful presentation this afternoon. I have a quick question and then an observation. How long have the changes been employed in British Columbia, and what

was the catalyst to make these, what I would say, very significant changes?

**Dr. John Gray:** The last set of significant changes were made in 1999, but they weren't that significant, really, because we always had a broad, broad committal criteria. It was called protection against harms, which is pretty broad. We brought in the deterioration and changed the words a bit. We also strengthened the rights aspect of CTOs, or our equivalent thereof. That was 1990. The changes came from a lot of pressure from coroners, from the schizophrenia society; opposition came from legal rights people, a little bit from CMHA, but not a huge amount.

**Mr. Jeff Leal:** Over the last nine months, people have shown incredible courage to come before this committee to share very personal stories. I think one of the common themes there is that the families become isolated and then estranged from many of their loved ones who have mental illness. It seems to me that some of the suggestions that you've brought forward today would break down both the isolation and the estrangement that people find when their families and their loved ones—if you could comment on that.

**Dr. John Gray:** I think that's true. It's interesting, for example, that our BC act encourages more, I think, interaction between clinicians, clients and family members, which is a helpful thing that way. The families don't get into the situation where they have to agree with or disagree with the doctor on treatment because the family is not involved; it's done by the hospital.

Another interesting issue that people have talked to me about here is involving the courts. When you can't get the doctor to see the person, then you have to go to the courts. Somebody was just telling me about how their daughter got dragged in with handcuffs, and that sort of thing. For whatever reason, in BC, I know of about three cases in all the years I've been there where the courts have been involved. Whether our doctors are good out there or whether our teams are, I'm not quite sure which. But if you don't have those sorts of things, they can be very alienating.

I think getting people better quicker will also help, because it's oftentimes that there's a good family situation, and then the son or the daughter becomes ill, they hate mom, and mom gets blamed in part for the delusions. And when they get treated they come back and think, "Good Lord." So I think that the emphasis on treatment can be helpful on that.

**Mr. Jeff Leal:** Thank you very much, sir.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Jeff. Howard?

**Mr. Howard Hampton:** I've got a couple of general questions. You alluded to one of them earlier when you said that British Columbia—I believe you said 1999 was when some of the amendments were made to the mental health legislation. What about Saskatchewan and Manitoba? Do you know?

**Dr. John Gray:** Saskatchewan was before that. I don't know the exact dates—it would probably be in the 1980s or early 1990s. What they did is, they were the

first province to bring in community treatment orders. They're actually more restrictive than yours. They also brought in the deterioration criteria that we talked about. They were the first to do that. Those were the major issues.

**Mr. Howard Hampton:** How about Manitoba?

**Dr. John Gray:** Manitoba was a bit after that, I think. Some of these issues have been driven by—somebody asked before about the motivation of why these things got going. Sometimes it's been because of regular pressure—I should have mentioned that coroners and police were very much in favour of ours—and sometimes there's been a tragedy, like the Brian Smith situation here.

In Alberta, they have just changed their laws. They had very close dangerousness laws just like yours—in fact, more tight than yours—and they have just brought in what basically everybody else has got. They did that because a guy who had been in hospital—they knew he was dangerous, but under their criteria, which was so tight, they had to let him out and he shot a Mountie. That was not received well, and that sparked a whole review of their mental health act. Now they have CTOs as well.

**Mr. Howard Hampton:** This is mainly a historical question. There's always been a contest here: the legal rights of the patient versus the likelihood of beneficial treatment. In reading your paper, you essentially say, I believe, that Ontario has followed the US model.

**Dr. John Gray:** Yes.

**Mr. Howard Hampton:** How do you account for this? Ontario going in one direction, most other Canadian provinces ending up somewhere else?

**Dr. John Gray:** I don't really know. I know that Alberta was, as I said, just until this last year, very similar to Ontario. My guess is that there's more of a north-south dialogue of ideas, whereas in BC there wasn't. There are a lot of lawyers who are very strong civil rights folks, and that whole civil rights movement in the States was attuned to them. So when you talked about changes in your act up here, it was those ideas that became dominant. But I don't have the specific details.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Dr. Gray. The final question for the afternoon goes to Liz.

**Mrs. Liz Sandals:** You began talking to us about mental illnesses that affect insight, where there isn't sufficient insight to understand that you require treatment, which I found a really interesting comment. From a legal perspective, do we need to deal with that, or do we simply need to deal with sorting out the definition of harm so that we're simply dealing generally with serious harm and deterioration—and if we take care of that from a legal perspective, the lack of insight will take care of itself?

**Dr. John Gray:** I would say that the latter is appropriate. In other words, the reason the person is there is because they wouldn't voluntarily come. There are very few people who come to hospital who agree that they're as ill as you think they are. Almost everybody who gets into an involuntary situation has an insight problem—

even though not everybody with schizophrenia, for example, has an insight problem. Those people with schizophrenia could be quite serious but don't have an insight problem. They'll say, "Yes, there's something funny going on here. I'll take those pills that you want me to take," and they'll get better.

Just to get back to your question, I don't think you're going to change the way you do approval of treatment. It's in the Health Care Consent Act; it's everywhere, so I think it would be a huge job to change it. Still, if there were a few changes made—changing the fact that you can't, when you're apparently competent, say, "Look, I don't want any of that medication," and then your mom having to go along with it and seeing you in hospital for longer periods of time. Use it, but have the override they've got in Nova Scotia and Manitoba. If somebody does go to the review board, the hearings have to be done within seven days. That's a bit long to keep somebody in hospital, but it's not completely unreasonable. The business of when treatment must stop while the court gets itself sorted out, which might be months or years, is unreasonable.

So I think that there are a few—they're not to my mind—

**Mrs. Liz Sandals:** If we take care of the other stuff, that issue will be taken care of by—we don't need to get into medical definitions?

**Dr. John Gray:** No. The definition of a mental disorder in your act is very broad. It just says, "any disease or disorder of the mind." Most of the rest of us have fairly detailed ones at the moment. I don't think it matters that much, because you've got other things that reduce the likelihood of the person being admitted.

**Mrs. Liz Sandals:** Thank you very much. This has been very, very helpful.

**The Chair (Mr. Kevin Daniel Flynn):** Dr. Gray, on behalf of the committee, thank you very much for coming all the way from BC. I think your report was just what the committee was looking for, and it was very clear.

Just for the members of the committee, the next meetings of this committee will be in 2010: February 1 and February 8 for report writing, so they will both be in closed session.

We're adjourned. Thank you.

*The committee adjourned at 1810.*





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