OPA MENTAL HEALTH LAW REFORM WORKING GROUP
Summary Report

Introduction:

In 2019, the OPA supported the formation of a working group to discuss and identify areas of reform in Ontario's mental health laws. Improvements in delivering mental health services and patients' access to timely and effective treatment were the overarching aims. Psychiatrists are in prime positions to lead and contribute to this important area, drawing from their professional experiences, expertise in patient care and interactions with families across various clinical settings.

The scope of this working group was to create an operational list of reforms that warrant further advocacy and are realistically attainable.

From July 2020 to December 2020, the working group met regularly and built consensus identifying five mental health law issues that warrant further advocacy.

Working Group Membership:

The Mental Health Law Reform Working Group's membership included the various stakeholder members listed below:

Dr. Karen Shin – Psychiatrist member and working group lead
Dr. Angela Ho – Psychiatrist member and OPA President Elect
Dr. David Cochrane – Psychiatrist member
Dr. Elizabeth Esmond – Psychiatrist member
Dr. David Gifuni – Psychiatry resident member
Ms. Kendra Naidoo – Lawyer member
Dr. Richard O'Reilly – Psychiatrist member
Dr. Lyndal Petit – Psychiatrist member
Ms. Mary Sarin – Family Advisor member
Dr. Kuppuswami Shivakumar – Psychiatrist member
Mr. Gordon Singer – Patient Advisor member
Mr. Lawrence Tsui – Family Advisor member

Working Group Outcomes

The working group highlighted five issues to recommend to the OPA executive for ongoing advocacy:

1. Form 1 and Form 3 Changes and Access to Early Treatment
2. Lengthen the First Involuntary Hospitalization Period
3. Treatment Pending Appeal
4. A More Humanistic Consent Capacity Board (CCB) Process
5. Changes to Community Financial Capacity Assessments

Each item is discussed in greater detail below.

Form 1 and Form 3 Changes and Access to Early Treatment

Our working group identified barriers to timely psychiatric care for patients created by the criteria and wording of Ontario's Form 1 and Form 3. The group focused on recommending the fewest number of modifications possible yet proposing key changes that would impact care and treatment for the most vulnerable and acute patients who require hospital-based psychiatric attention.

After careful review, the group identified that changes to the Box B criteria would be most appropriate and meaningful. The changes can remain narrow but potentially have the most impact. In Box B criteria, there are requirements for patients to have "shown clinical improvement as a result of the treatment" and that they are "apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one." These two criteria limit the ability for patients presenting with a first-onset illness being adequately treated in a psychiatric facility, even if they are at likely risk for substantial mental or physical deterioration or serious physical impairment.

As more literature highlights the importance of early treatment for better illness prognosis, this limitation in Ontario's mental health laws lags behind the science and best practices for mental health care. By eliminating these two criteria, the threshold of requiring involuntary hospitalization is still based on significant risk, but the opportunity to extend hospitalization and potentially offer treatment to more patients is available.

Other wording changes for the Form 1 and Form 3 include making explicit how the intended use of these forms is for patients requiring specialized treatment in psychiatric facilities for mental disorders. This is to highlight the limitation of these forms and to prevent them from being overly broad in their powers of detention.

From the group's discussions, there were other issues pertaining to the mental health forms that elicited interest for further review. Briefly, in some jurisdictions (Newfoundland and Labrador, Saskatchewan and Nova Scotia) a non-medical psychiatric staff-person has authority to detain patients in hospital from 3 to 24 hours depending on the province until the patient

can have a psychiatric assessment by a physician. These legislative changes in Ontario would enable non-medical psychiatric staff members to manage the acute safety situations when detention or restraint use becomes necessary during their care for a voluntary patient and a physician is not available.

While the exact wording of the Form 1 and Form 3 can undergo additional refinement, the overriding idea of eliminating the requirement of previous response to treatment as a criteria for involuntary hospitalization under Box B criteria is one that the working group would recommend for further advocacy.

Lengthen the First Involuntary Hospitalization Period

Another issue identified by the working group to target was the elimination of the two-week Form 3 hospitalization period and extend it to 30 days. Ontario is an outlier for having two weeks as its first involuntary hospitalization period. Apart from Nunavut and Ontario, all other provinces and territories have an initial 21-day or 30-day involuntary admission. In fact, the Northwest Territories, after reviewing their mental health legislation in order to update its practice and utility, extended their initial 14-day involuntary admission period to 30 days.

There are many reasons why the function of the two-week period for the Form 3 is questionable. There has been a steady increase in hearings for the Consent Capacity Board (CCB). For the 2018/2019 fiscal year, applications for hearings were over 8000 and nearly 5000 hearings were convened. Upheld Form 3s can almost immediately be followed by another Review Board for a Form 4. Often treatment improvement is not seen by the time the first Form 4 Review Board convenes. Repeatedly certifying patients negatively impacts the doctor-patient relationship and interactions can be predominated by this adversarial layer.

In 2018/2019 the Board received a total of 3673 involuntary status applications (Form 16 & Form 17). Approximately 33% of these applications resulted in a decision of the Board (the remainder were resolved in other fashions such as dismissal, withdrawal, issuance of a F5 etc). Of those that resulted in a decision, approximately 83% were confirmed. Similarly, in 2019/20 the Board received 3719 involuntary status applications, 32% of which resulted in a decision. 82% of those were confirmed. Unfortunately, the working group did not have data of the breakdown between Form 3 and Form 4 hearings, but overall, the majority of hearings upheld involuntary status applications.

A proposal to extend the custody of patients on a Form 3 to 30 days would be a change that would still provide patients with timely hearings after the determination for an involuntary hospitalization is made, be in keeping with clinical treatment timelines, ease resource requirements of the CCB and lessen the negative impact to the doctor-patient relationship inherent in the adversarial process. This extension would not be ignoring the norms for patient rights, as most involuntarily hospitalized patients across Canada are already under psychiatric care using this framework. In fact, this change would only bring Ontario to be more in-line with

other provinces and territories. There would be no proposed changes to the right for patients to challenge their involuntary admissions and for a tribunal to convene and review the facts in a timely manner.

Treatment Pending Appeal

When patients appeal a Review Board's decision to uphold a finding of incapacity, physicians cannot start treatment for a patient even if there is informed consent provided by the Substitute Decision Maker (SDM). Appeals are heard at the level of the Ontario Superior Court and this process take months and sometimes up to a year to be decided. During this time, patients can be detained in hospital and proposed treatment cannot begin. This neglects the patient's rights to freedom, treatment, wellness and health. Furthermore, patients must endure more suffering from their symptoms and potentially a more treatment-refractory and devastating course of illness can emerge because of the deleterious effects of untreated psychiatric symptoms. When untreated patients have symptoms contributing to aggression and agitation, other co-patients and staff are in a position of risk and the untreated patient can incur significant consequences if he or she causes harm to another.

The OPA has already supported the idea of advocating for treatment pending appeal. The automatic right to appeal exceeds the standards compared to other provinces and others allow for treatment pending appeal, such as British Columbia, Alberta, Newfoundland and Labrador, Nova Scotia, New Brunswick, Prince Edward Island and Saskatchewan.

The working group re-affirmed the desire to advocate for change allowing for treatment pending appeal, which would again bring Ontario closer in-line with other Provinces.

A More Humanistic Consent Capacity Board (CCB) Process

There was consensus in the working group that the CCB hearing experience has diminished the humanistic, care and recovery aspect when determining if a patient requires ongoing hospitalization. The use of a legal tribunal setting, mirroring a criminal justice model, creates an adversarial environment. However, identifying structural changes to the CCB process through legislation was a task too labyrinthine for the working group to reach a meaningful consensus. The CCB process is one that is established upon legal principles and precedents and unlikely to be abolished or profoundly altered.

Instead, the group decided to recommend and start working on improving communication between mental health stakeholders (eg. patients, advocate groups, psychiatrists) and the agencies involved in the CCB process, including the CCB itself, the Public Guardian and Trustee (PGT) and Psychiatric Patient Advocate Office (PPAO).

Some of our working group members have agreed to participate in an additional working group with the CCB to continue discussion about making the CCB more humanistic and patient-centered. The working group agreed to provide feedback to the CCB that the increasingly legalistic nature of hearings could ultimately be detrimental to the doctor-patient relationship and does not properly weigh the patient's right to health and how an involuntary hospitalization is for the purposes of medical treatment and stems from the ethical principal of beneficence. With the PPAO and PGT, we agreed to inquire whether these agencies had policies to ensure services on weekends and holidays to avoid unnecessary delays for hospitalized patients.

The OPA can take a more dedicated and prominent role advocating to the CCB, PPAO and PGT on issues that negatively impact patients and their experiences related to CCB hearings. A parallel effort can be initiated by the OPA to better communicate information obtained from these agencies to psychiatrists in Ontario and provide more continuing medical education leadership in this area.

Changes to Community Financial Capacity Assessments

The working group's discussions identified a gap in the mental health laws that create barriers for patients trying to obtain financial capacity assessments in the community. While there is a requirement that hospitalized psychiatric patients receive a financial capacity assessment, patients who do not require hospitalization, but are at financial risk because of the impact of their mental health symptoms, face barriers from obtaining an assessment. Presently, there is a cost for an outpatient assessment completed in the community, which can be prohibitive for patients and families.

The working group was unable to fully explore this topic to provide a consensus recommendation but would still like to draw attention to this issue as one warranting further exploration to clarify specific targets for change.

Next Steps:

While this Mental Health Law Reform Working Group draws to a close, the energy and interest expressed by psychiatrists and other stakeholders was notable. A final recommendation is for the OPA to continue this work and build on the generated momentum. The OPA can work with stakeholders to prioritize the items for reform and generate methods to begin advocating these ideas directly to the Ministry of Health in Ontario and start communicating and reaching out to stakeholders across the community.