

CHAPTER FOURTEEN: MENTAL HEALTH LAW

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CHAPTER FOURTEEN: MENTAL HEALTH LAW

I. INTRODUCTION

This chapter provides a very general overview of the rights of persons with mental illnesses, either as patients inside a mental health facility or as persons outside such a facility. The discussion of mental health law is intended to provide the reader with a general framework to use for their own information or as a basis for further research. An excellent resource for further information or referrals is the Community Legal Assistance Society (CLAS). CLAS runs a mental health law program that represents individuals at hearings before the BC Criminal Code Review Board, under Part XX.1 of the Mental Disorder provisions of the *Criminal Code of Canada* and the BC Mental Health Review Board under the *Mental Health Act*, RSBC 1996, c 288 [MHA]. CLAS also provides legal information and identifies potential test cases. See **Chapter 23: Referrals** for CLAS' contact information.

This chapter deals with the legal issues that may arise due to a person's mental disorder. By 'mental disorder', we are referring to the range of illnesses and disorders dealt with by psychiatry. It is important to keep in mind that mental illness is not the same as mental incapacity. For legal matters concerning capacity, such as the capacity to enter into a contract, make a will, or create a representation agreement, please consult **Chapter 15: Guardianship**.

For the purposes of this Chapter, the most important statute is the MHA. Other legislation that may be relevant is listed in Part II of this chapter; "Governing Legislation and Resources". If you have an issue with respect to a person who has come into conflict with the law and shows signs of psychiatric disturbance, you may also need to review the *Forensic Psychiatry Act*, RSBC 1996, c 156 [FPA]. This act governs the forensic psychiatry services, which assist with court ordered psychiatric assessments, including fitness to stand trial or "Not Criminally Responsible" designations.

A. *Mental Health, Capacity, and the Law: An Overview*

There are three distinct areas of concern in the intersection between the law, mental health, and capacity: persons who suffer or have suffered from psychiatric disorders, persons who have developmental disabilities, and persons who have diminished capacity. These issues are separated into three subcategories below to direct you to the pertinent chapter – some are covered in this chapter, while others are covered in **Chapter 15: Guardianship**. However, it is important to keep in mind that a client may experience several mental health challenges that overlap and blur the strict lines between the categories. For example, a person may have diminished cognitive capacity due to Alzheimer's, in addition to an underlying schizophrenia disorder they manage with medication.

1. *Psychiatric Disorders*

The first group encompasses those who may not have a developmental disability or diminished capacity, but who suffer from a psychiatric disorder. These can range from mild delusions, to mood disorders, to pervasive and severe psychosis. These people are the ones most likely to fall under the provisions of the MHA. The legal issues faced by this group are the main focus of **Chapter 14: Mental Health Law**. Therefore, in this chapter it is important to note that the term "mental disorder" refers to psychiatric illness and not to those with developmental delays or diminished capacity.

2. *Developmental Disabilities*

This second category refers to people who are developmentally delayed or "intellectually impaired" due to genetic factors, birth trauma, or injury early in life, and who may or may not be able to live independently within the community. Many of these people function at the level of a minor and therefore may not have legal capacity to make legal decisions or treatment decisions. Their family members should be encouraged to use the planning tools

found in **Chapter 15: Guardianship** to make provisions for the care of this person. To plan for their financial well-being, their family members may wish to consult the **Chapter 15** section “Overview of Incapacity – Section D. Wills and Estates.” However, developmental delays are not covered in-depth in the LSLAP Manual. The Ministry of Children and Family Development website (http://www.mcf.gov.bc.ca/spec_needs/) provides basic background information in this area and offers a starting point for further research.

3. Cognitive Incapacity

The third area of concern includes those people who, due to disease or trauma, become mentally incapable. It is important to note that the threshold for capacity may differ depending on the legal matter at stake – for example, there may be a different level of capacity needed for the decision to appoint a Representative in a Representation Agreement as opposed to the decision to draft a will. Family members and caregivers for this group would most likely be served by the information in **Chapter 15: Guardianship**.

II. GOVERNING LEGISLATION AND RESOURCES

A. Legislation

Adult Guardianship Act, RSBC 1996, c 6 [AGA].

Adult Guardianship and Planning Statutes Amendment Act, S.B.C 2007, c 34 [AGPSAA].

Criminal Code, R.S 1985, c. C-46 (Part XX.1, Mental Disorder provisions) [CC]

Forensic Psychiatry Act, RSBC 1996 c 156 [FPA].

Health Care (Consent) and Care Facility (Admission) Act, RSBC 1996, c 181 [HCCFA].

Mental Health Act, RSBC 1996, c 288 [MHA].

Mental Health Amendment Act, S.B.C 1968, c 27 [MHAA].

Mental Health Regulations, B.C Reg. 233/99; O.C. 869/99; B.C. Reg. 96/2018, May 15, 2018

Patients Property Act, RSBC 1996, c 349 [PPA].

Power of Attorney Act, RSBC 1996, c 370 [PAA].

Public Guardian and Trustee Act, RSBC 1996, c 38 [PGTA].

Representation Agreement Act, RSBC 1996 c 405 [RAA]

B. Resources

1. Counselling Services

Counselling is an invaluable resource for those experiencing distress resulting from legal issues. Some counsellors may also provide integrated case management for people that are suffering from more severe disorders and who require greater support.

Broadway Youth Resource Centre (BYRC)
2455 Fraser Street

Vancouver, BC V5T 0E6
Telephone: (604) 709-5720
Website: www.pcrs.ca

Fax: (604) 709-5721

- Offers counselling and support services in areas of youth and family, anger management, addiction, sexual orientation and/or gender identity issues.

Peace Portal Counselling Centre

c/o Peace Portal Alliance Church
15128 27B Avenue
Surrey, BC V4P 1P2
Email: counselling@peaceportalalliance.com
Website: www.peaceportalalliance.com

Telephone: (604) 542-2501
Fax: (604) 542-2501

- Provides professional counselling services, including the services of a clinical psychologist. Office is wheelchair accessible to serve clients from Abbotsford, Delta, Langley, Surrey, and White Rock. Evening appointments are available two days per week.

New Westminster UBC Counselling Centre

University of British Columbia
821 8th Street
New Westminster, BC V3M 3S9

Telephone: (604) 525-6651
Fax: (604) 517-6102

- Provides personal and career counselling from counsellors in training. Appointments are available days and evenings from September to June. Priority is given to New Westminster residents, but all lower mainland residents are welcome. There is no charge for their services.

Oak Counselling Services Society

949 West 49th Avenue
Vancouver, BC V5Z 2T1
E-mail: info@oakcounselling.org
Website:

Voicemail: (604)-266-5611
Fax: (604) 261-7205

www.oakcounselling.org/

- Offers professionally-supervised counselling for issues such as grief, relationships, and life transitions. Fees are based on a sliding scale, ranging upwards from \$10 per session.

2. *Advocacy Resources*

Access Pro Bono (Greater Vancouver and Victoria)

300 – 845 Cambie St
Vancouver, BC V6B 2P4
Website: www.accessprobono.ca/

Toll-free: 1-877-762-6664

- Provides advice on rights pertaining to mental health law upon appointment.
- May be available for *habeas corpus* applications, section 33 applications under the MHA, as well as applications for judicial review of Mental Health Review Board hearing decisions.

Peer Navigator Program (Canadian Mental Health Association)

110 – 2425 Quebec St
Vancouver, BC V5T 4L6
Email: peer.navigator@cmha.bc.ca
Website: www.vancouver-fraser.cmha.bc.ca/

Telephone: (604) 872-3148

- Provides peer-based support on a wide breadth of issues surrounding mental health, housing, income assistance, legal aid and community connections.

Disability Alliance BC (formerly BC Coalition of People with Disabilities)

Website: www.bccpd.bc.ca

Telephone: (604) 875-0188

TTY: (604) 875-8835

Toll-free: 1-800-663-1278

- A self-help umbrella group that raises public awareness of issues affecting people with disabilities.
- A great resource for people with any type of disability (mental or physical) that can provide help with a wide range of legal and non-legal issues.
- Clients should contact the Advocacy Access number, below.

Disability Alliance BC Advocacy Access team

204 – 456 West Broadway
Vancouver, BC V5Y 1R3

Telephone: (604) 872-1278

Toll-free: 1-800-663-1278

Website: www.povnet.org/node/2443

- Informs people with disabilities of their legal and social rights, provides lawyer referrals in disputes and holds educational workshops.

B.C Human Rights Clinic (CLAS)

Telephone: (604) 622-1100

Toll-free: 1-855-685-6222

Fax: (604) 685-7611

Website: www.bchrc.org

- Provides informational services and an advocacy programme to protect human rights and prevent discrimination.

Community Legal Assistance Society (CLAS)'s Mental Health Law Program

Website: www.clasbc.net/

Telephone: (604) 685-3425

Fax: (604) 685-7611

- Provides representation for involuntarily detained patients who have tribunal hearings either under the MHA or the mental disorder provisions of the Criminal Code. Other CLAS programs provide free legal services in specific areas such as tenants' rights, E.I., WCB and human rights.

COAST Foundation Society

Email: info@coastmentalhealth.com

Telephone: (604) 872-3502

Website: www.coastmentalhealth.com

Toll-Free: 1-877-602-6278

Fax: 604-879-2363

- Provides a variety of mental health services, including a mental health resource centre and community or shared housing options.

Crisis Centre of Greater Vancouver

Telephone: (604) 872-3311

Toll-free: 1-800-SUICIDE (784-2433)

- 24-hour hotline that provides emotional support for clients in distress and refers them to other resources for food, shelter, counselling and legal advice. **Please note this is not a counselling hotline.**

Kettle Friendship Society

1725 Venables Street.
Vancouver, BC V5L 2H3
Website: www.thekettle.ca

Telephone: (604) 251-2801
Fax: 604-251-6354

- A non-profit agency providing support and services to those suffering from mental illness. Services include providing housing assistance, employment advocacy and an on-site health clinic.

Legal Services Society (“Legal Aid BC”)

Website: www.lss.bc.ca/

Telephone: (604)-408-2172
Toll-free: 1-866-577-2525

- May be available for *habeas corpus* applications, section 33 applications under the MHA, as well as applications for judicial review of Mental Health Review Board hearing decisions. The request for assistance in these areas would go through the Legal Aid appeals department.

Motivation, Power, and Achievement Society (MPA)

Website: www.mpa-society.org

Telephone: (604) 482-3700
Fax: (604) 738-4132

- Offers information, counselling and representation for Review Panels.

Nidus Personal Planning Resource Centre and Registry

Website: www.nidus.ca/

- A non-profit organization that provides information about personal planning, specializing in Representation Agreements, and operates a centralized Registry for personal planning documents.
- Website includes self-help guides and templates.

3. Government Resources

British Columbia Review Board

Website: <http://www.bcrb.bc.ca>

Telephone: (604) 660-8789
Toll-Free: 1-877-305-2277
Fax: (604) 660-8809

- Makes review dispositions where individuals charged with criminal offences have been given verdicts of “Not Criminally Responsible” (NCR) on account of mental disorder or “Unfit to Stand Trial” UST on account of mental disorder, by a court.

Canadian Mental Health Association, BC Division

Email: info@cmha.bc.ca
Website: www.cmha.bc.ca/

Telephone: (604) 688-3234
Toll-free: 1-800-555-8222
Fax: (604) 688-3236

Department of Justice

Website: www.justice.gc.ca/eng/

- Website contains all federal statutes and links to related sites.

Guide to the Mental Health Act

Website: www.health.gov.bc.ca/mhd/mentalhealthact.html

Mental Health Review Board

Website: www.mentalhealthreviewboard.gov.bc.ca/ Telephone: (604) 660-2325

- Responsible for conducting reviews of involuntarily admitted patients, under the MHA.
- Website provides FAQ, Rules, and other helpful links.

Ministry of Health Services

Website: www.health.gov.bc.ca/mhd/mental_health_act_forms.html

- Provides downloadable *Mental Health Act* forms on their website.

MPA Court Services

Website: <https://www.mpa-society.org/>

Telephone: (604) 688-3417

Surrey area: (604) 572-2405

Vancouver area: (604) 660-4292

- Court workers assist clients with a mental health disability during the criminal court process. Clients may also be assisted following court appearances (e.g. with bail or probation orders).

Public Guardian and Trustee of BC (PGT)

Website: <http://www.trustee.bc.ca>

Telephone: (604) 660-4444

Fax: (604) 660-0374

- An independent, impartial public official and Officer of the Court who serves to balance protection with autonomy and to ensure people may live as they choose with the support of family and friends.
- Offers **Child and Youth Services**; namely upholds and protects the rights of those under the age of 19 by reviewing all personal injury settlements, legal contracts, trusts and estates involving minors and ensuring that children are properly represented in all legal matters.
- Acts as guardian of estate for children who are in provincial government care and for those undergoing adoption.
- **Services to Adults** are primarily to uphold the rights of adults who are unable to manage their own affairs. This role includes helping them with financial and legal matters and supporting their lifestyle and health care decisions.
- **Estate Administration** settles the estates of deceased persons when there is no named executor or when there is no one willing or able to act as executor. This includes securing assets, settling debts and claims against the estate and identifying and locating heirs and beneficiaries

Planned Lifetime Advocacy Network (PLAN)

Website: www.plan.ca

Telephone: (604) 439-9566

Fax: (604) 439-7001

- Provides advocacy services and up-to-date legal information on wills and estates, trustees and financial planning. Also, works with families in developing personal support networks

for relatives with disabilities and provides advocacy and monitoring services for families whose parents have passed away.

Vancouver Access & Assessment Centre (AAC)

Website: www.vch.ca/your-care/mental-health-substance-use/vancouver-access-assessment-centre

Telephone: 1-604-675-3700

- Located at Vancouver General Hospital, the AAC offers short term treatment on-site, by telephone and by mobile response. Clinical staff, including registered nurses, social workers, and psychiatrists, provide 24/7 support, stabilization, and crisis management to clients.

Vancouver Mental Health Emergency Services

Telephone: (604) 874-7307
or via 911

- A partnership between Vancouver Coastal Health and the Vancouver Police Department that provides rapid assistance in cases of mental health-related emergencies within the city limits of Vancouver.
- Offers a 24-hour Crisis Line and can provide specially trained police and nurse services when necessary.

III. THEORY AND APPROACH TO MENTAL HEALTH LAW

Admission to a mental health facility can seriously affect an individual's rights. Textbooks have advocated a "functional" approach to mental health law, encouraging courts to consider solely how the disability may relate to the specific issue brought before them. Incapacity in one area does not necessarily mean incapacity in all areas. Most mental health legislation, however, is over-inclusive, and therefore impairs the rights of mentally ill persons in areas where they might have the mental capacity to act for themselves. The common law tests for capacity can be found in **Chapter 15: Adult Guardianship**.

Section 15(1) of the *Canadian Charter of Rights and Freedoms* [Charter] has made it easier to preserve the rights of those affected by mental health law. While most discriminatory legislation in BC remains unchallenged, the MHA "deemed consent provisions" and the HCCFA and Representation Agreement Act "substitute decision making" provisions, are currently being challenged as unconstitutional at the BC Supreme Court (see *MacLaren v British Columbia (Attorney General)*, 2018 BCSC 1753). This litigation isn't expected to be resolved for quite some time however.

All Charter challenges have been directed towards either the MHA, the HCCFA, or the *Criminal Code*. The Community Legal Assistance Society may be able to assist with serious Charter challenges, including test litigation.

IV. LEGAL RIGHTS AND MENTAL HEALTH LAW

A. *Income Assistance*

Mentally ill persons may be eligible for benefits under the "Persons with Disabilities" (PWD) or "Persons with Persistent and Multiple Barriers to Employment" (PPMB) designations. Qualification requirements are strict, but decisions concerning eligibility can be negotiated with the Ministry of Employment and Income Assistance, or if need be appealed. Generally, a doctor must fill out a special form indicating that you would qualify. Disability Alliance BC assists with applications and appeals (for further details see **Chapter 21: Welfare Law**). There may be strict deadlines for these applications, so it is important to not delay in these cases.

B. Employment/Disability Income

If a person cannot work because of mental health issues, the person may be entitled to employment insurance, disability benefits, CPP disability benefits, or WCB benefits if the mental illness is work related. For information on CPP disability benefits, see **Section IX.D: Canada Pension Plan**, below. Be aware that there are strict time limits involved when applying for these benefits.

If a person is hospitalized in a psychiatric facility because of an injury at work, he or she may be eligible for WCB benefits. Please contact the Workers Advisory Group through CLAS for more information or refer to **Chapter 7: Workers' Compensation**.

C. Employment Insurance

Individuals either voluntarily or involuntarily admitted to a psychiatric facility may still be eligible to collect Employment Insurance benefits. However, the *Employment Insurance Act*, SC 1996, c 23 is a very complicated piece of legislation, detailing numerous requirements to qualify for benefits (e.g. number of hours worked, previous claims, unemployment rate, etc.). If a person is denied benefits, it is best to consult a lawyer with specific knowledge on these issues (e.g. CLAS). Be aware that there may be strict timelines in applying for benefits or appealing a denial of benefits. For more information, please consult **Chapter 8: Employment Insurance**.

D. Canada Pension Plan

Long-term patients may apply for disability pensions. A claim takes four or five months to process. Hospitalization does not affect a person's right to collect a pension and it is possible to receive CPP benefits for periods of time when an individual was hospitalized. Disability Alliance BC assists people with these applications if they reside in the community. For people who are hospitalized, contact the hospital social worker to assist with these applications as strict time limits may apply.

E. Driving

A mental disorder does not automatically disqualify a person from driving. The Superintendent of Motor Vehicles or a person authorized by the Superintendent does have the discretion to deny a licence to those deemed "unfit" under section 92 of the *Motor Vehicle Act*, RSBC 1996, c 318. This decision is based on the *2010 BC Guide in Determining Fitness to Drive* (available online at www.bcma.org/files/2010_BC_Fitness%20to%20Drive_Guide.pdf). Chapter 6 of that guide provides assessment policies and procedures. Assessments of cognitive function can be requested (see section 6.6 of the Guide). Chapter 19 of the Guide discusses Psychiatric Disorders while Chapter 27 discusses Cognitive Impairment (including dementia). Appeals can be made to the Superintendent, but only where medical reports were not properly interpreted, where proper allowances were not made for surgical procedures that the applicant was undergoing, or where the physician has not properly reported the patient's medical condition. An appeal may also require that the appellant undergo examination and/or testing.

F. The Right to Vote

Both voluntary and involuntary patients in mental health facilities have the right to vote. This has been the case since *Canada (Canadian Disability Rights Council) v Canada* (1988), 3 FC 622, where it was decided that a person is not disqualified from voting on the basis that a committee has been appointed for him or her. Polling stations are normally set up at long-term psychiatric care facilities. Because enumeration takes place at the facility, patients must vote in the riding where the hospital is located.

G. Human Rights Legislation

Under both BC and federal human rights legislation, it is contrary to human rights to discriminate against a person in the protected areas of housing/tenancy, employment or services customarily available to the public on the basis of mental illness. For information on launching a human rights complaint see **Chapter 6: Human Rights**.

H. *Civil Responsibility*

In general, mental incompetence or disability is no defence to an action for intentional tort or negligence. However, where a certain amount of intent or malice is required for liability, the fact that the defendant lacked full capacity to understand what he or she was doing may relieve him or her of liability. A defendant who lacks the ability to control his or her actions will not be liable. Involuntary actions do not incur liability. Anyone responsible for the care of a mentally ill person may be held responsible if the plaintiff proves a failure to take proper care supervising the person.

In civil suits, a guardian *ad litem* may be appointed with permission of the court (can be petitioned by a lawyer) to start or defend an action where a mentally ill person is a party and lacks the capacity to commence or defend that action. A person involuntarily detained under the MHA appears to meet the definition in the BC Supreme Court *Rules of Court* of a person under a legal disability for filing or defending a court action. Therefore, the person would need to proceed through a guardian *ad litem*. The guardian *ad litem* could be a friend or a relative of the person, but could also be an organization, or another individual chosen and appointed by the court.

Additionally, any person found not criminally responsible by reason of a mental disorder (NCRMD) under the *Criminal Code* may not be liable for damages as a result of the offence.

I. *Immigration and Citizenship*

Section 38 of the *Immigration and Refugee Protection Act* deals with inadmissibility on health grounds. Pursuant to section 38(1)(c), foreign nationals will be inadmissible if they “might reasonably be expected to cause excessive demand on health or social services.” This rule could potentially present a bar to admission for individuals determined to be developmentally delayed or those with a history of mental illness. However, section 38(2) lists certain exceptions. If a person may be classified as (a) a member of the family class and the spouse, a common law spouse, or a child of a sponsor; (b) a refugee or a person in similar circumstances; (c) a protected person, or; (d) where prescribed by regulation, one of their family members, that person will be exempted from the rule under section 38(1)(c).

J. *The Charter*

Sections 7 (the right to liberty), 9 (the right to protection against arbitrary detention) and 15 (the equality provision) of the *Charter* are particularly relevant to protecting the rights of the mentally ill. Rights protection provisions may also be applicable, including section 12, which concerns cruel and unusual punishment.

Fleming v Reid, (1991) OR (2d) 169 at paras 52-59 dealt with the impact of section 7 on provisions of Ontario’s mental health legislation. Mentally competent involuntary patients refused treatment despite their doctors’ opinions that it would be in their best interest. The Court held that the section of Ontario’s *Mental Health Act*, RSO 1980, c 262 that allowed a Review Board to override the refusal for treatment made by a substitute consent-giver of an involuntary patient based on the patient’s prior competent wishes violated the right to security of the person and was not in accordance with the principles of fundamental justice. However, the effect this case will have on BC’s legislation is yet to be determined.

In *Mazzei v British Columbia (Director of Adult Forensic Psychiatric)*, 2006 SCC 7 at paras 46-47 [*Mazzei*], it was decided that Review Boards have the power to issue binding orders to parties other than the accused. This power is usually exercised on the director of a hospital party to the proceedings, to whom the Review Board cannot dictate a specific treatment, but can impose conditions regarding treatment.

This power was granted to ensure that treatments are culturally appropriate. In *Mazzei*, conditions were imposed regarding drug and alcohol rehabilitation to ensure that the process was appropriately adjusted to the individual's First Nations' ancestry.

A more recent Supreme Court decision, *R v Conway*, 2010 SCC 22 at para 78 [*Conway*] responded to the issue of whether the Ontario Review Board (ORB) has the authority to grant remedies under section 24(1) of the *Charter*. The challenge was brought by Paul Conway, an individual found not responsible by reason of a mental disorder in 1983. He argued that his treatment and detention violated his *Charter* Rights, and therefore entitled him to an absolute discharge. The Supreme Court developed a test to determine whether an administrative tribunal is authorized to grant *Charter* remedies. The Supreme Court ruled that pursuant to section 24(1), the ORB is a "court of competent jurisdiction", but that an absolute discharge was not a remedy that could be granted by the ORB under the particular circumstances. Ultimately, the *Conway* decision affirms the application of the *Charter* to administrative tribunals, including MHA Review Boards. However, this decision limits the scope of available remedies under section 24(1) to those that have been specifically granted to a given body by the legislature. In *Conway*, the Review Board could make a determination that the provision was unconstitutional, but did not have the authority to strike it down.

In another case in which CLAS acted as an intervener (*Canada (Attorney General) v Downtown Eastside Sex Workers United Against Violence Society*, (2012) 2 SCR 524 at paras 73-74) opened the door for groups of individuals to bring *Charter* challenges. In this case sex workers were granted public standing as a group to bring *Charter* challenges. This decision impacts mentally ill people as well. It means that in the future, patients that are detained in mental health facilities could bring *Charter* challenges as a group, rather than being forced to do so on an individual basis. Organizations can start an action on behalf of a group of vulnerable people if there is no other way for the issue to be brought in front of a court.

***K* Legal Rights of Those in Group Homes**

Throughout the greater Vancouver area there are many "group homes" run by and/or for mentally ill persons who do not require confinement in a provincial mental health facility. Additionally, "Supportive Apartments" are a new tool that the provincial government has been using. These homes, run by groups such as COAST, the Motivation, Power, and Achievement Society (MPA) are governed by the *Community Care and Assisted Living Act*, SBC 2002, c 75. Foster homes and group homes of the provincial government fall under different Acts: the *Child, Family and Community Service Act*, RSBC 1996, c 46 and the *Hospital Act*, RSBC 1996, c 200.

These types of homes have some interesting interactions with the *Tenancy Act*, in that they may or may not be covered on a case by case basis. There is no definitive answer at this point – individuals in group homes with tenancy issues can contact CLAS or seek other legal help.

Municipalities often place restrictions on the location of group homes. A Winnipeg bylaw requiring a minimum distance between group homes was struck down for violating section 15 of the *Charter* (*Alcoholism Foundation of Manitoba v The City of Winnipeg* (1990), 69 DLR (4th) 697 (Man. C.A.)).

V. PATIENT ADMISSION: GENERAL INFORMATION

Admissions to mental health facilities under the MHA may be either voluntary under section 20 or involuntary under section 22 (see **Section VII** below). Admission can also occur due to a verdict of "Not Criminally Responsible by reason of Mental Disorder" or "Unfit to Stand Trial" for criminal charges. This is not considered an "involuntary" admission, but rather an "NCRMD" or "UST" admission. NCRMD and UST will see matters of treatment and release governed by a Review Board. Involuntary admission under the MHA revolves around doctors renewing the patients' involuntary admittance status.

It should be noted that patients who are initially admitted voluntarily may later have their status changed to involuntary using the admission procedure for involuntary patients described later in this chapter.

A. Charges for Mental Health Services

Section 4 of the *Mental Health Regulations* (BC Reg 233/99) [MHR] provides a formula for calculating the charges for care of persons admitted voluntarily (MHA, s 20) to a mental health facility. The formula is calculated by adding the daily Old Age Security maximum to the daily Guaranteed Income Supplement and multiplying by 85%.

It does not authorize or mention any charges for care to be paid by those persons who are admitted involuntarily (MHA, s 22). According to *Director of Riverview Hospital v Andrzejewski* (1983), 150 DLR (3d) 535 (BC County Court), section 11 of the MHA does not authorize any charges for mental health services where an individual is admitted involuntarily. Check for any changes to the *Mental Health Regulations* to determine the authorized charges for different classes of patients (i.e. voluntary and involuntary).

B. Consent to Treatment

Psychiatric treatment is legally considered a type of medical treatment. The *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181 [HCCFA] sets out the requirements for consent from the patient before a health care provider can legally provide health care. Generally, adults are presumed to be capable of consenting to treatment, and they have the right to give or refuse consent to treatment. However, there are significant exceptions in the realm of mental health or psychiatric treatment.

The HCCFA does not apply to the provision of psychiatric treatment where an individual is involuntarily detained under the MHA and/or is on leave from a psychiatric facility or has been transferred to an approved home (HCCFA, s 2). For those individuals, the director of the relevant psychiatric facility has the right to consent to psychiatric care on the involuntarily detained patient's behalf (see **Section VII** below). Additionally, for patients not involuntarily admitted, section 12(1) of the HCCFA allows an adult to be treated without their consent in an emergency situation in order to preserve that adult's life, to prevent serious mental or physical harm, or to alleviate severe pain if certain other conditions are met.

VI. MENTAL HEALTH ACT: CONSENT TO MEDICAL TREATMENT

The following subsections apply **only** to patients voluntarily admitted to a mental health facility or voluntarily receiving treatment from a health care/psychiatric service provider. Patients admitted involuntarily lose certain rights (see **Section VII** below).

A. Adult's Right to Consent

Every adult is presumed to be capable of giving, refusing or revoking consent to health care, and to their presence at a care facility (HCCFA, s 3).

Every adult who is capable has the right to give, refuse and revoke consent on any grounds (including moral and religious), even if refusal will result in death (HCCFA, s 4).

Every adult who is capable has the right to be involved to the greatest degree possible in all case planning and decision making (HCCFA, s 4).

B. Care Provider's Duty to Obtain Consent

A health care provider must not provide health care to an adult without consent, except in an emergency situation or when substitute consent has been given, and the care provider has made every reasonable effort to obtain a decision from the adult (HCCFA, ss 5, 12).

For consent to be valid, it must be related to the proposed health care, voluntary, not obtained by fraud or misrepresentation, informed (see HCCFA, s 6(e)), and given after an opportunity to make inquiries about the procedure (HCCFA, s 6).

C. Emergency Situations

A care provider may provide care to an adult without the adult's consent in an emergency situation where the adult cannot give or refuse consent and no personal guardian or representative is present (HCCFA, s 12). If a personal guardian or representative later becomes available and refuses consent, the care must stop (HCCFA, s 12(3)).

However, the above does not apply if the care provider has reasonable grounds to believe that the adult, while capable and after attaining 19 years of age, has expressed an instruction or wish applicable to the circumstances to refuse consent to the health care (HCCFA, s 12.1).

D. Personal Guardians and Temporary Substitute Decision Makers

A care provider may provide care to an adult without the adult's consent if the adult is incapable of giving or refusing consent and a personal guardian or representative gives consent (HCCFA, s 11).

If a personal guardian or representative refuses consent, the health care may be provided despite the refusal in an emergency if the person refusing consent did not comply with their duties under the HCCFA or any other act (HCCFA, s 12.2).

A temporary substitute decision maker (TSDM) can be chosen by the care provider in accordance with section 16 of the HCCFA. See sections 16-19 of the HCCFA for the authority and duties of a TSDM. There is a statutory list of those assigned to be a TSDM, beginning with a spouse, and moving down. More details can be found in **Chapter 15: Adult Guardianship**.

In situations where a mentally ill person is judged to be incapable of making a health care decision, the provisions for a substitute decision maker under the HCCFA continue to apply. However, if the person is declared an involuntary patient under section 22 of the MHA, then psychiatric treatment can be provided under the deemed consent provisions of section 32 of the MHA.

E. Consent to Treatment Forms

When admitted to a mental health facility, voluntary patients (or their committees, parents, guardians or representatives) may be asked to sign a "consent to treatment" form, which purports to "authorize the following treatment(s)". There is no basis in law for requiring this form be signed as a prerequisite of a voluntary admission, but the law does not prohibit such a requirement.

Under the HCCFA, consent will be considered to be "informed" only where the patient has been informed of the nature of the risks and benefits of the specific treatment, and of alternative treatments, and has agreed to be subject to the treatment. Signing the form may not be sufficient to indicate informed consent on its own.

1. Refusal to Sign Consent Treatment Form: Possible Consequences

A person who refuses to sign the consent form may be deemed a patient who "could not be cared for or treated appropriately in the facility" under section 18(b) of the MHA. This person runs the risk of being refused admission to the facility or being discharged if already admitted.

Under the *Patients Property Act* (PPA) hospitals could circumvent the issue of consent by seeking a court order, supported by two medical opinions, to have the patient declared incapable of managing his or her personal affairs. Minor changes were made to the PPA in

September 2011. Under the PPA, a legal guardian or public trustee is appointed as a committee to give consent on behalf of the patient. It is not sufficient for a family member to give consent for a voluntary informal patient without first obtaining legal guardianship or committeehip, or becoming a Representative under the *Representative Agreement Act*, or becoming a substitute decision maker under the HCCFA.

A decision from Nova Scotia regarding guardianship found that some of the central provisions of the *Incompetent Persons Act*, RSNS, 1989, c 218 are unconstitutional (*Webb v Webb*, 2016 NSSC 180 at paras 19-22). This legislation allows for the appointment of a guardian where a person is found incompetent (similar to the PPA), but it was found that the legislation was overbroad. It did not allow a court to tailor a guardianship order so that a person subject to that order could retain the ability to make decisions in respect of those areas in which they are capable. This may have an impact on the PPA in BC in the future.

Sections 50 to 59 of the *Adult Guardianship Act* (APA) allow for a person from a designated agency to make unilateral decisions which affect the adult's support and assistance without their consent, including treatment and removal from a residence. For instance, section 56 allows a person from a designated agency to apply for a court order which can determine an adult's mode of treatment. Furthermore, section 59 gives a person from a designated agency broad powers in regard to an adult, such as enter their premises without a warrant, remove them from their premises and convey them to "a safe place", and provide emergency medical care, so long as it is within the context of an emergency situation or the adult is incapable of providing consent. See **Chapter 15: Adult Guardianship** for more information.

The facility could also proceed under the HCCFA by declaring the patient incapable of consenting, using a temporary substitute decision maker (TSDM) and/or claiming that a state of emergency exists, such that the patient must be treated without his or her consent.

VII. MENTAL HEALTH ACT: INVOLUNTARILY ADMITTED PATIENTS

Patients who are admitted to a mental health facility without their consent are admitted involuntarily. The MHA provides mechanisms for both short-term emergency admissions and long-term admissions. The HCCFA or the *Representation Agreement Act* and all of their requirements regarding consent to treatment do not apply to psychiatric treatment of involuntarily admitted patients. Involuntarily admitted patients therefore have few legislative rights, but some parts of the MHA could be challenged under the *Charter*, such as the current CLAS challenge in BC to the "deemed consent" provisions of the *BC Mental Health Act* (see *MacLaren v British Columbia (Attorney General)*, 2018 BCSC 1753).

Such a challenge occurred in Ontario, in *PS v Ontario*, 2014 ONCA 900. The constitutionality of the provisions of the *Mental Health Act*, R.S.O. 1990, c. M.7 providing for involuntary committal as they apply to long-term detainees were challenged and found to violate section 7 of the *Charter*. The judgement stated that the patient must be provided meaningful procedural avenues to seek the accommodation and treatment they need to be rehabilitated, while being involuntarily detained. It was determined that the province does not have the power to detain mental health patients indefinitely, where such procedural protections are absent. This will likely change the role patients themselves play in determining the course and nature of their treatment in Ontario. It is unclear at this stage what effect this Ontario case may have in British Columbia.

The Mental Health Law Program (MHLPP) at CLAS assists involuntarily admitted patients at Mental Health Review Board (Review Panel) hearings. Since 2017, the Attorney General has agreed to fund representation for all involuntarily detained patients who cannot afford counsel at their Review Panel hearings. If CLAS is unavailable to make these representations, they have a roster of contracted lawyers who may provide counsel. Access Pro Bono also provides telephone assistance for people who are facing involuntary detention, and who wish to know their rights under the MHA.

Section 22 of the MHA provides that a person may be admitted involuntarily and detained for up to 48 hours on the completion of one involuntary patient certificate (Form 4 – BC MHR). The person must first be examined by a doctor and the doctor must provide a medical certificate stating that he or she is of the opinion that the person has a mental disorder and requires treatment to prevent "the substantial mental or physical deterioration" of the person or to protect that person or others. A second doctor must provide a second certificate if the person is to be detained for longer than the initial 48 hours. *Mullins v Levy* 2009 BCCA 6 at paras 105-110, the leading case in this area, applied a broad definition of "examination" and stated that the MHA does not require a personal interview of the patient in every instance. However, a patient is entitled to request a Review Panel hearing after the second certificate is completed, in accordance with section 25 of the MHA. The involuntary detention can be renewed for a period of one month, three months, and subsequent six-month periods. The involuntarily detained patient has a right to apply for a Review Panel hearing within each renewal period.

When the patient is re-evaluated, the facility must determine whether the involuntary admission criteria still apply and whether there is a significant risk that if the patient is discharged, he or she will be unable to follow the prescribed treatment plan and be involuntarily admitted again in the future.

The MHA also potentially allows involuntarily committed patients to be granted leave or extended leave under certain conditions, as authorized by their doctor. This means that the patient may be permitted to live outside the facility, but will still be considered to be involuntarily committed, and will remain subject to the provisions of the MHA.

A. Restraint and Seclusion While Detained Under the MHA

BC's MHA is silent on the issues of restraint and seclusion. Section 32 merely provides that every patient detained under the MHA is subject to the discipline of the director and staff members of the designated facility. Issues around restraint and seclusion have yet to be thoroughly considered in BC, and there are few cases in Canada that address them. In *Mullins v Levy* 2009 BCCA 6, the plaintiff sued a hospital and its staff for negligence, false imprisonment, and battery after he was detained and medicated for five days against his wishes, after doctors decided he required treatment for mania. The plaintiff also argued that his *Charter* rights were violated, and challenged the MHA and the HCCFA as unconstitutional, though the Court did not rule on the *Charter* arguments. The claim was denied at the BCCA on factual grounds, and the Supreme Court declined to hear Mullins' appeal.

This leaves the patient's rights in the hands of facility policy-makers. Such policy focuses on the benefits that seclusion may give to a patient for treatment purposes and regard is given to the safety of hospital staff. The uncertainty of the law in this area, combined with a serious potential for the deprivation of patients' rights, leaves open the possibility of a *Charter* argument to uphold patients' rights in the future.

B. Short-Term and Emergency Admissions

A person may be detained in a psychiatric facility upon the receipt of one medical certificate signed by a physician (MHA, s 22(1)). Such involuntary confinement can last for a maximum of 48 hours for the purposes of examination and treatment. A second medical certificate from another physician is required to detain the patient for longer than 48 hours (MHA, s 22(2)). As an alternate to the admissions criteria under the MHA, a patient may be given emergency treatment under section 12 of the HCCFA if they have not been involuntarily admitted.

1. Authority of a Police Officer

If a police officer believes a person has an apparent mental disorder and is acting in a manner likely to endanger that person's own safety or the safety of others, the police officer may apprehend and immediately take the person to a physician for examination, which includes admission to a psychiatric facility for examination by a physician there. (MHA, s 28(1)).

2. *Authority of a Provincial Court Judge*

Anyone may apply to a Provincial Court judge to issue a warrant authorizing an individual's apprehension and conveyance to a mental health facility for a period not exceeding 48 hours. To grant this warrant, the judge must be satisfied that admission under section 22 is not appropriate and that the applicant has reasonable grounds to believe that section 22(3)(a)(ii) and (c) of the MHA describe the condition of the individual (MHA, s 28(4)).

C. *Application for Long-Term Admissions*

A person can be admitted to a facility by the director of a provincial health facility on receipt of two medical certificates (Form 4 under the MHR), each completed by a physician in accordance with section 22(2). The patient will be discharged one month after admittance unless the detention is renewed (Form 6 under the MHR) in accordance with section 24 of the MHA.

D. *Contents of Medical Certificates (MHA, s 22 (3))*

The certificates must contain:

1. a physician's statement that the individual was examined, and the physician believes the person has a mental disorder;
2. an explanation of the reasons for this opinion; and
3. a separate statement that the physician believes the individual requires medical treatment in a provincial mental health facility to prevent the person's substantial mental or physical deterioration, to protect the person, or to protect others, and that the individual cannot be suitably admitted as a voluntary patient.

For admission to be valid, the physician who examined the person must sign the medical certificate (Form 4) and must have examined the patient not more than 14 days prior to the date of admission. For a second medical certificate (Form 4) to be valid, it must be done within 48 hours of the patient's admission. The MHA does not give details about the type of examination required, nor does it require that the patient be told the purpose of the examination, or that the examination is even being conducted. This practice has been the subject of a *Charter* challenge in the past, but was dismissed for other reasons (see *Mullins v Levy*, (2009), 304 DLR. (4th) 64 (BCC.A.)).

E. *Consent to Treatment*

Under section 31, a patient who is involuntarily detained under the MHA is deemed to consent to any treatment given with the authority of the director. This will override any decisions made by a patient's committee, personal guardian, temporary substitute decision maker or representative.

An involuntary patient, or someone acting on his or her behalf may request a second medical opinion on the appropriateness of the treatment authorized by the director. Under section 31(2), a patient may request a second opinion once during each detention period. Under section 31(3), upon receipt of the second medical opinion, the director need only consider whether changes should be made in the authorized treatment for the patient. There is no statutory right of appeal from the director's decision to treat the involuntary patient. Currently, this is being subjected to a *Charter* challenge. However, a decision has yet to be made. Please refer to *MacLaren v British Columbia (Attorney General)*, 2018 BCSC 1753.

F. *Right to Treatment*

Section 8 of the MHA requires directors to ensure that patients are provided with "treatment appropriate to the patient's condition and appropriate to the function of the designated facility." However, the content of such treatment and the scope of what this entitles patients to is unresolved. It is unclear what would constitute a failure to provide treatment, and whether a facility would be bound to discharge a patient should a failure be found.

A patient held without any treatment whatsoever may be able to claim civil damages on the basis of non-administration of treatment, constituting a breach of a statutory duty. Decisions regarding what amounts to appropriate treatment fall within the discretion of the institution. However, it is important to note that the common law of medical malpractice applies to treatment administered in a mental health facility, thus imposing certain limitations on that discretionary power.

G. Right to be Advised of One's Rights

Pursuant to section 34 of the MHA and Form 13 under the MHR, directors must fully inform patients orally and in writing of their section 10 *Charter* rights and the MHA provisions relating to duration, review, and renewal of detention; review hearings; deemed consent and requests for second opinions; and court applications for discharge. Directors are bound to ensure that patients are able to understand these rights.

H. Transfer of Patients or Extended Leave

Section 35 of the MHA gives the director authority to transfer a patient from one facility to another where the transfer is beneficial to the welfare of the patient. Under section 37, a patient may be given leave from the facility (no minimum or maximum time periods are specified for the duration of the leave). Under section 38 a patient may also be transferred to an approved home on specified conditions.

A person released from a provincial mental health facility on leave or transferred to an approved home is still considered to be admitted to that facility and held subject to the same provisions of law as if they were continuing to live at the institution (MHA, s 39(1)). The patient is still detained under the MHA and will be subjected to treatment authorized by the director, which is still deemed to be given with the consent of the patient. If the conditions of the leave or transfer are not met, the patient may be recalled to the facility he or she is on leave or was transferred from or may be sent to another authorized facility (MHA, s 39(2)). There is no statutory obligation on the institution to inform the patient that the leave is conditional or has expired, leaving the possibility that a patient may unknowingly violate the terms of his or her leave.

Under section 25(1.1) if a patient has been on leave or transferred into an approved home for more than 12 consecutive months without a request for a review panel hearing, his or her treatment record must be reviewed by the Mental Health Review Board. If the Mental Health Review Board believes there is a reasonable likelihood that the patient could be discharged, a Review Panel must be conducted. However, in practice, the Review Panel contacts the patient to ask if they want a hearing.

I. Discharge of Involuntary Patients

1. Through Normal Hospital Procedure

The director may discharge or grant leave to a person from an institution at any time (MHA, ss 36(1) and 37). Under section 23 "a patient admitted under s 22 may be detained in a provincial mental health facility for one month after the date of their admission, and they shall be discharged at the end of that month unless the authority for their detention is renewed in accordance with s 24". A doctor must renew that authority for further periods of one month, then three months, and then six months.

2. *Through a Review Panel Hearing*

An involuntary patient is entitled to a hearing before a Mental Health Review Board (Review Panel). Generally, a patient is entitled to one hearing during each period of involuntary detention. The application for a Review Panel hearing may be made by the patient or by someone acting on the patient's behalf (MHA, s 25). The application is completed by filling out an "Application for Review Panel" (Form 7 under the Mental Health Regulations), Section 6 of the MHR describes the process of a Review Panel hearing.

A Review Panel hearing takes place before a panel of three people, which must include a medical practitioner, a member in good standing with the Law Society of British Columbia (or a person with equivalent training) and a person who is not a medical practitioner or a lawyer. Under the MHA, the Minister, appoints the Chair and all the legal, medical and community members authorized to sit as Review Panel members. The Chair serves fulltime and the members serve part-time. The Chair appoints three members for each Review Panel hearing from the list of people previously chosen by the Minister.

In order to maintain a quasi-judicial character, it is policy that those who sit on the Review Panel do not have access to the patient prior to the hearing. Decisions are based on evidence and testimony presented at the hearing only. Section 24.3 of the MHA gives the Review Panel power to compel witnesses and order disclosure of information.

The hospital's position is usually presented by another medical practitioner acting as the hospital's representative, who is usually the involuntarily detained person's attending psychiatrist. The involuntary patient has a right to representation by a lawyer or trained legal advocate, who can present the patient's position at the hearing.

The Review Panel members generally rely on the hospital presenter and the patient's counsel to provide documents and evidence during the Review Panel hearing. However, the Review Panel does have the power to order disclosure of records that are relevant to making a decision. Procedure at review panel hearings is subject to the principles of fundamental justice under section 7 of the *Charter* and due process under the common law, as well as the provisions of the *Administrative Tribunals Act* listed under section 24.2 of the MHA.

a) *Patients' Rights at Review Panel Hearings*

The patient may retain counsel for representation at the hearing. This representative need not be a lawyer. Representation at a panel is provided free of charge by CLAS' Mental Health Law Program within the lower mainland or on an *ad hoc* basis outside of the lower mainland (see **Section I.B.2: Resources** for contact information).

The fundamental principles of justice dictate that one has a right to appear at one's own hearing. However, under section 25(2.6) of the MHA, the chair of the Review Panel may exclude the patient from the hearing or any part of it if they are satisfied that exclusion is in the patient's best interests. This power is rarely used, and often in accordance with the patients' wishes, as Review Hearings may cause a lot of stress. The patient or counsel can call witnesses to give evidence that supports the patient's argument in favour of discharge.

Within 48 hours of the end of the hearing, the Review Panel must decide (by majority vote) whether the patient's involuntary detention should continue. Decisions must be in writing. Reasons must be provided no later than 14 days after the hearing. Section 25(2.9) of the MHA compels the panel to deliver a copy of the decision without delay to the mental health facility's director and the patient or his or her counsel. If the decision is that the patient be discharged, the director must immediately serve a copy of the decision on the patient and discharge him or her.

b) *What the Review Panel Must Consider*

Under section 25(2) of the MHA, the Review Panel is authorized to determine whether the detention of the patient should continue. The patient's detention must continue if sections 22(3)(a)(ii) and (c) continue to describe the patient. That is, the patient is a person with a mental disorder who requires treatment in or through a designated mental health facility; the patient requires care, control and supervision in or through a designated mental health facility; the patient is a threat to him or herself or others; or detention is necessary to prevent substantial deterioration of the patient's mental or physical person and he or she is unsuitable as a voluntary patient. A Review Panel hearing must be conducted notwithstanding any defects in authority (Form 4 and Form 6) for the initial or renewed detention pursuant to section 22 of the MHA.

The Review Panel must consider the past history of the patient, including his or her past history of compliance with treatment plans. The panel must assess whether there is a significant risk that the patient will not comply with treatment prescribed by the director. Presumably, if the panel concludes that there is a significant risk that the patient will not comply with the treatment plan, it is open to them to conclude that sections 22(3)(a)(ii) and (c) continue to describe the patient (i.e. the patient may get worse if not compelled to continue treatment). Again, the MHA amendments have made the criteria for detention broader and it would seem likely that it will be more difficult for patients to end their detention under the MHA.

3. *Through Court Proceedings*

A person may apply to the Supreme Court for a writ of *habeas corpus*, which is a writ requiring a detained person to be brought before a court that will evaluate the lawfulness of the involuntary detention based on the documents used to detain them. This is most suitable where there were procedural defects in the patient's admission or defects in the involuntary detention certificates (Form 4 and Form 6 under the MHR). If the Court finds that the detaining authority did not strictly adhere to the statutory requirements regarding involuntary detention, there may exist an action in false imprisonment and civil battery for unauthorized treatment and a possible award of damages (*Ketchum v Hislop* (1984), 54 BCLR 327 (SC)).

Under section 33 of the MHA, a request can be made to the Supreme Court for an order prohibiting admission or directing the discharge of an individual. This request may be made by a person or patient whose application for admission to a mental health facility is made under section 20(1)(a)(ii) or 22, a near relative of a person or patient or anyone who believes that there is not sufficient reason for the admission or detention of an individual.

Legal Aid and Access Pro Bono may be available for *habeas corpus* applications, section 33 applications under the MHA, as well as applications for judicial review of Mental Health Review Board hearing decisions. Please see the "Advocacy Resources" section on page 3 for more details.

J. *Escapes from Involuntary Detention*

1. *Apprehension without a Warrant*

A patient detained involuntarily in a mental health facility who leaves the facility without authorization is, within 48 hours of escape, liable to apprehension notwithstanding that there has been no warrant issued (MHA, s 41).

2. *Warrant Constituting Authority for Apprehension*

Where a person involuntarily detained has been absent from a mental health facility without authorization, the director of the facility may, within 60 days, issue a warrant for apprehension, which serves as authority for apprehension and conveyance back to the facility (MHA, s 41(1)).

3. *Patient Considered Discharged After 60 Days*

A patient is deemed to have been discharged if he or she has been absent for over 60 days without a warrant being issued (MHA, s 41(3)). However, if the patient is “charged with an offence or liable to imprisonment or considered by the director to be dangerous to him or herself or others,” the person is not deemed discharged and a warrant may still be issued.

4. *Aiding Escapees*

Under section 17 of the MHA, any person who helps an individual leave or attempt to leave a mental health facility without proper authority, or who does or omits to do any act that assists a person in so leaving or attempting to leave, or who incites or counsels a patient to leave without proper authority, commits an offence under the *Offence Act*, RSBC 1996, c 338.

VIII. THE CRIMINAL CODE

A. *Fitness to Stand Trial*

An accused is presumed fit to stand trial until the contrary is proven on a balance of probabilities (*Criminal Code*, s 672.22). The burden of proof is on whoever raises the issue, either the accused or Crown counsel, (*Criminal Code*, s 672.23(2)).

An accused is deemed “unfit to stand trial” under section 2 of the *Criminal Code* if he or she is incapable of understanding the nature, object and possible consequences of the criminal proceedings, or is unable to communicate with counsel on account of mental illness. If the verdict is that the accused is unfit to stand trial, any plea that has been made will be set aside and the jury will be discharged (*Criminal Code*, s 672.31). Under section 672.32, the accused may stand trial once he or she is fit to do so. For more information on the test of fitness see *R v Taylor* (1992), 77 CCC (3d) 551, which outlines the various tests in greater detail

The court may order a trial (not an assessment) on the issue of the accused’s fitness to stand trial at any stage in the proceedings prior to a verdict, either on its own motion or on an application of either the prosecution or the defence (*Criminal Code*, s 672.23).

If a person is found unfit to stand trial, he or she may be detained in a mental health facility until he or she recovers sufficiently to be able to proceed with the trial (*Criminal Code*, s 672.58). However, the court cannot make a disposition order to have an accused detained in a health facility without the consent of the hospital or treating physician (*Criminal Code*, s 672.62(1)). A recent Supreme Court of Canada case, *R v Conception*, 2014 SCC 60 at para 3, confirmed the need for such consent. The court found that “[t]he hospital consent was required for the disposition order in its entirety, and not simply the treatment aspects of it.” The exception to this is the rare case in which a delay in treatment would breach the accused’s rights under the *Charter* and an order for immediate treatment is an appropriate and just remedy for that breach. An inquiry by the court must be held no later than two years after the verdict of “unfit” and every subsequent two years after that. The court may now extend the period for holding an inquiry where it is satisfied that such an extension is necessary to determine if sufficient evidence can be adduced to put the person on trial (*Criminal Code*, s 672.33).

After the court deems a person unfit to stand trial, a disposition hearing must be held by the Review Board within 45 days, taking into account the safety of the public and the needs of the accused. While the term in section 672.54 “least onerous and least restrictive” has been replaced by “necessary and appropriate”, the intent of the legislation has not changed, as explained under Disposition Hearings after NCRMD.

The BC Court of Appeal reviewed a Review Board decision regarding custody in a fitness case; *Evers v British Columbia (Adult Forensic Psychiatric Services)*, 2009 BCCA 560. The BCAA stated that the Review Board erred in proceeding with a disposition hearing in the absence of the accused without first attempting to ensure the accused’s presence by issuing a warrant or allowing a short adjournment. Further, the court stated that fear of non-compliance with medical treatment cannot be the main objective motivating a custody disposition order, nor can the Review Board impose treatment as a condition on the accused.

In *R v Demers*, 2004 SCC 46, the court found that the former sections 672.33, 672.54 and 672.81(1) violated the *Charter* rights of permanently unfit, non-dangerous accused persons. The court wanted to ensure that an accused found unfit will not be detained unnecessarily when he or she poses no risk to the public. Pursuant to this decision, these sections have been amended.

Now, a Review Board may make a recommendation to the court to enter a stay of proceedings if it has held a hearing and is of the opinion that the accused remains chronically unfit and does not pose a significant threat to public safety. Notice of intent to make such a recommendation must be given to all parties with a substantial interest in the proceedings (*Criminal Code*, s 672.851).

The Review Board, the prosecutor, or the accused may apply for an order of assessment of the accused’s mental condition if necessary to make a recommendation for a stay of proceedings, or to make a disposition if no recent assessment has been made (*Criminal Code*, s 672.121). A medical practitioner or any person designated by the Attorney General may also make an assessment. An assessment order cannot be used to detain an accused in custody unless it is necessary to assess the accused, or the accused is already in custody, or it is otherwise required.

An appeal from an order for a stay of proceedings may be allowed if the Court of Appeal finds the assessment order unreasonable or unsupported by evidence.

A recent case (*R v JG*, (2014) BCSC 2497 at paras 17-27) considered the issue of whether statements made by an accused during the fitness to stand trial hearing are admissible in the trial. In this case, the accused made an admission of guilt during the fitness hearing. The court ruled that the statements were inadmissible at trial.

B. Criminal Responsibility

1. Defence of Mental Disorder – Criminal Code, Section 16

An accused may be found “Not Criminally Responsible on account of a Mental Disorder” (NCRMD), if an accused is found to have been suffering from a mental illness at the time of the offence which resulted in:

- a lack of appreciation of the nature and quality of the offence (i.e. he or she could not foresee and measure the physical consequences of the act or omission) (*R v Cooper* (1980), 1 SCR. 1140; or
- a failure to realize that the act or omission was wrong (i.e. he or she did not know it was something that one should not do for moral or legal reasons) (*Chaulk v The Queen* (1990), 3 SCR 1303;

This is a verdict distinct from either guilty or not guilty. If an accused is found NCRMD, the court can decide whether the accused will receive an absolute discharge, a conditional

discharge, or a custody disposition to be detained in a psychiatric hospital. Alternately, and more often in practice, the court can defer this decision to the provincial Review Board designated under section 672.38 of the *Criminal Code*. If the accused is not found to be a significant threat to public safety (discussed below), he or she must be given an absolute discharge.

When dealing with the question of the accused's mental capacity for criminal responsibility, the court has much the same power to order an assessment to obtain evidence on this question (*Criminal Code*, s 672.11(b)) as it does with respect to an accused's fitness to stand trial. Pre-trial detention of an accused while awaiting in-custody assessments was held to violate section 7 of the *Charter* by an Ontario court (*R v Hussein and Dwornik* (2004), 191 CCC (3d) 113 (OSCJ) [*Hussein*]). However, *Hussein* was not followed in a more recent Ontario case (*Her Majesty the Queen in Right of Ontario v Phaneuf* [Indexed as: *Ontario v Phaneuf*] (2010), 104 OR (3d) 392 at para 19). The Ontario Court ruled that the relevant provisions in the *Criminal Code*, specifically s.672.11, cannot be interpreted as requiring accused individuals who are ordered to be assessed in custody in a hospital to be taken immediately to that hospital. It cannot be read as prohibiting their detention in a detention centre pending transfer to the hospital. Accordingly, it was held that *Hussein* was wrongly decided.

The accused is always entitled to raise a lack of mental capacity when facing criminal liability by calling evidence relating to it. The Crown may adduce evidence on the accused's mental capacity for criminal responsibility where the accused has raised the issue or has attempted to raise a reasonable doubt using a defence of non-mental disorder automatism (a mental state lacking the voluntariness to commit the crime). Where the accused pleads not guilty, does not put mental capacity in issue and does not raise the defence of non-insane automatism, the court may allow the Crown to adduce evidence on the issue of mental capacity only after it has been determined that the accused committed the act or omission (*R v Swain* (1991), 63 CCC (3d) 481 (SCC)).

An accused is presumed to not suffer from a mental disorder that exempts him or her from criminal responsibility until the contrary is proven on a balance of probabilities (*Criminal Code*, s 16(2)). An official finding that the accused is NCRMD will only occur when the Crown has otherwise proven the guilt of the accused beyond a reasonable doubt, and the mental disorder exempting the accused from criminal responsibility is proven on a balance of probabilities. The burden of proof is on the party that raises the issue (*Criminal Code*, s 16(3)).

C. *Disposition Hearings After NCRMD*

A finding of NCRMD ends criminal proceedings against the accused. There will then be a disposition hearing either in court or in front of the Review Board (*Criminal Code*, s 672.38). Under section 672.54 a person found NCRMD may be:

- a) discharged absolutely where the Review Board or court finds that the accused is not a significant threat to the safety of the public;
- b) discharged subject to conditions considered appropriate by the court or Review Board; or
- c) detained in custody in a psychiatric hospital subject to conditions considered appropriate by the court or Review Board.

With the passage of 2014 Bill C-14, discussed fully below, the court may also designate a person as a high-risk accused, and then the Review Board would only be able to make a narrow custody order. Amendments from Bill C-14 have also made changes to other sections of the *Mental Disorder* provisions of the *Criminal Code*, some of which are highlighted below.

When the Review Board renders a decision under section 672.54, it must take into consideration “the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused.” The 2014 Bill C-14

amendments have changed the wording from requiring the Review Board to make a decision that is “least onerous and least restrictive” to one that is “necessary and appropriate”. However, subsequent Review Board decisions and court decisions have confirmed that the intent and guiding principles from the Supreme Court of Canada case of *Winko v the Director of the Forensic Psychiatric Hospital* [1999] 2 SCR 625 [*Winko*] still apply. Therefore, the principle of making the least onerous and least restrictive order still applies to Review Board decisions. For further related case law please see *Ranieri (Re)* 2015 ONCA 444; *Re Osawe*, 2015 ONCA 280; *McAnuff (Re)* 2016 ONCA 280.

The Review Board must review cases in which a person is found NCRMD at least once a year if the person is still detained in a mental facility or is fulfilling conditions pursuant to the disposition hearing (*Criminal Code*, s 672.81). However, as a result of the operation of section 672.54, it is possible for individuals found NCRMD to be subjected to prolonged or indeterminate detention or supervision by the Review Board, even for committing relatively minor offences.

In response to a number of cases challenging the constitutionality of section 672.54, the Supreme Court in *Winko* rejected arguments that section 672.54 violates the *Charter*. According to *Winko*, a “significant risk to the safety of the public” means a real risk of physical or psychological harm to members of the public. The conduct giving rise to the harm must be criminal in nature. The process of determining whether the accused is a significant threat to public safety is non-adversarial, and the courts or Review Board may take into consideration a broad range of evidence. This includes the accused’s past and expected course of treatment, present medical condition, past offences, plans for the future and any community support that exists. See *Winko* for a complete discussion of the application of section 672.54. Bill C-14, discussed fully below, codifies some of this decision, such as the definition of “significant harm”.

Two Supreme Court of Canada cases considered the “least onerous and least restrictive” requirement of s 672.54. In *Pinet v St Thomas Psychiatric Hospital*, [2003] SCJ No 66, it was held that the “least onerous and least restrictive” requirement applies not only to the bare choice among the three potential dispositions – absolute discharge, conditional discharge or custody in a designated hospital, but also to the particular conditions forming part of that disposition. In *Penetanguishene Mental Health Center v Ontario (Attorney General)*, [2004] SCJ No 67, the court decided that this applied not only to the choice of the order, but also to the choice of appropriate conditions attached to the order, considering public protection and maximisation of the accused’s liberties.

The Review Board’s powers were considered in *Mazzei v BC (Director AFPS)*, [2006] SCC 7. It has the power to place binding orders and conditions on any party to the Review Board hearing, including the director of the psychiatric hospital. It does not prescribe or administer treatment. It may supervise and require reconsideration of treatment provided. Treatment is incidental to the objectives and focus on public safety and reintegration. The Review Board aids in only these two goals.

For information on pleading “Mental Disorder” and “Non-Mental Disorder” automatism, please consult the Continuing Legal Education Society’s manual on “Criminal Law and Mental Health Issues”.

1. Recent Changes

Bill C-14, the “Not Criminally Responsible Reform Act”, which received royal assent in April 2014, came into force on July 11, 2014. This new legislation is meant to strengthen the Criminal Code’s decision-making process relating to accused persons found NCRMD, in order to make public safety the primary consideration, enhance victim safety, and provide victims with a stronger voice in the process.

The primary function of the amendments is to create a new designation of “high-risk accused”. Section 672.64 of the *Criminal Code* allows the court to designate a person who was found NCRMD to also be a high-risk accused. This designation is available when the offence was a serious personal injury offence, as defined in section 672.81(1.3), the accused was over 18 when the offence occurred, and one of two additional factors are present. The first of these factors is when the court finds that there is a substantial likelihood that the accused will use

violence that could endanger the life or safety of another person. The second is when the court is of the opinion that the acts underlying the offence were of a brutal nature, which indicates a risk of grave physical or psychological harm to another person.

When deciding whether to render this designation, the court must consider certain factors, outlined in section 672.64(2) of the *Criminal Code*. Some of the factors pertain to the nature of the offence, the accused's current mental state, as well as expert opinion. Once a person is found to be a "high-risk accused", they are subject to mandatory hospital detention and may have increased time between Review Board hearings.

In order for the high-risk accused designation to be removed, the Review Board must first refer the finding to a superior court. The court may only revoke the designation if satisfied that there is not a substantial likelihood that the accused will use violence that could endanger the life or safety of another person.

Bill C-14 also aims to improve victim's rights, by providing notice to victims of the intended place of residence of any NCRMD accused who receives an absolute or conditional discharge. The victim is informed of the general location where the offender resides, but not the specific address. Furthermore, when the high-risk status of an accused is being reviewed by the court, victims may file impact statements which then must be considered by the court.

Significant criticism has been directed at these provisions prior to their coming into force, suggesting that they will do little to improve the rights and safety of victims, and are unnecessarily punitive in nature. Furthermore, it was argued that by placing the "high-risk" designation in the hands of the courts, the ability for the Review Board and hospitals to appropriately assist, treat and manage NCMRD patients will be diminished. For a full discussion of these concerns, see Lisa Grantham's "Bill C-14: A Step Backwards for the Rights of Mentally Disordered Offenders in the Canadian Criminal Justice System". However, since the provisions came into force, there have not been any significant changes to the Review Board and its authority.

In BC there is no person currently designated as a "high-risk accused". The only BC case involving a determination of "high-risk accused" status is *R v Schoenborn*, (2010) BSCS 220 [*Schoenborn*]. The accused was found NCRMD and was currently held in a mental health facility. In April 2015, the BC Review Board granted Schoenborn escorted community access at the discretion of the Director of the facility in order to aid his rehabilitation. In 2017, the Attorney General of BC applied unsuccessfully to the BC Supreme Court to have Schoenborn designated as a "high-risk accused". After many days of evidence in court, the judge found that Schoenborn did not meet the criteria for a "high risk accused" (*R v Schoenborn*, 2017 BCSC 1556).

There is some discrepancy between the provinces as to whether one can be retroactively classified as a "high-risk accused". In British Columbia, it has been found that applying a retroactive "high risk" designation to trials that occurred before the legislation came into effect is not unconstitutional (*Schoenborn* 2015 BCSC 2254).). However, in Quebec it was decided that a retroactive application is unconstitutional (see *R v CR*, 2015 JQ No 2448).

IX. COMPLAINTS TO THE OMBUDSPERSON

Complaints concerning provincial mental health facilities, their practices or their treatment of patients may be taken to the BC Ombudsperson. This office has the authority to investigate patient complaints, make recommendations to the facility, mediate problem situations that may arise between a patient and the facility and make recommendations to the Lieutenant-Governor and the Provincial Cabinet regarding the results of these investigations.

Complaints must be made in writing. The office is careful to ensure that, where necessary, the identity of the complainant is kept secret from hospital staff. Common complaints include concerns about over-medication, seclusion, or providing rights information. In such cases, the Ombudsperson has the authority to take the issue to an outside medical source to verify whether the patient is receiving appropriate levels of medication, to ensure the facility follows necessary protocols and reviews for placing people in seclusion and provides immediate rights information for those involuntarily detained. Complaints can be filed through the website at www.ombudsman.bc.ca or by calling the Ombudsperson's office at 1-800-567-3247.

X. REFERENCES

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Website for mental health related forms: http://www.health.gov.bc.ca/mhd/mental_health_act_forms.html

XI. LSLAP FILE ADMINISTRATION POLICY – MENTAL HEALTH

This chapter is specific to LSLAP clinicians. It sets out internal LSLAP practice and policy regarding Mental Health. Students with clients who have upcoming review panel hearings are encouraged to contact the Mental Health Law Program at CLAS for advice, and to see if a referral would be appropriate. The Mental Health Law Program (MHLPP) at CLAS assists involuntarily admitted patients at review panel hearings.