CHAPTER FOURTEEN: MENTAL HEALTH LAW

TABLE OF CONTENTS

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I. INTRODUCTION

Mental health law in British Columbia is contained largely in three statutes: the Mental Health Act, R.S.B.C. 1996, c. 288 [MHA]; the Patients Property Act, R.S.B.C. 1996, c. 349 [PPA]; and the Public Guardian and Trustee Act, R.S.B.C. 1996, c. 383. In 1999, a large-scale amendment to the MHA, called the Mental Health Amendment Act, S.B.C. 1968, c. 27, altered several significant aspects of the MHA including definitions, procedure for admissions to a mental health facility and the authority of directors of mental health facilities. There were further amendments in 2005 that changed how members were appointed to the Review Panel under the MHA.

Five other statutes also affect mental health law in B.C. Three of these Acts are: first, the Adult Guardianship Act, R.S.B.C. 1996, c. 6; second, the Health Care (Consent) and Care Facility (Admission) Act, R.S.B.C. 1996, c. 181; and third, the Representation Agreement Act, R.S.B.C. 1996, c. 405. Selective parts of these Acts were brought into force in February 2000. Over 75 amendments to these Acts were passed in March 2001. Be aware that these three Acts are under revision and check to see if any amendments have been made. The fourth Act is the Power of Attorney Act, R.S.B.C. 1996, c. 370. For information about adult guardianship and representation agreements in contexts where the Mental Health Act is not involved, see **Chapter 15: Guardianship – Committeeship, Power of Attorney and Representation Agreements**.

The fifth statute that affects mental health law is part XX.1 of the federal Criminal Code of Canada, R.S. 1985, c. C-46 (Mental Disorder provisions) which applies to people found unfit to stand trial or not criminally responsible by reason of mental disorder. These people would then be under the jurisdiction of the Review Board, which is an independent tribunal established under the Criminal Code. The Review Board's mandate is to protect public safety and safeguard the rights and freedoms of persons with mental disorders.

In 2005 there were amendments to the mental disorder provisions of the Criminal Code to give more power to the Review Board, expand the rights of the victim, grant authority to courts to hold an inquiry and order a judicial stay of proceedings, refine provisions on the transfer of the accused, offer wider choices for the police in enforcing disposition and assessment orders and repeal provisions related to imposing a cap of the detention period of the accused.

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 to offer advice, as a basis for further research, or to provide referrals to specific government agencies, members of the private bar, or to LawLINE of Legal Services Society, which provides free, brief legal advice over the telephone to financially eligible callers. Even if financial eligibility guidelines are not met, a caller may receive some legal information through Legal Services Society. See **Chapter 23: Referrals** for LawLINE's contact information.

A. Mental Disorders and Barriers to the Legal System:

Persons with mental disorders may face significant challenges in their daily lives. Their mental difficulties may create problems with interpersonal relationships and communication, and may create difficulties attaining and keeping a job. Mental disorders exist on a continuum. On one end of the spectrum exist chronic conditions; while on the other persons may only have acute problems that are only temporarily disruptive.

These mental disorders may seriously affect a person's capacity to deal with legal issues. The stress related to legal issues can aggravate both the symptoms of mental disorders and the individual's ability to resolve their problem. The combination of stressful events and mental disorders can lead to problems with poverty, with organizational and communication skills, and a lack of ability to seek appropriate remedies.

Mental disorders may affect a client's relationship with every aspect of the law. Acknowledging and addressing mental issues may be vital to the successful resolution of these client's legal issues.

B. Client Intake

Practitioners should be aware that mental disorders may not be that easy to spot. Some people may mask their mental disorder, recognizing that people treat them differently when they appear symptomatic. To an observer, this may be mistaken for withholding information. However, as the interview progresses it may become evident that the client exhibits odd behavior and thought processes.

In British Columbia there is a presumption that all adults are capable of making their own decisions unless the contrary is demonstrated. Behind a mental disorder may be a person with a genuine legal issue that needs to be addressed. It is therefore important not to dismiss a person because they have a mental disorder, or because you suspect that they may. Listen to their story to assess whether a legal problem exists.

Where no legal issues exist remember that the client may be seeking help of any sort from someone they feel they can trust. In these situations referrals are appropriate. Referrals to mental services can offer many advantages. Even persons who suffer acute mental stress due to the nature of their legal problems could use counselors to help them organize their thoughts and develop coping strategies to help them provide information to the practitioner and provide clear and concise evidence.

C. Governing Legislation and Resources

1. Legislation

Criminal Code of Canada, R.S. 1985, c. C-46 (Part XX.1, Mental Disorder provisions).

Health Care (Consent) and Care Facility (Admission) Act, R.S.B.C. 1996, c. 181.

Mental Health Act, R.S.B.C. 1996, c. 288. (MHA)

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

Patients Property Act, R.S.B.C. 1996, c. 349.

Power of Attorney Act, R.S.B.C. 1996, c. 370.

Public Guardian and Trustee Act, R.S.B.C. 1996, c. 38.

2. Resources

a) Counselling Services

Counselling may help people plan to deal with specific issues in their lives. Some counsellors may also provide systemic outpatient care for people that are suffering from more severe disorders and require greater involvement.

City University Community Counselling Clinic
Broadway Youth Resource Centre (BYRC)
691 East Broadway — Telephone: (604) 709-5729
Vancouver, B.C. V5T 1X7 — Fax: (604) 709-5721

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

Peace Portal Counselling Centre
c/o Peace Portal Alliance Church
15128 27B Avenue — Telephone: (604) 542-2501
Surrey, B.C. V4P 1P2 — Fax: (604) 542-2504

- Provides professional counselling services. Office is wheelchair accessible. Serves Abbotsford, Delta, Langley, Surrey, and White Rock.

New Westminster Counselling Centre
University of British Columbia
821 8th Street — Telephone: (604) 525-6651
New Westminster, B.C. V3M 3S9 — Fax: (604) 517-6390

- Provides personal, career, couple, and family 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. **They do not charge a fee for their services.**

Oak Counselling Services Society
949 West 49th Avenue — Voicemail: (604)-266-5611
Vancouver, B.C. V5Z 2T1 — Fax: (604) 261-7205
Web site: www.oakcounsellingservices.com
E-mail: info@oakcounsellingservices.com

- Offers professionally-supervised counselling for issues such as grief, relationships, and life transitions. Fees are based on a sliding scale. Fees are waived for people receiving social assistance or provincial disability pensions.

b) Others

Community Legal Assistance Society (CLAS)'s Mental Health Law Program
Telephone: (604) 685-3425

- Provides information on civil commitment, procedure, the rights of mental patients and the MHA amendments. Other CLAS programs provide free legal services in specific areas such as tenants' rights, E.I., W.B.C. and human rights.

- Provides representatives at tribunal hearings under the MHA and under the Criminal Code mental disorder provisions.

Motivation, Power, and Achievement Society (MPA)
Telephone: (604) 482-3700

- Offers information, counseling and representation for Review Panels

MPA Mental Health Empowerment Advocates Program
Telephone: (604) 482-3700 or (604) 738-5770
Toll-free: 1-877-536-4327

- Provides advocates with help in income assistance, provincial and federal disability, income tax and other issues to help assist individuals who have a mental health disability

MPA Court Services
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 B.C. (PGT)
Telephone: (604) 660-4444

- 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 that affect their lives.

- 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

B.C. Coalition of People with Disabilities
Telephone: (604) 875-0188 TTY: (604) 875-8835
Toll-free: 1-877-232-7400

- A self-help umbrella group that raises public awareness of issues affecting people with disabilities

Advocacy Access Team
Telephone: (604) 872-1278
Toll-free: 1-800-663-1278

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

B.C Human Rights Coalition
Telephone: (604) 689-8474
Toll-free: 1-877-689-7511

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

PLAN
Telephone: (604) 439-9566

- Provides advocacy services and up-to-date legal information on wills and estates, trustees and financial planning.

- 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.

ARA Mental Health Action Research and Advocacy Association of Greater Vancouver
Telephone: (604) 689-7938
Toll-free: 1-866-689-7938

- Advocates for people with mental illnesses, addressing issues including income assistance, tenancy, employment, education, medical/dental, substance abuse, appeals and tribunals.

Review Panel Office
Telephone: (604) 524-7220

- The office, located at Riverview Hospital, can provide information on the release of patients.

Crisis Centre of Greater Vancouver
Telephone: (604) 872-3311 Toll-free: 1-800-SUICIDE (784-2433)

- A 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.**

Department of Justice
Web site: http://canada.justice.gc.ca

- Web site contains all federal statutes and links to related sites.

Guide to the Mental Health Act
Web site: www.hlth.gov.bc.ca/mhd

Ministry of Health Services
Website: www.healthservices.gov.bc.ca/mhd/mhdforms.html

- Provides downloadable Mental Health Act forms on their website. See link directly above.

COAST Foundation
Telephone: (604) 872-3502

British Columbia Review Board
Website: www.bcrb.bc.ca Telephone: (604) 660-8789
Toll-Free: 1-877-305-2277

- Makes review dispositions where individuals charged with criminal offences have been given verdicts of not criminally responsible on account of mental disorder or unfit to stand trial on account of mental disorder, by a court.

Canadian Mental Health Association, B.C. Division
Telephone: (604) 688-3234
Toll-free: 1-800-555-8222

II. 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 only 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 disabled persons in areas where they might have the mental capacity to act for themselves.

Although governed by statute in areas concerning mental incapacity, courts still have the ability to exercise the *parens patriae* power, which allows the court to act in the best interests of the individual where gaps in the law exist. This power is not often exercised, however.

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. However, most discriminatory legislation in B.C. remains unchallenged. All Charter challenges have been directed towards either the MHA or the Criminal Code.

III. OVERVIEW OF INCAPACITY

The day-to-day challenges of incapacity issues are dealt with in **Chapter 15**: **Guardianship – Power of Attorney, Representation Agreements and Committeeship**. The present chapter focuses on Mental Health Law issues within the context of institutional and psychiatric cases. If a client presents with questionable mental capacity due to such challenges as dementia, brain injury or developmental intellectual disability, **Chapter 15** will provide further guidance.

A person's capacity to make a legally binding decision depends on the type of decision at hand. What follows is an overview of the interplay of incapacity with various legal decisions and responsibilities. The reader is also encouraged to consult **Chapter 15**.

A. Guardianship and Committeeship

1. Committeeship and the Public Guardian and Trustee of B.C.

When an individual is mentally incapable of managing his or her affairs, it is possible for someone else to be legally enabled to manage the individual's affairs or to make decisions about his or her personal care. The person or persons are called a "committee". A committee may be court appointed or may result from the operation of the Patients Property Act when an individual is a patient in a mental health facility (see **Chapter 15** for a complete discussion).

2. Adult Guardianship Legislation

B.C. legislation affecting Guardianship is in a transitional period. At the time of writing, the Patients Property Act, R.S.B.C. 1996, c. 349 (PPA) is still in effect. However, modern Guardianship legislation has been passed but is not yet in force. Guardianship will be governed by the PPA until the new legislation comes into force. Please also refer to **Chapter 15** for more information on the new legislation.

B. Marriage, Divorce and Children

1. Marriage

A person entering into a marriage contract must have the mental capacity to understand the nature of the contract and the legal consequences and responsibilities involved. The Marriage (Prohibited Degrees) Act, S.C. 1990, c. 46 sets out the grounds for declaring a marriage void. Mental capacity is not listed as grounds for prohibition. Mental disability may be grounds for annulment if, at the time of the marriage, the mentally disabled person did not understand the nature and consequences of marriage (e.g. that a partner can marry only one person, has a financial obligation to that person and marriage can only end by death or divorce).

2. Divorce

Mental illness itself is not grounds for divorce. A person who is mentally disabled must have the capacity to form the intention to "live separate and apart" to proceed with a divorce. Mental or physical cruelty is grounds for divorce, and mental illness is not a defence. Adultery is grounds for divorce, but in the case of a mentally ill person, the adulterous act must have occurred voluntarily and with consent for the adultery to be valid grounds for divorce.

3. Children

The law concerning sterilization of the mentally disabled is relatively undefined and contentious. In *E. (Mrs.) v. Eve*, [1986] 2 S.C.R. 388 sterilization for only partially therapeutic reasons was held to be illegal. *Muir v. The Queen in Right of Alberta* (1996), 132 D.L.R. (4th) 695 (Alta. Q.B.) [*Muir*] concerned the wrongful sterilization of a young woman. In *Muir* the court dealt strictly with procedures that did not adhere to the exact requirements of the legislation, but made no direct comment on the legality of all sterilization procedures. Maximum damages, both regular and aggravated, were awarded to the victim for her pain and suffering.

In *D.E. (Guardian ad litem) v. British Columbia,* 2005 BCCA 134 the court decided that there would be no limitation period for sexual sterilization. That said, the court in *Arishenkoff v. British Columbia*, 2005 BCCA 481 decided that liability for abuse or injury caused by government employees cannot be retroactively assigned to the Crown if it occurred before the Crown Proceedings Act, S.B.C. 1974, c. 24 came into law on August 1, 1974. This may deny many abuse victims the ability to claim compensation for abuse suffered before August 1, 1974. And indeed, the *Arishenkoff v. British Columbia* decision was followed in *Richard v. British Columbia*, 2008 BCSC 254 to deny a cause of action to victims from the Woodlands School for abuse arising before August 1, 1974.

Custody of children may be granted to a person with a mental illness, subject to the "best interests of the child" test. If one parent is detained in a mental health facility and the other is unwilling or unable to care for the children, the children may be placed with a friend or relative. The Ministry of Children and Family Development will only step in at the request of someone who believes the arrangements made for the children are unsuitable, and will only enter into an agreement with the parent for short-term care of a child if no friend or relative is available. The parent retains control over important decisions for the child and carries financial responsibility for the child. The agreement is voluntary and can be ended at any time, allowing a parent to regain custody upon release. The Ministry will not enter into such an agreement, however, with someone who is unable to understand the nature of the agreement. In such a situation, if no friend or relative are available, the Ministry will likely apprehend the child.

4. Financial Obligations

The Family Relations Act, R.S.B.C. 1996, c. 128 imposes obligations on spouses to support each other (s. 89) and on adult children to support parents dependent on the child due to age, illness or mental infirmity (s. 90). The Divorce Act, R.S.C. 1985, c. 3 requires that a parent support his or her children past the age of sixteen if that child is unable to support him or herself by reason of mental disability. These obligations do not cease if the person is admitted to a mental health facility. A person entitled to support may apply to Provincial Court for an order requiring payment. The courts will decide whether or not a divorced mentally ill person is entitled to maintenance based on how dependent the mentally ill spouse has become on the marriage.

C. Capacity to Make a Contract

If a mentally disabled person meets the definition of "incapable" pursuant to the Patients Property Act, R.S.B.C. 1996, c. 349 (PPA) (see **Chapter 15, Section II**), he or she most likely lacks the capacity to enter into a contract. This capacity is relative to each particular transaction. To enter into a contract, a person must have the mental capacity to understand both the nature of the contract and its effect on his or her interests. If a contractor is unaware that the contractee is mentally ill, the contract may be enforceable against the mentally disabled individual and/or the committee. Some cases indicate, however, that even if the contractor had no notice of the contractee's incapacity, the contract may still be set aside as "unfair". If the contractor knows or a reasonable person would have known that the contractee was mentally ill, the contract is generally void.

D. Wills and Estates

1. Drafting a Will

There is no statutory authority specifically declaring that a mentally disabled person cannot draft a will. However, it is advised that a mentally disabled person have a written doctor's opinion confirming his or her capacity to draft a will. Under the PPA, transfers of property are void when arranged by persons deemed incapable. The appointment of a committee prior to the testator having made the will in question does not in itself demonstrate incapacity to make a will, though there is a much heavier burden on the person making the will to prove testamentary capacity.

2. Inclusion in the Will of a Child with a Mental Illness

Parents of a child with a mental illness contemplating drawing up a will should consult a lawyer. There are many legal complexities involved that, if not properly considered, could result in a variation of the will and affect the child's inheritance.

IV. LEGAL RIGHTS AND MENTAL HEALTH LAW

A. Income Assistance

Mentally disabled 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 appealed. The B.C. Coalition of People with Disabilities assists with applications and appeals (for further details, see **Chapter 21: Income Assistance**).

B. Employment/Disability Income

In *Fenton v. Forensic Psychiatric Services Commission*, (1991), 56 B.C.L.R. (2d) 170 (C.A.), the Court of Appeal overturned a B.C. Supreme Court decision that struck down provisions of the Employment Standards Act, R.S.B.C. 1996, c. 113 that allowed employers to pay mentally disabled employees less than minimum wage while working under a work rehabilitation program. Leave to appeal to the Supreme Court of Canada was refused.

If a person cannot work because of mental illness, the person may be entitled to employment insurance, disability benefits, CPP disability benefits or WCB benefits, provided that the mental illness is work related. For information on CPP disability benefits, see **Section IV.D: Canada Pension Plan**, below.

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.

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, S.C. 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 client is denied benefits, it is best to consult the Act directly as a first step or to contact a lawyer knowledgeable in the issues (e.g. Community Legal Assistance Society).

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. The British Columbia Coalition of Persons with Disabilities 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 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 s. 92 of the Motor Vehicle Act, R.S.B.C. 1996, c. 318. This decision is based on The Guide for Physicians in Determining Fitness to Drive a Motor Vehicle, which does not mention mental disability. 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 F.C. 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 also takes place at the facility, patients must vote in the riding where the hospital is located.

G. Human Rights Legislation

Under both B.C. and federal human rights legislation, it is contrary to human rights to discriminate with regard to housing, employment or services available to the public against a person who is mentally disabled. For information on launching a human rights complaint, see **Chapter 19: 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 disabled 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 to start or defend an action where a mentally disabled 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 B.C. 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*.

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

I. Immigration and Citizenship

A history of mental illness could result in an individual being classified as a member of an "inadmissible" class of persons under s. 38(1)(c) of the Immigration and Refugee Protection Act, S.C. 2001, c. 27. This section states that admission will not be granted where there are reasonable grounds to believe the applicant may cause excessive demand on health or social services. However, there are exceptions under s. 38(2).

J. The Charter

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

To date, the case law regarding the mentally ill and the Charter is not extensive. In *Thwaites v. Health Sciences Centre Psychiatric Facility* (1988), 48 D.L.R. (4th) 338 (Man. C.A.), involuntary admissions criteria not based on dangerousness were held to infringe s. 9. A similar case in B.C. challenging the detention criteria on constitutional grounds was unsuccessful (see *McCorkell v. Riverview Hospital Review Panel* (1993), 104 D.L.R. (4th) 391 (B.C.S.C.)). See also the discussion of Charter considerations under **Section VI. B: Criminal Responsibility**, below.

Fleming v. Reid (1991), 82 D.L.R. (4th) 298 (Ont. C.A.) dealt with the impact of s. 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 interests. The Court held that the section of Ontario's Mental Health Act, R.S.O. 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 B.C.'s legislation is yet to be determined. (See also *Starson v. Swayze*, 2003 SCC 32.)

In *Mazzei v. British Columbia (Director of Adult Forensic Psychiatric)*, 2006 SCC 572, it was decided that Review Boards have the power to issue binding orders to parties other than the accused. Also, the Review Board cannot prescribe a specific treatment, but can impose conditions regarding treatment. It is obligated to ensure that treatments are culturally appropriate.

K. Legal Rights of Those in Group Homes

Throughout the greater Vancouver area there are many "group homes" run by and/or for mentally disabled persons who do not need to be confined in a provincial mental health facility. These homes, run by groups such as COAST and the Motivation, Power, and Achievement Society (MPA), are governed by the Community Care and Assisted Living Act, S.B.C. 2002, c. 75. Foster homes and group homes of the provincial government fall under different Acts: the Child, Family and Community Services Act, R.S.B.C. 1996, c. 46 and the Hospital Act, R.S.B.C. 1996, c. 200.

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 s. 15 of the Charter (*Alcoholism Foundation of Manitoba v. The City of Winnipeg* (1990), 69 D.L.R. (4th) 697 (Man. C.A.)).

L. Voluntarily Admitted Patient

Admissions to mental health facilities may be either voluntary under s. 20 of the MHA or involuntary under s. 22 of the MHA (see **Section V: Involuntary Admissions Under The Mental Health Act**, below).

1. Charges for Mental Health Services

Section 4 of the Mental Health Regulations (B.C. Reg. 233/99) provides a formula for calculating the charges for care of persons admitted voluntarily (under s. 20 of the MHA) to a mental health facility. It does not authorize or mention any charges for care to be paid by those persons who are admitted involuntarily (under s. 22 of the MHA). According to *Director of Riverview Hospital v. Andrzejewski* (1983), 150 D.L.R. (3d) 535 (B.C. County Court), s. 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.

2. Consent to Treatment

Psychiatric treatment is legally considered a type of medical treatment. The Health Care (Consent) and Care Facility (Admission) Act, R.S.B.C. 1996, c. 181 [HCCFA] sets out the requirements for consent from the patient before a health care provider can legally provide health care. In the absence of specific provisions under the HCCFA, the common law continues to apply.

The HCCFA applies to the provision of psychiatric treatment except 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 retains the right to consent to health care on the patient's behalf (see **Section V: Involuntary Admissions**, below).

NOTE: 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.

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, s.5)

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 substitute decision maker, guardian or representative is present. (HCCFA, s.12)

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) 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 substitute decision maker, guardian or representative gives consent. (HCCFA, s.11)

If a substitute decision maker, 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)

The above-mentioned substitute decision maker can be a temporary substitute decision maker (TSDM), chosen by the care provider in accordance with HCCFA, s.16. See HCCFA, ss.16-19 for the authority and duties of a TSDM.

In situations where a mentally ill person is judged to be incapable of making a health care decision, it is likely that the MHA provisions for deemed consent to treatment will be used to authorize health care rather than the provisions for a substitute decision maker under the HCCFA. In such a case, the health care provider would seek to have the patient declared an involuntary patient under s. 22 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 new HCCFA, it is unlikely that mere signing of this form constitutes informed consent to treatment. Only where the patient has been informed of the nature of the risks and benefits of having or not having the specific treatment, of alternative treatments and has agreed to be subject to the treatment, will consent be considered to be informed.

3. 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 s. 18(b) of the HCCFA. This person runs the risk of being refused admission to the facility or being discharged if already admitted.

The hospital 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 person under the PPA. A legal guardian or public trustee would be appointed as committee to give consent for the patient. It is not sufficient for a family member to give consent for a voluntary informal patient without first obtaining legal guardianship, committeeship or becoming a substitute decision maker under the HCCFA.

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. The director of a hospital can also issue a director's order supported by only one medical opinion. A director's certificate of incapability pursuant to the PPA covers the patient's legal and financial affairs and can be obtained without going to court. Once a patient is discharged, a director's order is lifted under certain circumstance (see the Public Guardian and Trustee website: www.trustee.bc.ca, or the PPA). Prior to that, however, a patient can only have such an order vacated by court order.

NOTE: Much of the HCCFA is now no longer in force. As there may be future changes, students should check the statute before advising clients.

V. INVOLUNTARY ADMISSIONS UNDER THE MENTAL HEALTH ACT

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 for long-term admissions. **The HCCFA does not apply to psychiatric treatment of involuntarily admitted patients.**

The Mental Health Law Program at CLAS assists involuntarily admitted patients at review panel hearings. LSLAP clinicians should contact CLAS to see if a referral is appropriate.

Section 22 of the MHA allows a person to be admitted involuntarily if the person has a mental disability and requires treatment, supervision and control in or through a mental health facility to prevent the person's substantial mental or physical deterioration, to protect the person, or to protect others (s.22(3)(a)(ii) and (c)).

When the patient is re-evaluated, the facility or Review Panel must determine whether the involuntary admission criteria persist and consider the risk of the patient, if discharged, being detained again under s.22. Patients, even those no longer suffering form the symptoms of mental disorder, may continue to be detained if the risk is significant.

Under the MHA, it is possible for an individual residing in the community to be under the authority of the director of a mental health facility on extended leave. This may affect an individual's right to live where they want.

A. Restraint and Seclusion While Detained Under the MHA

B.C.'s MHA is silent on the issues of restraint and seclusion. Section 32 merely provides that every patient detained under the Act is subject to the discipline of the director and staff members of the designated facility. Issues around restraint and seclusion have yet to be considered in B.C., and there are few cases in Canada that address them.

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.

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 (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 (s. 22(2)).

1. Authority of a Police Officer

Where 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, then the police officer may apprehend and immediately take the person to a physician for examination (see 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 to exceed 48 hours. To grant this warrant, the judge must be satisfied that admission under s.22 is not appropriate and that the applicant has reasonable grounds to believe that s.22(3)(a)(ii) and (c) of the MHA describe the condition of the individual (see 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, each completed by a physician in accordance with s. 22(2). The patient will be discharged one month after admittance unless the detention is renewed in accordance with s. 24.

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 cannot be suitably admitted as a voluntary patient.

For admission to be valid, the physician who examined the person must sign the medical certificate and must have examined the patient not more than 14 days prior to the date of admission. For a second medical certificate 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 may be open to a Charter challenge. (See *Mullins v. Levy,* (2009), 304 D.L.R. (4th) 64 (B.C.C.A.)

E. Consent to Treatment

Under s. 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 guardian, committee, substitute decision maker or representative.

An involuntary patient or someone on his or her behalf may request a second medical opinion on the appropriateness of the treatment authorized by the director. Under s. 31(2) a patient may request a second opinion once during each detention period. Under s. 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. This may be open to a Charter challenge.

F. Right to Treatment

The legal question of whether an individual involuntarily detained in a mental health facility has a right to treatment, thereby compelling the facility to either provide treatment or release the individual, has not yet been resolved in Canada. Under s. 8 of the MHA a patient's right to receive treatment appears to depend on what the facility can provide.

A patient held without any treatment whatsoever may be able to claim civil damages on the basis of non-admission of treatment constituting a breach of statutory duty. Even though what constitutes appropriate treatment is within the discretion of the institution to determine, the common law of medical malpractice applies to treatment administered in a medical institution.

G. Right to be Advised of One's Rights

Under s. 34 of the MHA a person who is involuntarily admitted and detained, renewed or transferred must be informed by the director or officer in charge immediately, or as soon as the person is capable of comprehension, of the reasons for detention, the duration of the detention, the rights set out in s. 10 of the Charter; the right to a Review Panel and the right to apply to the Supreme Court for a review of his or her detention.

H. Transfer of Patients/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 s. 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 s. 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 continuing to live at the institution (s. 39(1)). The patient is still detained under the MHA and will be subjected to treatment authorized by the Director 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 to another authorized facility) (s. 39(2)). There is no statutory obligation on the institution to inform the patient that the leave is conditional or has expired, leaving open the possibility that a patient may unknowingly violate the terms of his or her leave.

Under s. 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, and if 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 (ss. 36(1), 37). Under s. 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", for further periods of one month, three months and six months.

2. Through a Review Panel Hearing

An involuntary patient is entitled to a hearing before a Review Panel. Generally, a patient may have a hearing once during each period of detention. The application for a Review Panel Hearing may be made by the patient or by someone else on the patient's behalf (s. 25). The application is completed by filling out an Application for Review form contained in the MHA Regulations. Section 6 of the Regulations describes the conduct of Review Panel Hearings. Students are encouraged to contact the Mental Health Law Program at CLAS to see advice and a possible referral.

A 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.

The Ministry of Health appoints all three members from a list of people previously accepted by Order in Council.

It is policy that to maintain a quasi-judicial character, those who sit on the 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 require whatever evidence they need.

The hospital's position is presented by another medical person acting as the hospital's representative, usually another member of the medical staff. The patient can be represented by counsel or by an advocate who can present the patient's position at the hearing.

The Review Panel may examine the current hospital record of the patient, as well as the records of any previous admissions. Procedure at Review Panel hearings is subject to the principles of fundamental justice under s. 7 of the Charter and due process under the common law.

NOTE: Adjournments are procedural options when appearing before a Panel.

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 the Mental Health Law Program of the Community Legal Assistance Society staff within the Lower Mainland or on an ad hoc basis outside of the Lower Mainland (see **Section I.C.2: Resources** at the start of the chapter for contact information).

The rules of natural justice dictate that one has a right to appear at one's own hearing. However, under s. 25(2.6) of the MHA the Chair of the Review Panel may exclude the patient from the hearing or any part of it, but only if satisfied that exclusion is in the best interests of the patient. 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 or not the patient's detention should continue. The decision 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 director of the mental health facility and to 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 s. 25(2) the Review Panel is authorized to determine whether the detention of the patient should continue. The patient's detention must continue if ss. 22(3)(a)(ii) and (c) continue to describe the patient: i.e. 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). Also, despite any defect or apparent defect in the authority for the initial or continued detention of a patient detained under s. 22, a Review Panel must conduct a hearing and determine

whether the detention should continue because the factors in s. 22(3)(a)(ii) and (c) continue to describe the condition of the patient.

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 ss. 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* to challenge the authority upon which she or he is being detained. This action is most suitable where there was some procedural defect in the patient's admission and may be applied for as often as desired.

If the committing authority does not strictly adhere to the statutory requirements regarding committal, there exists an action in false imprisonment and a possible award of damages (*Ketchum v. Hislop* (1984), 54 B.C.L.R. 327 (S.C.)).

Under s. 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 s. 20(1)(a)(ii) or s. 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.

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 (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 (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 (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/herself or others," the person is not deemed discharged and a warrant may still be issued.

4. Aiding Escapees

Under s. 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, R.S.B.C. 1996, c. 338.

VI. 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 (s. 672.22 of the Criminal Code). The burden of proof is on whichever side raises the issue (s. 672.23(2)).

An accused is deemed "unfit to stand trial" under s. 2 if he or she is incapable of understanding the nature, object or 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 (s. 672.31). Under s. 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 C.C.C. (3d) 551.

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 (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. An inquiry must be held not later than two years after the verdict and every 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 (s. 672.33).

After the court finds 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, and must make a disposition that is the least onerous and restrictive to the accused pursuant to s. 672.54.

In *Demers v. Attorney General of Canada*, 2004 SCC 46, the court found that ss. 672.33, 672.54 and 672.81(1) violate 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 (s. 672.851).

The Review Board, the prosecutor or the accused may apply to order an 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 (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.

Appeal for an order for a stay of proceedings may be allowed if the Court of Appeal deemed the order as unreasonable or cannot be supported by the evidence.

B. Criminal Responsibility

1. Defence of Mental Disorder – Criminal Code Section 16

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), 51 C.C.C. (2d) 129 (S. C.C.)); 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* (1991), 62 C.C.C. (3d) 193 (S. C.C.));

then that person may be found not criminally responsible by reason of a mental disorder (NCRMD). This is a verdict distinct from either guilty or not guilty. If an accused is found NCRMD, the court decides whether the accused will receive an absolute discharge, conditional discharge, or be detained in a psychiatric hospital. 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 (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 s.7 of the Charter by an Ontario court (*R. v. Hussein and Dwornik* (2004), 191 C.C.C. (3d) 113 (O.S.C.J.)).

The accused is always entitled to put mental capacity for criminal responsibility into issue by calling evidence relating to it. The Crown is allowed to 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 C.C.C. (3d) 481 (S.C.C.)).

An accused is presumed not to suffer from a mental disorder that exempts him or her from criminal responsibility until the contrary is proven on a balance of probabilities (s. 16(2)). An official finding that the accused is not NCRMD will occur only when the Crown has otherwise proven the accused guilty beyond a reasonable doubt and the mental disorder exempting the accused from criminal responsibility is proven on a balance of probabilities, the burden of which is on the party that raises the issue (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 by the Review Board (s. 672.38). Under s. 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.

When the Review Board renders a decision under s. 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" and must choose the option that is "the least onerous and least restrictive to the accused".

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 (s. 672.81). However, as a result of the operation of s. 672.54, it is possible for individuals found NCRMD to be subject 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 s. 672.54, the Supreme Court in *Winko v. Director of Forensic Psychiatric Institute and the Attorney General of B.C.*, [1999] 2 S.C.R. 625 [*Winko*] rejected arguments that s. 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 that is serious in the sense of extending beyond the mere trivial or annoying. 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, including the past and expected course of the accused's treatment, present medical condition, past offences, the accused's plans for the future and any community support that exists. See *Winko* for a complete discussion of the application of s. 672.54.

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] S.C.J. 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, but it also applies to the particular conditions forming part of that disposition. In *Penetanguishene Mental Health Center v. Ontario (Attorney General)*, [2003] S.C.J. 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. B.C. (Director A.F.P.S.)*, [2006] S.C.C. 7. The Board's mandate requires it to hold the power to make orders and conditions binding 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 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 (2005 – 2007)

a) Review Board Powers

Several amendments expand the role of the Review Board. The Review Board may adjourn a hearing for 30 days (s.672.5), convene a hearing and issue a summons or warrant. With the consent of the Attorney General, the Review Board may, in certain circumstances, extend the time to review a disposition for up to 24 months (s.672.81).

b) Assessment Orders

The Review Board can order an assessment of the accused's mental condition to help determine a disposition if no previous assessment was done, or if none has been done within the past 12 months or if the accused is transferred from outside the province. The assessment may also be ordered when deciding whether to recommend that an inquiry be held to determine if a judicial stay of proceedings should be ordered for an accused likely to be permanently unfit to stand trial. An assessment order is generally in force for 30 days, but can be extended to 60 (s. 672.15).

c) Permanently Unfit Accused

The Review Board may refer the accused to Court to consider a stay of proceedings. If there is evidence, including an assessment, that suggests that the accused is permanently unfit and is not a significant threat, the Court may grant a stay of proceedings (s. 672.851).

d) Victims

After an NCRMD verdict and before disposition, the Review Board must ask whether the victim has been advised of the opportunity to make a victim impact statement (VIS) (s. 672.5(15.2)). Note that the victim is entitled to notice of hearing and relevant provisions of the Criminal Code (s. 672.5(5.1)). The victim can read or present a VIS unless it would interfere with the proper administration of justice (s. 672.5(15.1)). The hearing may be adjourned to allow time for the victim to prepare the statement (s. 672.5(15.3)).

e) Transfer Provisions

If a transfer would promote recovery or reintegration of an accused found NCRMD and consent is received from the Attorney General and Review Board of both the sending and receiving jurisdictions, an accused can be transferred to another province (s. 672.82(1)). A transfer may happen regardless of whether an accused is in custody or on a conditional discharge.

f) Police Powers to Enforce Dispositions

Amendments have been made to expand the choices for the police in arresting a person found NCRMD or unfit to stand trial. For instance, the police could issue a summons or appearance notice instead of using detention. The police can also let an accused stay in the place he or she is required to reside instead of holding the accused in custody until seen by a justice of the peace.

Note that related changes to the Youth Criminal Justice Act, S.C. 2002, c. 1 and the National Defence Act, R.S.C. 1985, c. N-5 have also been proposed to achieve consistency.

g) Publication Ban

The Review Board must make an order protecting the identity of victims or witnesses under 18 years old in relation to sexual offences, prostitution, money

laundering or child pornography related offences (ss. 672.502(1) and (2)). An application may be made to protect the identity of a victim or witness of any age if required for the proper administration of justice. A hearing will be held to assess risks, interests and alternatives (s. 672.501(3)). Please see s. 672.501 for more details.

h) Statutory Timelines

A court disposition no longer ceases to be in force after 90 days (s. 672.47(3)), but instead remains in force until the Review Board replaces it (s. 672.63). Also, there is no maximum period for the detention of the accused.

NOTE: For more information regarding Review Board Procedures, students may consult the following resources and resource persons:

CLAS' Mental Health Law Program (see section **I.C.2.**, Resources, above)

British Columbia Review Board (see section **I.C.2.**, Resources, above)

Lyle Hillaby, Crown Counsel
Telephone: (604) 927-2156

- Mr. Hillaby has extensive experience at Review Board Hearings and has volunteered to be a contact person for LSLAP clinicians.

VII. COMPLAINTS TO THE OMBUDSPERSON

Complaints concerning provincial mental health facilities, their practices or their treatment of patients may be taken to the 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. In such cases, the Ombudsperson has the authority to take the issue to an outside medical source to verify whether or not the patient is receiving appropriate levels of medication. One can go to the web site www.ombud.gov.bc.ca to file a complaint or call the Ombudsperson's office at 1-800-567-3247 for further information.

VIII. REFERENCES

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APPENDIX INDEX

A. CONSENT FOR TREATMENT (VOLUNTARY PATIENT)

B. APPLICATION FOR WARRANT (APPREHENSION OF PERSON WITH APPARENT MENTAL DISORDER FOR PURPOSE OF EXAMINATION)

C. REQUEST FOR SECOND MEDICAL OPINION

D. NOMINATION OF NEAR RELATIVE

Web site for mental health related forms: www.healthservices.gov.bc.ca/mhd/mhdforms.html.

APPENDIX A: CONSENT FOR TREATMENT (VOLUNTARY PATIENT)

FORM 2
MENTAL HEALTH ACT
[Section 20, R.S.B.C. 1996, c. 288]

CONSENT FOR TREATMENT (VOLUNTARY PATIENT)

I, _____ ,
patient's first and last name (please print)

in _____
name of designated facility

authorize the following treatment(s) _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The nature of my condition, options for my treatment, the reasons for and the likely benefits and risks of the treatment(s) described above have been explained to me by _____ .
name and position/title

_____ _____
signature (patient, if 16 years of age or older) *date of signature (dd / mm / yyyy)*

or

_____ _____
signature (parent or guardian, if patient is under 16 years of age) *date of signature (dd / mm / yyyy)*

_____
name of parent or guardian, if applicable (please print)

_____ _____
signature (witness) *date of signature (dd / mm / yyyy)*

_____
first and last name of witness (please print)

HLTH 3502 Rev. 99/11/15

APPENDIX B: APPLICATION FOR WARRANT (PAGE 1)

FORM 9
MENTAL HEALTH ACT
[Section 28, R.S.B.C. 1996, c. 288]

APPLICATION FOR WARRANT (APPREHENSION OF PERSON WITH APPARENT MENTAL DISORDER FOR PURPOSE OF EXAMINATION)

I, _____ , make application under section 28 (3) of
first and last name of applicant (please print)

the *Mental Health Act* with respect to _____ ,
first and last name of person about whom application is made

of _____ .
last known address of person about whom application is made

I have reasonable grounds to believe that:

(a) section 28 (3) of the Act applies to the above-named person; and

(b) section 22 of the Act* cannot be used without unreasonable delay.

** Section 22 requires that a physician examine the person to determine whether the person meets the criteria for involuntary admission to a designated facility.*

THE GROUNDS FOR MY BELIEF ARE:

_____

_____

_____

_____

_____
If additional space is required, use an additional page and date and initial that page

The applicant requests that a warrant be granted to apprehend the person.

Dated _____ at _____ , British Columbia
date (dd / mm / yyyy)

_____
signature of applicant

Applicant's relationship to the person who is the subject of this application, and how long the applicant has known this person:

_____ _____
relationship *length of time (months/years)*

AFFIDAVIT OF APPLICANT

I, _____ , ☐ swear ☐ affirm that:

1. I am the applicant for the warrant for apprehension of a person with a mental disorder.
2. The grounds for my belief are true to the best of my knowledge.

_____
signature of applicant

☐ Sworn ☐ Affirmed before me on _____
date (dd / mm / yyyy)

at _____ , British Columbia

_____
Commissioner for Taking Affidavits in British Columbia

HLTH 3509 Rev. 2002/11/18 page 1 of 2

APPENDIX B: APPLICATION FOR WARRANT (PAGE 2)

Instructions for Completing this Application

You are encouraged, but not required, to use the headings provided below to describe why you believe that a warrant under section 28 (3) of the Mental Health Act is needed. Further, if you believe that public knowledge of this written application could reasonably be expected to result in harm to your safety or mental or physical health, you may ask the judge or justice for permission to present your information verbally instead of completing this form, or for restrictions on the release of the information that forms the basis of this application.

1. **Indications of mental disorder** (e.g., hallucinations, delusions, depression, extreme excitement, specific difficulties in relating to others)

2. **Need for psychiatric treatment** (The above indications of mental disorder may also indicate a need for psychiatric treatment. List any other indications of need for treatment, such as previous psychiatric treatment, use of medication for mental disorder, recent changes in behaviour.)

3. **Need to prevent the person's substantial mental or physical deterioration** (e.g., failure to eat, uncharacteristic verbal abusiveness, sleep problems, extreme withdrawal. Were the early signs of any previous episodes the same or similar?)

4. **Need for protection of self or others resulting from the mental disorder** (Are there examples of clearly or potentially harmful behaviour or symptoms? e.g., suicidal ideation, potential loss of job, aggressive behaviour, uncharacteristic harmful financial actions. Has this person had similar previous episodes?)

5. **Refusal to attend voluntarily for examination by physician**

The information on this form is collected pursuant to section 28 of the *Mental Health Act*. It will be used by a judge to determine if a warrant should be issued for the apprehension and examination of the person. Any questions you have about this form may be addressed to the Clerk of the Court.

APPENDIX C: REQUEST FOR SECOND MEDICAL OPINION

FORM 11
MENTAL HEALTH ACT
[Section 31, R.S.B.C. 1996, c. 288]

REQUEST FOR SECOND MEDICAL OPINION

I, _____ , request a second medical opinion
first and last name (please print)

Check one box only

☐ on the appropriateness of my treatment.

OR

☐ on the appropriateness of the treatment of _____
first and last name of patient

who is an involuntary patient at _____ .
name of designated facility

Note: Complete either 1 or 2

1. Request for a specific physician

I request the examination be carried out by Dr. _____

of _____ .
address of physician (if known)

If my first choice is not available, I request Dr. _____

of _____ .
address of physician (if known)

I confirm that I have been advised that there may be a cost to me depending upon the distance the physician has to travel.

OR

2. Request to director to appoint a physician

I request that the director appoint a physician to conduct the examination.

_____ _____
signature *date (dd / mm / yyyy)*

_____ _____
signature of witness *name of witness (please print)*

_____
address and phone number (if applying on behalf of the patient)

HLTH 3511 Rev. 2002/11/18

APPENDIX D: NOMINATION OF NEAR RELATIVE

FORM 15
MENTAL HEALTH ACT
[Section 34.2, R.S.B.C. 1996, c. 288]

NOMINATION OF NEAR RELATIVE

The information on this form is collected pursuant to section 34.2 of the *Mental Health Act*. It will be used to document your nomination of near relative. Any questions you have about this form may be addressed to the director or staff of this facility.

The *Mental Health Act* requires that the director must send a notice to a near relative immediately after a patient's admission, discharge or an application to the review panel (where applicable).

If you do not name a near relative, the director must choose a near relative to be notified. If the director has no information about your relatives, notification will be sent to the Public Trustee.

I, _____ , would like the near relative named below
first and last name of patient (please print)
to be notified of my admission or discharge or an application to the review panel (as applicable).

Person to be notified:

_____ _____
first and last name *telephone number*

_____ _____
address *postal code*

This person's relationship to me is: (please check one only):

☐ wife	☐ husband	☐ common-law spouse	☐ committee of person
☐ mother	☐ father	☐ same-sex partner	
☐ grandmother	☐ grandfather	☐ friend	
☐ daughter	☐ son	☐ companion	
☐ sister	☐ brother	☐ legal guardian	
☐ half sister	☐ half brother	☐ caregiver	

_____ _____
signature of patient *date (dd / mm / yyyy)*

_____
name of designated facility

For office use only

☐ No known relative

☐ Patient declined to complete form

_____
staff signature

HLTH 3515 Rev. 2002/11/18