

English Mental Health Reform: Lessons from Ontario?

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Reforms in areas related to mental disability are under debate in England to an extent unprecedented for almost half a century. The Law Commission's proposals on incapacity, following further consultation from the Lord Chancellor's Department, have now largely been accepted in principle by the government for legislative enactment at some time in the undetermined future.² A joint green paper from the Home Office and the Department of Health has established a policy agenda concerning the governance of people with serious personality disorders.³ Proposals by an expert committee chaired by Professor Genevra Richardson on mental health reform have likewise been followed up by a government green paper,⁴ and the two green papers have in turn resulted in a joint white paper on reform of the Mental Health Act 1983.⁵ All this takes place as the Human Rights Act 1998 takes effect, with its guarantees relating to liberty and security of the person, standards for hearings, respect for private and family life, and protection from inhuman or degrading treatment. Throughout the development of the reforms, a number of similar themes have recurred, involving civil rights, the provision of appropriate legal processes, anti-discrimination, the respect for people with capacity, the extension of controls into the community, and the safety both of people with mental disabilities and of the public as a whole. At least in the public arena, most of the debate has focussed on the English situation. The premise of this paper is that the situation in the rest of the world may have something to teach us. The paper examines the law of Ontario. While it focuses primarily on those issues related to the Richardson Report and its subsequent government response, Ontario legislation divides issues somewhat differently to English law, and thus overlap with the other reform proposals is inevitable.

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2 Law Commission, *Mental Incapacity*, Law Com No. 231 (London: HMSO, 1995); Lord Chancellor's Department, *Making Decisions*, Cm. 4465 (London: TSO, 1999).

3 'Managing Dangerous People with Severe Personality Disorder - proposals for policy development'. (London: TSO, 1999).

4 Expert Committee, 'Review of the Mental Health Act 1983', chair: G. Richardson, (London: Department of Health, 1999); Department of Health and the Welsh Office, 'Reform of the Mental Health Act 1983: Proposals for Consultation' (London: TSO, 1999).

5 Department of Health and the Home Office, 'Reforming the Mental Health Act', 2 vols., Cm 5016-1 (London: TSO, 2000).

Historical Overview

The contemporary history of mental health law in Ontario conveniently begins in 1967, with the passage of a new Mental Health Act.⁶ In its general themes, it is comparable to the English Mental Health Act 1959. Both can be understood as broadly deferential to doctors' views, with admission criteria acknowledging a considerable degree of medical discretion, subject to review by an administrative tribunal. Both were silent on treatment issues. Unlike the English legislation, issues of incapacity were dealt with primarily under a separate statute, the Mental Incompetency Act. Nonetheless, where previously Ontario psychiatric inpatients had routinely lost the control of their estates, the 1967 act provided a system of routine assessments by the admitting physician of inpatient's capacity to manage their financial affairs, with the Public Trustee taking over management of the estates of those lacking such capacity, a system not reflected in the English legislation.

Significant revisions to the Ontario Mental Health Act were made in 1978. Where the 1967 act can be seen as reflecting developments in England, the 1978 act can be seen as anticipating them. Treatment provisions were introduced for the first time, on much the same model that would appear five years later in England: treatment of voluntary patients would be governed by common law, treatment of involuntary patients would be either by consent of the patient or else with a second opinion provided by a psychiatrist. Unlike the English system introduced in 1983, however, there was in Ontario no three-month grace period where treatment could be given without consent or second opinion, and the imposition of treatment without consent became subject to review by the administrative tribunal. Where the involuntary patient lacked capacity, consent could be provided by the patient's nearest relative as defined in the act, although no right of review was available to a doctor's decision regarding incapacity. Rights to view the clinical record were introduced at this time, although later strengthened considerably. A right to a tribunal review of the admitting physician's decision that the patient lacked financial capacity was introduced. More important for the body of this paper, amendments were made to the criteria for involuntary admission. Where the 1983 English act continued with vague criteria referring to the health or safety of the patient and the protection of others, the Ontario statute defined dangerousness in considerable detail.

To this point, the Ontario law had developed according to the evolution of political and professional thinking. The next set of amendments was forced by broader constitutional considerations. The Canadian Charter of Rights and Freedoms was introduced to the Canadian constitution in 1982. Along with enshrining rights for example to liberty and security of the person and to due process upon arrest or detention, section 15 of the Charter protected against non-discrimination on the basis, *inter alia*, of mental handicap. The implementation of section 15 was delayed until 1986, to allow the amendment of legislation to comply with the section. Amendment of the Mental Health Act was thus effectively forced upon the Ontario legislature. There was no consensus in the governing Liberal Party as to how to proceed: the Minister of Health, reflecting the perceived view of the medical establishment, did not favour major legislative amendment notwithstanding the introduction of the Charter provisions; the Attorney General, who would have had to defend the legislation in court, was much more open to changes. In the end, the matter was forced by amendments proposed and spearheaded by the opposition New Democratic Party.⁷

6 S.O. 1967, c. 51, contained in the following decennial statutory consolidation as R.S.O.1970, c. 269.

7 The amendments were introduced by the Equality Rights

Statute Law Amendment Act, 1986, S.O. 1986, c. 64 and the Mental Health Amendment Act, 1987, S.O. 1987, c. 37, both amending the Mental Health Act, R.S.O. 1980, c. 262.

The 1986 amendments were significant for a number of reasons. Procedural protections were clarified and strengthened. Patients who had capacity to do so were given the right to appoint the person who would serve as their substitute decision-maker in the event that they later lost capacity. Children admitted on the consent of their guardians (called ‘informal’ patients following the amendments)⁸ were given rights to tribunal review of their admissions. Most important for this paper, however, was the affirmation that a patient with capacity had the right to refuse treatment, whether that patient was voluntarily or involuntarily admitted to the hospital, and this refusal could not be overridden. The act further stipulated that patients lacking capacity could be treated on the consent of their substitute decision-maker, and detailed instructions were provided as to how this individual was to exercise that authority. The decision of the substitute would be based on the wishes of the patient when competent; or if none were known, best interests as defined by the statute.⁹ For the first time, the decision of a treating physician that a patient lacked capacity could be appealed to the review board. A provision allowing the refusal of the substitute to be overridden in the best interests of the patient was struck out by litigation as contrary to the equality provisions of the Charter.¹⁰ The result was that rights to consent to psychiatric treatment became entirely separate from admission status, although at this time both were still contained in the same legislation, the Mental Health Act.

This approach was taken a step further in 1992. Legislation regarding personal and financial guardianship had long been acknowledged in need of reform. The relevant legislation, the Mental Incompetency Act,¹¹ involved unwieldy court processes, and did not allow for partial guardianship arrangements beyond the distinction between financial and personal matters: an individual could manage all or none of their property and estate, and/or all or none of their personal affairs, but nothing in between. No more specific orders were possible. Some legislative tinkering had been done, such as the introduction of enduring powers of attorney for financial (but not personal) matters in 1983,¹² but no one was particularly satisfied with the state of the law. Various committees and inquiries had been struck,¹³ but reform had languished in an absence of consensus and political will. A change of government in 1990 brought the political will, with the election of the New Democratic Party.

8 Prior to 1996, Ontario law had followed the English style of categorising patients as involuntary (i.e., civilly confined) or informal (i.e., inpatients not civilly confined). Notwithstanding the legal definitions, the latter were generally referred to as ‘voluntary’, and the 1996 legislation amended the legal terminology to reflect this usage. ‘Informal’ became the term used for those aged from 12 to 16 who were admitted to the facility on the consent of another, usually the parent but sometimes a legal guardian or social services authority. For consistency, this paper will refer to adults not civilly confined as ‘voluntary’ even when the reference is prior to 1996, when ‘informal’ would technically have been the correct term.

9 Creating sections 1a(6) and 35(5) of the Mental Health Act then in force, reflected in the 1990 statutory consolidation as R.S.O. 1990, c. M.7, s. 2(6) and 49(5) respectively.

10 *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (O.C.A.).

11 This was based in the 1909 Lunacy Act, 9 Edu. VII, c.

37 (Ont.), itself really a codification of Victorian law. Amendments in 1911 slightly expanded the definition of incapacity, and new terminology was introduced in 1937. Otherwise, the act remained largely unchanged until its repeal in 1992: see R.S.O. 1970, c. 271, R.S.O. 1980, c. 264, R.S.O. 1990, c. M-9. Like the corresponding portion of the English legislation (Mental Health Act 1959, 7/8 Eliz II, c. 72, pt. VIII), the Mental Incompetency Act was directed at people with mental disabilities generally, not merely people under psychiatric care in hospital.

12 S.O.1983, c. 74, s. 2.

13 Eg., Attorney General of Ontario, ‘Interim Report on the Estates of Persons Incapable of Managing their Property’ (August, 1985); Tri-ministerial Committee on Guardianship (Chair: G. Sharpe) (1986); Attorney General of Ontario, ‘Report of the Committee on those Incapable of Managing their Affairs’ (Chair: S. Fram) (1987); Ministry of Health, ‘Report of the Enquiry on Mental Competence’ (Chair: D. Weistub), (Toronto: Queen’s Printer, 1990).

For present purposes, the 1992 reforms extended the Mental Health Act approach to the remainder of health care decision-making. The Consent to Treatment Act 1992¹⁴ provided a statutory right of competent patients to make treatment decisions, and the list of substitutes to make decisions in the case of incapable patients, without distinction between physical and mental disorders. The movement of these provisions from the Mental Health Act to the Consent to Treatment Act further articulated the division between treatment decision-making and institutional confinement, and emphasising a similar approach to mental and physical treatment. At the same time, new guardianship legislation covering financial and personal decisions other than health care and mental health confinement was passed as the Substitute Decisions Act 1992.¹⁵ The government was acutely aware of the need for effective enforcement and administration of these statutes. As a result, these statutes in combination with yet another piece of legislation, the Advocacy Act 1992,¹⁶ placed rights advice and advocacy on a statutory footing and created a bureaucracy run by a board to administer rights advice and advocacy services.

Advocacy Ontario was short-lived. Its establishment and initial operation had been controversial and problematic for a variety of reasons, and it was abolished following a change of government in 1995, although rights advice remains a part of the system, in a somewhat reduced form. The new government also replaced the Consent to Treatment Act 1992 with the Health Care Consent Act 1996.¹⁷ That statute continued the broad structure of the previous statute, respecting the treatment decisions of capable patients regarding both psychiatric and physical treatment.

In Ontario, homicides by those with psychiatric difficulties have in recent years been high profile as they have been in England, and the government responded with Brian's Law (Mental Health Legislative Reform), 2000.¹⁸ This law makes minor amendments to the existing confinement criteria, as well as adding a new ground of confinement concerning people who lack capacity to consent to treatment and whose mental illness is both of a recurring nature and has been shown amenable to treatment. As such, like the Richardson proposals, it would introduce a different standard of confinement for those incapable of consenting to treatment. It also introduces a new form of regulation of treatment outside the psychiatric facility, described as a 'community treatment order'. As will become clear below, this is more similar to a contract than a coercive order, as it requires the patient if competent (and otherwise the substitute decision-maker) to consent to the order. Consent can further be withdrawn on 72 hours notice. While the possibility of informal coercion is of course not to be underestimated,¹⁹ this model appears to be particularly strong on patient autonomy and, once again, does not undercut the basic position in Ontario law that persons with capacity have a right to refuse treatment.

14 S.O. 1992, c. 31.

15 S.O. 1992, c. 30.

16 S.O. 1992, c. 26.

17 S.O. 1996, c. 2, sch. A.

18 S.O. 2000, c. 9.

19 Regarding the prevalence of such informal coercion in the context of 'voluntary' admissions to psychiatric

hospitals, see J. Gilboy and J. Schmidt ' "Voluntary" hospitalization of the mentally ill' 66 Northwestern Law Review (1971) 429, V. A.Hiday. 'Coercion in Civil Commitment: Process, Preferences, and Outcome', 15 International Journal of Law and Psychiatry (1992) 359. Particularly good in assessing J. Monahan et. al. 'Coercion and commitment: Understanding involuntary mental hospital admission' 18 International Journal of Law and Psychiatry (1995) 249.

Lessons for England?

The Ontario law orders the regulation of mental health in a very different way to its English counterpart. On its face, it appears to take into account many of the concerns raised regarding English reform proposals. The Ontario Mental Health Act is acknowledged to have a policing function: it is about public safety, reflecting similar concerns of the UK government, expressed in its green and white papers. There is no restriction on the range of mental disorders which are covered by the act. People with serious personality disorders are dealt with in the same way as persons with any other mental disorder: if they are dangerous within the meaning of the Act, they are locked up. This matches the concerns of the government contained in the proposals on people with serious personality disorder. While dangerous people with mental disorders are dealt with differently from dangerous people without mental disorders, a point suggesting some possible discrimination in approach, the Ontario legislation seems otherwise to be as close to non-discriminatory as is reasonably possible. Specifically, treatment decisions under the Health Care Consent Act and other decisions covered by the Substitute Decisions Act are made on the basis of ability to make the decision in question: people with psychiatric problems are dealt with in exactly the same way as people with non-psychiatric incapacity, and psychiatric treatments in essentially the same way as physical treatments.²⁰ Capacity and the desire to regulate mental disorders in the same way as physical disorders are thus given a central role as envisaged by the Richardson report, with no sacrifice to the safety of the community. Procedural safeguards in the form both of rights advice and review tribunals, are provided efficiently and in abundance, and human rights are acknowledged. This seems to represent the range of concerns in the current English debate. Closer examination of the Ontario proposals further provide guidance on how English legislation might appropriately balance the above concerns.

Criteria and Process for Involuntary Admission

If the government is to increase the role of public safety as a guiding principle of the English Mental Health Act, as the white paper claims,²¹ it ought to do so responsibly. The risk with dangerousness criteria is that large numbers of non-dangerous people are falsely identified as dangerous and thus inappropriately confined.²² The current English criteria, referring only to it being 'necessary for the health and safety of the patient or the protection of other persons' that the individual be admitted for treatment,²³ provide no guidance as to how the appropriate threshold of risk is to be determined and thus provides no check on the over-prediction of dangerousness. The Richardson Report, somewhat surprisingly, does not propose any alteration of

20 *The one exception is the new community treatment orders, which apply only to treatments for mental disorder. Even these, however, can be terminated by the competent patient or the substitute of the incompetent patient. The difference is thus one of notification: a doctor must be notified if a patient goes off treatment for mental disorder governed by the order, where no comparable rule applies to physical disorder.*

21 *In the government's words, '[E]xisting legislation also failed to provide adequate public protection from those whose risk to others arises from severe personality disorder. We are determined to remedy this.'* White paper, p.1.

22 *See for example, P. Bowden, 'Violence and Mental Disorder', in N. Walker (ed.), Dangerous People, (London: Blackstone Press, 1996); J. Monahan, 'Risk Assessment of Violence Among the Mentally Disordered: Generating Useful Knowledge', 11 International Journal of Law and Psychiatry (1988), 249; J. Monahan and H. Steadman (eds), Violence and mental disorder: developments in risk assessment, (Chicago: University of Chicago Press, 1994).*

23 *Mental Health Act 1983, s. 3(2)(c); see also similar wording in section 2(2)(b) regarding admission for assessment.*

this wording. The white paper refers to 'risk of serious harm, including deterioration of health' or 'significant risk of serious harm to other people' as initial criteria for the imposition of a compulsory assessment, although the former criterion lapses into an ill-defined best interest test coupled with a treatability requirement when ongoing compulsion is at issue in the subsequent compulsory assessment.²⁴ Compare these to the 1978 Ontario criteria, contained in section 15(1) of the Mental Health Act:

- 15(1) Where a physician examines a person and has reasonable cause to believe that the person,
- (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
 - (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
 - (c) has shown or is showing a lack of competence to care for himself or herself
- and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,
- (d) serious bodily harm to the person;
 - (e) serious bodily harm to another person; or
 - (f) imminent and serious physical impairment of the person
- the physician may make application in the prescribed form for a psychiatric assessment of the person.

Substantively similar provisions apply to allow police officers and Justices of the Peace to remove an individual to a psychiatric facility, where the section 15 examination takes place.

The provision makes a serious attempt to clarify what sort of behaviour will warrant confinement. Subsections (a) through (c) make it clear that the prediction cannot be based on pure speculation: a threat or attempt of bodily harm, violent behaviour or causing someone else to fear violent behaviour, or a demonstrated lack of competence to care for the self is required.²⁵ A standard of predicted behaviour is also required: *serious* bodily harm or physical impairment must be likely (not 'possibly') to occur. The word 'imminent' in subsection (f), removed by Brian's Law in 2000, suggested a time factor: things had to have reached or reasonably neared a crisis.²⁶

24 White paper, para. 3.15, 3.18. The white paper contains no obvious enforcement mechanism for the former set of criteria, apart from judicial review.

25 The case law stops short of insisting that an 'overt act of commission' be committed for subsections (a) through (c) to take effect: *Azhar v. Anderson* (1985, Dist. Ct., unrep.), in obiter. This would seem to raise a variety of rather tedious word-games: are threats 'overt acts of commission'? Is living in sufficient squalor to place oneself at risk of serious bodily harm or serious physical impairment an overt act? Or is it merely an omission to care for self? If these are the sort of situation the case holds to be included in subsections (a) to (c), the point is unobjectionable, if unexciting. If instead the finding that 'overt acts' are not required is intended to imply that

predictions need not be grounded in identifiable, actually existing prior conditions, the decision (from a lower level, non-Superior court) must be simply wrong on this point. It is difficult to see how the statute could be clearer.

26 The word 'imminent' was removed by Brian's Law, s. 3(1), for reasons not explained in the explanatory note to that statute. It would seem that one reason was that there was no consensus as to what the word meant. While it is an open question as to whether 'imminent' is the appropriate word, it does seem that some form of time frame should be understood as part of the predictive scheme. That said, there is no obvious reason why the risk of physical impairment should be treated differently than the serious bodily harm referred to in paragraphs 15(1)(d) and (e) in this respect.

Section 3(2) of Brian's Law 2000 adds a new and distinct set of confinement criteria to section 15:

15(1.1) Where a physician examines a person and has reasonable cause to believe that the person,

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

(b) has shown clinical improvement as a result of the treatment,

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

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

(d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment; and

(e) is apparently incapable, within the meaning of the Health Care Consent Act, 1996, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained,

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

While a marked departure from the 1978 clauses, it shows some parallel structure. For the behavioural criteria in the paragraphs 15(1)(a) to (c), this subsection substitutes specific experience of successful treatment for mental disorder now afflicting the individual. The dangerousness criteria of paragraph 15(1)(d) to (f) are reflected in paragraph (1.1)(d) of the new section, albeit with the additional ground of substantial mental or physical deterioration.

Significant for current discussion, the section applies only for persons incapable of consenting to the proposed treatment and where the consent of the substitute decision-maker has been obtained. Where section 15(1)(c) may have implicitly created a standard of confinement in which capacity was a relevant factor, the new subsection 15 (1.1) explicitly creates a standards of confinement based on the treatment capacity of the potential patient. This is a direct precedent for the Richardson proposals, which would create different criteria of compulsion based on capacity to consent to treatment. Effectively, the proposal allows slightly earlier intervention to ensure treatment of those lacking capacity to consent, where the substitute decision-maker consents and when there is a track record of successful treatment for the disorder. Here again, the right of competent patients to control their treatment is not affected: the provision applies only to those patients lacking capacity and does not in any way restrict the allegedly incapable person from applying for a review of his or her capacity in the usual way.

The initial admission provision allows confinement of an individual in a psychiatric facility for up to 72 hours. There is no review provided by the Act in this period, although judicial review by way of habeas corpus and civil actions for wrongful confinement are available, if not necessarily very

practical. In the 72 hour period, a more extensive examination is to occur pursuant to section 20 of the act, after which a further confinement may be permitted if the attending physician takes the view that the patient is indeed suffering from a mental disorder of a nature or quality which will likely result in one of the conditions in subsection 15(1)(d) to (f) or 15(1.1) above if the person does not remain in the facility, and the person is not suitable for voluntary admission. Section 20 confinements can be renewed as they approach their expiry.

The first of these section 20 confinements lasts for two weeks, the second for a month, the third for two months, and the fourth and subsequent for three months. These time periods are considerably shorter than the current English equivalents of twenty-eight days under a section 2 confinement, six months for the first two section 3 confinements, and one year thereafter.²⁷ These periods are significant both because they require the doctor to re-assess the case for confinement, a process which may result in the doctor taking the view that confinement is no longer justified, and also because in Ontario, as in England, the patient has a right to a review of detention by the tribunal once per certificate. There is much to be said for the Ontario approach here, which better reflects the time that psychiatric interventions require to take effect. A patient who opts for a hearing at the beginning of his or her confinement would thus have a right to a second one a couple of weeks later, as prescribed drugs are taking effect and when there may therefore be a real change in the applicability of the confinement criteria to the patient. In England, if hearings were held promptly (which of course they are not - more on that below), the condition of a patient opting for a hearing at the beginning of the confinement period could have changed markedly, to the point where the confinement criteria cease to be met, months before the patient would have the opportunity to apply for another hearing. The fact that this system works effectively in Ontario raises the question of whether the right to periodic review of detention established by *X v. United Kingdom*²⁸ ought to be interpreted considerably more strictly.

Informal/Bournewood Patients

The 1986 amendments to the Ontario Mental Health Act introduced the concept of an 'informal' patient. This is someone admitted on the authority of another, and thus bears some resemblance to *Bournewood* patients.²⁹ The Mental Health Act provision applied only to persons between the ages of twelve and sixteen years,³⁰ but in 1992, similar provisions were introduced regarding adults

27 See Ontario Mental Health Act, s. 20(4), and English Mental Health Act 1983, s. 20(1) and (2). While the English white paper abolishes the distinction between section 2 and 3 admissions (for assessment and treatment respectively), it does not alter the length of compulsory orders. These will remain at 28 days for the first order, six months for the following two, and a year for each order thereafter: para 3.10.

28 (1981) 4 EHRR 188.

29 That is, patients of the sort at issue in *R. v. Bournewood Community and Mental Health NHS Trust*, ex parte L [1998] 3 WLR 107 (HL). These are adults who lack the mental capacity to decide where they will live, and merely acquiesce to remaining in hospital. At issue in the case was whether these persons were 'confined', and whether they could be admitted to psychiatric facilities as

informal patients or whether instead civil confinement procedures needed to be applied. The House of Lords held that informal admission was acceptable, but the case has triggered discussion as to how such persons ought to be dealt with in law.

30 Mental Health Act, R.S.O. 1990, c. M.7, s. 13. Admission of minors as informal patients also occurs in England: see *R v. Kirklees Metropolitan Borough Council*, ex parte C [1993] 2 FLR 187 (CA), and Ralph Sandland, 'The Common law and the "informal" minor patient', 5:3 *Journal of Forensic Psychiatry* (1994) 569. The need for a separate regime determining the appropriateness of children in this situation has not as yet formed part of the English debate. Again, the Ontario legislation may provide a model for consideration.

in the Consent to Treatment Act and continued in the Health Care Consent Act 1996.³¹ Even now, the parallel with Bournewood patients is not exact, as the Ontario legislation clearly has in mind individuals who are not acquiescing to their admission. The acts grant objecting patients who apparently lack the capacity to decide their own hospital admission the right to have their admission to the psychiatric facility reviewed by tribunal. Absent such application, review of the admission of minors under the Mental Health Act occurs automatically at the end of six months, but there is no such routine scrutiny for adults.

The Richardson Report argues for the importance of statutory regulation covering the voluntary admission of incompetent acquiescing patients, who cannot be expected actively to challenge their admissions. The government's response in the white paper suggests an approach similar to that of Ontario: applications by the patient or their representative will be possible to challenge *de facto* detentions.³² The Ontario legislation may provide a model for the criteria which might be used to determine the appropriateness of such admissions:

34(5) In reviewing the decision to admit the person to the hospital, psychiatric facility or health facility for the purpose of treatment, the Board shall consider,

- (a) whether the hospital, psychiatric facility or health facility can provide the treatment;
- (b) whether the hospital, psychiatric facility or health facility is the least restrictive setting available in which the treatment can be administered;
- (c) whether the person's needs could more appropriately be met if the treatment were administered in another place and whether space is available for the person in the other place;
- (d) the person's views and wishes, if they can be reasonably ascertained; and
- (e) any other matter that the Board considers relevant.³³

It is clear that the admission of those who lack capacity to decide where they will live should not be as limited in the same way as civilly confined patients. If the Law Commission proposals on incapacity are implemented in their present form, acquiescing Bournewood patients would be admissible on the basis of their best interests, although not confineable absent judicial intervention.³⁴ While the factors contained in the statutory test of best interests overlap with the Ontario criteria somewhat and would be appropriate additions to the above factors, it is at least arguable that the specific issues contained in the Ontario criteria ought to be specifically considered before the admission of a Bournewood patient.

Treatment Provisions

As noted above, the Health Care Consent Act concerns all medical treatment, not merely psychiatric treatment. The key provision for current purposes is contained in section 10, which provides that treatment may not be given unless the practitioner offering the treatment has ensured that the patient consents and is capable of doing so. Capacity is in turn defined by section 4(1) of that act:

31 See *Consent to Treatment Act 1992*, s. 19, 32, and *Health Care Consent Act*, s. 24, 34.

32 *White paper*, paras. 6.4, 6.11.

33 *Health Care Consent Act*, s. 34(5). Similar provisions

may be found regarding children as informal patients in the *Mental Health Act*, s. 13(3).

34 *Law Commission, Mental Incapacity*, para. 4.30-33, 7.13.

4(1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

In this provision there is no express requirement of a mental illness or diagnosis. Unlike the English test in *Re C*,³⁵ there is no express requirement that the individual believe the information provided. This difference is largely illusory, however, given the requirement that the individual appreciate the reasonably foreseeable consequences of his or her choice. It would be an unusual, but not theoretically impossible case, where the individual appreciated the foreseeable consequences of the choice to be made, without believing the information provided.

Where the patient lacks capacity to consent, the prescribed substitute decision-maker has authority to give or withhold consent. The substitute will be, in order of preference, a court-appointed guardian, the holder of a power of attorney for personal care authorising the holder to make such decisions, an individual appointed by the review board to fulfil this role, or a family member according to a prescribed list of proximity or relationship.³⁶ The way in which the decision is to be made regarding treatment of the incapable patient is also closely defined by the legislation. Consistent with the respect accorded to patient capacity, wishes expressed by the patient while competent and over the age of sixteen years must be honoured, and only in the absence of such wishes may resort be had to the patient's best interests.³⁷ 'Best interests' is in turn defined by section 21(2):

21(2) In deciding what an incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

- (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
- (b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1) [i.e., the paragraph requiring competent wishes to be followed]
- (c) the following factors:
 1. Whether the treatment is likely to,
 - i. improve the incapable person's condition or well-being,
 - ii. prevent the incapable person's condition or well-being from deteriorating, or
 - iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
 2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.

35 [1994] 1 All ER 819.

36 See s. 20.

37 See s. 21(1). The right of a competent adult patient to refuse physical treatment and the enforceability during subsequent incapacity of wishes made regarding physical treatment while the patient had capacity are established in English law: see, eg, *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819.

These rights also presumably apply in England to treatments for mental disorder for informal patients and those living in the community, but they cease to apply if the individual is civilly confined. In that event, the Mental Health Act allows most treatments to proceed without patient consent and without any formal scrutiny for three months, and allows patient consent to be overridden thereafter: s. 57, 58, 63.

3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

These criteria are binding on substitute decision-makers. While the Ontario legislation remains deferential to the wishes of the individual expressed while competent, some flexibility is accorded to the review tribunal within that framework:

36(3) The Board may give the substitute decision-maker permission to consent to the treatment despite the wish [i.e., the previously expressed refusal of the patient while competent] if it is satisfied that the incapable person, if capable, would probably give consent because the likely result of the treatment is significantly better than would have been anticipated in comparable circumstances at the time the wish was expressed.

Under Ontario law, unlike the English situation following *F v. West Berkshire Health Authority*,³⁸ the doctor never makes the final decision as to whether treatment will be given, and the person making that decision on behalf of a person lacking capacity must decide according to a specific set of criteria. Once again, Ontario adopts an approach requiring specificity.

The intent of the Ontario system was to ensure that there would always be a second view of the doctor's proposal for treatment, a reality check serving a function analogous to informed consent by a competent patient, ensuring that the proposal was appropriate for the patient's particular circumstances. This second view has been the case for mental health in Ontario since 1978.³⁹ In the early years, the approach did not entirely fulfil this objective. The perception among patient rights advocates was that it was treated more as an obligation to inform family members of treatment rather than as scrutiny prior to consent, and in any event, it was thought that families tended to be too deferential to the medical views even when they conflicted with the patient's earlier, competent choices. For this reason, the closer guidance as to how consent should be given was included in the 1986 amendments. This, along with some administrative back-up to the provisions to inform substitutes of the criteria, has probably improved matters in this regard. It is difficult to see that it is sufficient to provide any real check on appropriateness of proposed treatments, however, as the person providing consent will in practice rely upon the advice provided by the doctor, advice which will normally point to the desirability of treatment. Appropriate audit structures may thus be a more effective mechanism of professional scrutiny, although one which is again likely to reflect medical values. That said, the Ontario provisions did introduce clearer guidance to doctors and substitute decision-makers as to how decisions regarding treatment are to be made.

One object of the 1986 reforms had been to force a second, non-medical opinion for the patient who was incapable, but was acquiescing to treatment. Treatment on this basis had been illegal without the consent of the substitute since 1978, but the experience of the patient rights bar was that such consent was nonetheless often not obtained. While publicity surrounding the law may have altered this to some degree, particularly in extreme cases, it is not clear that it has solved the problem. There remains anecdotal evidence that psychiatrists are negotiating treatment regimes with patients of at best marginal capacity, to avoid the perceived administrative hassle of

38 [1989] 2 All ER 545 (HL).

39 Until Charter rights took effect, the refusal of the patient or substitute could be overruled by the review

board. The board contained lay, legal and medical perspectives on it, however, so this did not in theory detract from the principle of scrutiny of the treatment proposals of the attending physician.

approaching the nearest relatives. While a partial solution should not necessarily be criticised because it is not a total solution, the Ontario situation may here promise more than it delivers.

The difficulties of involving family members and carers formally in decision-making structures have received some discussion in England. Particularly when the list of substitutes is fixed, inappropriate results may occur. As an extreme case, a patient might quite reasonably not want a parent informed of the particulars of their treatment, if the parent has been abusing the patient. The Richardson proposals, reflected in the government white paper, proposes a system which would reduce the formal role of nearest relatives, and instead create a more informal role for nominated persons, appointed by the patient if competent and a review tribunal if not.⁴⁰ While the role in Ontario is more formal, the appointment system is much as the government and the Richardson Committee envisage. The green paper raises questions about the mechanics of appointment,⁴¹ unanswered in the white paper; the government might do well to consult with the Ontario review tribunal regarding practicalities.

Community Treatment Orders

There has been no tradition of community treatment orders as such in Ontario. The approach of the Ontario legislation, which separates capacity and treatment from confinement, creates a markedly different environment for the consideration of such orders. At least theoretically, the provision of physical or mental treatment of an incapacitated person in the community has not posed problems, as it may be performed on the consent of a substitute. Further, when treatment cannot be enforced on a non-consenting competent patient in a psychiatric facility, it is unsurprising that it similarly cannot be enforced in the community.

Brian's Law introduced what it describes as a community treatment order, in 2000. In Ontario, as in England, political pressure had been towards further control of persons with mental health problems in the community, and in particular those ceasing prescribed treatment. The act itself was named in memory of Brian Smith, an individual killed by such a person.

Certainly, realities must be acknowledged: the act brings these patients into a new legal regime, subjecting them to particular professional scrutiny, and creating practical pressures to conform to treatment proposals. At least on paper, however, the Ontario model is not so much about enforcing a treatment programme on an unwilling patient, as it is about the provision of a coherent programme of after-care to those in particular need. There is no Ontario equivalent to the English right to after-care under section 117; if such care is to be required, the CTO is the only mechanism to do so. The intention in the drafting of the provisions seems to be to require doctors and the patient (or the patient's substitute decision-maker, if the patient lacks capacity) to reach an agreed solution embodied in a community treatment plan as to what treatment is appropriate in the community. It is available only if the patient has been an in-patient in a psychiatric facility on two or more separate occasions, or for a cumulative period of 30 days or more in the previous three years, or has previously been subject to a CTO in the previous three years. If the subject is not at the time of the order an in-patient, the physician must determine that the patient meets the criteria for compulsory admission under subsection 15(1) or 15(1.1), discussed above. In addition, it must be determined that the person is able to comply with the community treatment plan; that the care

⁴⁰ *Richardson Report*, para 12.17-23; *white paper*, para 5.5-9.

⁴¹ *Green paper*, para. 10.10.

and treatment proposed is available in the community; and, in section 33.1(2)(c), that 'if the person does not receive continuing treatment or care and continuing supervision while living in the community, he or she is likely, because of mental disorder, to cause serious bodily harm to himself or herself or to another person or to suffer substantial mental or physical deterioration of the person or serious physical impairment of the person'⁴² If these conditions are met, so long as the subject agrees (or the subject's substitute, if the subject is incapable), the CTO takes effect. It runs for six months, and is subject to renewal if the above conditions are still applicable.

The statute is curiously silent about the scope of what may be included in a community treatment plan. Clearly, a regimen of medicine would be possible; but it is unclear how far the plan may extend outside the medical sphere and into the realms of social care, contact with services and accommodation.

The subject of the order may request a re-assessment of the situation at any time. Alternatively, consent of the subject or the substitute may be withdrawn on 72 hours notice. In either case, the attending physician may terminate the treatment order following a review of the individual's condition, if appropriate. If the physician believes that the subject is failing to comply with the order, an assessment may be ordered under section 15, the usual entry route to civil confinement, but only if the risks of bodily harm, physical or mental deterioration or physical impairment identified above are thought to exist, and if reasonable efforts have been made to assist the subject in complying with the order and warning of the possibility of admission if the order is not complied with.

The CTO also places responsibilities on the treatment providers named in the order. While the new section 33.6 of the Mental Health Act exempts treatment providers from liability for default of others in the provision of the treatment, it makes no such exception for treatment which the named treatment provider is charged with providing himself or herself under the order. This suggests quite a different approach from that of the English court in *Clunis v. Camden and Islington HA*,⁴³ where the court specifically denied any duty of care either in breach of statutory duty or in negligence for the supervision of a patient under section 117 aftercare. Such a duty of care would presumably be found in Ontario. As such, the Ontario CTO can be seen as enforcing standards of care from treatment providers as much as enforcing compliance in the patient population. This, again, is a step beyond what is proposed for England. The Richardson Report does propose that rights to assessment and to aftercare would exist, but there is no indication how these would be enforced. Certainly, there is no suggestion that the failure to assess or provide aftercare would lead to civil liability. After the decision in *Clunis*, it is difficult to see that such an amendment can be intended in the absence of express language. In the government white paper, even the formal right to an assessment has been removed.

The CTO is a sufficiently new mechanism in Ontario that it is not yet possible to suggest how successful it will be. There does seem to be considerable evidence that patient concordance with treatment is affected by the standard and availability of that treatment. If that is indeed the case, the Ontario approach may well be worth taking seriously.

⁴² *Brian's Law*, s. 14, creating s. 33.1(2)(c) of the Mental Health Act. ⁴³ [1998] 3 All ER 180.

The Consent and Capacity Review Board and Due Process Protections

The Consent and Capacity Review Board hears applications relating to capacity to consent to treatment, financial capacity and challenging civil confinement. It also hears applications for review lodged by informal patients as discussed above, and similar applications from allegedly incapacitated adults objecting to being admitted by substitute decision-makers to nursing homes and similar institutions. It can appoint substitute decision-makers for treatment and care purposes when the patient lacks capacity and has not done so, and can provide directions as to the effect of wishes expressed by the patient regarding care and treatment. As in England, the board generally sits in panels of three: one psychiatrist, one lay person, and a lawyer as chair. Unlike the English tribunals, standards are contained in the legislation as to expeditiousness. Hearings must commence within seven days of the application unless all parties agree to a postponement. A decision must be communicated to the parties within one day of the completion of the hearing. The parties must be informed of their right to request reasons, and if requested, reasons must be handed down within two days.⁴⁴ Once again, the decisions of the European Court of Human Rights on speedy determination of rights begins to look extraordinarily feeble, particularly when the Ontario legislation is much more generous in the frequency of hearings to challenge confinement.

The review board system is supported by a fairly extensive system of rights advice. Major psychiatric facilities contain full-time rights advisors, and a network of part-time advisors exists in the broader community. These individuals make routine visits when decisions of significant legal import are made relating to the patient, such as a finding of incapacity, original civil confinement, or the renewal of civil confinement. They do not in their rights advisor role represent patients before the review board, although some of the part-time advisors in the community are lawyers who may take on briefs in that capacity. Instead, rights advisors generally put patients wishing to challenge decisions in contact with lawyers, who are funded through legal aid. This provision is in addition to the services in large psychiatric facilities of professional patient advocates, who assist patients with administrative matters outside the competence of review boards. While some rights advisors are part time, this is not an ad hoc programme. It shares with the patient advocate programme a small secretariat in Toronto. It is through this central office that the advisors are trained and employed; they may work in the psychiatric facilities, but they are not employed by them. This system has been in place for almost twenty years.

There was, briefly, a much more extensive and high-profile system of advocacy, Advocacy Ontario, created by legislation in 1992. This was a government office intended to provide rights advice and advocacy services to people with physical or mental disabilities, to act in the best interests of those incapable of instructing advocates when the health or safety of those individuals was at stake, to engage in public education, to press for systemic change to improve the situation of people with disabilities, and generally to promote respect for the rights, freedoms, autonomy and dignity of people with physical or mental disabilities.

Advocates employed by the agency had considerable power. They were for example to have access at all reasonable times to any place where a vulnerable person was thought on reasonable grounds to be, although entry to private dwelling houses would be only by warrant of a Justice of the Peace.⁴⁵ They had access to the health and other administrative records relating to an individual

44 *Health Care Consent Act 1996*, s. 75.

45 *Advocacy Act 1992*, S.O. 1992, c. 26, s. 20-23.

lacking capacity upon whose behalf they were acting, and otherwise by consent of the individual,⁴⁶ as well as a facility's administrative procedural manuals and records for the purposes of systemic advocacy.⁴⁷ The office was to be overseen by a board of commissioners. Eight of the twelve members of this board along with the chair were required by statute to be drawn from a list of individuals nominated by groups representing people with physical or mental disabilities, to ensure accountability to the users of advocacy services. To protect against potential co-option, Advocacy Ontario was placed under the Ministry of Citizenship, removed from the Attorney-General and Health Ministries which were responsible for the other legislation relating to mental health and incapacity.

One can readily understand the logic behind Advocacy Ontario. Rights advice supported by legal representation works in individual cases, with clients who have capacity to instruct. It is not efficient at creating systemic change, however, and it is not effective for clients lacking capacity to press for their own rights. When the rights in question are those relating to personal guardianship, invoked because of a perception that an individual lacks capacity, it is obvious that an ability to press for ones rights cannot be assumed. Further, it is simply not true that all carers are good carers. Canadian estimates are that seven to ten per cent of elderly people suffer some form of physical, mental, or financial abuse, generally at the hands of their families. One cannot assume that other vulnerable people fare better. If the principles behind the Ontario reforms of the early 1990s were to be meaningful, the logic goes, appropriate support services had to be put in place.

Sadly, Advocacy Ontario was not a success. The reasons are manifold. It became a political issue, associated in the public mind with a government which had become deeply unpopular by the time Advocacy Ontario was up and running. The unpopularity was articulated in a variety of ways. It was perceived as over-funded and profligate. It was perceived as overly interfering in the private lives of Ontario's families, caring for their loved ones. While it is true that the powers accorded were significant, it is not in fact obvious that they were excessive. If the people at risk in the community were to be protected from abuse, for example, a process to get a warrant to enter a private dwelling seems to be a necessity, but in Ontario, as in England, the risks to which vulnerable people are subjected in the family and in other 'safe' environments are not something that many politicians are prepared to tackle. The first chair of Advocacy Ontario, a former shadow health minister and former user of psychiatric services, was hailed with broad enthusiasm upon his appointment. As the stock of the government in general and Advocacy Ontario in particular fell, he became perceived as a purely political appointment. The problems were not all perceptual, however. Appointments to the advisory board and to the Commission were apparently chosen to reflect the diversity of views relating to advocacy and patient rights issues. While this might have been effective in other circumstances, the board sadly seemed incapable of working together. Under these stresses, Advocacy Ontario had largely imploded before a new government finally abolished it, shortly after an election in 1995.⁴⁸

The result is problematic. There is now in Ontario no systemic mechanism in place to ensure that the law is being followed. As rights advisors act only on competent instructions, they have little effect for persons unable to provide such instructions. For those persons, advocacy services are largely absent, and the honour system seems to be relied upon for the application of the law.

46 *Advocacy Act 1992*, s. 24.

48 *See S.O. 1996*, c. 2, s. 72.

47 *Advocacy Act 1992*, s. 26.

The English government has in the green paper agreed to consider the provision of advocacy in a mental health context. The existing Ontario model, and Advocacy Ontario, provide a mixture of success and failure. We might well learn from more detailed study of this experience.

Problems

From the foregoing, it will be clear that there is much for English analysts to consider. The overarching structure of the Ontario legislation is designed to take into account both patient rights and safety of the public and the patient. These are central to the concerns of the government in its green paper and of the Richardson Committee. While there may still be some problems with enforcement mechanisms, the presence and efficacy of the Ontario rights advice and review board structure does provide the English onlooker with cause for pause.

There are, of course problems, real and apparent. The major theoretical difficulty with applying the Ontario system to England is that Ontario's Mental Health Act expressly acknowledges a policing role of psychiatric confinement, based on dangerousness rather than the need for or availability of treatment. Theoretically, it would be possible for patients to be detained in psychiatric facilities *ad infinitum*, untreated because there is no effective treatment, or because they are competent and refuse consent, or because they lack capacity and refused the required treatment prospectively. The concern is that the ethos of the facility would change from hospital to patient warehouse.

Certainly, the express acknowledgement of dangerousness rather than treatability as the criterion for confinement does have a symbolic importance, but it is easy to overstate the difference with the current English system. After all, English statute law allows confinement not just on health grounds, but also for the 'safety of the patient or for the protection of other persons', a dangerousness criterion, albeit coupled with the alternative best interest criterion of 'health'. There is further no express treatability requirement for either severe mental impairment or mental illness, but only for the small minority of cases which are categorised as psychopathic disorder or (non-serious) mental impairment. The requirement of treatability rather than dangerousness as a prerequisite for involuntary admission in England is thus already largely a myth. The Ontario legislation is more specific in its articulation of how dangerousness is to be determined, but it is not obviously theoretically different for that.

In practice, the concern seems ill-founded, since virtually no competent patients in Ontario psychiatric facilities refuse all treatment. Ontario facilities have simply not become warehouses of patients 'rotting with their rights on', any more than their English counterparts. Certainly, some patients refuse some treatments, requiring negotiation between doctor and patient towards an agreed treatment regime. While this may result in some compromise on what are perceived by the doctors as medical best interests, the increased communication between doctor and patient which is implied has its own advantages. It ensures that the patient is more involved in the development of the treatment plan, at least in theory meaning that the patient has a greater emotional stake in the resulting deal. This should in turn mean better rates of treatment continuation – a desirable medical result.

The cost of the review board structure is an obvious area of curiosity, but it does not seem exorbitant. The Ontario Consent and Capacity Review Board received 3091 applications in 1998-9, resulting in 1785 hearings. The cost of this to the taxpayer was just over \$CDN 2 million, or about £900,000.⁴⁹ In this period, roughly 15,000 people (excluding criminal confinements) were involuntarily admitted to psychiatric facilities in the province. The higher number of confinements in England would militate towards an increase in this figure,⁵⁰ but the higher population density would counteract this to some degree, as transportation costs to get board members to hearings would be reduced. The cost hardly seems excessive, for provision of an efficient tribunal structure.

The more severe criticisms relate to the key terms of the legislation. It is all very well to focus on dangerousness as the criterion of confinement, but even after the closer criteria of the Ontario legislation, dangerousness is notoriously unpredictable. Studies generally find that between half and three quarters of those predicted to be dangerous by psychiatric professionals do not in the end turn out to be violent.⁵¹ Capacity is similarly an extremely slippery concept. And while the standards in the legislation appear to provide considerable power to patients, the effect of informal coercion is not to be underestimated. In what sense, for example, is consent to treatment 'voluntary' as required by the Health Care Consent Act,⁵² if it is provided after the doctor explains (perhaps quite accurately) that the treatment is the patient's only hope of recovering far enough to be released from the psychiatric facility, or if carers in the community will only accept the patient if he or she agrees to medication? These problems exist equally in the current and proposed English systems, however, and the closer wording and clearer structuring of the Ontario acts at least provides an improvement on the vague English legislation in these regards. The fact that it is only a partial solution does not necessarily justify extreme criticism, given what else is on offer.

Conclusion

Admittedly, the Ontario acts have their problems. At the same time, they do seem to provide a coherent system, which takes into account the variety of interests and concerns under discussion in the current reform debate. The risk is not merely that the government may re-invent the wheel in the to-ing and fro-ing leading up to mental health reform, but perhaps more important, that they may not re-invent it very well. The Ontario example provides a wealth of experience which should be tapped. The English commentators and legislators would do well to give it further heed.

49 My thanks to David Hoff of the Ontario Consent and Capacity Review Board for providing this information.

50 In England, just over 25,000 people were civilly confined under part II of the Mental Health Act.

51 For surveys of the relevant literature, see P. Bowden, 'Violence and Mental Disorder', in N. Walker (ed), *Dangerous People*, (London: Blackstone, 1996), J. Monahan, 'Risk Assessment of Violence among the Mentally Disordered: Generating Useful Knowledge', 11 *International Journal of Law and Mental Health*

(1988) 249, J. Monahan, 'The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy', 141 *American Journal of Psychiatry* (1984) 10. Further, factors such as race, sex and class appear to be among the best predictors of dangerousness, raising profound discrimination questions as to how dangerousness can or should be used in social policy relating to mental illness: see S. Wessely, 'The Epidemiology of Crime, Violence and Schizophrenia', 170 (supp. 32) *British Journal of Psychiatry* (1997) 8.

52 Section 11(1).