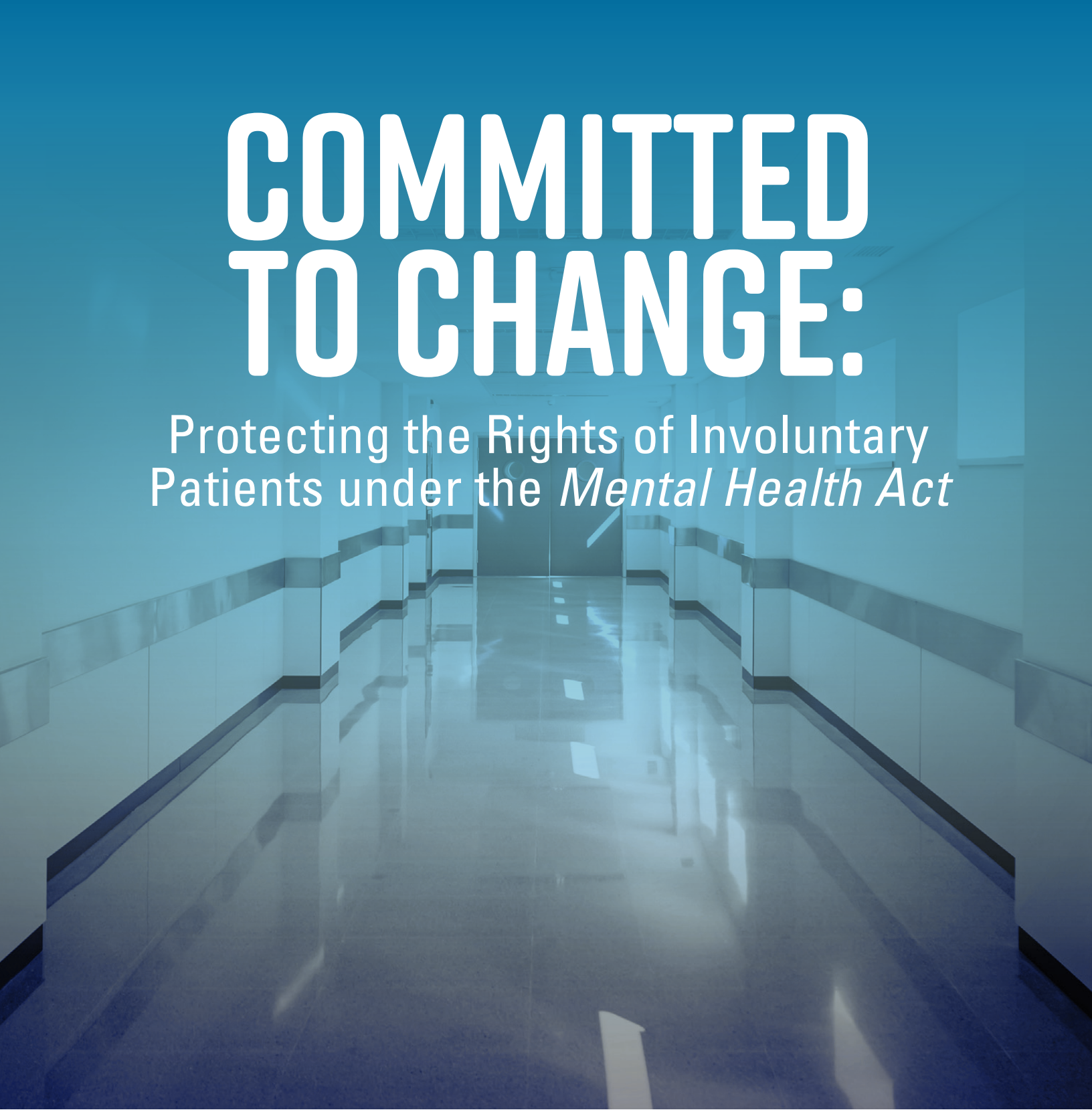

COMMITTED TO CHANGE:

Protecting the Rights of Involuntary Patients under the *Mental Health Act*

Special Report No. 42

The Office of the
Ombudsperson
B.C.'s Independent Voice for Fairness

40 years 1979-2019

March 2019

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The Office of the
Ombudsperson
B.C.'s Independent Voice for Fairness

March 2019

The Honourable Darryl Plecas
Speaker of the Legislative Assembly
Parliament Buildings
Victoria BC V8V 1X4

Dear Mr. Speaker,

It is my pleasure to present the Ombudsperson's Special Report No. 42, *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act*.

The report is presented pursuant to section 31(3) of the *Ombudsperson Act*.

Yours sincerely,

Jay Chalke
Ombudsperson
Province of British Columbia

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FROM THE OMBUDSPERSON

In our daily lives, many of us take for granted the rights that provide us the distinction of living in one of the most open, democratic and free societies on earth. Embedded in the *Canadian Charter of Rights and Freedoms*, these rights recognize and protect our autonomy – to express ourselves as we wish, control our bodily integrity and make choices about where we live.

These freedoms are something we don't always think about until in extraordinary circumstances, they are removed. Because these human rights are so fundamental, there are only a few circumstances where these liberties, that are so critical to the core of who we are, can be removed by the state. Detaining a mentally ill person against their will is one of these extraordinary circumstances. In British Columbia, around 15,000 mentally ill people were involuntarily detained in one of B.C.'s over 70 psychiatric facilities in 2016/17 – a number that has grown by approximately 70 percent in the last decade.

The people admitted to a mental health facility – our friends, our children, our siblings, our parents, and grandparents – are at significant risk because of their illness. They are suffering and in need of immediate treatment but, perhaps because of that illness, are unwilling or unable to accept it. In these situations, the state can step in with the greatest power it has – the right to remove a person's liberty by detaining and treating them.

> *"Treatment and rights need not be mutually exclusive. One need not come at the expense of the other. They must work hand in hand."*

Those who have sought mental health treatment for a family member or friend know how intensely stressful and confusing these situations can be. Patients and families have a barrage of questions for mental health professionals focusing on diagnosis and medication. Questions also emerge about what rights a patient still has after they have been detained such as the right to a lawyer, the right to a second opinion regarding treatment, the right to have their relatives notified and the right to have their status as an involuntary patient reviewed. Receiving clear answers to these questions can significantly temper what is often a chaotic time.

Understanding the health care needs of the patient and delivering the right treatment in a timely way is essential. At the same time, it is equally critical to pay close attention to the procedural safeguards in B.C.'s *Mental Health Act* to ensure the rights of involuntary patients are being protected. These two priorities – treatment and rights – need not be mutually exclusive. One need not come at the expense of the other. They must work hand in hand.

Society's approach to mental health care has changed over the past half-century. Transformative advances in treatment are both saving lives and allowing individuals to live and work in communities in ways that would never have been previously possible. We have moved away from viewing institutionalization as the norm. An increased emphasis on patient rights has resulted in statutory changes in mental health civil commitment laws across Canada, including in British Columbia. These laws seek to strike a balance between protecting fundamental rights that are foundational in the *Canadian Charter of Rights and Freedoms* and concurrently providing timely and effective treatment. In the mental health context, the greatest challenge in striking this balance relates to those who require the most intrusive form of intervention: involuntary detention.

B.C.'s *Mental Health Act* sets out the rules that relate to individuals who are involuntarily detained in the province. These rules are precise procedural steps that must be followed and include the legal duty to provide information to patients and their loved ones. The courts have relied on the statutory protections in the *Mental Health Act* in upholding the constitutionality of the power to involuntarily detain individuals. However, the rules and procedural steps in the *Mental Health Act* will only protect the patient's civil rights if they are in fact being followed. Our investigation set out to determine whether these rules are being complied with in British Columbia's mental health facilities.

To conduct this investigation we obtained the documentation – mental health forms – that psychiatric facilities are legally required to complete as they move patients with mental illness through the path of involuntary admission and detention. These forms are not mere paperwork. Where the state is exercising the extraordinary power to remove a person's liberty, legal documentation is a fundamental requirement that must be observed. Completing these forms authorizes the state to detain and treat individual patients, and they provide evidence that rules and procedural steps have been followed.

While we found pockets of good practice in some facilities, the overall picture is not positive. Far too often the individuals and institutions responsible for complying with the *Mental Health Act* did not meet their obligations. Sometimes, the designated facility was unable to provide us with the required form at all. In other instances, the information was unintelligible and in others, the form was completed using boilerplate language that was not individualized to the patient. We even saw instances of rubber stamps used to describe a broad range of possible treatments instead of specific information about the treatment intended for the individual patient.

Why does this matter? On a broad systemic level it matters that the state, when it uses an extraordinary power to restrict an individual's fundamental freedoms, is not complying with the law. This is a distressing finding in and of itself. But further, for patients and their families, the lack of adequate documentation naturally raises questions about the reasons for detention. For example, could less restrictive alternatives have been used? Ultimately, the lack of documentation raises questions about whether individuals at their most vulnerable have been detained lawfully and fairly. As a result, public confidence in the system at large is jeopardized.

These findings are made more serious by the limited options for redress available to involuntary patients. If a patient believes their procedural rights have been denied in the course of an involuntary admission, that person's only recourse is to go to court. The court system can be difficult to navigate, even for those who are not in crisis. Patients can more easily access the Mental Health Review Board. The Review Board does important work by reviewing a patient's medical situation and determining whether that patient's continued status as an involuntary patient is warranted. However, the Review Board has no authority to provide a remedy where there has been a procedural defect such as a failure to complete the legally required forms.

"The 24 recommendations in this report are designed to ensure the rights of people with serious mental illness are respected and public confidence in our mental health system is enhanced."

What has led to this systemic failure to follow the law is not obvious. We did not find that it was a result of lack of commitment by health care professionals to the health and welfare of their patients. To the contrary, individuals working in mental health facilities are highly dedicated professionals committed to treating and caring for patients whose lives are impacted by serious mental illness.

Rather, the health care system, specifically the health authorities and the Ministries of Health and Mental Health and Addictions, have not taken sufficient steps to uphold patient rights by implementing external oversight and internal management practices sufficient to ensure statutory compliance. Moreover, they have not developed a culture within the mental health care system that places sufficient emphasis on the importance of an involuntary patient's legal rights.

How can these failings be addressed? The 24 recommendations in this report are designed to ensure the rights of people with serious mental illness are respected and public confidence in our mental health system is enhanced.

I recommend in this report that government create an independent rights advisory body to provide individualized advice and support to involuntary patients upon admission. Twenty-five years ago, our report *Listening: A Review of Riverview Hospital* expressed similar concerns about the lack of independent rights protections. A quarter century later, that gap still exists. The independent rights advisory service we recommend would have legislated powers to assist involuntary patients upon admission to a psychiatric facility. This new service would complement existing legal advocacy services provided by the Community Legal Assistance Society and others before the Mental Health Review Board.

I am further recommending that the health authorities establish accountability measures, including internal audits and performance measures aimed at reaching 100 percent compliance with the *Mental Health Act*'s procedural safeguards. I am also recommending that training for clinical staff be enhanced. In addition, I am recommending that province-wide standards be developed pertaining to reporting data in relation to involuntary admissions.

There are already reasons to be optimistic. When we shared our preliminary findings with mental health facilities, some of them voiced surprise and dismay with their own poor results and they got to work to identify systemic sources of non-compliance and find ways to improve practice. Such ready recognition that practice needed to be improved suggests that many of the problems we identified resulted from lack of attention or inertia rather than conscious choice.

It is significant and welcome that the Ministries of Health and Mental Health and Addictions and the health authorities have accepted all of the recommendations directed to them in this report and are committed to making these important changes. The acceptance in principle by the Ministry of the Attorney General of recommendations for an independent rights advisory service will provide the ongoing support needed to achieve enhanced rights protection for all patients involuntarily admitted in this province.

We will monitor and publicly report on the implementation of these recommendations.

Jay Chalke
Ombudsperson
Province of British Columbia

EXECUTIVE SUMMARY

Mental illness can affect any of us. It affects how a person thinks, feels and behaves. As with any other health care matter, people with mental illness deserve care and support. What do we do when a person with a serious mental illness is not well enough to appreciate that they need treatment and because of their illness, they pose a risk to themselves or others? As a society, how can we best ensure that people with serious mental illness get the treatment they need? One way we have answered this question in British Columbia is to involuntarily admit the person to a designated psychiatric facility for assessment and treatment.

Through British Columbia's *Mental Health Act*, the directors of designated psychiatric facilities have the power to involuntarily admit a person to that facility for psychiatric treatment if the person meets the Act's criteria for admission. The physician must have determined after examining the person that the person has a mental disorder that seriously impairs their ability to react appropriately to their environment or to associate with others. The physician must also have determined that the person needs to be hospitalized for psychiatric treatment, to prevent substantial mental or physical deterioration, or to protect that person or others.

The director's ability to involuntarily admit the person for treatment is in some cases, a life-saving power. The proper exercise of this power means people in crisis due to a mental disorder can receive necessary treatment, in a safe environment, that allows them to stabilize and recover.

At the same time, the ability to involuntarily admit and detain a person in a psychiatric facility and treat them without their consent is an extraordinary power. The exercise of this power is constrained by the rights afforded each person in Canadian society to be free and to make decisions about their own bodies.

The right to liberty and personal autonomy is established in the *Canadian Charter of Rights and Freedoms*. The involuntary admission process under the *Mental Health Act* impinges upon both of these rights – involuntary patients cannot leave the facility without authorization nor can they refuse psychiatric treatment prescribed for them. Thus, rights are not absolute. They can be limited where justified by broader societal interests, and the courts have emphasized that the purpose of the *Mental Health Act* is to protect people with mental illness. Judicial decisions point out that the *Mental Health Act* is aimed at ensuring a balance between individual rights and society's broader obligation to take care of people with mental illness.

The *Mental Health Act* contains certain legal procedures that staff of psychiatric facilities must follow to ensure that every involuntary admission is appropriate and fair. These procedural safeguards embedded in the *Mental Health Act* require staff of psychiatric facilities to complete a set of prescribed legal forms when admitting and detaining patients. These forms:

- authorize and set out the reasons for the initial admission and detention and any subsequent renewals (Forms 4 and 6)
- describe and authorize a proposed course of psychiatric treatment for the patient (Form 5)
- require a physician to assess the capability of the patient to give consent to psychiatric treatment (Form 5)
- provide the patient with notice of and information about their rights (Form 13)
- provide patients an opportunity to designate a near relative and notify that relative of the admission and detention and the patient's rights (Form 15 and Form 16)

Investigation

Our office receives and investigates complaints from people who have been involuntarily admitted to psychiatric facilities throughout the province. We have investigated many complaints that the safeguards described above were not being followed. While we were able to achieve individual resolutions in many of these cases, we were not able to answer the broader systemic question: are the safeguards in the *Mental Health Act* being followed on a regular basis?

In July, 2017, we began a systemic investigation into the extent to which health authorities, and the psychiatric facilities they operate, are complying with their obligation to complete Forms 4, 5, 6, 13, 15 and 16 in relation to involuntary admissions. We obtained records of all involuntary admissions in British Columbia in June 2017. Using these records, we were able to answer three questions:

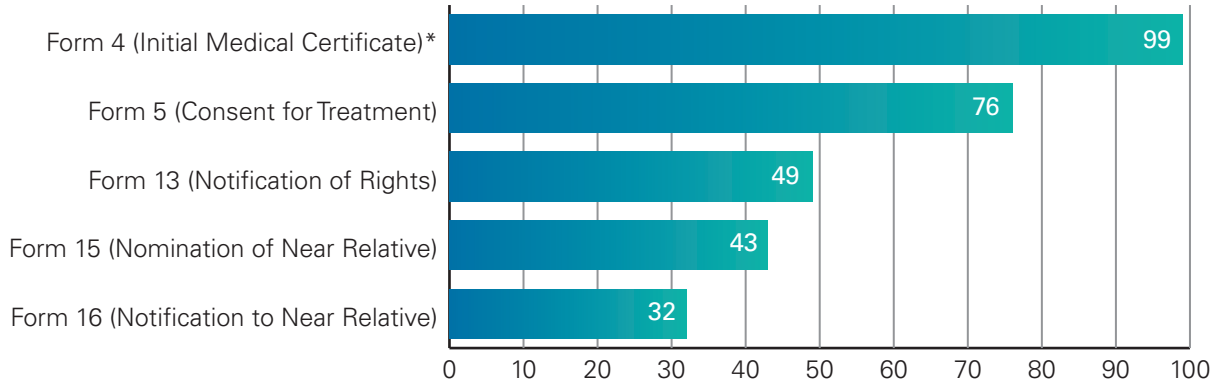
1. Are the required forms present on each patient's file?
2. Were the forms completed within required timelines after the patient's admission?
3. If the form records a decision for which reasons are required, are those reasons adequate?

Ombudsperson Findings

We were disappointed to find significant levels of non-compliance when we reviewed the forms. In many cases, forms were simply not completed. In many other cases, the forms were completed late or in a manner that did not provide anything close to adequate reasons. For example, some facilities used standard rubber stamps to describe a broad range of possible authorized treatment for individual patients instead of describing the specific treatment prescribed. Some physicians failed to explain why a person met the criteria for involuntary admission. Some forms lacked the necessary signatures or dates.

Our overall findings about form completion rates are summarized below.

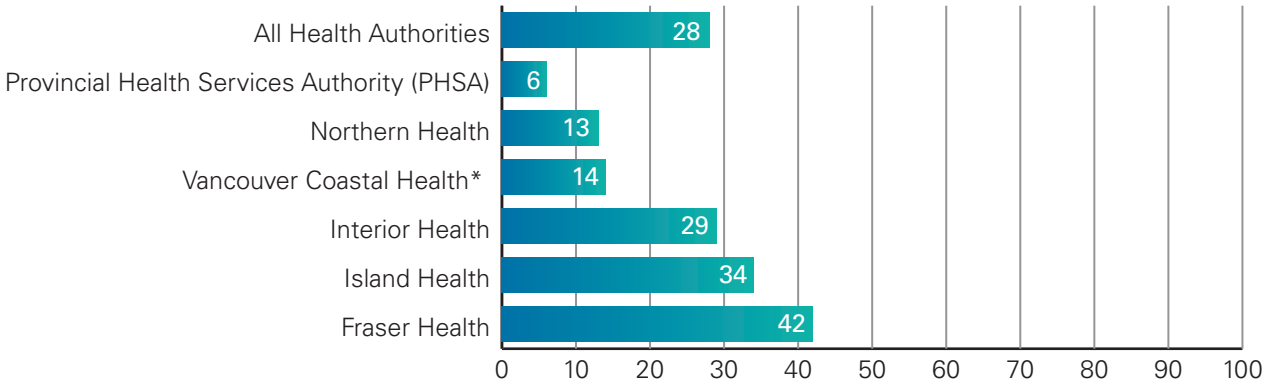
Percentage of Patient Files Containing Required Form, all Health Authorities, June 2017



Note: ** The Form 4 percentage relates only to the initial Form 4 that must be completed when a person is first involuntarily admitted.*

As the following figure shows, all of the health authorities fell well short of 100 percent compliance with completing the forms required by the Act. In fact, all of the health authorities were non-compliant in well over half of the files that we reviewed. Across the province, the health authorities completed all of the forms that are required only 28 percent of the time.

Percentage of Patient Files Containing an Initial Form 4, Form 5, Form 13, Form 15 and Form 16, by Health Authority, June 2017



Note: ** includes patients admitted to St. Paul's Hospital, operated by Providence Health Care in partnership with Vancouver Coastal Health Authority.*

In all, we made 20 findings in relation to the failure of psychiatric facilities, health authorities and the provincial government to ensure compliance with the *Mental Health Act*'s procedural safeguards.

Failure to complete these forms is not just a matter of missed paperwork; it is a failure to follow the law. The safeguards in the *Mental Health Act* protect the inherent rights and dignity of some of the most vulnerable people in our society. When they are not observed, the balance between individual rights and society's interest in protecting people with mental illness is upset.

Ombudsperson Recommendations

Our investigation highlighted key factors that are necessary for the proper operation of the involuntary admissions process under the *Mental Health Act*. In this report we make 24 recommendations for systemic improvement that can be grouped into three main categories.

First, there needs to be a robust scheme of oversight and accountability that shares responsibility for complying with the procedural safeguards between the psychiatric facilities, health authorities and provincial government. Many health authorities were unaware of the compliance issues until our investigation brought them to their attention. To that end, we have made recommendations about:

- The facilities and health authorities conducting regular compliance audits, addressing issues on an ongoing basis and reporting the results of the audits to the Ministry of Health
- Establishing annual performance targets of 100 percent form completion for the facilities and similar employee performance goals for each health authority CEO
- Improved records management processes
- Increased public reporting of information about involuntary admissions

Second, the people responsible for administering the Act need to be properly trained and provided with appropriate policy guidance in how to exercise their responsibilities. We made recommendations about:

- Mandatory training for all persons exercising decision making authority in relation to involuntary admissions
- Providing guidance to individuals who are completing forms under the Act, primarily through an updated and reissued edition of the *Guide to the Mental Health Act*
- The Ministries of Health and Mental Health and Addictions developing and codifying provincial standards for complying with the procedural safeguards in the Act

Third, and perhaps most importantly, involuntarily admitted patients need to have an independent, freely available avenue through which they can learn about their rights and receive assistance in exercising them. Because the involuntary admissions process significantly impacts a person's liberty and autonomy rights, it becomes even more important for them to be able to understand why they have been admitted and what they can do if they disagree with the detention. Ensuring that involuntary patients can understand and exercise their rights is a key part of restoring the balance inherent in the *Mental Health Act*. We have therefore recommended that government establish an independent rights advisory service for all involuntarily admitted patients that can provide timely, in-person advice on a patient's options based on their particular circumstances.

Conclusion

This investigation has shed light on a process that is often hidden from public scrutiny. Even the health authorities were not aware of their facilities' poor compliance with the *Mental Health Act*'s procedural safeguards until we conducted our investigation and shared our draft findings with them.

However, all of the authorities to whom the recommendations were addressed – provincial government ministries and each of the six health authorities – have accepted and agreed to implement the recommendations made in this report. Full implementation will result in a fairer and more accountable involuntary admissions process, which will benefit all British Columbians. We will be closely monitoring and publicly reporting on the progress made by the provincial government and the health authorities in implementing these recommendations over the next months and years.

INTRODUCTION

This report is about the rights of individuals when they are involuntarily admitted to, and detained in, a psychiatric facility because the state has determined this is the only way they can be provided with necessary treatment for their mental disorder. A person who is involuntarily admitted cannot leave the facility of their own accord and is deemed to consent to any prescribed psychiatric treatment. The existence of a legislated process for involuntary admissions reflects the value that our society places on ensuring that people with mental disorders receive treatment when they are too ill to seek help on their own.

People with mental health issues who are involuntarily admitted often represent the most vulnerable and marginalized in our society. When detained, they are subject to compulsory psychiatric treatment because a medical professional has determined that it is in their best interests. Health authorities told us that their health-care professionals – doctors, nurses and others – strive to provide this treatment in a caring and professional manner, and the compulsory treatment provided while individuals are involuntarily detained may be the only thing that allows them to recover. Some individuals, but for the involuntary admissions process, might not have received treatment at all. In some cases, the treatment can be life-saving.

The involuntary admissions process, set out in the *Mental Health Act*, establishes the circumstances under which people can be admitted, detained and treated in a mental health facility for as long as is necessary. The intent of the Act is therapeutic and protective rather than punitive. It is meant to allow for necessary psychiatric treatment to be provided in a safe environment.

At the same time, when a person is involuntarily detained because health-care professionals believe the detention is necessary to help or to protect the person, that person is denied their liberty and can be administered psychiatric treatment without their consent. Involuntary admissions and detentions engage issues of individual rights and freedoms that are enshrined in the *Canadian Charter of Rights and Freedoms*, including the right to life, liberty and security of the person and the right not to be deprived of that liberty or security of the person "except in accordance with the principles of fundamental justice."[1]

Given the significant impact that detention has on the rights of vulnerable individuals, it

[1] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c. 11, s. 7.

is incumbent on the state – as represented by the provincial government, health authorities, designated facilities and their employees – to ensure that involuntary admissions are compliant with the Act and in accordance with the principles of fundamental justice. The procedural safeguards embedded in the *Mental Health Act* are intended to protect patients from violations of their rights and unjustified deprivations of their liberty and their right to make decisions about their own health care. Put another way, the constitutionality of the *Mental Health Act* depends on whether "a fair balance" is struck "between the rights of the individual to be free from restraint by the state and society's obligation to help and protect the mentally ill."[2]

One of the ways in which the legislature has tried to strike this balance is through procedural protections embedded in the *Mental Health Act* that require staff of mental health facilities to complete a set of prescribed forms when admitting and detaining patients. These forms:

- authorize and set out the reasons for the initial admission and detention and any subsequent renewals (Forms 4 and 6)
- describe and authorize a proposed course of psychiatric treatment for the patient (Form 5)
- require a physician to assess the capability of the patient to give consent to psychiatric treatment (Form 5)
- provide the patient with notice of and information about their rights (Form 13)
- provide the patient with an opportunity to designate a near relative and notify that relative of the admission and detention and the patient's rights (Form 15 and Form 16)

In often busy and fast-paced environments, such as emergency departments, where health-care professionals may involuntarily admit patients who present a sometimes complicated array of issues, the importance of completing each of these forms can be overlooked. However, these forms are not mere paperwork. They are critical legal steps designed to safeguard the rights of involuntarily admitted patients and document that the admission was in accordance with the *Mental Health Act* and the Charter. In this way, completing the forms in a timely and appropriate way is a recognition of the inherent rights and dignity of people with mental illness.

Providing for the health and welfare of British Columbians with mental disorders and respecting and giving effect to their legal and constitutional rights are not mutually exclusive actions. Strict adherence to procedural safeguards, including appropriate documentation and notice to families, fosters the likelihood that involuntary admissions will be consistent with the Charter and administratively fair. Moreover, such adherence promotes both accountability in individual decision making and public confidence in government institutions.

Our office is able to receive and investigate complaints from British Columbians who have been involuntarily admitted under the *Mental Health Act* to facilities across the province. Because the Act refers to these people as "patients," this is the terminology we have used throughout our report.

Under the *Mental Health Act* and the Charter, patients who are involuntarily admitted have a number of legal rights. Those rights include:

- the right to be informed about their rights and be told the name and location of the facility they are detained in
- being provided with information about the reasons and the legal basis for their detention

[2] *McCorkell v. Riverview Hospital* [1993] B.C.J. No. 1518.

- the ability to contact a lawyer, without delay
- the right to appear before a court to have the validity of their detention determined
- the right to regular medical examinations to see if they still need to be an involuntary patient
- the ability to apply to a review panel for a hearing about whether they should be discharged
- the right to a second medical opinion about the appropriateness of their treatment

Some patients who made complaints to our office reported that the facility had not told them about their legal rights or provided access to a lawyer. Patients and their family members told us that they did not understand the patient's rights and were unsure why they were not allowed to leave the hospital. These patient complaints led our office to consider broader questions about whether facilities are appropriately following the process set out under the Act and, therefore, whether they are respecting patients' rights.

Below are two examples of the kinds of complaints we have investigated about the use of the *Mental Health Act* to involuntarily admit patients.

Leslie's Story[3]

Leslie admitted herself to a hospital voluntarily for observation, treatment and discharge planning. A few days after, the hospital readmitted Leslie involuntarily under the *Mental Health Act* because she attempted to leave the hospital and the psychiatrist believed she was at high risk of harming herself. The hospital held Leslie in a seclusion room, which the hospital deemed necessary for her safety. The hospital did not tell Leslie that it had involuntarily admitted her, nor did it explain the reason for her involuntary detention.

After the hospital discharged Leslie, she requested a copy of her file. She found there was no record of the hospital providing her with the form that notified her of her rights (known as Form 13) when she was admitted involuntarily. When we investigated, the hospital confirmed that it had not provided Leslie with a Form 13 and that no one from the hospital had informed Leslie of her rights during her detention.

[3] All names in the stories in this report have been changed to protect privacy.

Ernest and Joyce's Story

Ernest, who has Alzheimer's disease, had been living at home with his wife, Joyce, as his caregiver. He fell at home and was admitted to the hospital for care for a resulting infection. Joyce found that Ernest's behaviour changed after the hospital put him on medication. He was also agitated because the hospital had tied him to the bed, which the hospital considered necessary for his and the staff's safety.

One day, when Ernest had been in the hospital for about a month, Joyce arrived at his hospital room to discover that he had been moved to a room in the geriatric psychiatric ward. Joyce learned that – unbeknownst to her – the hospital had involuntarily admitted Ernest under the *Mental Health Act* when he had arrived at the hospital one month earlier. However, no one from the hospital had notified Joyce or any other family member about Ernest's involuntary admission, as is required under the Act (using Form 16). The facility had also not notified Ernest of his rights under the Act.

Joyce was surprised to learn that Ernest had been involuntarily admitted to hospital, as she expected that he would return home to her care once the infection was treated.

Four days later, and almost five weeks after Ernest was involuntarily admitted, staff finally completed and signed the required rights notification forms. Joyce then tried to obtain the forms on which the hospital had recorded the reasons for his admission and detention, without any success. Joyce found the hospital process confusing and upsetting. She was never really sure why the hospital continued to detain Ernest once his medical condition improved or what his rights were when he was involuntarily detained. As a result, she was unable to advocate for him or seek support or assistance in relation to his detention.

In light of the serious issues raised by the complaints described above and others we have investigated, and given that detention is an extraordinary and intrusive state power, the Ombudsperson initiated a systemic investigation to examine involuntary admissions and detentions under the *Mental Health Act*. Our investigative powers – namely, the ability to gain access to records and other information that is not publicly available – allow us to gain unique insight into this process that otherwise, as advocates have highlighted, "operates in darkness."[4]

We investigated to see whether facilities were, in practice, complying with the procedural requirements[5] for involuntary admissions in the *Mental Health Act*. We found that facilities' compliance rates are inconsistent and that some are far below the full compliance we would expect. The case law in British Columbia, described later in this report, provides that compliance with the *Mental Health Act* is a key element in ensuring that the constitutional rights of patients are protected. Accordingly, because we found widespread and repeated instances of non-compliance with the Act, we cannot be confident that the manner in which the existing involuntarily admissions process is being implemented protects patients' rights in a way that is consistent with the Charter.

4 Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System, November 2017* <https://d3n8a8pro7vhmx.cloudfront.net/clastest/pages/1794/attachments/original/1527278723/CLAS_Operating_in_Darkness_November_2017.pdf?1527278723>.

5 The *Mental Health Act* establishes substantive requirements for involuntary admissions, providing that people must meet the statutory criteria in section 22(3)(a) and (c) prior to admission. An assessment of the appropriateness of the involuntary admissions criteria in the Act or whether individual patients in fact met those criteria was outside the scope of our investigation.

BACKGROUND

The Power to Involuntarily Admit and Detain

Designated Facilities

The *Mental Health Act* allows the Minister of Health to designate facilities that can involuntarily admit patients under the Act.[6] Currently, there are approximately 75 such facilities in the province.[7] Designated facilities are classified depending on their role as Schedule A, B or C facilities. Schedule A facilities are buildings or premises designated as provincial mental health facilities. Many of the admissions to Schedule A facilities are transfers from other facilities. Schedule B and C facilities are public hospitals, or parts of the hospital, that have been designated as a psychiatric units (Schedule B) or observation units (Schedule C). Of the 75 facilities, most are located in public hospitals. Schedule B facilities account for 37 of the 75 facilities that can involuntarily admit patients and are responsible for a significant majority of involuntary admissions.

Throughout this report, we have used the terms "facility" or "designated facility" to refer to a hospital or other facility designated under the *Mental Health Act*. The majority of these facilities are operated by one of the five regional health authorities or the Provincial Health Services Authority.[8] The Youth Forensic Psychiatric Services Inpatient Assessment Unit and Maples Adolescent Treatment Centre, both Schedule A designated facilities, are operated by the Ministry of Children

6 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 3.

7 See Appendix C for a complete list of the facilities that are currently designated under the *Mental Health Act*. When we began our investigation in July 2017, there were 72 such facilities. Since that time, St. Joseph's General Hospital in Comox and the Gorge Road Hospital in Victoria have been removed from the list of designated facilities (Ministerial Order 327/2018). Riverview Hospital, Port Coquitlam is not included in this count because it was closed in 2012, although it still appears in the list (Ministerial Order M 393/2016). Four facilities have been added to the list: Parkview, Vancouver (Ministerial Order 409/2017, effective December 12, 2017), North Island Hospital, Courtenay and Campbell River (Ministerial Order 285/2017, effective October 1, 2017), and Haida Gwaii Hospital and Health Centre-Xaayda Gwaay Ngaaysdll Naay, Village of Queen Charlotte (Ministerial Order 026/2018, effective January 25, 2018). Given the dates on which they were added to the list of designated facilities, we did not include any of these four facilities in our investigation.

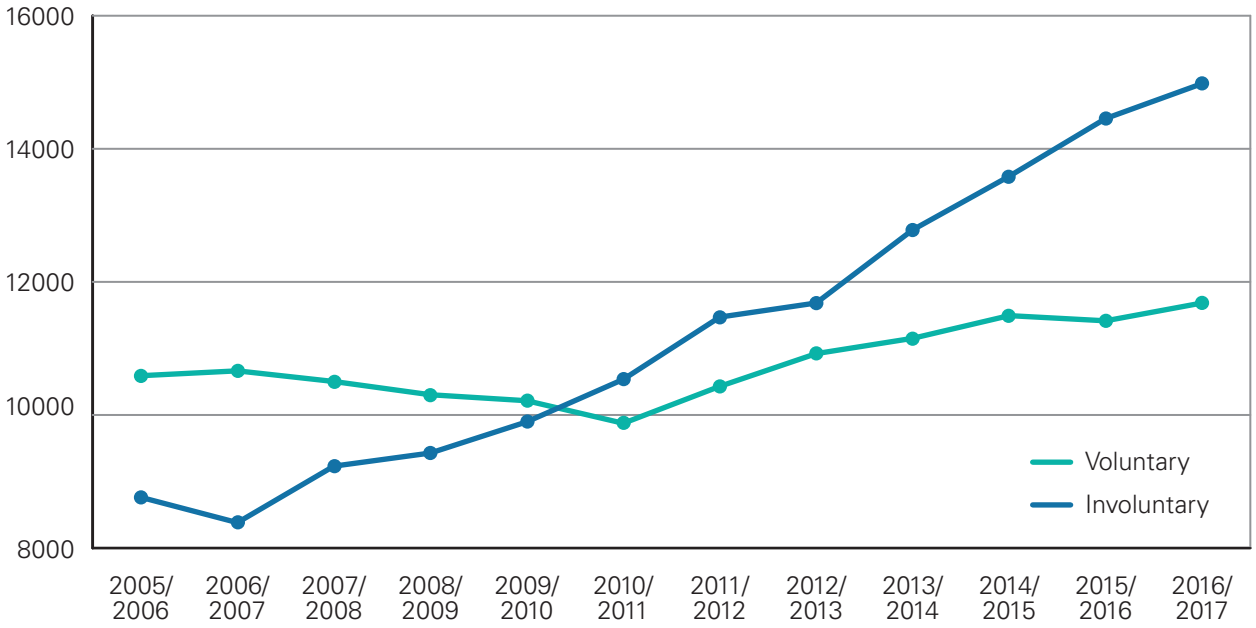
8 See Appendix C for a list of the designated facilities operated by each health authority. A number of patients held at the Forensic Psychiatric Institute, Burnaby Centre for Mental Health and Addiction, and Maples Adolescent Treatment Centre are not detained and treated under the *Mental Health Act* but by a court or British Columbia Review Board order; our investigation focused only on the individuals in those facilities who are detained under the *Mental Health Act*. The Regional Treatment Centre is part of the Pacific Institution (a federal correctional facility) and is operated by Correctional Services of Canada. As the federal government is outside our jurisdiction, we did not include this facility in our investigation.

and Family Development. The Provincial Assessment Centre for Community Living Services, also a Schedule A facility, is operated by Community Living BC.

The Ministry of Health provided us with aggregate statistical data about the number of involuntarily admitted patients discharged from Schedule B and C facilities and the Forensic Psychiatric Institute (a Schedule A facility).[9] In the 2016/17 fiscal year, these facilities discharged 20,483 patients who had been involuntary admitted under the *Mental Health Act*.[10] The 20,483 discharges involved 14,980 unique patients – meaning that many individuals were involuntarily admitted more than once. During the same year, there were 17,656 voluntary psychiatric discharges from Schedule B and C facilities, involving 11,683 unique patients.[11]

Figures 1 and 2 indicate that involuntary admissions, as reflected in the number of discharges, have increased steadily since 2006/07, while voluntary admissions have stayed relatively static over the same period.

Figure 1: Discharges of Unique Voluntary and Involuntary Psychiatric Patients from Schedule B and C Facilities Designated under the *Mental Health Act,* by Fiscal Year[12]



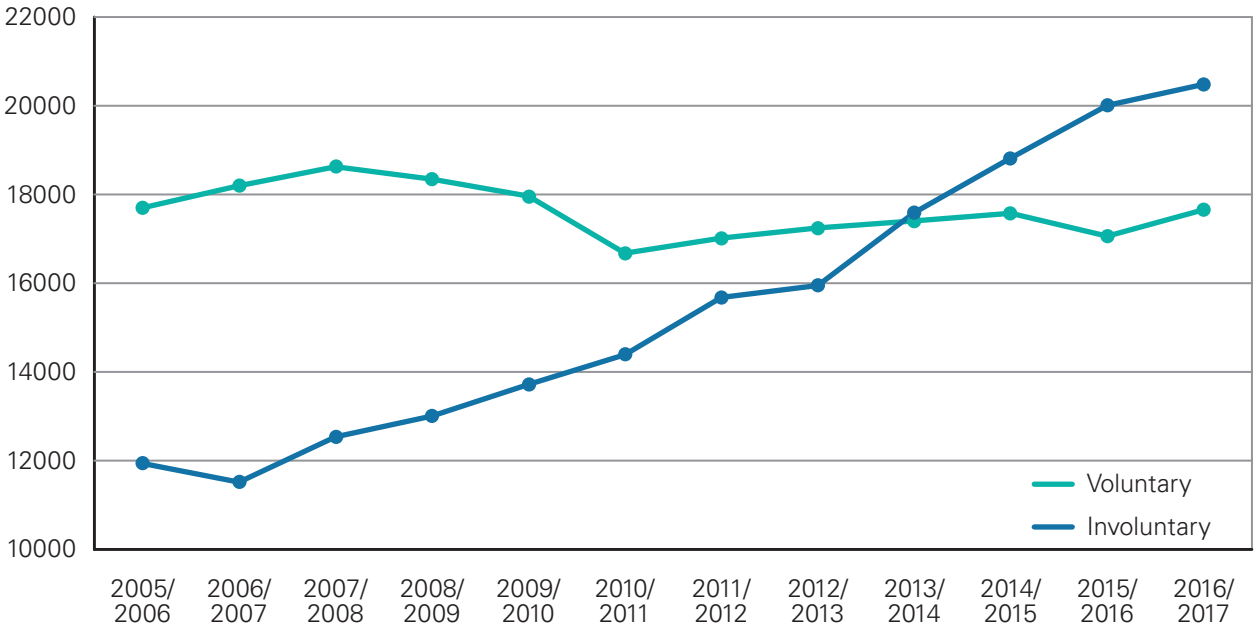
9 Letter from Director, Mental Health and Substance Use, Ministry of Health, to Ombudsperson staff, 18 April 2018, enclosing data.

10 Since aggregate data is gathered after discharge, the fiscal year discharge data is not necessarily equivalent to the number of admissions in that same fiscal year. Some patients who were discharged would have been admitted during an earlier fiscal year. Additionally, the discharge data does not account for patients who were admitted but not discharged in 2016/17.

11 Under section 20 of the *Mental Health Act*, the director of a designated facility may voluntarily admit a person with a mental disorder who is over age 16 and requests admission, or a person with a mental disorder who is under age 16 and whose parent or guardian requests their admission.

12 Letter from Director, Mental Health and Substance Use, Ministry of Health, to Ombudsperson staff, 18 April 2018, enclosing data. The data in Figure 1 shows discharges of unique patients with a mental health diagnosis. This means that in this dataset, a person who was admitted and discharged on more than one occasion is only counted once in this data set. It includes discharges from the Forensic Psychiatric Institute.

Figure 2: All Discharges of Voluntary and Involuntary Psychiatric Patients from Schedule B and C Facilities Designated under the *Mental Health Act,* by Fiscal Year[13]



The Ministry of Health's discharge dataset provides statistical information that is useful in understanding recent trends in *Mental Health Act* admissions. The discharge data show that over the past decade, the number of involuntarily admitted patients steadily increased, both absolutely and relative to the number of individuals who are voluntarily admitted under the *Mental Health Act*. Between 2005/06 and 2016/17, when the population of British Columbia increased by 15 percent,[14] the number of involuntarily admitted patients increased at a significantly higher rate. The discharge data indicates a growth in involuntary admissions of approximately 71 percent over the same period.

In contrast, voluntary admissions have remained fairly consistent, meaning that when population growth is taken into account, the use of voluntary admissions has decreased on a per capita basis. This investigation did not address the reasons why involuntary admissions have significantly increased. However, the rise in involuntary admissions emphasizes the importance of having a system that is administered fairly and consistently.

The involuntary admission provisions of the *Mental Health Act* apply to all persons who meet the admission criteria, regardless of the person's age. The Ministry of Health's discharge dataset shows that 2,566 of 20,483 involuntary admission cases in 2016/17 were children or youth up to age 19.[15] Of that number:

- 27 were 0–9 years old
- 501 were 10–14 years old
- 2,038 were 15–19 years old

[13] Letter from Director, Mental Health and Substance Use, Ministry of Health, to Ombudsperson staff, 18 April 2018, enclosing data. The data in Figure 2 shows the total cases of discharged patients with a mental health diagnosis. This data includes each occasion on which an individual patient was discharged. It includes discharges from the Forensic Psychiatric Institute.

[14] B.C. Data Catalogue, "Population Estimates" <https://www2.gov.bc.ca/gov/content/data/statistics/people-population-community/population/population-estimates>.

[15] Letter from Director, Mental Health and Substance Use, Ministry of Health, to Ombudsperson staff, 18 April 2018, enclosing data.

BC Children's Hospital is unique among facilities designated under the Act in that the vast majority of its patients are minors. Given the age of these patients, their parents or guardians may be involved and engaged with the facility's staff and physicians concerning their care.

There is no limit to how long an individual may be involuntarily detained under the Act – detentions may last for hours, days, months or years. If a person is not discharged by the director of the facility, the person's only other avenues for release are an application to a review panel under the *Mental Health Act* or an application to court. During the 2016/17 fiscal year, the average length of stay for an involuntary patient at a Schedule B or C facility was 14 days. This average has remained consistent over the past three fiscal years.

The discharge statistics mentioned above do not include discharges of involuntary patients from mental health tertiary care (Schedule A) facilities. These facilities offer specialized psychiatric care over an extended period of time, which results in much longer average stays. Individuals may remain at these facilities for months or sometimes years.

Role and Duties of the Director

A director is appointed to be in charge of each designated facility[16] and is empowered to admit both voluntary and involuntary patients.[17] The director must ensure that:

- each patient admitted to the designated facility is provided with professional service, care and treatment appropriate to the patient's condition and appropriate to the function of the designated facility and, for those purposes, a director may sign consent for treatment forms for a detained patient
- standards appropriate to the function of the designated facility are established and maintained[18]

A director includes a person "authorized by a director to exercise a power or carry out a duty conferred or imposed on the director under this Act or the *Patients Property Act*."[19] In practice, and depending on the nature and extent of delegation, this means that any number of facility staff, including physicians and nurses, can be responsible for involuntarily admitting patients, authorizing treatment and issuing any of the notices required under the *Mental Health Act*.

Section 22 of the Act allows the director of a designated facility to detain a person for up to 48 hours for examination and treatment on receiving a medical certificate completed by a physician using a prescribed form (Form 4).[20] The medical certificate must include:

- a statement that the physician has examined the person, and when they did so
- an opinion of the physician that the patient has a mental disorder that requires treatment, and the reasons for that opinion
- an opinion of the physician that the patient:
  - requires treatment in a designated facility
  - requires care, supervision and control at the facility to prevent mental or physical deterioration, for their own protection, or the protection of others
  - cannot suitably be admitted as a voluntary patient[21]

16 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 1.
17 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 20(1), 22(1).
18 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 8(a) and (b).
19 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 1.
20 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 22(1).
21 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 22(3).

The information on the medical certificate constitutes the legal justification for the person's admission and continued detention. A physician must have completed an examination of the patient and the medical certificate (Form 4) within 14 days prior to the admission or the certificate expires.[22] The majority of the medical certificates we looked at in our investigation were completed at the time of a patient's admission to a designated facility. In many cases, this occurred through a hospital emergency department.

The director must also ensure on admission that the forms respecting consent for treatment (Form 5), notification to involuntary patient of rights (Form 13), and the nomination and notification of near relative (Forms 15 and 16) are completed.

The director can extend the initial detention for up to one month from the date of the initial admission if a different physician examines the patient, completes a second Form 4 medical certificate and provides reasons for their opinion that the patient meets the involuntary admission criteria.[23] The second certificate is only valid if it is completed within 48 hours of the initial admission.[24]

After one month, the director can complete renewal certificates (Form 6) to extend the detention in successive one-month, three-month and six-month increments. After the first six-month renewal, any subsequent renewal can also be for up to six months.[25] To approve a renewal, the director or a physician authorized by the director must examine the patient, conclude that the

Voluntary Admissions of Patients Under Age 16

The involuntary admission provisions in the *Mental Health Act* apply equally to all persons, regardless of age. The Act, which also governs voluntary admissions, contains specific provisions that apply only in the case of a voluntary admission of a person under 16 years of age. Our investigation did not include an examination of voluntary admissions. However, it is important to briefly explain the legislative scheme as it applies uniquely to voluntary admissions of children and youth.

The Act provides that a director can admit a person under 16 years of age as a voluntary patient if a parent or guardian requests admission, and if an examining physician determines that the person has a mental disorder.[26] The director must discharge the young patient in circumstances where the parent or guardian requests discharge or where the physician determines that the patient does not have a mental disorder.[27]

The young patient cannot legally consent to their voluntary admission or discharge.

In cases where the young patient desires discharge but the parent or guardian does not request discharge, the patient is entitled to a hearing before a review panel.[28] The review panel will review the patient's condition to determine whether the patient should be discharged.[29] If the review panel determines the patient does not have a mental disorder, the director must discharge the patient.[30]

[22] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 22(4).
[23] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 22(2), (3) and (5).
[24] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 22(5).
[25] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 24.
[26] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 20(1).
[27] *Mental Health Act*, R.S.B.C. 1996, c. 288, s.20(3), s.20(6)(b) and (c).
[28] *Mental Health Act*, R.S.B.C. 1996, c. 288, s.21(1). The role of the review panel is discussed further at page 23.
[29] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 25.
[30] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 21(2).

involuntary admission criteria in section 22 still apply, and set out the reasons for this conclusion in the prescribed form (Form 6).[31] The examination must consider evidence regarding the patient's history of mental disorder and whether there is a "significant risk" that the patient will fail to follow the treatment plan if discharged.[32] If the patient does not meet the criteria for continued detention, the facility must discharge them.

Table 1 provides a visual explanation of the forms required for each certification period, together with the permitted length of detention.

Table 1: Summary of Detention Periods under the *Mental Health Act*[33]

Certification period	Certificate required	Maximum length of detention permitted
First period	One Form 4	48 hours
Second period	Second Form 4	One month from admission date
Third period	One Form 6	One month
Fourth period	One Form 6	Three months
Fifth period	One Form 6	Six months
All subsequent periods	One Form 6	Six months

Because the *Mental Health Act* empowers directors to authorize admissions and ongoing detentions, their role is critical in ensuring that detention decisions are consistent with the Act and substantively and procedurally fair.

We would not necessarily expect a director to question the physician's clinical opinion that a patient is in need of admission or detention. At a minimum, however, the director should ensure that the physician who has reached this opinion has clearly articulated and documented the reasons on which they have based their opinion, and that the reasons adequately demonstrate that the legal requirements for admission set out in the Act are present.

Once a person is involuntarily admitted and detained under the *Mental Health Act*, that person is deemed to consent to any psychiatric treatment that the director authorizes.[34] This "deemed consent" means that even a patient who has the capacity to refuse treatment no longer has the right to refuse medication, procedures or other psychiatric treatment. Furthermore, if an adult patient is mentally incapable of appreciating the nature of the treatment or need for it, the statutory list of substitute decision makers set

[31] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 24.
[32] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 24(2.1).
[33] Table 1 adapted from Community Legal Assistance Society, *Operating in Darkness: BC's* Mental Health Act *Detention System,* November 2017, 21 <https://d3n8a8pro7vhmx.cloudfront.net/clastest/pages/1794/attachments/original/1527278723/CLAS_Operating_in_Darkness_November_2017.pdf?1527278723>.
[34] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 31(1).

out in Part 2 of the *Health Care (Consent) and Care Facility (Admission) Act*[35] does not apply; rather, it is up to the director to authorize psychiatric treatment.

In contrast to British Columbia, Ontario considers involuntary detention and involuntary treatment to be distinct legal issues. In Ontario, if an involuntarily detained person is nevertheless capable of making an informed treatment decision, they may refuse consent to treatment. If a health practitioner believes that the person is incapable of giving informed consent, they may administer treatment if the person's substitute decision maker, as defined in section 20 of Ontario's *Mental Health Act*,[36] has given consent on the person's behalf. However, where the person appeals to the Consent and Capacity Board, treatment depends on whether the board confirms the health practitioner's finding of incapacity or determines instead that the person is capable with respect to the treatment.[37]

There is no equivalent legislative safeguard in British Columbia. As a result, the director's role in authorizing treatment assumes greater importance. That role should be exercised with the utmost care and in a manner that reflects the gravity of their responsibility to the patients who are in their care. The director's role in authorizing treatment is not merely a rubber stamp. The director should be prepared to question or require sufficient justification for medical recommendations so the director is confident, when authorizing treatment, that it is appropriate to the patient's condition.[38]

Charter Rights of Patients Who Are Involuntarily Admitted

The purpose of involuntary admissions and detentions under the *Mental Health Act* is "to treat and protect people with severe mental disorders and to protect the public."[39] Although involuntary admissions and accompanying psychiatric treatment are intended to help people who suffer from mental disorders, involuntary admissions nonetheless deprive an individual of their liberty and the ability to refuse treatment. As previously mentioned, the limitations on the director's powers and the procedural protections set out in the Act are meant to balance a mentally ill patient's rights to liberty and security of their person with the objective of providing the treatment they need.

The detention of a patient under the *Mental Health Act* engages the rights set out in sections 7, 9 and 10 of the *Canadian Charter of Rights and Freedoms*.

Section 7 of the Charter states:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.[40]

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35 The *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, establishes a process for appointing a person to provide consent to health care on behalf of an adult who is incapable of providing consent and who has not already appointed such a decision maker. Health care is defined in this Act as "anything done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health" (s. 1). The list of temporary substitute decision makers set out in the Act is hierarchical, and the health-care provider must choose the first of the individuals in the list who is available and qualified to provide substitute consent to major or minor health care: the adult's spouse, child, parent, brother or sister, grandparent, grandchild, anyone else related by birth or adoption, a close friend, and a person immediately related to the adult by marriage. If no person qualifies or if there is a dispute, the health care provider must choose a person authorized by the Public Guardian and Trustee (PGT), which may include an employee of the PGT's office (s. 16). Section 2 of that Act provides that it does not apply to the provision of psychiatric treatment to an involuntarily detained individual.

36 *Mental Health Act*, R.S.O. 1990, c. M.7.

37 See generally *TC v. Hastings*, 2017 ONSC 374.

38 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 8.

39 Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, 1. <http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf>

40 *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (UK), 1982, c. 11, s.7.

The involuntary admission process deprives a patient of their liberty because the patient is detained and cannot leave a facility of their own volition. Because a patient cannot refuse psychiatric treatment after admission, that patient's right to security of the person is also affected. Deciding whether to refuse medical treatment is a central element of a person's right to exercise control over their body.

In this context, the Act has empowered the director to override the involuntary patient's right to refuse treatment in cases where psychiatric treatment is necessary to protect the patient who is suffering from a mental disorder and to protect the patient or the public from harm. Strict adherence to the prescribed process in both substance and form will help ensure that the patient is not deprived of these fundamental rights without justification.

Section 9 of the Charter provides that "everyone has the right not to be arbitrarily detained or imprisoned." The courts have held that a detention will be arbitrary where there are no criteria that govern the decision to detain.[41] For detentions in the mental health context, the criteria for involuntary admissions and detentions are found in section 22 of the *Mental Health Act*. If even one of those four criteria is absent, there is no authority under the Act to involuntarily admit and detain. Accordingly, if a physician does not form the opinion that all four criteria are met, there is no basis for an involuntary admission, and any detention under the Act that follows is a potential violation of the person's right to be free from arbitrary detentions. As described above, the Act requires a physician to set out in writing the reasons why they are of the opinion that the person has a mental disorder, and to confirm in writing their opinion that the patient meets the involuntary admission criteria. Failure to observe this requirement could render a detention under the Act arbitrary.

Section 10 of the Charter states:

> Everyone has the right on arrest or detention
>
> a) to be informed promptly of the reasons therefor;
>
> b) to retain and instruct counsel without delay and to be informed of that right; and
>
> c) to have the validity of the detention determined by way of habeas corpus and to be released if the detention is not lawful.[42]

Involuntary admissions and detentions under the *Mental Health Act* are detentions within the meaning of the Charter. When an individual is involuntarily admitted under the Act, that individual has the right to be advised of the basis for the detention and of the right to a lawyer, and must be given access to a lawyer if they wish. Section 34 of the *Mental Health Act* expressly provides that upon detention, involuntary patients must be informed of their section 10 Charter rights,[43] and the *Mental Health Regulation* prescribes the form (Form 13) that the rights notification must take.

The procedural protections in the Act are designed to protect the rights of involuntary patients, but it is the individuals and agencies exercising authority under the Act that must give life to those safeguards. A failure to observe the safeguards in the involuntary admissions process may put the Charter rights of affected patients at risk. Further, a

41 *R. v. Hufsky* [1998] 1 SCR 621.
42 *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c. 11, s. 10.
43 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34(2)(b).

procedurally defective admissions process could be seen as an exercise of state action that is incompatible with the values of individual liberty and freedoms that the Charter is intended to protect.

In the case of patients who are children and youth, in addition to Charter principles, facility directors must also be guided by the United Nations *Convention on the Rights of the Child*, which was ratified by Canada in 1991. The Convention requires Canada to act in the best interests of the child, to provide children with the highest standard of health and rehabilitation of health, to periodically review any treatment provided to young people and – in cases where the young person is temporarily deprived of their family environment – to provide special protection and assistance.[44]

Our investigation and report do not address broader questions of constitutionality related to government's power to involuntarily admit and detain a person for psychiatric examination and treatment.[45] Rather, our analysis focuses on the question of compliance with the *Mental Health Act* requirements as important supports in any determination that the legislative scheme is constitutional. Thus, to the extent that we refer to the Charter in this report, it is to explain and emphasize the importance of complying with the statutory requirements and is not a commentary on the constitutionality of the provisions themselves.

Patients' Rights under the *Mental Health Act*

In addition to the Charter rights of individuals who are involuntarily admitted, the *Mental Health Act* establishes additional safeguards, the purpose of which is to assist in making the admission and detention substantively and procedurally fair. These safeguards include steps that the director must take (informing the patient about where they are detained, notifying a near relative) and review processes that are available to the patient (requesting a review of treatment or detention). A brief summary of the available review processes can be found in the chart on page 22.

When informing a patient of their rights under section 10 of the Charter (see above), the director must also tell the patient the name and location of the designated facility where they are detained, that the patient has the right to a review of the detention, and that the patient has the right to a second medical opinion on any proposed psychiatric treatment.[46] Moreover, if the director is satisfied that a patient did not understand their rights when that notice was first given, the director must give notice to the patient again as soon as the patient is capable of understanding the information in the notice.[47]

The director must notify a near relative of the patient's rights immediately after detention. This notice must be in writing in the prescribed form (Form 16) and must be sent

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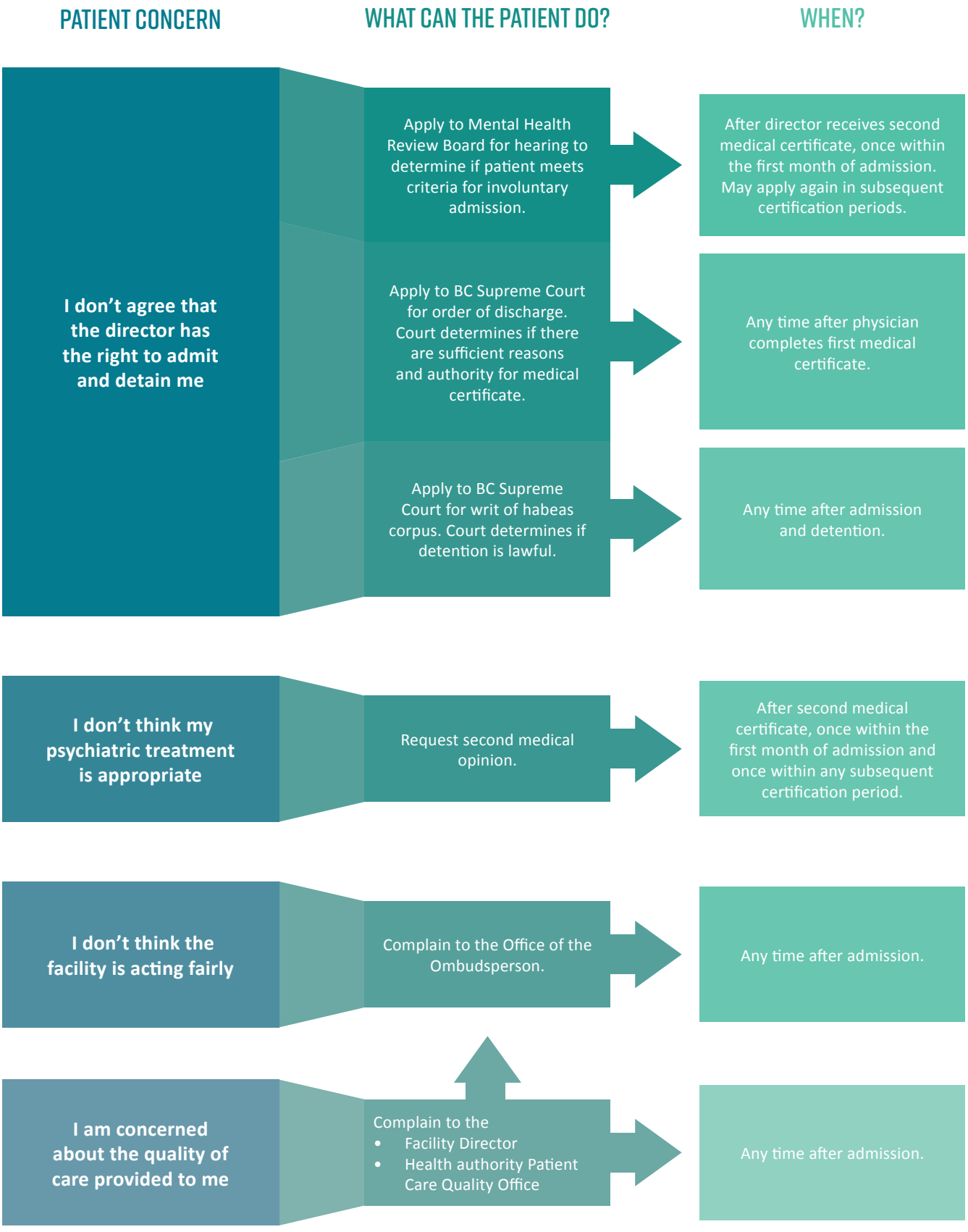
[44] *Convention on the Rights of the Child*, 20 November 1989, 1577 UNTS3 (entered into force 2 September 1990, ratified by Canada 13 December 1991) <https://www.ohchr.org/en/professionalinterest/pages/crc.aspx>.

[45] For example, questions related to the constitutionality of section 31 of the *Mental Health Act* (known as the "deemed consent" provision) were the subject of a Charter challenge filed in 2016 by the Community Legal Assistance Society on behalf of two individuals and the Council of Canadians with Disabilities. The two individuals later withdrew their claims, and on October 12, 2018, the Council of Canadians was denied standing to bring this action on its own and the claim was dismissed: *Maclaren v. British Columbia (Attorney General)*, 2018 BCSC 1753. Currently, the B.C. Supreme Court decision to deny standing is under appeal; see <http://www.clasbc.net/current_cases>.

[46] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34(2). This information is set out in the *Mental Health Regulation,* B.C. Reg 233/99, Form 13, which must be used for this purpose.

[47] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34(3).

REVIEW PROCESSES FOR INVOLUNTARILY ADMITTED & DETAINED PATIENTS



immediately after admission.[48] The information on the Form 16 about the patient's location and rights provides the relative with necessary information so relative can contact the patient and help them seek advice or representation. The director must ask the patient to nominate a near relative to whom the notice will be sent.[49] If the patient does not name a near relative, the director must choose a near relative to be notified.[50] If the director has no information about the patient's relatives, the director of the facility can discharge this responsibility by notifying the Public Guardian and Trustee of British Columbia of a patient's involuntary admission.[51]

There is no statutory obligation on a person who has received a Form 16 to take any action. Indeed, they do not have a right, merely by virtue of receiving the form, to take any action such as obtaining records related to the patient or acting on the patient's behalf.

As noted above, patients who are involuntarily admitted do not have the right to refuse psychiatric treatment. However, they can request a second medical opinion on the appropriateness of any psychiatric treatment authorized by the director. Patients can only make these requests during prescribed periods and, within the first month of their detention, can only request a second medical opinion once.[52] The designated facility is not required to reimburse the patient or someone acting on their behalf for any expenses the patient or their representative incur in obtaining this second medical opinion.[53] Upon receiving a copy of the second medical opinion, the director must consider whether changes should be made to the authorized treatment plan but is not required to follow any of the recommendations made in that opinion.[54]

Role of the Mental Health Review Board in Involuntary Admissions

- The Mental Health Review Board is an independent tribunal established under the *Mental Health Act.* Its members include physicians, lawyers and laypeople.
- An involuntarily admitted patient can apply to the Review Board for a hearing once within the first month of admission and again in subsequent certification periods.
- After holding a hearing and considering the evidence, the panel determines whether the patient should continue to be detained because they still meet the criteria for involuntary admission.
- The panel may not consider the issues related to compliance with the *Mental Health Act*'s admission and detention process in making its decision.

Patients are entitled to have their detention reviewed by a review panel under the *Mental Health Act*.[55] The Mental Health Review Board is an independent adjudicative tribunal established under the Act. Its role is to conduct review panel hearings to determine, following a hearing, whether a person meets the criteria for continued detention. In considering a review application, the panel

48 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34.2.
49 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 1.
50 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 1; *Mental Health Regulation,* B.C. Reg. 233/99, Form 15.
51 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34.2(4).
52 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 31(2)(a).
53 *Mental Health Regulation*, B.C. Reg. 233/99, s. 8(4).
54 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 31(3).
55 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 25(1).

applies the admissions criteria in section 22 of the Act. This means that review panel hearings concern the substance of the detention (for example, whether as of the date of the hearing, the patient continues to have a mental disorder) rather than the process by which the patient was detained (for example, whether a Form 4 medical certificate was properly completed upon admission). Hearings are conducted by a panel of three board members. Patients cannot use the review panel to request alternative psychiatric treatment or a review of treatment.

The Act is clear that if a patient requests a review of their detention, the review panel must focus on the substantive basis for the detention:

> Despite any defect or apparent defect in the authority for the initial or continued detention of a patient detained under section 22, a review panel must conduct a hearing and determine whether the detention should continue because the factors in section 22(3)(a)(ii) and (c) continue to describe the condition of the patient.[56]

Further, the Act says,

> A review panel may proceed with a hearing *despite a defect or apparent defect* in any form required under this Act [emphasis added].[57]

This means that if, for example, a facility detains a patient whose medical certificate was never completed or has expired, the review panel can still consider whether the patient should continue to be detained, despite the fact that the facility had no legal authority to detain the patient in the first instance. The appearance before a review panel allows the panel to conduct its review as if the medical certificate had been done properly. For the review panel's purposes, it does not matter whether a facility has properly complied with the statutorily mandated process during admission. This means that if the review panel determines that the patient meets the involuntary admission requirements, it will order the continued detention of the patient.

The limited role of the review panel means that there is no independent body that reviews on a regular or ongoing basis whether facilities are respecting patients' rights and whether their detentions accord with the principles of fundamental justice. For example, there is no independent body in a position to regularly verify each involuntarily admitted patient's forms to ensure that they were completed properly, or at all.

Individual patients can make complaints to our office about the process by which they were admitted. Aside from this, the only recourse available to a patient to address procedural defects or a lack of legal authority for their detention is to apply to the B.C. Supreme Court for a writ of habeas corpus or an order for discharge under section 33 of the *Mental Health Act*. However, this is rarely done, likely in part because of the complexity of making a court application as an involuntarily admitted patient. This makes independent advice, representation and rigorous adherence to the procedure laid out in the Act even more important.

Case Law on Involuntary Admissions

In British Columbia, the leading case regarding involuntary admissions and the Charter is a 1993 decision of the B.C. Supreme Court, *McCorkell v. Riverview Hospital*.[58]

[56] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 25(2.2).
[57] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 25(2.3)(a).
[58] [1993] B.C.J. No. 1518.

In *McCorkell*, the plaintiff argued that the *Mental Health Act* infringed both his section 7 and section 9 Charter rights on the grounds that the procedures for committal ("committal" is another way of referring to involuntary admission) and review of committal lacked sufficient safeguards to protect individual liberty.[59] The court concluded that the extensive criminal law Charter jurisprudence was inapplicable because of the therapeutic and protective context of the *Mental Health Act:*

> It is necessary at this point to repeat what I said earlier concerning the use of criminal cases to decide a mental health matter: the objects and purposes of criminal law and mental health legislation are so different that cases in one area will be of little guidance in the other. A protective statute and a penal statute operate in dramatically dissimilar contexts. Strict and narrow criteria for the detention of persons in a criminal law context reflect our society's notions of fundamental justice for an accused person and protection of the public is a foremost consideration. But in the field of mental health, the same criteria would defeat the purpose of the legislation which is to help seriously mentally ill people in need of protection.[60]

The court found that the purpose of the Act was "the treatment of the mentally disordered who need protection and care in a provincial psychiatric hospital."[61] The court dismissed the argument that the Act is too broad or vague and reasoned that it must be so to permit the exercise of some discretion: "Overly detailed language may only serve to confuse those who have to apply it and it may leave out unforeseen circumstances that should be included in the scheme."[62]

Ultimately the court determined that the standards for committal under the Act struck a reasonable balance between the "rights of the individual to be free from restraint by the state and society's obligation to help and protect the mentally ill." The court went on to explain, "In determining the fairness of the balance, I take into account my perception that Canadians want to live in a society that helps and protects the mentally ill and that they accept the burden of care which has always been part of our tradition."[63]

With regard to the procedural safeguards in the Act, the court wrote:

> I am satisfied that there are adequate procedural safeguards in place in the current Act. The certification by two physicians, each independent of the other, is preferable to a hearing prior to committal because those who are certifiable are in urgent need of treatment. Applications to court are expensive and time consuming. The patient is informed, soon after admission, of the right to a review, and the services offered by [Community Legal Assistance Society] . . . provides ready advice and representation to the patient. The Act lays down time limits for the duration of the involuntary status and a physician must recertify the patient or the patient will be released.[64]

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59 *McCorkell v. Riverview Hospital* [1993] B.C.J. No. 1518, para. 2.
60 *McCorkell v. Riverview Hospital* [1993] B.C.J. No. 1518, para. 63.
61 *McCorkell v. Riverview Hospital* [1993] B.C.J. No. 1518. The court's view in *McCorkell* has been adopted in subsequent decisions: see *Mullins v. Levy*, 2009 BCCA 6; *Stewart v. Postnikoff*, 2014 BCSC 707.
62 *McCorkell v. Riverview Hospital* [1993] B.C.J. No. 1518, para. 52.
63 *McCorkell v. Riverview Hospital* [1993] B.C.J. No. 1518, para. 68.
64 *McCorkell v. Riverview Hospital* [1993] B.C.J. No. 1518, para. 73.

The court's conclusion that the provisions of the *Mental Health Act* relating to involuntary admission and detention were constitutional was informed by its determination that the safeguards in the Act ensured the protection of individual liberty. Importantly, the court relied on the fact that patients received "ready advice and representation," which was a service offered by the Community Legal Assistance Society (CLAS) at the time.[65] The constitutional viability of involuntary admissions under the Act, according to *McCorkell*, is predicated in part on the fact that individuals detained are not only notified of their rights but given access to representation and advice. Since *McCorkell*, the legal advice and representation offered to involuntarily admitted patients has diminished, a situation that we discuss later in this report.

The court ruled that the criteria for involuntary admissions were not so vague as to offend the Charter, and that the procedures, timelines and reviews in the Act, in concert with independent advice, rendered the provisions in the Act relating to involuntary admissions constitutional. Accordingly, the *McCorkell* decision supports the proposition that each procedural step of the involuntary admissions process must be carefully followed to ensure that the detention is, as the Charter requires, "in accordance with the principles of fundamental justice."

[65] Community Legal Assistance Society (CLAS) operates the Mental Health Law Program, which provides "legal advice and representation to people who have been involuntarily detained pursuant to the BC *Mental Health Act*": Community Legal Assistance Society, "CLAS Programs" <http://www.clasbc.net/>. As we describe in more detail later in the report, CLAS used to routinely provide legal rights advice to involuntary patients upon admission at Riverview Hospital and the major general hospitals in the Lower Mainland, but no longer does. Currently, CLAS provides legal representation to patients detained under the *Mental Health Act* at review panel hearings, and provides advice about detention issues to patients at the Forensic Psychiatric Institute.

INVESTIGATION

Involuntary Admissions in June 2017

We provided notice of our investigation to each of the 71 facilities in British Columbia that could involuntarily admit patients in June 2017.[66] We issued summonses[67] for the following records for each person who was involuntarily admitted to the facilities in June 2017:

- Medical Certificate (Form 4) – the medical certificate that authorizes a patient's admission and initial detention for up to 48 hours (the first Form 4) and then up to one month (the second Form 4)
- Consent for Treatment (Form 5) – to be signed by patients who have been involuntarily admitted or by the facility director on the patient's behalf to authorize psychiatric treatment proposed by a physician
- Medical Report on Examination of Involuntary Patient (Renewal Certificate) (Form 6) – authorizes continued detention after the first month of admission
- Notification to Involuntary Patient of Rights under the *Mental Health Act* (Form 13) – notifies a patient of their rights under the Charter and the *Mental Health Act*
- Nomination of Near Relative (Form 15) – allows a patient to identify a near relative who they would like the facility to inform about their detention
- Notification to Near Relative (Form 16) – a form that the facility must send to the patient's near relative or if the facility has no information about the patient's relatives, to the Public Guardian and Trustee, to inform them of the patient's admission and detention and the patient's rights under the Act[68]

We also notified the Public Guardian and Trustee (PGT) of our investigation, because the *Mental Health Act* requires facilities to notify the PGT about an involuntary admission (using a Form 16) if the facility does not have information about the patient's relatives. We obtained all of the Form 16s that the PGT received in June 2017. We were interested in learning about the steps the PGT takes upon receiving notice so we could assess whether this provision of the Act constitutes a meaningful safeguard.

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66 An additional four facilities were designated after June 2017 and two facilities that were designated at the time of our investigation were later removed from the list. Involuntary admissions to the four facilities designated since June 2017 are not included in our investigation. We also did not include the Regional Treatment Centre (Pacific) because it is outside our jurisdiction. See Appendix C for a list of all facilities in British Columbia designated under the *Mental Health Act*.

67 Pursuant to the powers set out in section 15 of the *Ombudsperson Act*, R.S.B.C. 1996, c. 340.

68 See Appendix D for a copy of each of these forms.

We reviewed the *Mental Health Act* forms we received to answer three key questions:

1. Are the required forms present on each patient's file?
2. Were the forms completed within required timelines after the patient's admission?
3. If the form records a decision for which reasons are required, are those reasons adequate?

The focus of our investigation was to determine whether facilities that involuntarily admit people are doing so in a manner that complies with the *Mental Health Act*. We reviewed the forms that facilities must complete for each admission and detention under the Act. In certain cases where the forms were missing, we asked the facilities to provide us with an explanation of why this was the case. In this way we were able to understand the interactions between patients and facilities in the initial period of admission and detention and whether facilities are complying with their statutory obligations.

Under the *Mental Health Act*, a physician determines whether the statutory criteria to involuntarily admit someone are met. The physician must assess factors including whether a person has a mental disorder and whether they can be treated voluntarily. The substance of that medical opinion is outside our expertise. However, we reviewed whether the reasons contained on the legal forms for the physician's conclusion that the person met the involuntary admission criteria were adequate. In doing so, we assessed whether the reasons provided a summary of the information considered in reaching the conclusion, facilitated understanding of the basis for the decision, and could allow for the meaningful review or appeal of the decision.[69]

During our investigation, we referenced the *Guide to the Mental Health Act* published by the Ministry of Health. The guide articulates the Ministry of Health's interpretation of the Act and is intended to provide the health authorities with much of their policy guidance on involuntary admissions. The guide is intended to make the Act more understandable and promote consistency in interpreting the Act, so people who need involuntary psychiatric treatment receive help in a responsible and lawful manner.[70]

The guide recognizes that while the primary purpose of the Act is "to provide authority, criteria and procedures for involuntary admissions and treatment," it also contains protections to ensure that the Act is applied lawfully and individual rights are safeguarded. In this respect, the guide complements the legislative framework by emphasizing the importance of fully and accurately completing the required forms for admissions and detentions.

In addition to reviewing documents, policies and statistics related to involuntary admissions, we interviewed people who are directly engaged with mental health services in British Columbia, including staff and management at designated facilities, representatives of the Community Legal Assistance Society, academics, educators, family members and people who had been involuntarily admitted. Their stories, expertise and experiences provided invaluable insight into the involuntary admission process.

Authority Responses to Requests for Patient Records

As described above, we requested records related to each patient who was involuntarily admitted to facilities designated under the *Mental Health Act* in June 2017. In many

[69] Office of the Ombudsperson, *Code of Administrative Justice* 2003, 16. <https://www.bcombudsperson.ca/documents/code-administrative-justice>.

[70] Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, iv. <http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf>.

cases, the facilities and the health authorities that operate them had difficulty fulfilling this request. The health authorities told us that *Mental Health Act* forms were not maintained electronically or in another way that allows for easy retrieval. In order to provide our office with the requested forms, each designated facility had to review individual patient files manually and copy the forms.

This solution was relatively straightforward, if inefficient, for facilities that primarily treat mental health patients, because involuntary patients are a significant proportion of the patients at the facility. However, it was an impractical solution for hospitals where involuntary patients are a small proportion of all patients and can be detained in different departments. For these facilities, finding the *Mental Health Act* records we requested was more challenging.

The only other means of more easily locating these records arises after a patient is discharged. Once a patient leaves a facility, their health records are classified electronically. Because of the volume of records that need to be classified, there is often a considerable delay between a file closing and its classification. As a result, in March 2018 we continued to receive records from health authorities for patients who were admitted in June 2017 and later discharged. After we provided the authorities with our draft report, we learned that one health authority had not provided all of its involuntary admission records from June 2017. We obtained these records in September 2018 and included them in our investigative data.

Since there is no systematic means of tracking records for patients who are involuntarily admitted, and specifically, the forms that are required under the *Mental Health Act*, we cannot know with complete certainty whether the records we obtained accurately represent all of the involuntary admissions in June 2017. We also do not know whether we received each completed form for every patient. It is possible that some completed forms were not provided to us as a result of poor records management practices.

Our conclusions are based on the evidence provided to us by the facilities, as they were required to do under the *Ombudsperson Act*. As the authorities were under a legal obligation to provide these records, it is our expectation that the forms we received represent the vast majority, if not all, of the involuntary admissions in June 2017. As part of the process of receiving the health authorities' representations on the draft report, we reconfirmed with each that they had provided all requested forms related to all of their involuntary admissions in June 2017. We are therefore confident that we have reached sound conclusions based on reliable evidence.

Investigative Scope

As described above, our investigation focused on involuntary admissions in June 2017. This means that our review captured only those people who were certified under section 22 of the *Mental Health Act* in June 2017. We focused on the *Mental Health Act* forms that are legally required to be completed at the time of each initial involuntary admission.

Focusing our investigation in this way ensured that the investigation was manageable for both our office and the authorities that were providing records. For the reasons described above, responding to our investigation and providing our office with the requested patient health records required significant effort on the part of the designated facilities. We wanted to minimize the impact of our investigation on the facilities' provision of care while ensuring that we obtained sufficient evidence to allow us to draw conclusions about how well the involuntary admission process is being administered in British Columbia.

We considered whether the public interest would be served by expanding our investigation to examine additional patient health records or to assess compliance over additional months. We decided for the following reasons that our investigative scope was appropriate:

- expanding our investigation would require more work on the part of the health authorities and facilities
- the overall compliance rates for June 2017 were so far below the expected standard that it appeared unlikely to be an aberration
- we provided each facility and health authority with the opportunity to respond and provide corrections to our data, which we incorporated into this final report
- upon reviewing our draft report, the health authorities agreed that their compliance with the provisions of the *Mental Health Act* fell below the required standards

Given the requirements in the *Mental Health Act*, we expected that each involuntary patient file would contain, at a minimum, at least one Form 4, Form 5, Form 13, Form 15 and Form 16.

There are legitimate reasons why forms might not be completed for a specific patient. While we requested only patient files related to new admissions in June 2017, some facilities may have provided us with records of involuntary patients who were transferred to their facility or recalled from extended leave in June 2017, but were in fact involuntarily admitted prior to that month. Sometimes physicians complete a Form 4 medical certificate in error for a recalled patient, because they do not realize that the person is already an involuntary patient under the Act. In those circumstances, the new Form 4 is appropriately disregarded and no second Form 4 is required, nor is a Form 13, 15 or 16.[71] As well, a second Form 4 medical certificate may appear to be missing in circumstances where a first Form 4 is completed but the admission then proceeds on a voluntary basis.

"Given the requirements in the Mental Health Act, we expected that each involuntary patient file would contain, at a minimum, at least one Form 4, Form 5, Form 13, Form 15 and Form 16."

To assess timeliness in relation to form completion, we used the date on a Form 4 medical certificate as the date of admission. While a Form 4 can be completed up to 14 days prior to a person's admission,[72] in the vast majority of cases it is completed at the time of the person's admission.

Patients who were certified under section 22 of the Act prior to June 2017 were outside the scope of our review. This means that patients who were involuntarily admitted prior to June 2017 and recalled from extended leave (under section 39(2) of the *Mental Health Act*) or transferred between facilities in June 2017 were not included in our review. While these patients were detained during the month of June, we excluded them because our investigative focus was on the completion of forms on initial admission. Where we learned that a patient who appeared to have been involuntarily admitted in June 2017 was in fact recalled from extended leave during that

[71] However, if a person is being recalled from extended leave of six or more consecutive months, they are deemed to have been admitted under section 22(1) of the *Mental Health Act* on the date they return to the facility, and a new Form 13 must be completed for the patient: *Mental Health Act*, R.S.B.C. 1996 c. 288, s. 39(4); Ministry of Health, *Guide to the Mental Health Act*, 4 April 2005, 38. We excluded such patients from the scope of our investigation because they were involuntarily admitted prior to June 2017.

[72] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 22(4).

month, we excluded that patient from our review.

Some patients who were initially involuntarily admitted to a facility in June 2017 were later transferred to another facility. We considered this to be a single admission under the *Mental Health Act* and attributed all completed forms to the initial admitting facility, regardless of which facility completed the forms.

At the conclusion of our investigation, we provided each of the health authorities with a copy of our draft report and data showing the number of admissions to each facility and the number of each type of form completed in respect of those admissions. The health authorities had the opportunity to provide additional information to ensure that our data accurately reflected their practices. As a result, some health authorities supplied additional information that allowed us to update our data.

Overall Form Completion Rates

The records we obtained during our investigation represent a snapshot of the facilities' practices over a one-month period. Our review involved 1,468 sets of forms related to involuntary admissions in June 2017. These records allowed us to gain insight into practices around involuntary admissions. Each set of forms relates to the involuntary admission of one patient. Some individuals were involuntarily admitted more than once during the month, which meant we had more than one set of forms related to that patient.

The patient forms reviewed in this investigation represent involuntary admissions to 44 designated facilities. The other 27 facilities had no involuntary admissions in June 2017 that fell within the scope of our investigation.[73]

The *Mental Health Act* requires the forms we reviewed in our investigation (with the exception of Form 6, which is required when a person's detention is renewed) to be completed promptly upon a person's involuntary admission. A Form 4 medical certificate must be completed in order to involuntarily admit a patient. A Form 5 must be completed before any psychiatric treatment is provided. A Form 13 must be completed "on the patient's detention" under section 22(1),[74] and a Form 16 must be completed "immediately after" admission and detention under section 22(1).[75] Because a Form 15 is a prerequisite to a Form 16, it too must be completed immediately after admission and detention. Therefore, irrespective of the duration of the involuntary admission, Forms 4, 5, 13, 15 and 16 must be completed. The chart on pages 32-33 shows the forms that are required at each stage of the involuntary admission process. The chart also shows our overall findings in respect of completion rates for each of the forms.

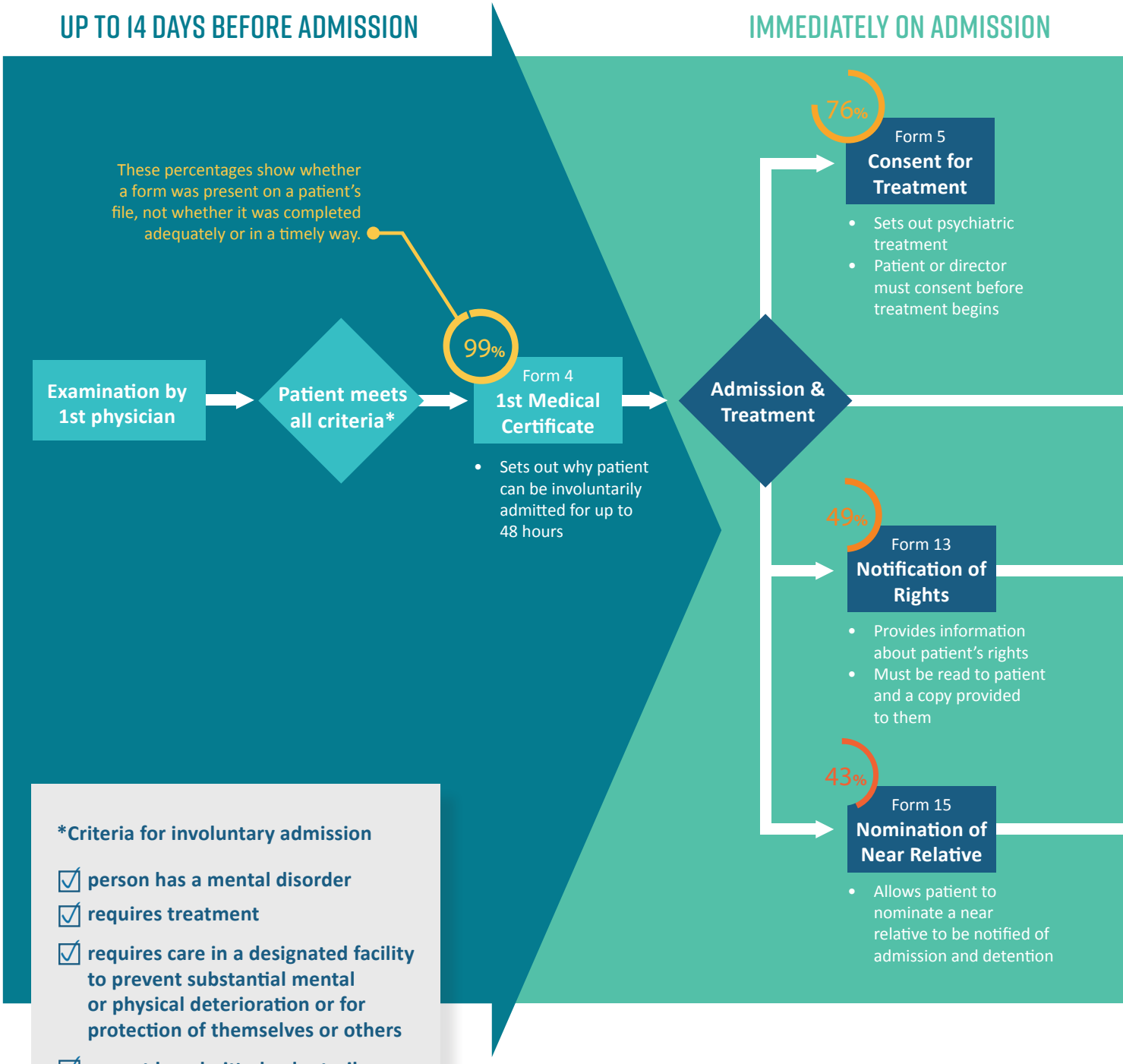
Because facilities are statutorily required to comply with the process in the *Mental Health Act,* and because the presence of a form helps to demonstrate that the detention is in accordance with the Charter, we expected to see that the forms were properly completed for each admission. This was not the case. Instead, we found significant problems with the timely and adequate completion of Form 4, Form 5, Form 13, Form 15 and Form 16. We found that many forms were missing, incomplete or completed after the relevant legislated time frames, and that many also contained inadequate reasons. The data

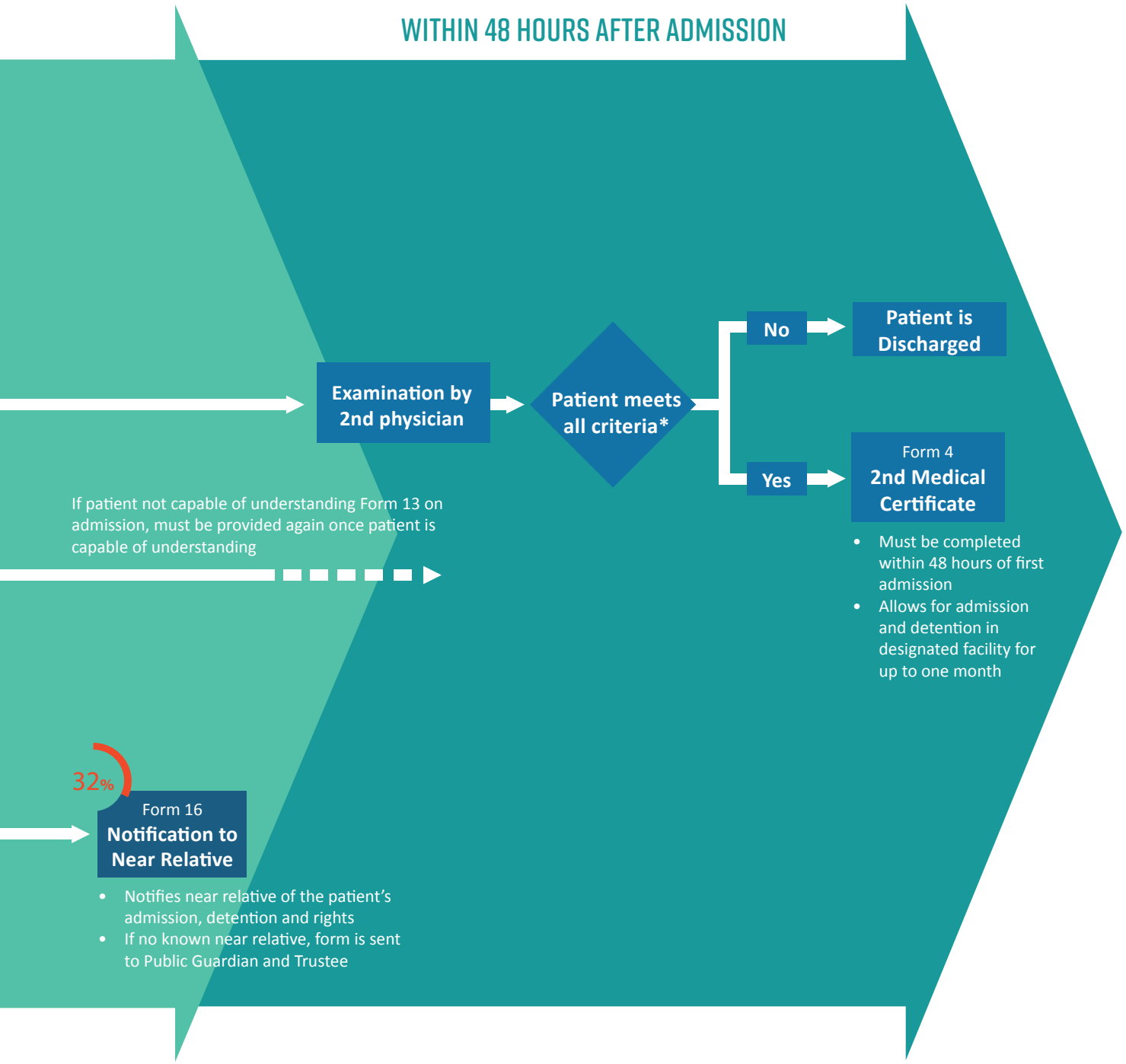
[73] See Appendix C for a list of designated facilities with no involuntary admissions in June 2017. As noted above, we did not investigate the Regional Treatment Centre (Pacific), as it is operated by the federal government.
[74] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34(1)(a).
[75] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34.2(1)(b).

INVOLUNTARY ADMISSION PROCESS

COMPLIANCE WITH FORMS REQUIRED UNDER THE *MENTAL HEALTH ACT*

ADMISSIONS IN JUNE 2017



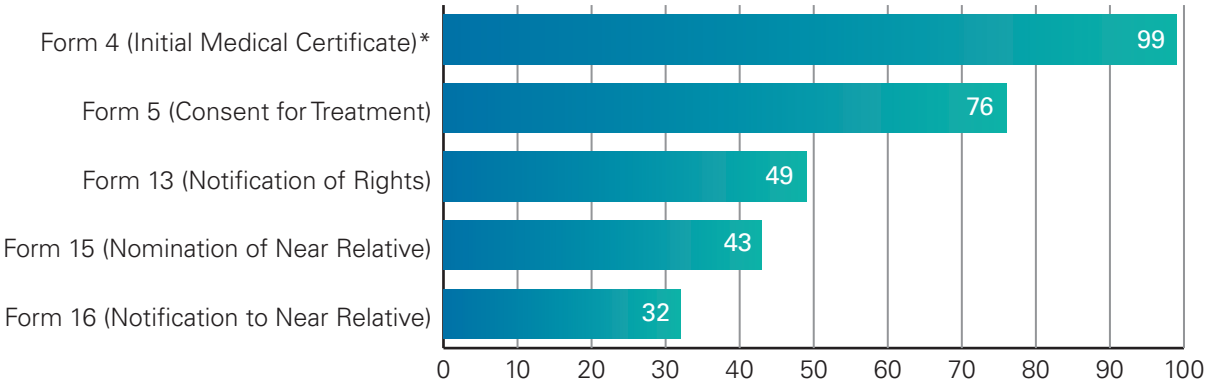

WITHIN 48 HOURS AFTER ADMISSION
Examination by 2nd physician
Patient meets all criteria*
No
Patient is Discharged
Yes
Form 4
2nd Medical Certificate
Must be completed within 48 hours of first admission
Allows for admission and detention in designated facility for up to one month
If patient not capable of understanding Form 13 on admission, must be provided again once patient is capable of understanding
32%
Form 16
Notification to Near Relative
Notifies near relative of the patient's admission, detention and rights
If no known near relative, form is sent to Public Guardian and Trustee

presented in this report focuses primarily on completion rates by health authority. As patients may be transferred to different facilities within a health authority in order to receive the most appropriate care, focusing on overall compliance rates by health authority provides, in our view, a more accurate picture of compliance.[76]

Even a short-term detention restricts a person's liberty. The full process set out in the *Mental Health Act* must therefore be observed for every admission regardless of its duration. This means completing a consent for treatment form, notifying the patient of their rights, providing an opportunity to nominate a near relative and notifying that near relative of the admission, and doing all of this at the time of the patient's admission under the first Form 4.

The overall rates – across all health authorities – for completion of each of the forms required on a person's involuntary admission under the *Mental Health Act* are shown in Figure 3. This data reflects only the presence or absence of the forms, not whether the forms were appropriately completed or whether they were completed in a timely way.[77]

Figure 3: Percentage of Patient Files Containing Required Form, All Health Authorities, June 2017



Note: ** The Form 4 percentage relates only to the initial Form 4 that must be completed when a person is first involuntarily admitted.*

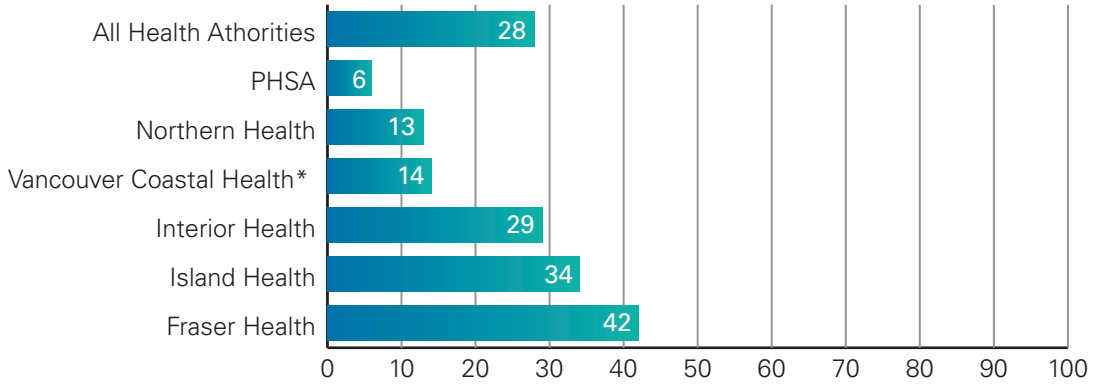
We note that all of these forms are legally required for every involuntary admission, and the rate of compliance for each should therefore be 100 percent. The percentages in Figure 3 show whether a form was completed at some point during a patient's admission and detention, but not whether it was completed in a timely way. For example, a Form 13 existed in 49 percent of the patient files we reviewed; however, the Form 13 was completed on the day of admission in only 13 percent of the files. The Form 16 was completed on the same day as the first Form 4 in only 7 percent of the patient files we reviewed.

[76] A person may also be transferred from one health authority to another after being involuntarily admitted. Such transfers occur rarely and did not affect our data in a meaningful way.

[77] For example, this data includes forms that are illegible, unsigned and undated and forms that were completed outside of statutory time limits. It includes consent for treatment forms (Form 5) where the description of treatment is left blank and notification to near relative forms (Form 16) that are missing pages.

We also examined whether each of the health authorities had completed all of the forms that are required on a person's involuntary admission. Figure 4 shows the percentage of patient files in each health authority that contained at least the initial medical certificate (Form 4), a consent for treatment (Form 5), a notification of rights associated with the initial admission (Form 13), and nomination and notification of near relative (Form 15 and Form 16) forms.

Figure 4: Percentage of Patient Files Containing an Initial Form 4, Form 5, Form 13, Form 15 and Form 16, by Health Authority, June 2017



Note: ** includes patients admitted to St. Paul's Hospital, operated by Providence Health Care in partnership with Vancouver Coastal Health Authority.*

All of the health authorities fell well short of 100 percent compliance with completing the forms required by the Act. In fact, all of the health authorities were non-compliant in well over half of the files that we reviewed. On average, the health authorities completed all of the forms that are required only 28 percent of the time.

Form Completion for Short-Term Involuntary Admissions

Not every health authority was of the view that the forms must be completed in all cases.

Two health authorities told us that the emergency departments of hospitals within their regions usually did not complete Forms 13, 15 and 16 for involuntary patients who were admitted for a short duration (usually less than 24 hours).

One of these health authorities told us that some of the patients involuntarily admitted for a short time do not meet the criteria under section 22 of the *Mental Health Act* and accordingly should not be involuntarily admitted at all. The health authority said some intoxicated patients are involuntarily detained in the emergency department of hospitals until they are sober and may safely leave, at which point the patients are de-certified and discharged. These patients generally do not receive psychiatric treatment and a Form 5 consent for treatment is not completed in respect of their involuntary admission.

The other health authority told us that section 22 of the *Mental Health Act* is broad enough to include intoxicated patients who present with some evidence of mental disorder, such as suicidal ideation. The health authority said these patients generally receive treatment,

such as a withdrawal protocol, and a Form 5 is completed. Once the patient is no longer intoxicated and they can be better evaluated, they are released if they do not meet the involuntary admissions criteria. Just over 25 percent of the Form 4 medical certificates completed for patients admitted to the emergency departments of this health authority's facilities for less than 48 hours contained information suggesting that one reason for the patients' admission was intoxication through alcohol or drug use. None of these patient files contained a Form 13, 15 or 16.

> *"Mental Health Act forms are not just paperwork. They provide the legal authority for an involuntary admission and detention."*

There are clearly differing views across health authorities as to how to best respond to individuals who arrive at the emergency department too intoxicated to be assessed. However, there is no separate admissions process for short-term involuntary admissions. If there is insufficient evidence that the person meets the criteria for involuntary admission, the director does not have the authority under the *Mental Health Act* to involuntarily admit that patient. However, if there is sufficient evidence to support an opinion that the person meets the criteria for involuntary admission, directors of designated facilities must ensure that all required forms are properly completed.[78]

It is important to re-emphasize that these *Mental Health Act* forms are not just paperwork. They provide the legal authority for an involuntary admission and detention and, when properly completed, provide evidence that facilities are safeguarding patients' constitutional rights in the admissions process. As described in *McCorkell*, the *Mental Health Act* is premised on a balance between respecting individual rights and providing necessary psychiatric treatment for people with mental disorders who are in need of protection. When the procedural steps and accompanying forms that are central to the process outlined in the Act are not completed, this balance is upset.

Compliance with Required *Mental Health Act* Forms

In the following sections, we describe our findings with respect to each of the types of forms that we obtained and reviewed in our investigation.

Medical Certificate (Form 4) and Medical Report on Examination of Involuntary Patient (Form 6)

A medical certificate provides the legal basis for a designated facility to admit a patient involuntarily and to detain them for up to 48 hours. A director of a facility may admit a person involuntarily on receiving a medical certificate completed by a physician.[79] The *Mental Health Regulation* requires the physician to complete a medical certificate using the prescribed Medical Certificate (Involuntary Admission) (Form 4).[80] A person can be detained for up to one month after the initial admission if a different physician examines the patient and completes a second medical certificate (also using a Form 4) before the initial 48-hour period expires. This

[78] Section 22 of the *Mental Health Act* provides that the director "may" admit a person involuntarily upon receiving a medical certificate completed by a physician in accordance with sections 22(3) and (4) of the Act. Those sections set out the four criteria that must be met prior to an involuntary admission.
[79] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 22(1).
[80] *Mental Health Regulation*, B.C. Reg. 233/99, s. 11(4).

second certificate provides the legal authority for the ongoing detention.

Without an appropriately completed medical certificate, there is no authority under the *Mental Health Act* to detain a patient involuntarily. As such, we would expect that in all cases this form was completed immediately upon admission and contained an adequate explanation of the reasons why involuntary admission was necessary.

Section 24 of the *Mental Health Act* allows a physician (either the director of a facility or a physician authorized by a facility) to extend a patient's involuntary admission beyond one month by issuing a renewal certificate. The *Mental Health Regulation* provides that all renewal certificates must be completed using a Medical Report on Examination of Involuntary Patient (Renewal Certificate) (Form 6).[81]

When deciding whether to issue a renewal certificate, a physician must examine the patient and determine whether the patient continues to meet the involuntary admission criteria in section 22. In making that determination, the examining physician is required to review "all reasonably available evidence concerning the patient's history of mental disorder," including hospitalization for treatment and compliance with treatment plans after hospitalization.[82] The physician must also assess whether there is a significant risk that the patient, if discharged, will fail to follow the treatment plan that the director or physician considers necessary to minimize the possibility of another involuntary admission.[83] As noted earlier, there is no limit on the length of time that someone can be involuntarily detained under the *Mental Health Act*. Instead, the Act provides for periodic reassessments and, if the criteria are met, a renewal of the detention (see Table 1, page 18).

Much like the medical certificate (Form 4), the renewal certificate (Form 6) sets out the renewal criteria and requires the physician to explain and document why they have formed the opinion that the patient's continued detention is necessary. The renewal certificate is a legal document that authorizes the designated facility to continue to detain a patient involuntarily. It is important that a physician engaged in the renewal process comply with the statutory requirements in the Act and appropriately document the reasons for their opinion that the involuntary detention of a patient should continue.

The *Guide to the Mental Health Act* explains the importance of timely completion of renewal certificates in relation to the validity of detentions under the Act:

> The Form 6 (and the examination on which it is based) must be completed and signed by the examining physician before midnight on the last day of the current period. If this is not done, new medical certificates (Form 4) would be required for further involuntary care and treatment. A certificate or renewal which is not properly completed may result in a claim for damages of false imprisonment and assault and battery.[84]

In other words, without a valid medical certificate or renewal certificate, the detention is without legal authority under the *Mental Health Act*. Therefore, it is critical that facilities ensure that these forms are appropriately completed for every involuntary admission. None of the health authorities put forward an alternative legal or factual basis for a patient's detention in those cases where we identified a missing Form 4.

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81 *Mental Health Regulation*, B.C. Reg. 233/99, s. 11(6).
82 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 24(2.1)(a).
83 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 24(2.1)(b).
84 Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, 26.

The Medical Certificate (Form 4) and Renewal Certificate (Form 6) are completed by physicians. They contain medical information, such as a list of symptoms, supporting the physician's opinion that the patient has a mental disorder. However, they are much more than just a medical record. In the case of a medical certificate and renewal certificate, the physician's reasons provide the rationale for the involuntary detention of a person and the corresponding deprivation of their liberty. Failure to document, in these forms, reasons for the admission and detention risks depriving vulnerable people of their freedom without justification.

The physicians completing these forms have a duty to complete the forms adequately and appropriately. Directors of designated facilities have an obligation to exercise the involuntary admission and renewal power only in circumstances where there is an appropriately completed Form 4 or Form 6 documenting the physician's opinion and reasons for concluding that the patient meets the admission or renewal criteria.

Reasons provide the rationale and justification for decisions and are a means to facilitate understanding and to allow for a meaningful appeal or review.[85] The information contained in the medical certificate may form the basis for the patient to challenge the admission before a review panel or the court. Failure to provide adequate reasons can disadvantage a person who wants to challenge their detention. Accordingly, when providing reasons for an involuntary admission and detention, the physician must document in summary form how they concluded the statutory criteria were met.

We have grouped our analysis of Form 4 and Form 6 in this section, as these certificates have a similar role in authorizing the ongoing detention of a person with a mental disorder.

Form 4 Completion Rates

We assessed whether an initial medical certificate (Form 4) was present for each admission. If there was a second Form 4, we assessed whether it was completed before the initial 48 hours had expired.

The overall compliance rate for initial Form 4s is excellent, at 99 percent. Notably, the Provincial Health Services Authority and Interior Health had 100 percent compliance. We note, however, that if there were involuntary admissions without a completed Form 4, the files might not have been identified by the health authorities or designated facilities and thus would not have been provided to us during our investigation. Put another way, if someone was involuntarily admitted and detained without any documentation under the *Mental Health Act*, they would not have to come to our attention during our investigation.

The law requires the directors of designated facilities to ensure that a physician completes a Form 4 for every admission, with no exceptions. Even a 99 percent compliance rate means that the health authority did not produce evidence of the legal basis for the detention of every involuntarily admitted patient. The facilities provided us with no associated Form 4 for 19 of the 1,468 patients that the facilities considered to have been involuntarily admitted in June 2017. In other words, the medical certificates that are legally required to be completed when a person is first involuntarily admitted were missing for these 19 patients.

In addition to the 19 missing initial Form 4s, we identified four Form 4s that were completed one or two days after the patients' associated consent for treatment forms were

[85] Office of the Ombudsperson, *Code of Administrative Justice 2003*, 16.

completed. This suggests that the medical certificates were not completed as part of the admission process but were instead prepared at a later date.

We also reviewed all of the files we received to determine whether the second medical certificate had been completed in cases where the patient was not released within 48 hours. We identified at least 29 files where, based on the other file materials, it appeared that the facility had continued to detain a patient beyond 48 hours without completing a second Form 4. We made this identification based on the assumption that there should be a second Form 4 if either of the following indications of continued detention were present:

- the file contained a Form 6 (which authorizes continued detention for more than one month)
- the file contained a Form 5, Form 13, Form 15 or Form 16 signed more than two days after the Form 4 was completed

The first Form 4 authorizes a person to be detained for only 48 hours. The second Form 4 authorizes detention for much longer: up to one month from the date of admission. If there is no second medical certificate, the patient should be released.[86]

Any missing or delayed Form 4s are particularly concerning because the medical certificate is the keystone document that provides the legal basis for a person's involuntary admission and detention. Without it, there is no authority under the *Mental Health Act* to involuntarily detain and treat a patient. The missing and delayed Form 4s suggest that medical certificates are not always completed on admission. In the absence of any other authority to involuntarily detain, a detention without completion of a medical certificate is likely unlawful.

A detention without a completed Form 4 may also be a violation of an individual's Charter rights. As described earlier, the Charter is engaged because unlawful detentions deprive patients of their liberty in a manner that will generally not be in accordance with the principles of fundamental justice as required under section 7. Moreover, unlawful, undocumented detentions may offend section 9 of the Charter, which protects the right not to be arbitrarily detained. Detentions without a medical certificate may be arbitrary because, without a physician's opinion that the statutory criteria are present, there may be no legal or factual foundation under the Act for the detention.

"Any missing or delayed Form 4s are particularly concerning because the medical certificate is the keystone document that provides the legal basis for a person's involuntary admission and detention."

In the absence of any other evidence of a basis for the detention, we concluded that some of the admissions in June 2017 were without a legal basis under the *Mental Health Act* and that, because of this, there was an increased risk that the detaining facilities violated the section 7 and section 9 Charter rights of those patients who were involuntarily admitted without a medical certificate.

Adequacy of Reasons – Medical Certificate (Form 4)

We reviewed the reasons for admission and detention contained in the Medical Certificate (Form 4) completed for the June 2017 involuntary admissions. In doing so, we considered whether the reasons provided

[86] This assumes that the patient was not a patient recalled from extended leave or a patient who was initially certified but then remained in the facility voluntarily.

could explain the basis of the detention with reference to the statutory criteria. We did not assess whether the physician's medical opinion or diagnosis was medically sound or appropriate.

To issue a medical certificate, a physician must form the opinion that a patient:

- has a disorder of the mind that requires treatment and that seriously impairs the patient's ability to react appropriately to their environment or to associate with others
- requires treatment in or through a designated facility
- requires care, supervision and control in or through a designated facility to prevent the patient's substantial mental or physical deterioration or for the protection of the patient or for the protection of others, and
- cannot suitably be admitted as a voluntary patient[87]

The *Mental Health Act* requires the physician to provide reasons for their opinion that the patient has a disorder of the mind.[88] While the Act does not require reasons for the other three elements that must be present in order to involuntarily admit a patient, the *Guide to the Mental Health Act* strongly suggests that reasons be provided.[89] The *Guide to the Mental Health Act* also emphasizes the importance of legible medical certificates: "since the forms are legal documents, legible printing or writing is important."[90]

Providing reasons for admission and detention that are adequate and legible means that a facility can better comply with its obligation under section 10 of the Charter to ensure that involuntarily admitted patients are "informed promptly of the reasons"[91] for their detention. In this respect, we note that Form 13, which directors are obliged to provide to patients to notify them of their rights, lists the four statutory criteria for admission and then states, "the reasons why the medical doctor thinks you should be here are written on the medical certificate," thus referring patients back to the Form 4 for an explanation of why they have been admitted. This heightens the importance of providing legible and adequate reasons as to why the patient meets all of the admission criteria.

Moreover, providing adequate reasons for concluding that criteria are present is also important from a procedural fairness perspective. Reasons are likely to assist the patient in understanding why they have been admitted, in obtaining legal advice about their admission, and in making applications to the Review Board or the court.

The Form 4 lists the statutory criteria a patient must meet to be involuntarily admitted. The form provides 19 blank lines, or a correspondingly large blank space, for the physician to set out the reasons for their opinion. It also provides that the physician can continue writing on the back of the form if space on the front is insufficient. It was rare, on our review of the Form 4s, that a physician made use of this space to provide detailed reasons for their opinion that the patient met the criteria for involuntary admission. While information about the patient's condition may be found in the patient's chart, the purpose of the Form 4 is to relate the physician's observations of the patient's medical and psychiatric condition to the specific requirements for involuntary admission in the *Mental Health Act.*

87 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 22(3).
88 *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 22(3)(b).
89 Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, 72.
90 Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, 72.
91 *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c. 11, s. 10(a).

Some health authorities offer online training to physicians on the involuntary admissions process under the Act. The *Guide to the Mental Health Act* provides some guidance for physicians on how to complete the medical certificate.[92] The College of Physicians and Surgeons of British Columbia publishes "Legislative Guidance: Involuntary Admissions under the *Mental Health Act,*" which is primarily a restatement of the criteria for admission under the Act.[93]

Sometimes physicians in the community complete a Form 4 prior to the patient's arrival at a designated facility. Some health authorities explained to us that they have minimal control over the practice of community physicians who may not be affiliated with or employed by a health authority. While this may be the case, it should not prevent the directors of designated facilities (who are health authority employees) from examining Form 4s to ensure that they are adequate. In cases where a Form 4 completed by a community physician does not contain adequate reasons, we would expect the director of any designated facility where admission is sought to exercise their discretion to seek additional written explanations from the physician or another physician on a separate Form 4 so they can be satisfied that all of the criteria set out in section 22 are, in fact, met. A director should not admit a person involuntarily in cases where the director does not have sufficient information to support the need for the involuntary admission.

We assessed whether the Form 4s we received for June 2017 admissions included adequate information on each of the legislative criteria for admission set out in the *Mental Health Act*. We assessed the forms in light of the legal requirement to provide reasons for the opinion that the patient has a mental disorder. As well, we considered the patient's perspective: we assessed what information they would reasonably require on the Form 4 in order to understand the reasons for their admission and detention. In this way, we considered whether the reasons provided on the forms were consistent with broader principles of administrative fairness.

We have not included a specific compliance rate for adequacy of reasons in this report because we recognize that people can come to differing conclusions about whether a particular set of reasons is adequate. However, we reviewed many Form 4s that fell below a reasonable standard. That is, they lacked information relating to one or more of the criteria for admission or were illegible.

We found that, generally, the second medical certificates (issued within 48 hours of the first) had marginally better reasons than the initial medical certificates, perhaps because they were completed in less emergent circumstances.

To illustrate the issue, we have excerpted physicians' opinions contained in five Form 4s that provided the basis for designated facilities to detain those five individuals. When we reviewed these forms, we concluded that the reasons provided by the physicians are inadequate because the forms simply list symptoms – which may or may not amount to a mental disorder – without explaining why the patient requires care through a designated facility to prevent their mental or physical deterioration or for the protection of the patient or others. The forms also do not explain why the patient is not suitable for admission as a voluntary patient.

[92] Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, Appendix 4.
[93] College of Physicians and Surgeons of British Columbia, "Legislative Guidance: Involuntary Admissions under the *Mental Health Act*," approved by the Executive Committee, effective 26 June 2015 <https://www.cpsbc.ca/files/pdf/LG-Involuntary-Admissions-under-the-Mental-Health-Act.pdf>.

Form 4 – Example 1

1. In my opinion, this person:
   has a disorder of the mind that requires treatment and which seriously impairs the person's ability to react appropriately to his/her environment or to associate with others (section 1 of the *Mental Health Act*);

2. In my opinion, this person:
   (a) requires treatment in or through a designated facility; and
   (b) requires care, supervision and control in or through a designated facility to prevent his/her substantial mental or physical deterioration or for the protection of the person or for the protection of others; and
   (c) cannot suitably be admitted as a voluntary patient.

This person ☐ was ☒ was not brought to me by a police officer or constable under section 28 of the Act.

In summary form, the reasons for my opinion are: (information may be obtained through interviews, observations and collateral sources)

Anxious

Paranoid

Failed Stabilization

Note: if above space is insufficient, continue on back of form

Form 4 – Example 2

1. In my opinion, this person:
   has a disorder of the mind that requires treatment and which seriously impairs the person's ability to react appropriately to his/her environment or to associate with others (section 1 of the *Mental Health Act*);

2. In my opinion, this person:
   (a) requires treatment in or through a designated facility; and
   (b) requires care, supervision and control in or through a designated facility to prevent his/her substantial mental or physical deterioration or for the protection of the person or for the protection of others; and
   (c) cannot suitably be admitted as a voluntary patient.

This person ☒ was ☐ was not brought to me by a police officer or constable under section 28 of the Act.

In summary form, the reasons for my opinion are: (information may be obtained through interviews, observations and collateral sources)

Patient c̄ Bizzare Behaviour,
[illegible] c̄ Psych meds
[illegible]

Yes

Note: If above space is insufficient, continue on back of form

Form 4 – Example 3

1. In my opinion, this person:

   has a disorder of the mind that requires treatment and which seriously impairs the person's ability to react appropriately to his/her environment or to associate with others (section 1 of the *Mental Health Act*);

2. In my opinion, this person:

   (a) requires treatment in or through a designated facility; and

   (b) requires care, supervision and control in or through a designated facility to prevent his/her substantial mental or physical deterioration or for the protection of the person or for the protection of others; and

   (c) cannot suitably be admitted as a voluntary patient.

This person ☐ was ☐ was not brought to me by a police officer or constable under section 28 of the Act.

In summary form, the reasons for my opinion are: (information may be obtained through interviews, observations and collateral sources)

Psy Cat - NOS

Poor judgment

Note: if above space is insufficient, continue on back of form

Form 4 – Example 4

1. In my opinion, this person:

   has a disorder of the mind that requires treatment and which seriously impairs the person's ability to react appropriately to his/her environment or to associate with others (section 1 of the *Mental Health Act*);

2. In my opinion, this person:

   (a) requires treatment in or through a designated facility; and

   (b) requires care, supervision and control in or through a designated facility to prevent his/her substantial mental or physical deterioration or for the protection of the person or for the protection of others; and

   (c) cannot suitably be admitted as a voluntary patient.

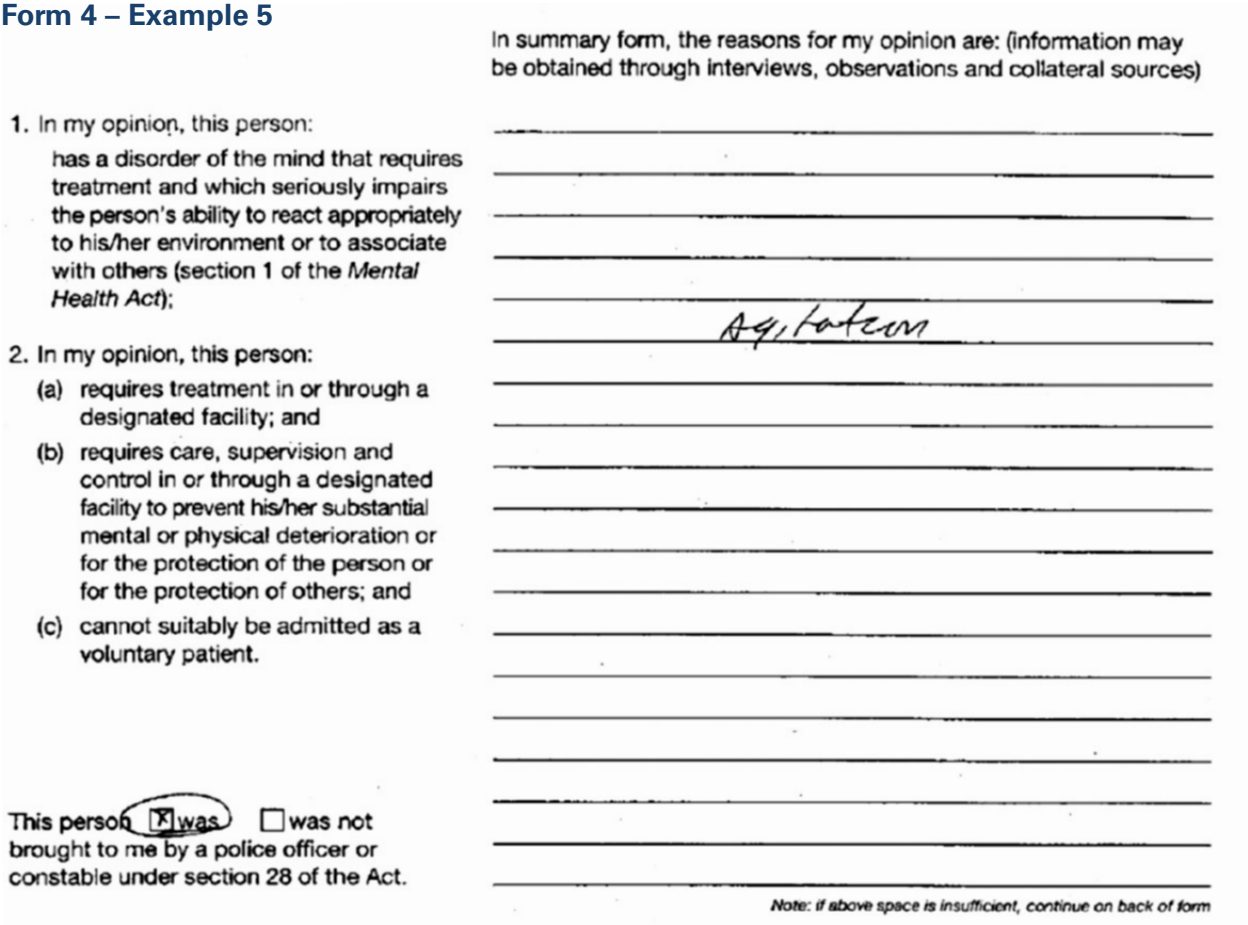
This person ☐ was ☐ was not brought to me by a police officer or constable under section 28 of the Act.

In summary form, the reasons for my opinion are: (information may be obtained through interviews, observations and collateral sources)

- disorganized thought & speech.

Note: if above space is insufficient, continue on back of form

Form 4 – Example 5



1. In my opinion, this person:
   has a disorder of the mind that requires treatment and which seriously impairs the person's ability to react appropriately to his/her environment or to associate with others (section 1 of the *Mental Health Act*);

2. In my opinion, this person:
   (a) requires treatment in or through a designated facility; and
   (b) requires care, supervision and control in or through a designated facility to prevent his/her substantial mental or physical deterioration or for the protection of the person or for the protection of others; and
   (c) cannot suitably be admitted as a voluntary patient.

This person [X] was [ ] was not brought to me by a police officer or constable under section 28 of the Act.

In summary form, the reasons for my opinion are: (information may be obtained through interviews, observations and collateral sources)

Ag, tatem

Note: if above space is insufficient, continue on back of form

The reasons provided in the medical certificates shown above are inadequate because they fail to demonstrate how the physicians concluded that the statutory criteria were met. In none of the certificates is there an explanation as to why the patients require treatment, why the patients could not be admitted on a voluntary basis, or why they needed to be admitted to a designated facility for the protection of themselves or others. In some cases, no mental disorder is specified. Parts of the reasons are illegible.

The Form 4 is a legal document. It must be completed adequately in order to properly authorize an admission and detention. The problems with the Form 4s that we identified in our investigation led us to conclude that some of the involuntary admissions that occurred in June 2017 were not done in a way that met the requirements of the *Mental Health Act*.

Finding 1: In June 2017, a number of directors of designated facilities admitted and detained people involuntarily under the *Mental Health Act* without first receiving:

a. medical certificates in the prescribed Medical Certificate (Form 4), contrary to section 22 of the *Mental Health Act*, or

b. medical certificates in the prescribed Form 4 that contained adequate information and reasons to demonstrate how the patients met the statutory criteria for involuntary admission

Adequacy of Reasons – Renewal Certificate (Form 6)

We also assessed whether each Medical Report on Examination of Involuntary Patient (Renewal Certificate) (Form 6)

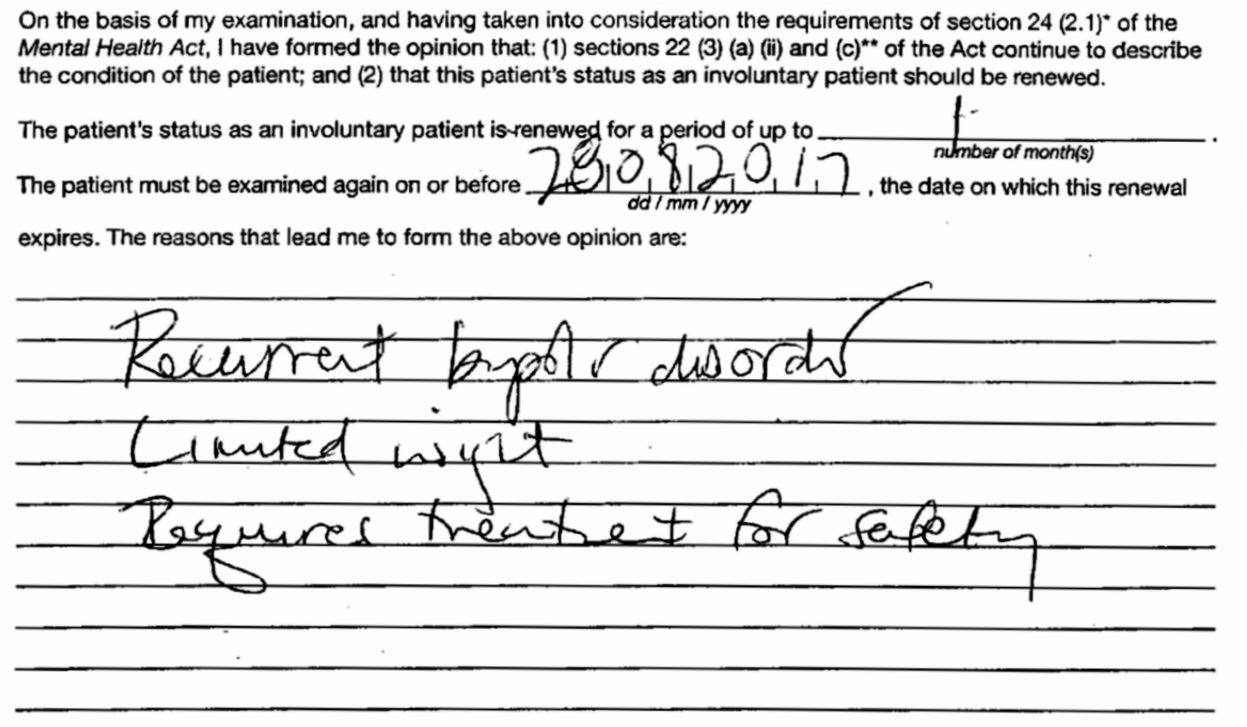
contained information that explained how the physician concluded that the statutory criteria for continued detention were met.[94] The *Mental Health Act* requires the director or a physician to examine the patient. If after that examination the director or physician concludes that the patient still meets the criteria for involuntary admission, the director or physician must set out in writing (using a Form 6) the reasons for concluding that all four of the criteria are met.[95]

We assessed the adequacy of the reasons on the Form 6 renewals by taking into account both what is required by the Act and what we would expect, as a matter of fairness, to assist the patient in understanding why they continued to be detained and in exercising their rights to seek a review of the renewal decision.

We concluded that many of the renewal certificates did not provide adequate reasons for the decision to continue the patients' involuntary status.

For example, below are two excerpts from renewal certificates that we determined did not provide an adequate explanation of why the physician believed that the patient still needed to be held and treated involuntarily. In the first example, the physician stated that the patient "requires treatment for safety" but did not explain how they had reached that conclusion. In the second example, the physician made conclusory statements that the patient required certification and hospitalization but did not explain whether, for example, there was a "significant risk that the patient, if discharged, will as a result of the mental disorder fail to follow the treatment plan."[96] Because they do not explain a key part of the statutory test for renewal of detention, the reasons cannot be considered adequate.

Form 6 – Example 1



On the basis of my examination, and having taken into consideration the requirements of section 24 (2.1)* of the *Mental Health Act*, I have formed the opinion that: (1) sections 22 (3) (a) (ii) and (c)** of the Act continue to describe the condition of the patient; and (2) that this patient's status as an involuntary patient should be renewed.

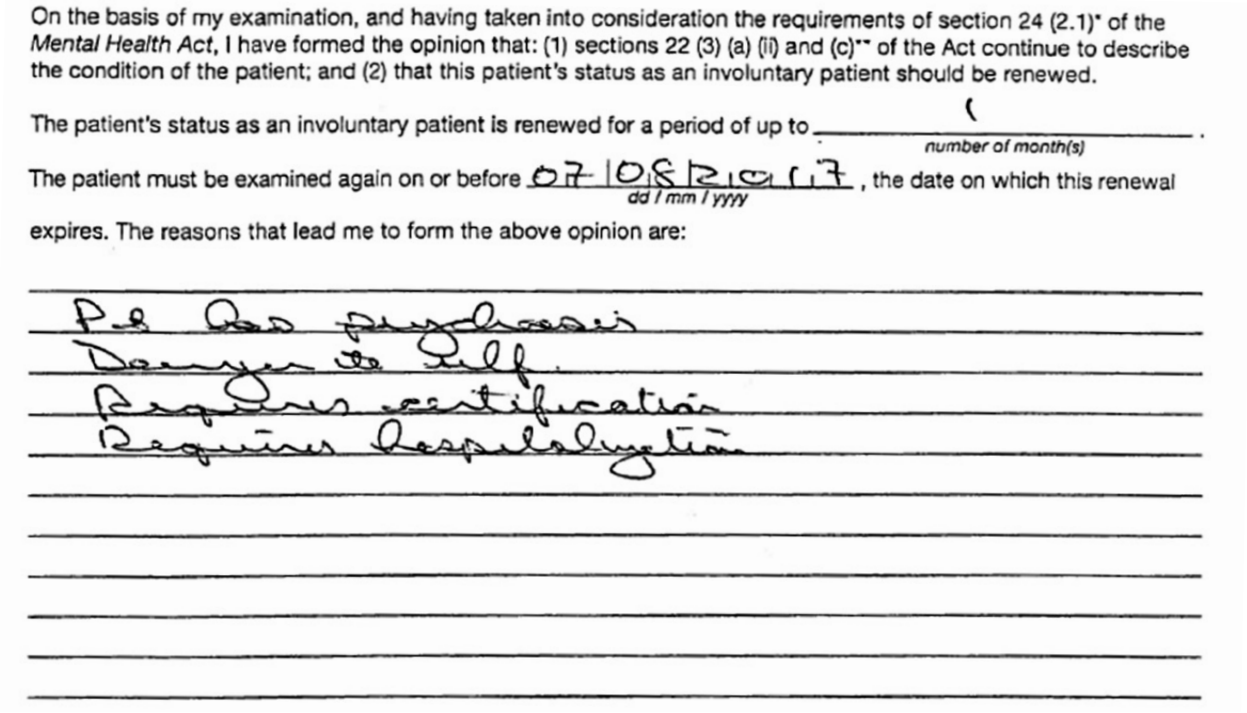
The patient's status as an involuntary patient is renewed for a period of up to 1 (number of month(s)).

The patient must be examined again on or before 28/12/2017 (dd / mm / yyyy), the date on which this renewal expires. The reasons that lead me to form the above opinion are:

Recurrent bipolar disorder
Limited insight
Requires treatment for safety

[94] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 24.
[95] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 24 (2.2); *Mental Health Regulation*, R.S.B.C. 1996, c. 288, s. 11(6).
[96] As required by section 24(2.1)(b) of the *Mental Health Act*, R.S.B.C. 1996, c. 288.

Form 6 – Example 2



On the basis of my examination, and having taken into consideration the requirements of section 24 (2.1)* of the *Mental Health Act*, I have formed the opinion that: (1) sections 22 (3) (a) (ii) and (c)** of the Act continue to describe the condition of the patient; and (2) that this patient's status as an involuntary patient should be renewed.

The patient's status as an involuntary patient is renewed for a period of up to ((number of month(s)).

The patient must be examined again on or before 07/05/2017 (dd / mm / yyyy), the date on which this renewal expires. The reasons that lead me to form the above opinion are:

Pt has psychosis
Danger to Self
Requires certification
Requires hospitalization

Finding 2: In June 2017, a number of directors of designated facilities acted contrary to section 24 of the *Mental Health Act* by renewing patients' involuntary admissions without first receiving completed renewal forms (Form 6) explaining how the patients met the statutory criteria for continued involuntary detention.

Consent for Treatment (Form 5)

The purpose of an involuntary admission is to allow for treatment of a person's mental disorder.[97] The *Mental Health Act* defines treatment as "safe and effective psychiatric treatment and includes any procedure necessarily related to the provision of psychiatric treatment."[98] In practice, such treatment may include medication, counselling, seclusion, restraint and electroconvulsive therapy.

Section 8 of the Act requires the director to ensure that patients who are involuntarily detained receive "professional service, care and treatment appropriate to the patient's condition and appropriate to the function of the designated facility and, for those purposes, a director may sign consent for treatment forms."[99] Section 31 provides that treatment authorized by the director is deemed to be given with consent of the patient. The director can authorize psychiatric treatment where the patient cannot or will not consent.

[97] Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, 18.
[98] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 1.
[99] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 8.

The *Mental Health Act* requires that the patient's consent, or the director's authorization, be documented in the consent for treatment form.[100] Consent for treatment (Form 5) can be completed one of two ways:

- If a physician confirms that the patient is capable of consenting, and the patient consents to the treatment, the patient completes Part A of the form, confirming that they consent to the proposed treatment.
- If a physician believes that the patient is incapable of appreciating the nature of treatment or their need for it, the director of the designated facility or delegate completes Part B of the form, authorizing the treatment on behalf of the patient.[101]

A person who is involuntarily admitted to a designated facility may require non-psychiatric medical treatment. For example, they may have an infection that requires a prescription for antibiotics or they may have a broken bone that requires X-rays and orthopedic surgery. The *Mental Health Act* does not give the director the authority to authorize such treatment on behalf of the patient, and to the extent that a Form 5 purports to authorize such treatment, it is invalid. Instead, consent to such medical treatment is governed by the *Health Care (Consent) and Care Facility (Admission) Act* (for adults) and the *Infants Act* (for children). To illustrate the point, Table 2 sets out the various circumstances and identifies who can provide consent on behalf of an adult patient.

Table 2: Person with Legal Authority to Consent to Psychiatric or other Medical Treatment for an Adult Involuntary Patient

Patient Capacity	Type of Treatment	
	Psychiatric Treatment	**Other Medical Treatment**
Incapable	**Director under the *Mental Health Act* using Form 5 (Part B)**	**Substitute decision maker under the *Health Care (Consent) and Care Facility (Admission) Act***
Capable	**Patient using Form 5 (Part A)** **Director under the *Mental Health Act*, if patient refuses treatment**	**Patient**

[100] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 8; *Mental Health Regulation,* B.C. Reg. 233/99, s. 11(5). See Appendix D for a sample Form 5.

[101] The consent for treatment form does not specifically provide for circumstances where the patient is capable of understanding the nature of the treatment but nonetheless refuses it. In such circumstances, section 31 of the *Mental Health Act* provides that the director may authorize the treatment.

In circumstances where the facility is providing psychiatric treatment to a patient, the *Mental Health Act* and regulation requires treatment to be documented and authorized using a Form 5.[102]

The Form 5 serves three important functions.

First, in cases, where the patient consents to psychiatric treatment, the form provides a space to document the course of treatment the patient has consented to, and the time and date of that consent. Documenting a patient's consent to treatment is particularly important in the context of an involuntary admission, because legally, the patient has been deprived of their right to refuse it.

Second, in cases where the patient does not or cannot consent, the form provides a process whereby the prescribing physician must obtain the director's authorization to proceed with the proposed treatment. The form documents that authorization for treatment has been sought and received from the director, who is ultimately responsible for ensuring the patient receives treatment appropriate to their condition. This documentation is especially important in the circumstances of an involuntary admission, because the patient is not free to leave and the director can authorize treatment against the patient's wishes.

Third, the Form 5 serves as an essential part of the documentary record for patients who exercise their right to seek a second medical opinion on the appropriateness of the treatment authorized by the director.[103]

A Form 5 should clearly document the authorized treatment so that the patient can make an informed decision as to whether to request a second medical opinion. If a patient decides to exercise this right, only the Form 5 shows the reviewing physician what treatment the director has in fact authorized. The patient and their physician are better able to revisit the authorized treatment if it is clearly written on the Form 5. This is particularly important for those patients who may have been incapable of appreciating the nature of their treatment when admitted but who gain some capacity at a later point in their detention.

Because completing the Form 5 is a statutory requirement, we expected to find a Form 5 attached to every involuntary patient file. We also expected to see the Form 5s completed in a way that demonstrated that either the patient or the director was provided with the information necessary to determine whether to authorize the proposed treatment. However, as we explain below, these were not our findings.

Form 5 Completion Rates

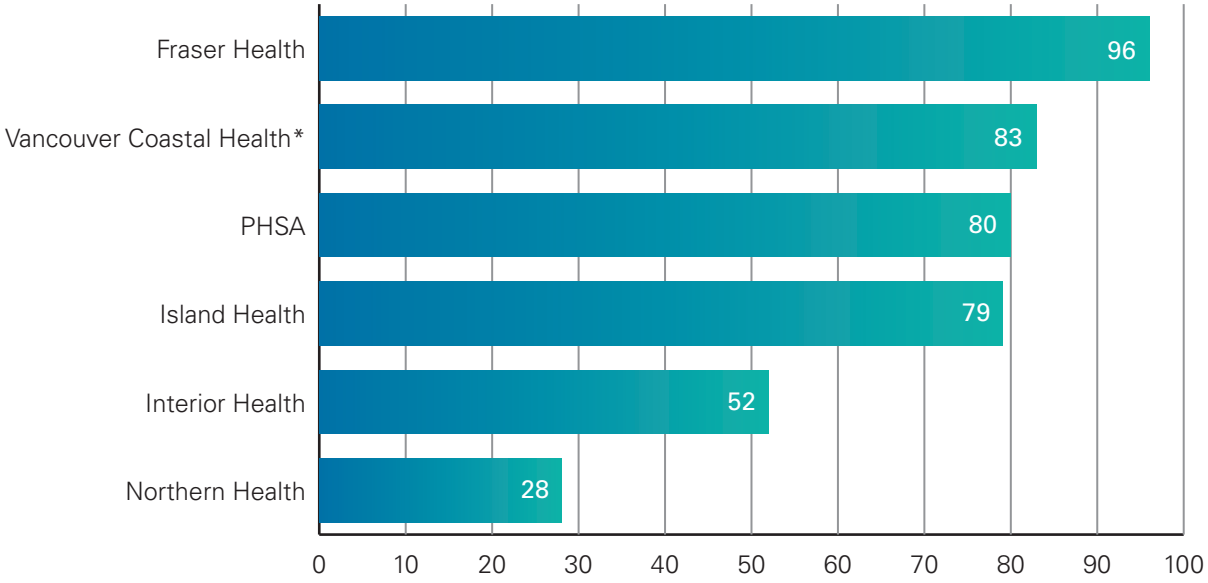
Of the 1,468 involuntary admissions we reviewed from June 2017, 1,122 patient files included a Consent for Treatment (Form 5) and 346 files did not. In other words, about 24 percent of the patient files did not include a Form 5. The rate at which Form 5s were completed varied between health authorities.

[102] There is some authority to treat patients under section 12 of the *Health Care (Consent) and Care Facility (Admission) Act,* R.S.B.C. 1996, c. 181; however, that section is intended to apply only on an emergent basis.

[103] Patients can request a second medical opinion at defined points during their admission. Upon receipt of the second medical opinion, the director must consider whether changes to the authorized treatment should be made and authorize any changes the director considers should be made: *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 31(2) and (3).

Figure 5 shows the percentage of June 2017 involuntary admission patient files in each health authority that contained a Form 5.

Figure 5: Percentage of Patient Files Containing a Consent for Treatment (Form 5), by Health Authority, June 2017



Note: ** includes patients admitted to St. Paul's Hospital, operated by Providence Health Care in partnership with Vancouver Coastal Health Authority*

In addition to the variations among health authorities, the use of Form 5s to document consent to treatment varied widely among designated facilities. Nine facilities had a Form 5 for each admission in June 2017; however, five of these had four or fewer admissions in the month.

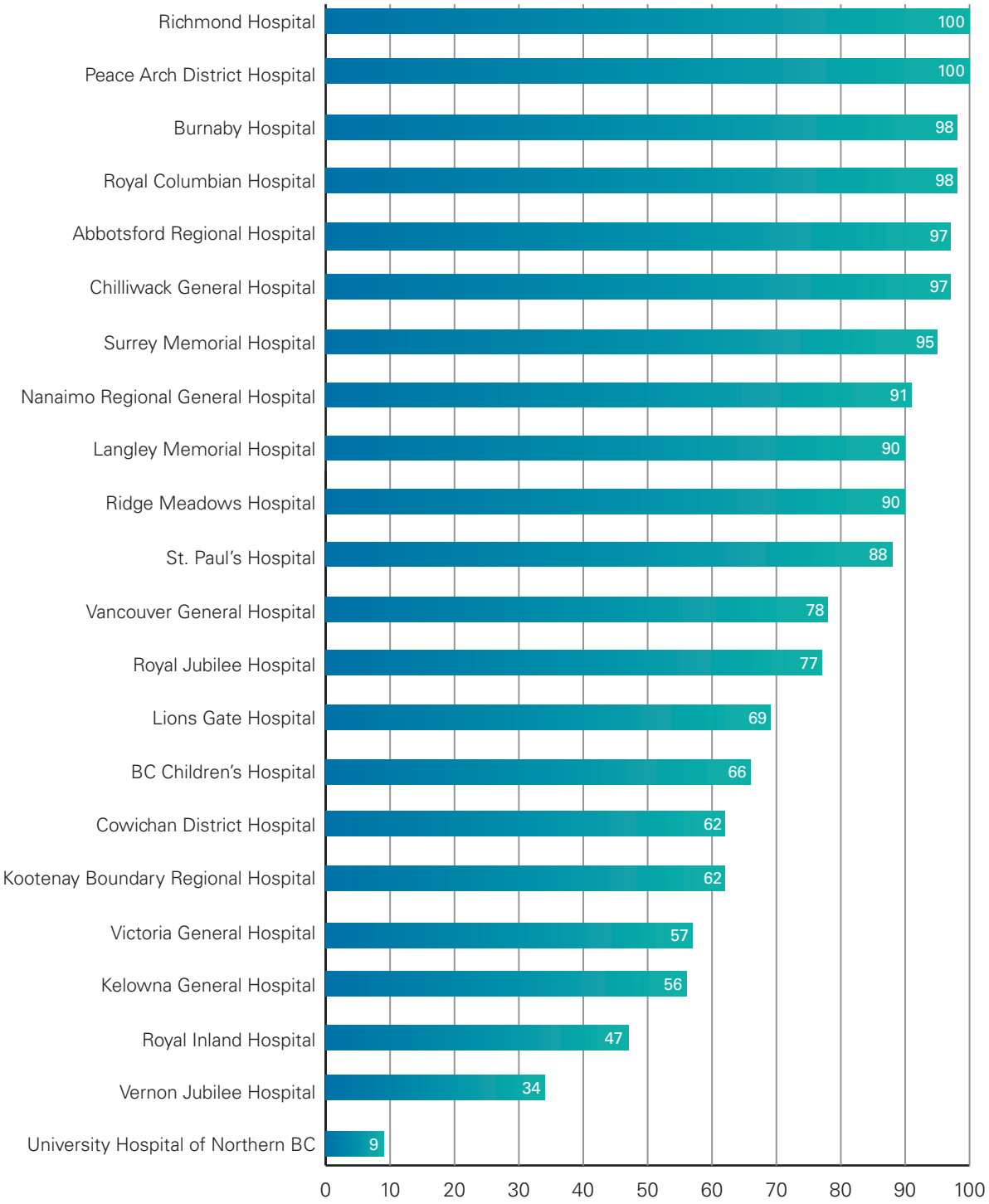
In contrast, facilities in the Fraser Health Authority attach a blank Form 5 to the blank Form 4 medical certificate so that both are generally completed in the admissions process. This simple administrative practice brings the Form 5 to the attention of facility staff even in busy hospital environments. For example, in June 2017, Abbotsford Regional Hospital had 121 involuntary admissions and a Form 5 was present on all but four files.

Similarly, Surrey Memorial Hospital had 91 involuntary admissions and a Form 5 was present on all but five files.

Thirteen facilities had a Form 5 in 80 to 99 percent of their admissions in June 2017. At the other end of the spectrum, nine facilities completed a Form 5 in fewer than half of admissions. One facility, the University Hospital of Northern British Columbia, completed a Form 5 in only 9 percent of its admissions. To put it another way, only seven of the 74 involuntary admissions to the University Hospital of Northern British Columbia in June 2017 had a Form 5 on file that authorized the provision of psychiatric treatment to those patients.

Figure 6 shows the rate of completion of Form 5s at each facility with more than 20 admissions in June 2017.

Figure 6: Percentage of Patient Files Containing a Consent for Treatment (Form 5), by Designated Facility with More Than 20 Involuntary Admissions, June 2017



The low Form 5 completion rates at some designated facilities is unacceptable. Except in limited circumstances, any psychiatric treatment administered to patients without first completing a Form 5 is contrary to the *Mental Health Act*.[104] A patient may have consented to the treatment, or the director may have authorized it. However, without a Form 5, that consent or authorization has not been documented in the manner contemplated by the Act. In some cases, the lack of a completed Form 5 may mean that psychiatric treatment was provided without any legal authority.

We followed up with seven hospitals in relation to 62 of the 346 patient files that were missing the Form 5. The purpose of this follow-up was to determine why the facilities were not completing the forms. We also wanted to know whether patients who did not have a Form 5 on their file received psychiatric treatment while they were detained and, if so, the nature of the treatment provided.

The information we received through this follow-up showed that in circumstances where no consent for treatment form was completed, involuntary patients were nonetheless receiving psychiatric treatment. In reviewing some patients' medical records, we determined that treatment administered without the authority of a Form 5 included oral and intravenous medications (such as anti-anxiety and anti-psychotic medications), sedation, restraints and seclusion. In some cases, facilities indicated that the patients had verbally consented to treatment. In other cases, the patients were treated against their wishes.

Generally, the facilities told us that the lack of completion of a Form 5 resulted from inadvertence on the part of the treating physicians or, in some cases, a lack of knowledge among physicians and staff. In many cases, the facilities could not explain why the form was missing from the file.

In response to our request about why Form 5s were not completed, some facilities told us that they had followed up with physicians and other staff and had taken proactive measures to address the problem. For example, Victoria General Hospital told us that "each physician involved with these patients' care has been provided additional education on the importance of ensuring the appropriate mental health forms are completed." Island Health told us it was planning a one-day conference to provide its staff with further education, including on the *Mental Health Act*. BC Children's Hospital implemented several strategies to improve completion of all *Mental Health Act* forms, including Form 5, with a goal of attaining 100 percent compliance. We describe BC Children's Hospital's strategies in more detail later in the report.

The response that we received from the University Hospital of Northern British Columbia (UHNBC) was markedly different. UHNBC had the worst Form 5 compliance rate of all of the designated facilities that had more than two admissions, completing a Form 5 for only seven of 74 involuntary admissions in June 2017. This failure to observe key legal requirements under the *Mental Health Act* to document the treatment provided and the director's authorization or patient's consent is especially troubling because UHNBC is a teaching hospital and a training ground for physicians.

When we spoke with staff at Northern Health about why Form 5s were not being completed, we were told that nurses place the forms on patient charts but that the

[104] The *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, states the following at page 20: "Common law also recognizes that, in an emergency, where a person's life is at risk or where there may be serious harm to the person's health and where the individual is incapable of consenting to treatment, emergency treatment may be provided to a person of any age without that person's consent. Common law suggests that these emergency powers include the restraint of a person who is likely to cause serious harm to themselves or others."

psychiatrists regularly refuse to complete them, viewing it as an unnecessary step. Some staff told us that they had met with the psychiatrists to emphasize the legal importance of completing consent for treatment forms for involuntary patients, but that the psychiatrists did not change their practice. It is important to emphasize that a physician does not have discretion to decide whether or not to complete the Form 5; it is a legal requirement.

Whether an involuntary patient indicates their consent to treatment or not, and whether a director has authorized the treatment or not, in all cases a Form 5 must be completed, and failure to do so – whether intentionally or inadvertently – is contrary to the *Mental Health Act*. Further, as noted in the *Guide to the Mental Health Act*, failure to complete a consent for treatment form can expose the hospital and treating physicians to claims of assault and battery.[105] This risk is heightened in circumstances where the patient has refused to consent to treatment.

Finding 3: In June 2017, a number of directors of designated facilities acted contrary to the *Mental Health Act* and the *Mental Health Regulation* in failing to ensure that consent for treatment forms (Form 5) were completed for all involuntarily admitted patients before psychiatric treatment was provided to those patients.

Finding 4: In June 2017, a number of directors of designated facilities acted contrary to section 8 of the *Mental Health Act* in permitting the psychiatric treatment of involuntarily detained patients in circumstances where the patient objected to treatment and no Consent for Treatment (Form 5) was completed.

Finding 5: The University Hospital of Northern British Columbia acted improperly in failing to ensure that consent for treatment forms (Form 5) were completed for involuntary patients who were admitted under the *Mental Health Act*, in circumstances where it knew or should have known that the forms were not being completed as a matter of practice.

Recommendation 1: By September 30, 2019, the board of directors of Northern Health Authority:

a. appoint an independent reviewer to produce a written report outlining the reasons for low Consent for Treatment (Form 5) compliance rates at the University Hospital of Northern British Columbia, and require the reviewer to provide the completed report to the board of directors, chief executive officer and the Ministry of Health

b. in consultation with internal stakeholders and the Ministry of Health, approve a strategy to address the issues identified in the report

c. work with internal stakeholders and the Ministry of Health to implement the resulting strategy, and

d. ensure that the results of the monthly audits conducted in accordance with Recommendation 17 examine the effectiveness of the strategy in improving compliance

Description of Treatment – Form 5

It is not enough to simply have a Form 5 on a patient's file. To be properly completed, a Consent for Treatment (Form 5) must contain an adequate description of the proposed psychiatric treatment or course of treatment for the patient.

[105] Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, 26.

We assessed whether physicians adequately described the proposed treatment on the Form 5s. We did not evaluate the appropriateness of the treatment itself. Instead, we assessed whether physicians adequately identified the specific treatment proposed (for example, if a drug was prescribed, the name of the drug, how often it was to be given and in what amount), in order to give either the patient or the director an opportunity to provide informed consent. Informed consent has been described as follows:

> The information given to a capable person, or to a person making decisions on an incapable person's behalf, to make an informed decision should include the nature of the condition, the nature of the treatment, the expected benefits of the treatment, the material risks of the treatment including the material side effects, alternative courses of action, and the likely consequences of not having the treatment.[106]

The *Guide to the Mental Health Act* outlines the approach that a physician should adopt in seeking informed consent to treatment in the context of an involuntary admission:

> During the process of obtaining a consent decision, the physician must inform the patient of the nature of their condition, as well as the reasons for and likely consequences of the treatment. In the process . . . of completing this form, the physician evaluates the patient's mental capability to make a consent decision regarding the proposed treatment.[107]

If the patient is incapable of consenting or refuses to consent, the physician must seek substitute consent from the director. The *Guide to the Mental Health Act* provides that at this stage, "the physician explains, either orally or in writing, to the director or designate the nature of the patient's condition and the reasons for and likely benefits and risks of the treatment."[108] Therefore, whether consent to treatment is given by the patient, or deemed consent is given by the director, the prescribing physician must provide sufficient information about the condition and the risks and benefits of treatment, to enable the patient or the director to make an informed decision. The standard of information required is not lower for the director than for the patient.

We found that nearly all of the treatment descriptions in the Form 5s either were so vague as to be meaningless or consisted of an exhaustive list of all treatments available at the facility. Only 10 of the 1,122 consent for treatment forms – less than 1 percent – had an adequate description of the treatment proposed for the patient. We also noted that 49 signed Form 5s contained no description of the proposed treatment at all; instead, that part of the form was left completely blank. Most of the remaining forms contained standard, generic descriptions that were not specific to the patient. For example, staff at one facility routinely completed the Form 5 by describing the proposed treatment as "psychiatric treatment and evaluation as recommended by the attending physician."

"... nearly all of the treatment descriptions in the Form 5s either were so vague as to be meaningless or consisted of an exhaustive list of all treatments available..."

[106] John E. Gray, Margaret A. Shone and Peter F. Liddle, *Canadian Mental Health Law and Policy* (2nd. ed.), 2008 (Markham: LexisNexis Canada), 220.
[107] Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, 19.
[108] Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, 85.

At least 16 facilities regularly completed the Form 5 by using a rubber stamp, pre-filled form or similar boilerplate language that provided a standard description of treatment, which was not always limited to just psychiatric treatment.

A document that the Interior Health Authority relies on to provide guidance to staff on the involuntary admissions process cautions against the "rubber stamp" approach to completing the Form 5:

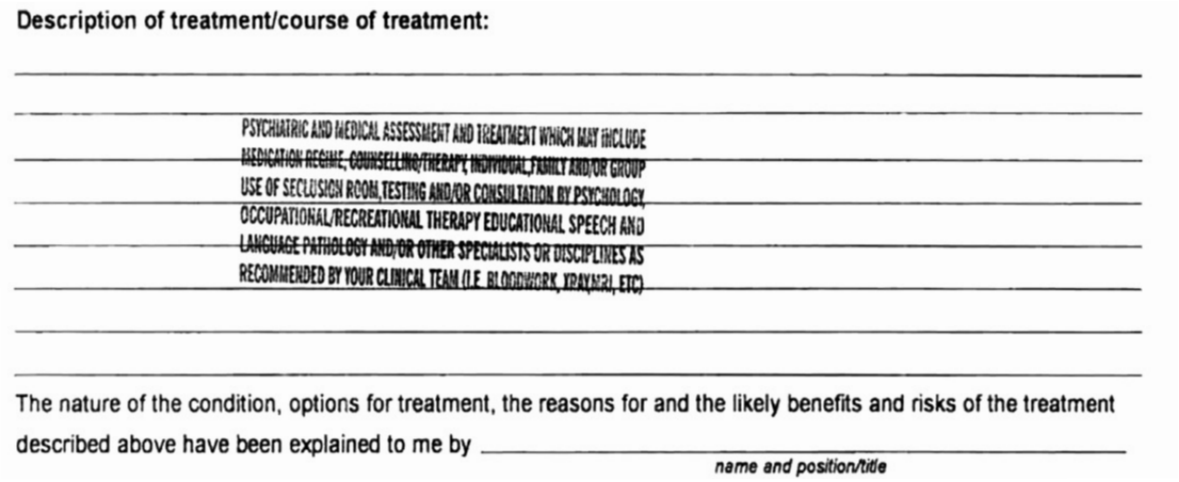
> Is it possible to pre-populate Form 5 with "Description of treatment/course of Treatment" options?
>
> No. The intent of Form 5 is to provide relevant information to the patient so s/he clearly understands the treatment(s) being prescribed. The description should include all of the treatments the patient can expect to undergo, and should not include those which the patient should not expect to experience. The courts do not like "catch all" lists.[109]

In practice, we found that few facilities used the Form 5 as intended.

The following example illustrates the significant implications of using standard language to complete Form 5s. We reviewed a Form 5 for a 15-year-old youth who was admitted involuntarily to a designated facility. The form does not provide an adequate description of the treatment proposed, instead relying on a rubber stamp describing "psychiatric and medical assessment and treatment" as including virtually all treatments available at the facility. It is particularly troubling that the stamp concludes the list of treatments with "etcetera," as it is impossible for a person to provide informed consent to – and the director should not be authorizing on the patient's behalf – an open-ended list of possible treatments.

Moreover, the portion of the form meant to indicate who had explained to the youth "the nature of the condition, options for treatment, the reasons for and the likely benefits and risks of the treatment" was left blank. The youth signed the form to indicate that they consented to the treatment. However, the description of possible treatment in the form is so broad that it does not provide enough information to allow for informed consent. In addition, the text of the stamp encompasses both psychiatric and other medical treatment. As discussed earlier, consent to non-psychiatric treatment is not covered by the *Mental Health Act* and should not be dealt with in a Form 5.

Form 5 – Example 1


Description of treatment/course of treatment:

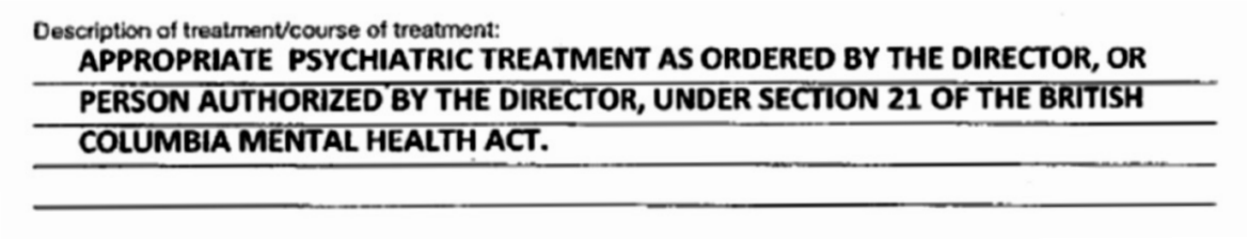
PSYCHIATRIC AND MEDICAL ASSESSMENT AND TREATMENT WHICH MAY INCLUDE MEDICATION REGIME, COUNSELLING/THERAPY INDIVIDUAL, FAMILY AND/OR GROUP USE OF SECLUSION ROOM, TESTING AND/OR CONSULTATION BY PSYCHOLOGY, OCCUPATIONAL/RECREATIONAL THERAPY EDUCATIONAL SPEECH AND LANGUAGE PATHOLOGY AND/OR OTHER SPECIALISTS OR DISCIPLINES AS RECOMMENDED BY YOUR CLINICAL TEAM (I.E. BLOODWORK, XRAY, ECG, ETC)

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

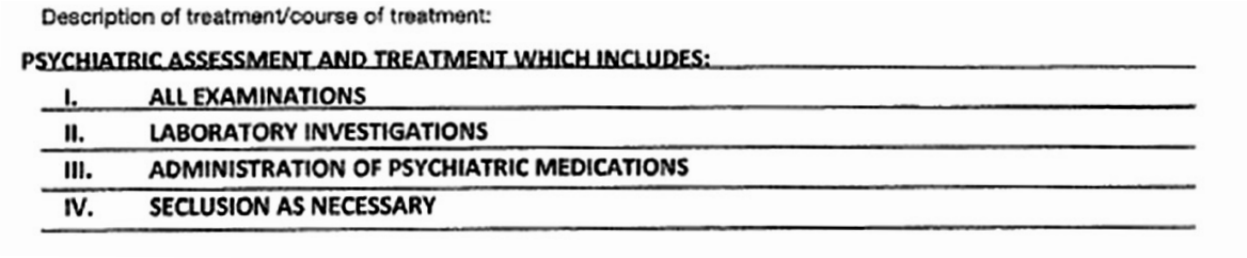
[109] Interior Health, "*Mental Health Act* Clinical Practice Standard Q&A," informed and reviewed by Gerrit W. Clements, 16 September 2015.

Below are two further examples of designated facilities using generic language to describe the treatment and referring to the wrong section of the Act:

Form 5 – Example 2


Description of treatment/course of treatment:
APPROPRIATE PSYCHIATRIC TREATMENT AS ORDERED BY THE DIRECTOR, OR PERSON AUTHORIZED BY THE DIRECTOR, UNDER SECTION 21 OF THE BRITISH COLUMBIA MENTAL HEALTH ACT.

Form 5 – Example 3

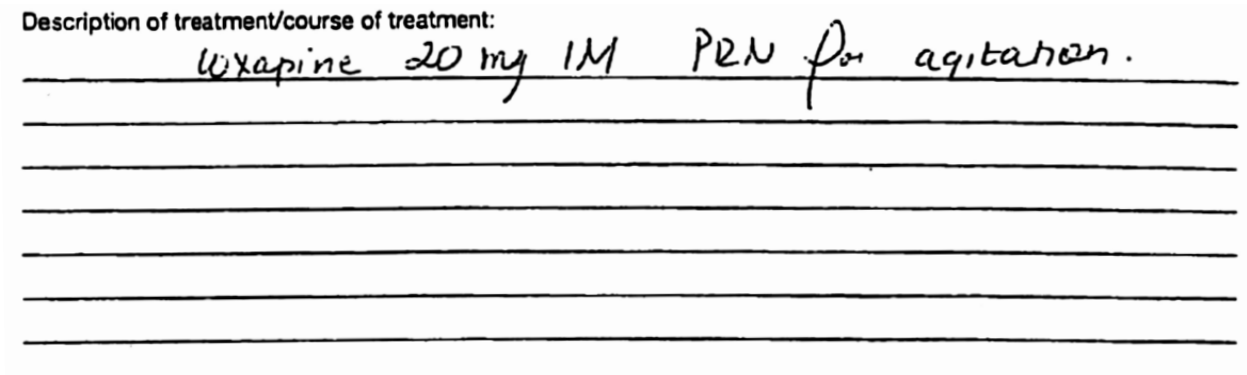

Description of treatment/course of treatment:
PSYCHIATRIC ASSESSMENT AND TREATMENT WHICH INCLUDES:
I. ALL EXAMINATIONS
II. LABORATORY INVESTIGATIONS
III. ADMINISTRATION OF PSYCHIATRIC MEDICATIONS
IV. SECLUSION AS NECESSARY

In other facilities, staff completed Form 5s by hand but used a catch-all approach to describing treatment. For example, treatment was described as "prescribed treatment," "prescribed psychiatric treatment" or "assessment and treatment of a mental illness." Staff at other facilities regularly used phrases such as "requires further assessment and treatment as ordered by attending physician" and "hospitalization, investigations, counseling, medications" to complete the Form 5.

These practices do not satisfy the requirement to provide a description of the proposed treatment for the patient and raise concerns about whether and how informed consent to treatment is sought.

In contrast, below is one of the 10 Form 5s that we determined provided an adequate description of the proposed treatment. As discussed above, the criteria that we used to determine adequacy was whether the physician provided enough information to identify a specific treatment or course of treatment for the individual patient. While the description here is brief, it clearly identifies a particular course of treatment for the patient. We considered the description on this form to be sufficient to allow the patient, or the director, to understand what treatment was being recommended.

Form 5 – Example 4


Description of treatment/course of treatment:
Olxapine 20 mg IM PRN for agitation.

The Consent for Treatment (Form 5) is the legal document that authorizes the involuntary patient's treatment. Verbal consent or authorization is not sufficient in the context of an involuntary admission.[110] The Form 5 must be signed by the patient to demonstrate their consent, or by the director to demonstrate their authorization. If the patient signs the form, their signature must be witnessed and a physician must attest that the patient was capable of understanding the consent at the time it was signed. If the director authorizes the treatment, the director or their delegate must sign the form. In practice, the person signing the form is often the nurse in charge at the facility.

Patients had signed 76 of the Form 5s that we reviewed, indicating their consent to treatment. However, only one of those forms contained an adequate description of the proposed treatment. In the other 75 cases, the physician may have provided a verbal explanation to the patient that is not reflected in the form. However, the failure to replicate those details on the form makes it difficult to see how the patient could have provided informed consent. At best, these forms demonstrate an unreasonable level of documentation of the patient's consent. At worst, they raise the question of whether the patient was provided with sufficient information to be able to give informed consent.

We observed other recurring problems with the way that Form 5s were completed.

Some forms were undated, and as a result it was impossible to assess whether the forms were completed in a timely way prior to the patient receiving treatment.

The names of the treating physician and the director authorizing treatment were illegible on many forms. In other cases, it was apparent that the physician who proposed the treatment was also the director who authorized the treatment. This runs contrary to the scheme contemplated by the Act, which provides for a separation of duties: the physician proposes the treatment, while the director has the authority to consent on behalf of the patient. The separation of roles serves an important function. While the physician's primary concern is with how best to treat the patient's condition, the person tasked with deciding whether to authorize treatment should consider a broader range of factors, including the patient's previously expressed and current wishes.

When the treating physician and the director authorizing treatment are the same person, it means that the physician who is proposing the treatment is also consenting to it on the patient's behalf. The absence of a separate decision maker also means there is no opportunity for the director to discuss the treatment plan with the physician, to weigh the benefits and drawbacks or discuss alternatives. It means the physician is exercising extraordinary power in relation to the patient and their condition. The *Guide to the Mental Health Act* cautions against this overlap in roles, stating that whenever possible, the prescribing physician should not also authorize treatment as the director under the Act.[111]

Finding 6: Except in circumstances where there is no alternative, the practice of having the director who authorizes treatment on behalf of an involuntary patient also act as the prescribing physician is unreasonable because it fails to provide for an adequate separation of duties.

[110] Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, 20.
[111] Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, 19.

Recommendation 2: Beginning immediately, the health authorities require directors of designated facilities, and their delegates, to cease the practice of authorizing treatment in circumstances where they are also the treating physician, except in circumstances where there is no alternative.

Analysis: Completing the Consent for Treatment (Form 5)

The facilities' significant non-compliance with Form 5 completion in June 2017 raises serious questions about whether involuntary patients' rights under the Act and the Charter are being observed.

It is important to note the societal importance of preserving personal autonomy in the context of medical decisions. A person's right to make decisions about their own body and health care is a fundamental value in common law and is enshrined in the Charter. At common law, people have the "unfettered right to consent, or not consent, to medical treatment" – subject to one exception: "where the person is incapable of making decisions about medical treatment, a decision must be made by others."[112]

The Supreme Court of Canada recently described the importance of protecting autonomy in medical decision making:

> The law has long protected patient autonomy in medical decision-making. In *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181, a majority of this Court, per Abella J. (the dissent not disagreeing on this point), endorsed the "tenacious relevance in our legal system of the principle that competent individuals are – and should be – free to make decisions about their bodily integrity" (para. 39). This right to "decide one's own fate" entitles adults to direct the course of their own medical care (para. 40): it is this principle that underlies the concept of "informed consent" and is protected by s. 7's guarantee of liberty and security of the person (para. 100; see also *R. v. Parker* (2000), 49 O.R. (3d) 481 (C.A.)). As noted in *Fleming v. Reid* (1991), 4 O.R. (3d) 74 [page 370] (C.A.), the right of medical self-determination is not vitiated by the fact that serious risks or consequences, including death, may flow from the patient's decision. It is this same principle that is at work in the cases dealing with the right to refuse consent to medical treatment, or to demand that treatment be withdrawn or discontinued: see, e.g., *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119; *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.); and *Nancy B. v. Hôtel-Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Que. Sup. Ct.).[113]

Section 7 of the Charter, in addition to protecting a person's right to liberty, also protects their life and the security of their person. The right to security of the person encompasses notions of personal autonomy and freedom from state interference in one's bodily integrity[114] and is also engaged "by state interference with an individual's . . . psychological integrity."[115] The right to liberty also protects "the right to make fundamental personal choices free from state interference."[116]

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[112] *TC v. Hastings,* 2017 ONSC 374, paras. 54–55.
[113] *Carter v. Canada* (Attorney General), 2015 SCC 5, para. 67.
[114] *Rodriguez v. British Columbia (Attorney General)* [1993] 3 S.C.R. 519, pp. 587–88, as per Sopinka J., referring to *R. v. Morgentaler,* [1988] 1 S.C.R. 30.
[115] *Carter v. Canada (Attorney General),* 2015 SCC 5, para 64.
[116] *Blencoe v. British Columbia (Human Rights Commission),* 2000 SCC 44, para. 54.

It is important to note that under the *Mental Health Act* patients can only be involuntarily admitted for the purpose of treatment. Compulsory psychiatric treatment is a serious intrusion on a person's physical and mental integrity. The deemed consent provisions in the *Mental Health Act* interfere with that fundamental right on the basis that the state has an interest in treating a mentally disordered person even if they have capacity and refuse treatment. When the state subjects a person to psychiatric treatment against their will, the exercise of that power must be done with the utmost care and careful observance of the law.

> *"Compulsory psychiatric treatment is a serious intrusion on a person's physical and mental integrity."*

British Columbia is the only province in Canada where a capable, involuntary patient has no right to refuse psychiatric treatment. This is a significant departure from the approach adopted elsewhere in Canada. In some provinces, capable patients cannot be involuntarily admitted,[117] while in other provinces, capable patients who are involuntarily admitted can refuse treatment.[118] In those provinces and territories, treatment decisions for incapable patients are made by the patient's proxy, a substitute consent giver or a substitute decision maker. Finally, in some provinces, capable patients can refuse treatment but may have their refusal overridden by a review board or tribunal.[119]

Although the *Mental Health Act* contains no requirement to assess a patient's capacity to consent to treatment, completion of the Form 5 requires the physician to attest that the patient has capacity to consent to treatment or to attest that the patient is incapable of appreciating the nature of treatment or their need for it. Form 5 makes no specific provision for physicians who determine that a patient is capable of consenting to treatment but refuses to do so. Under the *Mental Health Act*, the director's ability to authorize a patient's treatment is not limited to patients who are incapable of making decisions about medical treatment; instead, the director can authorize treatment for all involuntarily admitted patients, including those who are capable.[120] The *Guide to the Mental Health Act* specifically provides:

> Where a patient is capable but refuses to sign the form, or where the patient is incapable, the form is given to the director or designate. These individuals have powers under sections 8 and 31 of the Act to sign the consent form on behalf of a patient and thereby authorize treatment.[121]

[117] See Saskatchewan, *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 24(2)(a)(ii); Nova Scotia, *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 17(e); Newfoundland and Labrador, *Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1, s. 17(1)(b)(ii)(B).

[118] See Manitoba, *Mental Health Act*, C.C.S.M. c. M110; Ontario, *Mental Health Act*, R.S.O. 1990, c. M.7; Quebec, Civil Code of Quebec, C.Q.L.R. c. CCQ-1991; and Nunavut, *Mental Health Act*, R.S.N.W.T. 1998, c. M-10.

[119] See Alberta, The *Mental Health Act*, R.S.A. 2000, c. M-13; Yukon, *Mental Health Act*, R.S.Y. 2002, c. 150; New Brunswick, *Mental Health Act*, R.S.N.B. 1973, c. M-10; Prince Edward Island, *Mental Health Act*, R.S.P.E.I. 1988, c. M-61; and Northwest Territories, *Mental Health Act*, S.N.W.T. 2015, c. 26.

[120] As we have noted elsewhere in this report, the constitutionality of section 31 of the *Mental Health Act* (which allows the director to consent to treatment on behalf of any involuntary patient) was the subject of a Charter challenge filed in 2016 by the Community Legal Assistance Society on behalf of two individuals and the Council of Canadians with Disabilities. The two individuals later withdrew their claims, and on October 12, 2018, the Council of Canadians was denied standing to bring this action on its own and the claim was dismissed: *Maclaren v. British Columbia (Attorney General),* 2018 BCSC 1753. Currently, the B.C. Supreme Court decision to deny standing is under appeal; see <http://www.clasbc.net/current_cases>.

[121] Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, 19.

Consenting to treatment on behalf of a capable involuntary patient modifies principles that are enshrined in the Charter and the common law. The provisions in the *Mental Health Act* must balance personal autonomy with providing psychiatric care and treatment to patients in need. Maintaining this balance is not an easy feat and requires, at a bare minimum, full compliance with the legislation. Given the extraordinary power provided by the *Mental Health Act*, enabling directors to consent to treatment on behalf of both incapable and capable patients, it is of the utmost importance that all legal requirements and procedural safeguards contained within the Act are followed.

The obligations of physicians and detaining facilities to ensure that any treatment administered to involuntary patients is authorized must be viewed within this legal context. Administering psychiatric treatment without the patient's informed consent or the informed consent of the director on the patient's behalf is a potential violation of the patient's section 7 Charter rights and may constitute an assault and battery – the good intentions of the treating physician do not insulate them from legal action.[122] Where no Consent for Treatment (Form 5) is completed, any psychiatric treatment that is administered to a patient lacks the proper documentation and is a breach of the Act.

Nearly one-quarter of the 1,468 files that we reviewed lacked a consent for treatment form, raising questions as to whether these individuals were administered psychiatric treatment without the necessary authorization required by the Act.

Further, just over 4 percent of the consent for treatment forms that we reviewed contained no description of the treatment proposed.

A majority of the remainder of the forms contained generic or boilerplate descriptions of all psychiatric treatment available at the facility. This raises questions about whether the patient could give informed consent to treatment, or whether the director had sufficient information to consent on the patients' behalf.

Without any documentation of informed consent in the manner contemplated by the Act, the psychiatric treatments are unauthorized, violating the Act and increasing the risk that the facility has infringed the patients' Charter rights.

One health authority told us that because the consent for treatment form is completed at the time of admission, the treatment plan it details is necessarily general because a full assessment of the patient has not yet occurred. While this may sometimes be the case, any known specifics of assessment or treatment should be documented in the first Form 5, and if the treatment plan changes significantly after an assessment, a new Form 5 detailing the specifics should be completed.[123] A patient cannot give blanket informed consent to all possible treatments for mental disorders, nor is it an appropriate exercise of the director's authority to purport to do so on a patient's behalf. Documenting a treatment plan in a Form 5 that is tailored to the individual patient is one way to safeguard the patient's rights in circumstances where the director is exercising the extraordinary power to authorize treatment that the patient has refused.

At a minimum, the consent for treatment forms should contain a description of a specific proposed treatment or group of treatments so that either the patient or the director can assess it. If the treatment

[122] As noted in the Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, 19.

[123] As set out in the *Guide to the Mental Health Act (2005 Edition), 4 April 2005*, which states at page 87, "if there is a significant change to the treatment plan (e.g., more than a change of dosage or classification of medication), a new Form 5, Consent for Treatment (Involuntary Patient), must be completed."

changes in a significant way, then a new form should be completed and a new authorization provided. Our investigation found that this documentation rarely occurs in practice. In the absence of clear documentation to demonstrate that the director has considered whether the treatment is appropriate, we cannot conclude that the treatment provided to patients has been properly authorized.

Finding 7: In June 2017, a number of directors of designated facilities authorized psychiatric treatment of involuntarily detained patients in circumstances where the consent for treatment forms (Form 5s) did not include sufficient details about the nature of the proposed treatment to support the directors' authorization decisions.

Finding 8: In June 2017, a number of designated facilities followed an unreasonable process in using boilerplate language, including rubber stamps, to describe treatment in consent for treatment forms (Form 5), in that the descriptions failed to adequately identify the specific treatment proposed for individual patients.

Finding 9: In June 2017, a number of directors of designated facilities purported to authorize non-psychiatric medical treatment of involuntary patients through the use of a Consent for Treatment (Form 5), despite the lack of legal authority to do so.

Recommendation 3: Beginning immediately, the health authorities require all persons responsible for completing consent for treatment forms (Form 5) in the designated facilities to cease using boilerplate language to describe a proposed course of treatment in Form 5s and to tailor the description of treatment to specify the actual particularized treatment proposed for the individual patient.

Recommendation 4: Beginning immediately, the health authorities require the designated facilities to apply the policy guidance set out in the *Guide to the Mental Health Act* and require all persons responsible for completing consent for treatment forms (Form 5) to complete a new Form 5 when there is a significant change to a patient's treatment plan.

Recommendation 5: Beginning immediately, the health authorities:

a. instruct the directors of designated facilities to cease purporting to authorize non-psychiatric treatment of involuntary patients by way of consent for treatment forms (Form 5), and

b. instruct all staff that non-psychiatric treatment of involuntary patients can only be administered in accordance with Part 2 of the *Health Care (Consent) and Care Facility (Admission) Act* or the *Infants Act*

Notification to Involuntary Patient of Rights under the *Mental Health Act* (Form 13)

The Notification to Involuntary Patient of Rights under the *Mental Health Act* (Form 13) notifies involuntary patients of their rights under the *Mental Health Act* and their rights under section 10 of the *Charter of Rights and Freedoms*.[124] The *Mental Health Act* requires the director of a facility to notify the patient of their rights, including their Charter rights, when the patient is first admitted and detained, when the patient is transferred to a designated facility, and when the patient's detention is renewed.[125] Under the Act, if a patient is unable to understand the notice of rights at the time it is provided, the director must give the notice again as soon as the patient is capable of understanding the information. The designated facility keeps the signed Form 13, and a blank copy is provided to the patient.[126] In addition to notifying each patient of their rights on admission and detention, the director of each facility must also post Form 13 in a "conspicuous place that is accessible to patients."[127]

Form 13 is prescribed by the *Mental Health Regulation*.[128] The first page of the two-page form sets out information that must be read aloud to the patient and has a space for the patient's signature, the date, and the name of the person who provided the information. The second page contains more specific information about the patient's rights, including information about accessing the reasons for admission contained in the medical certificate, contacting a lawyer, renewal certificates, appealing the admission decision to the Mental Health Review Board, judicial review, appeals to the court, and the right to a second medical opinion regarding treatment. The form also contains information about how to exercise those rights and contact information for the Community Legal Assistance Society's Mental Health Law Program.

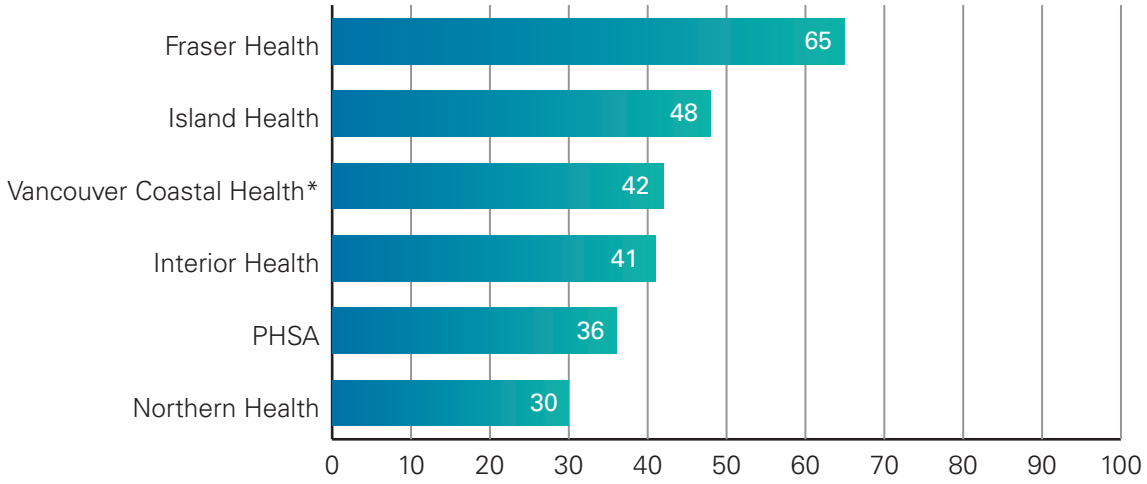
In some instances, a patient may be unable or unwilling to sign a Form 13. In those cases, we would expect the facility to still provide the notice to the patient, document the patient's refusal or inability to complete the form and maintain a copy on file to demonstrate that the notification was provided in a timely way. Such a practice would be consistent with the Charter, the Act and the *Guide to the Mental Health Act*.[129]

Given the legislative requirements, we expected to see at least one Form 13 for each involuntary admission. We also expected that the Form 13s would be completed on the date of admission. However, our review showed that with the exception of Fraser Health (which had a Form 13 in 65 percent of patient files, still far from full compliance), the Form 13 was absent in the majority of each health authority's involuntary patient files. Of the total 1,468 admissions we reviewed, a Form 13 was present in only 49 percent of patient files, representing 713 involuntary admissions.

[124] Section 10 of the Charter provides that everyone who is detained has the right to be informed promptly of the reasons for their detention, to retain and instruct counsel without delay and to be informed of that right, and to have the validity of that detention determined by way of habeas corpus and to be released if the detention is not lawful: *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c. 11, s. 10.
[125] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34.
[126] *Mental Health Regulation*, B.C. Reg 233/99, s. 11(13).
[127] *Mental Health Regulation,* B.C. Reg. 233/99, s. 5.
[128] *Mental Health Regulation,* B.C. Reg 233/99, s. 11(13).
[129] Ministry of Health, *Guide to the Mental Health Act* (2005 Edition), 4 April 2005, 41.

Figure 7 shows the percentage of involuntary patient files that contained a Form 13 completed at some point during the patient's involuntary detention for each health authority in June 2017.

Figure 7: Percentage of Patient Files Containing a Notification of Rights (Form 13) by Health Authority, June 2017[130]



Note: ** includes patients admitted to St. Paul's Hospital, operated by Providence Health Care in partnership with Vancouver Coastal Health Authority.*

As a Form 13 must be completed "on the patient's detention"[131] in a designated facility, we looked at whether the Form 13s were dated on the day of the patient's admission. We found that only 13 percent of the Form 13s we received were dated the same day as the first Medical Certificate (Form 4). This represents a mere 6 percent of the 1,468 admissions we reviewed and raises serious questions about whether patients were promptly informed of their rights upon detention in the other 94 percent of involuntary admissions. On average, facilities completed the Form 13 within four days of completing the initial Form 4, but some took much longer.

Our data shows that 23 facilities – accounting for 942 admissions in June 2017 – completed a Form 13 less than half the time. Only five of the 44 facilities with admissions in June 2017 completed a Form 13 for all involuntary admissions in the month. These five facilities had only one or two admissions in the month. Additionally, only seven facilities completed a Form 13 in 80 to 99 percent of admissions. Two of these seven facilities – Chilliwack General Hospital and Peace Arch District Hospital – had more than 20 admissions, while the rest had fewer than 20. Peace Arch District Hospital completed a Form 13 for all but one involuntary patient. This patient was transferred to another facility within three days of the initial admission and a Form 13 was completed by the receiving facility at time of transfer.

BC Children's Hospital had a Form 13 compliance rate of just 10 percent. It informed us that staff provide verbal information

[130] The data in this figure represents a "best case" scenario of facility compliance with the requirement to immediately notify patients of their rights, as it depicts only the presence or absence of a Form 13 on a patient's file, and not whether the form was completed in a timely way. As we have noted above, only 13 percent of Form 13s were dated the same day as the initial Form 4. In some cases, patients were transferred to a different facility, which then completed the Form 13. In such cases, we attributed the form to the initial admitting facility.

[131] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34(1).

about rights and complete a Form 13 for patients who are involuntarily admitted "as long as it is determined that a child/youth is able to comprehend the information (based on their mental health)." They told us that if they determine that the patient cannot comprehend the information, they wait to provide the information until they determine that the patient can understand. This approach is not in accordance with the *Mental Health Act*, which requires that the director give the patient rights information upon detention, and, if the director believes the patient did not understand the information, the director must provide it again once the patient is capable of understanding. In short, whether the director believes that the patient can understand the rights information or not, the *Mental Health Act* requires the director to provide it at the time the patient is detained.

Facilities' failure to provide rights information to involuntary patients increases the risk that the facilities are violating patients' Charter rights. Despite the constitutional and legislative requirements to provide the rights information, fewer than half of the involuntary admissions files from June 2017 contained a Form 13 associated with the initial medical certificate. Of those that did, most were not completed in a timely manner and were signed days after the initial admission.

Finding 10: In June 2017, a number of directors of designated facilities acted contrary to section 34 of the *Mental Health Act* in failing to provide patients, immediately or at all, with notice of their rights in the prescribed Notification to Involuntary Patient of Rights under the *Mental Health Act* (Form 13).

Nomination of Near Relative (Form 15) and Notification to Near Relative (Form 16)

Immediately after a patient is involuntarily admitted, the *Mental Health Act* requires the director of a designated facility to give written notice to the patient's near relative using the prescribed Notification to Near Relative (Form 16).[132] The notice informs the near relative of the patient's admission and rights under the Act and the Charter. The Nomination of Near Relative (Form 15) allows a patient to nominate someone to receive notice of the patient's admission, discharge and any application they make to the review panel. Where a patient declines to nominate a relative, staff must document that fact on the Form 15[133] and the director must then choose a relative to notify. If the director has no information about the patient's relatives, the director's obligation to provide notice is discharged by sending a Notification to Near Relative (Form 16) to the Public Guardian and Trustee.[134]

The Act defines a near relative as a person "designated by a patient" and includes a person's grandparent, parent, child, spouse, sibling, half sibling, friend, companion, caregiver, legal guardian, representative under a representation agreement or committee of the person under the *Patients Property Act*.[135] Because "near relative" is defined in the Act as a person "designated by a patient," providing the patient with an opportunity to nominate a near relative using a Form 15 is a prerequisite to completing a Form 16. In other words, the Act requires both a Form 15 and a Form 16 to be completed immediately upon a patient's admission.

[132] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34.2.
[133] *Mental Health Regulation,* B.C. Reg. 233/99, s. 11.
[134] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34.2(4).
[135] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 1. A committee of the person may be appointed by the court to make decisions for a person who is otherwise incapable of managing themselves, and once appointed the committee may make all personal decisions on behalf of the patient, including consenting to the provision of medical care: *Patients Property Act,* R.S.B.C. 1996, c. 349, s. 15.

The definition of "near relative" in the Act was expanded in 1998 to include relationships other than family, such as friends, caregivers and companions. A member of the legislative assembly described the supportive purpose of the amendment:

> At the moment, all of the persons who are defined as a relative are those we normally consider as family relatives. But many persons who are mentally ill may not have a relative per se available to them, or in some cases it may not be a relative who would be helpful to them. I think the indication is that we want to be able to notify a person who will be supportive of and helpful to the person. So what we've suggested is that we add the words for persons who can be notified and who would be ones who would take the place of relatives. They would be a friend, caregiver or companion designated by the patient.[136]

Unlike the *Health Care (Consent) and Care Facility (Admission) Act*, which sets out a ranked list of people who can act as a temporary substitute decision maker to make health-care decisions on behalf of another person, the notification process under the *Mental Health Act* contains no such hierarchy. Even if the patient has a committee of their person or estate, there is no requirement to notify that committee of the admission. Moreover, there is no legal obligation on the recipient of the notice to take any action. The Act does not bestow any right on the nominated person to access the patient's information and records other than what is contained in Form 16.

Instead, the notification to near relative form (Form 16) is intended to fulfill the critical function of advising someone who can provide support that the patient has been involuntarily admitted and detained, and the patient has various rights and procedural protections under the Charter and the *Mental Health Act* that they are entitled to exercise. By providing this information, a properly completed and sent Form 16 allows the families of people with mental disorders to be allies in ensuring that the system of involuntary admissions is credible and effective and protects their loved ones in time of crisis.

The information on Form 16 includes:

- the length of time that the patient can be detained involuntarily before a renewal certificate must be completed
- information about the renewal certificate
- information about how to access the review panel to seek a review of the patient's detention
- the patient's right to apply to the B.C. Supreme Court to have their detention judicially reviewed
- contact information for the Legal Services Society and the Community Legal Services Society, for obtaining legal advice
- the patient's right to a second medical opinion on the appropriateness of the treatment plan[137]

> *"... a properly completed and sent Form 16 allows the families of people with mental disorders to be allies..."*

Providing this notice to someone other than the patient is important because a physician has already determined that the person has a mental disorder and requires treatment in a designated facility to prevent their substantial mental or physical deterioration or to protect them or others. Accordingly, at the time of their admission and detention, a patient may not be in a position to effectively understand or exercise their rights.

[136] British Columbia, Official Report of Debates of the Legislative Assembly (Hansard), 36th Parl, 3rd Sess, Vol 12, No 11 (29 July 1998), 10681-2. <https://www.leg.bc.ca/documents-data/debate-transcripts/36th-parliament/3rd-session/19980729pm-Hansard-v12n11#10681>.

[137] See Appendix D for a copy of Form 16.

Following is an example of a complaint we investigated where – among numerous other problems – the facility did not complete the required Form 16.

Florence and Albert's Story

Florence had Alzheimer's disease and was admitted involuntarily under the *Mental Health Act* after she was brought to the hospital's emergency department. The hospital completed a Medical Certificate (Form 4) that authorized her initial admission and detention for up to 48 hours. However, there was no evidence that a second Form 4 was completed, meaning that the hospital did not have legal authority to keep her admitted once the 48 hours had expired.

Florence ended up being involuntarily admitted for just over three weeks. During this time, the hospital did not notify Florence of her rights as an involuntary patient, nor did it provide her with an opportunity to nominate a near relative to receive notification of her detention and rights. Her file contained no written notification to a near relative and, in particular, there was no evidence that a Form 16 had been provided to Florence's husband, Albert, who was her caregiver. There was also no completed Consent for Treatment (Form 5) in Florence's file. At least three times during the three-week detention, the hospital refused to discharge Florence when she or Albert requested that she go home. On one occasion, staff called security. The hospital refused these discharge requests despite having no legal authority to continue to detain Florence. Neither Florence nor her family were aware of her right to have her involuntary admission and detention reviewed by the Mental Health Review Board.

Several months later, Florence was again admitted to the hospital as an involuntary patient. The facility completed the required Medical Certificate (Form 4). However, again there was no documentation to show that Florence had been notified of her rights or given an opportunity to nominate a near relative. Although the facility advised Albert verbally that Florence would be detained for up to a month, the facility did not provide him with a Notification to Near Relative (Form 16). As a result, both Florence and Albert continued to be unaware that they could challenge the decision to admit Florence involuntarily by applying to the Mental Health Review Board for a hearing.

The director renewed Florence's detention after the first month, but the way in which the Renewal Certificate (Form 6) was completed made it unclear whether the physician had properly considered the criteria in the *Mental Health Act* in making this decision. Florence was eventually transferred to residential care, but there was no evidence that the facility made this transfer in accordance with the Act.

The lack of information on her rights caused considerable distress for both Florence and Albert and, given the facility's failure to observe other key procedures in relation to both of Florence's admissions, adversely affected Albert's ability to advocate for Florence's discharge.

Form 15 and 16 Compliance Rates

Given that the *Mental Health Act* requires Forms 15 and 16 to be completed immediately upon admission, we hoped that Florence's case would be an anomaly. We expected that there would be a Form 15 and Form 16 associated with every involuntary admission in June 2017.

Instead, we found that the overall compliance rates for Form 15 and Form 16 fell well below 100 percent. Of the 1,468 patient files that we reviewed, only 631 had a Nomination of Near Relative (Form 15) in the patient's file. This is an overall compliance rate of about 43 percent. Each file should have had a Form 15, as staff are required to document a patient's refusal to nominate a near relative on the Form 15.[138]

Further, of those 1,468 patient files, only 471 contained a Notification to Near Relative (Form 16). This is a compliance rate of about 32 percent. In other words, based on the information provided to us, the parents, siblings, children or other near relatives of 997 involuntary patients admitted in British Columbia in June 2017 did not receive the required formal notice that their family member had been involuntarily admitted or, importantly, the information about that person's right to challenge their detention.

We also found that 27 percent of patient files with a completed Form 15 did not have a corresponding Form 16. This suggests that no notice was provided to family members in 170 cases where patients had nominated a family member to receive written information about their detention and associated rights.

Finally, only 34 Form 16s were dated the day of the patients' admission. Of the 471 Form 16s we received, 289 were dated after the patients' admission date. This is contrary to the requirement in the Act that the director "immediately" notify a near relative or the Public Guardian and Trustee (PGT) of a patient's involuntary admission and the patient's rights, using Form 16.[139] In addition, 148 Form 16s were not dated at all, which makes it impossible to know whether the facility complied with its legal obligation to "immediately" notify a near relative or the PGT.

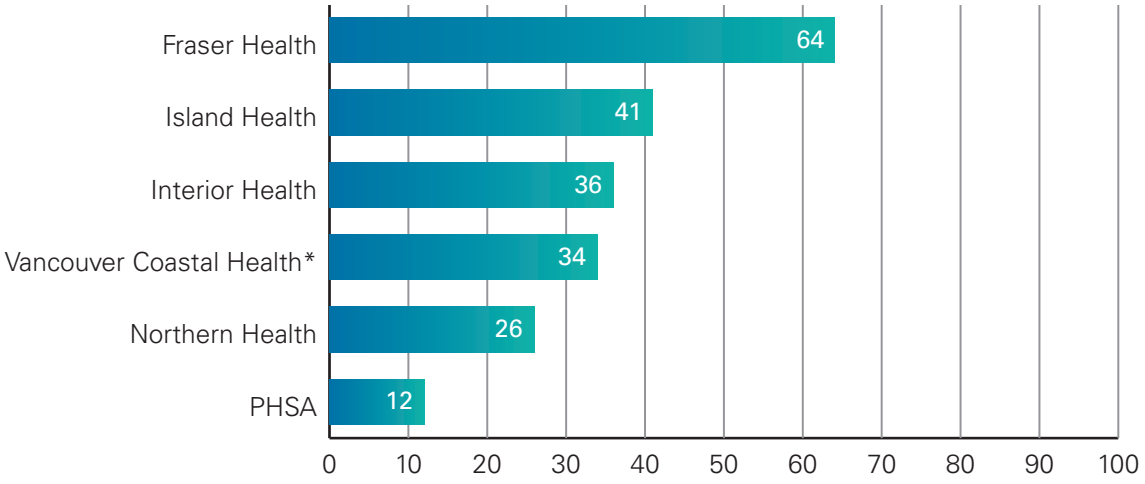
> *"... near relatives of 997 involuntary patients admitted in British Columbia in June 2017 did not receive the required formal notice that their family member had been involuntarily admitted..."*

One health authority told us that Forms 15 and 16 do not have to be completed until a second Form 4 is completed. In taking this position, the health authority relied on a "*Mental Health Act* Clinical Practice Standard Q&A" document that it had developed. However, this position regarding the timing of completion of Forms 15 and 16 is not consistent with the *Mental Health Act*, which requires the director to give notice to an involuntary patient's near relative immediately upon admitting the patient under the first Form 4 medical certificate and, by necessary implication, requires the director to give the patient the opportunity to nominate that near relative.

[138] *Mental Health Regulation,* B.C. Reg. 233/99, s. 11.
[139] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34.2.

Figure 8 shows the percentage of involuntary patient files that contained a Form 15 for each health authority in June 2017.

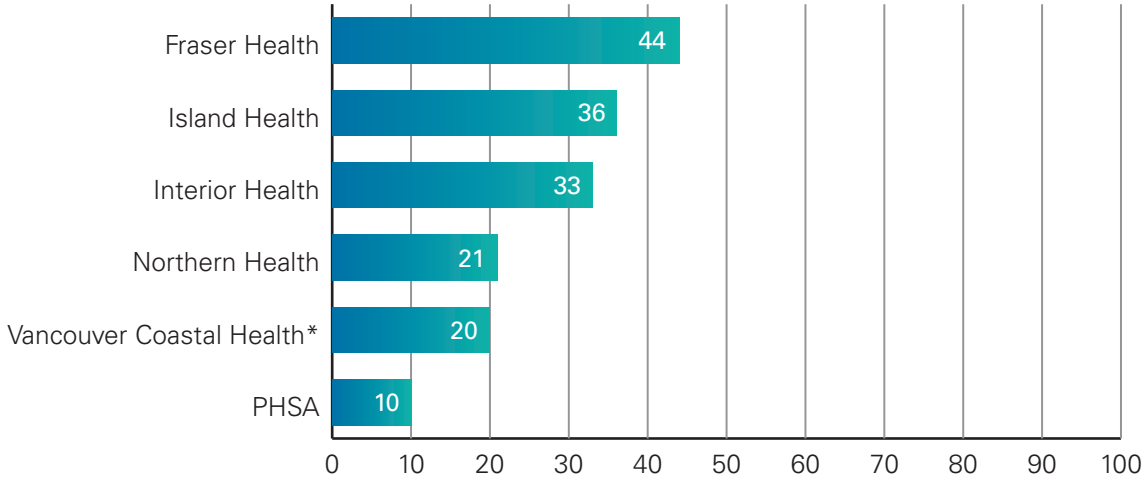
Figure 8: Percentage of Patient Files Containing a Nomination of Near Relative (Form 15), by Health Authority, June 2017



Note: ** includes patients admitted to St. Paul's Hospital, operated by Providence Health Care in partnership with Vancouver Coastal Health Authority.*

Figure 9 shows the percentage of involuntary patient files that contained a Form 16 for each health authority in June 2017.

Figure 9: Percentage of Patient Files Containing a Notification to Near Relative (Form 16), by Health Authority, June 2017



Note: ** includes patients admitted to St. Paul's Hospital, operated by Providence Health Care in partnership with Vancouver Coastal Health Authority.*

Of the 471 Form 16s that we received, only 137 were complete – that is, they contained all pages, were signed and dated, and included relevant phone numbers (see below) and information about the patient's admission.

The rest of the Form 16s contained significant omissions. For example, many of the Form 16s we reviewed were missing the second page. On the second page of each form is a space for the date and the director's signature, as well as a section that advises relatives of a patient's rights before the courts. That section reads as follows:

Form 16 – Excerpt

5. Right to apply to the Supreme Court of British Columbia

The patient or someone acting on the patient's behalf may have the validity of the patient's admission and detention determined by way of an application (in the nature of *habeas corpus*) to the court under the *Judicial Review Procedure Act*. The patient or someone acting on the patient's behalf may also apply to the court under section 33 of the Act, to determine whether there is sufficient reason and authority for the medical certificate. Legal advice concerning these matters may be obtained from independent counsel or through the Legal Services Society or the Community Legal Services Society (CLAS).

The phone number of the local Legal Services Society office is _____.

The phone number for CLAS is _____.

Where the second page was missing, the recipient would not have received this essential information about the patient's rights. Some of these Form 16s may have been incompletely copied when they were provided to our office. However, we noticed that even where the Form 16s contained the second page, many still lacked the phone number for the Legal Services Society or the Community Legal Services Society. The lack of contact information could hinder the recipient's ability to access services on behalf of the patient. As well, many forms were missing the name or signature of the director, suggesting a lack of accountability in relation to form completion.

The *Mental Health Act* requires all detaining facilities to accurately complete a Form 15 and Form 16 for every involuntarily admitted patient. There is no authority for facilities to opt out of following that process. While we recognize that facilities may take other steps to involve families in a patient's plan of care, this involvement is not a substitute for providing nominated relatives or friends with statutorily required information about the patient's legal rights.

The Provincial Health Services Authority (PHSA) told us that two detaining facilities, the Burnaby Centre for Mental Health and Addictions and the Forensic Psychiatric Institute, typically do not complete Form 15 and Form 16. This practice is reflected in PHSA's poor completion rate for these forms, at only 12 percent for Form 15 and 10 percent for Form 16 in June 2017. PHSA said that social workers typically contact families of involuntary patients at the Forensic Psychiatric Institute to obtain information on a patient's history, and that it makes ongoing efforts to involve family in patients' care. PHSA informed us that at the Burnaby Centre for Mental Health and Addictions, Form 15 and Form 16 are not typically used because clinical teams work to identify next of kin and try to obtain patients' consent upon admission to share information with families. While this practice may be useful to the patients, the facilities still have an obligation to also complete Forms 15 and 16 on admission.

Finding 11: In June 2017, a number of directors of designated facilities acted contrary to section 1 of the *Mental Health Act* and section 11(15) of the *Mental Health Regulation* in failing to ensure that patients were given an opportunity to nominate a near relative to be notified of their admission using the prescribed Nomination of Near Relative (Form 15).

Finding 12: In June 2017, a number of directors of designated facilities acted contrary to section 34.2 of the *Mental Health Act* in failing to ensure that notice of the patient's involuntary admission was provided, immediately or at all, to either a near relative or the Public Guardian and Trustee, using the prescribed Notification to Near Relative (Form 16).

Finding 13: The practice at the Forensic Psychiatric Institute and the Burnaby Centre for Mental Health and Addictions of not completing Nomination of Near Relative (Form 15) and Notification to Near Relative (Form 16) for patients who are involuntarily detained under the *Mental Health Act* is contrary to section 11(15) of the *Mental Health Regulation* and sections 1 and 34.2 of the *Mental Health Act*.

Notification of Public Guardian and Trustee

As previously noted, the *Mental Health Act* allows the director to discharge the responsibility to notify a relative of the patient by sending a Notification to Near Relative (Form 16) to the Public Guardian and Trustee (PGT) if the director has no information about the patient's relatives.

The PGT is established under the *Public Guardian and Trustee Act* to protect the interests of British Columbians who do not have the legal capacity to protect their own interests. The PGT's mandate is to:

- protect the legal and financial interests of children and youth under age 19
- protect the legal, financial, personal and health care interests of adults who need assistance in decision making
- administer the estates of deceased and missing persons

The PGT currently serves just over 30,000 clients each year and is independent from government when making decisions on behalf of clients.[140]

As part of our investigation, we obtained all of the Form 16s that the PGT received in June 2017 and compared them with the Form 16s that we received from the designated facilities.

In June 2017, the PGT received, from designated facilities, 113 Form 16s relating to 108 patients.[141] One of these Form 16s was sent to the PGT without the patient's name.

The legislative scheme requiring Form 16s be sent to the PGT is both over- and under-inclusive. It is over-inclusive in that the PGT received notice for patients who were not its clients and with whom it had no connection. The PGT told us that none of the 108 patients for whom it received Form 16s in June 2017 were active PGT clients. On the other hand, the scheme is under-inclusive because the PGT would not have received notice, even where the patient was a PGT client, if the patient nominated someone other than the PGT on the Form 15.

[140] Public Guardian and Trustee of British Columbia, "Who We Are" <http://www.trustee.bc.ca/who-we-are/Pages/default.aspx>.

[141] Not all of these 108 patients were within the scope of our investigation; for example, some of the Form 16s were for patients who were transferred to a Schedule A facility in June 2017.

We considered the length of time it took for the PGT to receive the Form 16 once sent. The PGT date-stamps each form upon receipt, which allowed us to compare the date on which the Form 16 was received with the date on which the patient was admitted. In just over half of the cases, the PGT received the form within seven days of the patient's admission. The average length of time that it took for the PGT to receive the notice form was nine days. In one case, the PGT did not receive the Form 16 until 50 days after a patient's admission. Some of the delay in receiving the forms can be attributed to the delivery methods used – in some cases, the forms were mailed to the PGT.

Given some of the facilities' delays in completing the forms and providing them to the PGT, we have concluded that detaining facilities are not always fulfilling their statutory duty to immediately notify the PGT of a patient's detention in circumstances where they have no near relative.

We also considered whether the PGT received the forms that were intended to be sent to its office. We identified in the patient records we received 76 instances where a facility had completed the Form 16 indicating that it was sending a notice to the PGT. However, the PGT received only 63 of these 76 Form 16s. In other words, the PGT did not receive 13 of the Form 16s intended for it in June 2017. Because facilities do not track whether a near relative has received a Form 16, we have no way of knowing whether a similar pattern exists for forms that are not sent to the PGT. However, the fact that the PGT did not receive 13 completed notification forms raises concerns that some completed Form 16s are not sent by the facility or are not received by the intended recipients.

Form 16s serve an important purpose. They are a crucial step in informing and involving the family members of involuntarily admitted patients. Our findings, however, show that this critical step is missed in a majority of cases. In addition to adopting processes that improve Form 16 completion rates, the directors of facilities should follow up to ensure that near relatives receive the notice. Such follow-up would likely involve only a small number of involuntarily admitted patients – those who are not discharged quickly (in such cases, there would be no need for follow-up with the near relative) and whose nominated near relative cannot be provided with the form in person, which would allow the director to immediately confirm receipt. Moreover, the process of following up could be simplified by including, with the Form 16, a letter asking the addressee to contact the director to confirm receipt of the form.

Finding 14: The failure of directors of designated facilities to take steps to confirm that notification to near relative forms (Form 16) were received by the addressees is unreasonable.

Recommendation 6: By January 1, 2020, the health authorities develop a process for implementation by the directors of designated facilities by February 1, 2020, to confirm receipt of each Notification to Near Relative (Form 16) by its addressee, and, if the form was not received, to issue a further Form 16 to another near relative of the patient.

Role of PGT on Receiving Form 16

As part of our investigation, we met with PGT staff to discuss that office's role under the *Mental Health Act*. Although the *Mental Health Act* requires a designated facility to notify the PGT if the facility cannot identify a nearest relative, it does not authorize the PGT to act on behalf of a patient or otherwise give the PGT a mandate to intervene or review the involuntary admission.[142] Unless the patient is already a client, the PGT has no legislative authority to act on the notices that it receives. The PGT is frequently notified of the involuntary admissions of individuals

[142] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34.2.

who have no relationship with the PGT, and as a result the Form 16 triggers no action or response. The form is simply placed in a file.[143] In June 2017, none of the Form 16s that the PGT received related to PGT clients and, accordingly, none of the notifications triggered any action on the part of the PGT.

Patients Who Are PGT Clients

When the PGT receives notification of the involuntary admission of a patient who is already a client of the PGT, the client's case manager is notified. In most cases, the PGT's involvement with a client relates only to financial matters. The case manager generally examines the client's financial situation and considers whether:

- the client requires funds while in the facility, the client will require PGT assistance with discharge planning, or whether the PGT case manager should attend a case conference
- the PGT should take action to address the client's housing situation if the property is vacant
- any insurance coverage on the client's assets is required or needs to be adjusted to address the client's absence from home
- any disability benefits or other income should be redirected to the facility for the client's benefit

Further, the case manager considers whether the PGT client needs legal representation and may assist with a referral to the Community Legal Assistance Society or independent legal counsel to support a Mental Health Review Board hearing.

Under the existing legislation, however, the PGT may be notified of the involuntary admissions of its clients if the patient specifically requests notification of the PGT as committee when completing the Form 15, or if the patient does not nominate a near relative and the director is unable to identify the patient's near relatives. Of course, such notification is also dependent on the facility complying with its obligations under the Act to complete the Form 15 and 16 upon the patient's admission.

There is value in developing a process that ensures that the PGT is notified when its clients are involuntarily admitted under the *Mental Health Act*. Of course, the provincial government and health authorities will need to ensure that privacy concerns are appropriately addressed in relation to these notifications. In addition, such a process will require the allocation of additional resources. However, this is justified given the kind of assistance that the PGT can provide once it is notified. For example, if the PGT is committee of the patient's estate under the *Patients Property Act*,[144] notification would allow the PGT to safeguard the adult's assets while they are detained. In other cases, the PGT may review its client's circumstances and decide that no action is necessary. In our view, the PGT is in the best position to decide on the appropriate course of action in relation to a particular client, but this requires that it be notified each time a client is involuntarily admitted. Currently, however, designated facilities do not have a formal process or requirement to identify which patients are PGT clients, which means some PGT clients may not receive the assistance described above in a timely way.

In response to our draft report, the PGT raised concerns about potential conflicts between the PGT and a near relative who receives notice but does not have legal authority to act on a patient's behalf. We acknowledge that such a conflict may arise, but the nomination of a near relative does not establish any legal powers or authority. While the near relative may provide important support to the patient,

[143] The PGT told us its practice is to retain the forms for two years and then destroy them.
[144] *Patients Property Act,* R.S.B.C. 1996, c. 349, s.6.

without a court order or agreement the near relative's role would not override the PGT's ability to act on the patient's behalf within the scope of its legal authority.

For some PGT clients, the Form 16 achieves what it is intended to by providing information about a person's involuntary detention to an entity that has the capacity to assist. However, in many cases receipt of the Form 16 by the PGT is of no assistance to the involuntary patient. It is unreasonable that the *Mental Health Act* allows the director to discharge their duty to notify a near relative of a patient by providing a Form 16 to the PGT without the director first ascertaining that the PGT has authority to assist the patient. It is similarly unreasonable that the *Mental Health Act* does not require the PGT to be notified of its clients' involuntary admissions when it may be able to take steps to assist or support these clients.

In enacting the *Mental Health Act*, the legislature has appropriately identified the need to provide notice and rights information related to involuntarily admitted patients to an interested third party with the ability to assist the patient. However, the Act is both under- and over-inclusive in terms of the requirement to provide notice to the PGT. The Act fails to provide protection for patients who do not have near relatives and who are not PGT clients and, equally, it fails to ensure that the PGT is also notified when it is in the role of a decision maker with respect to a patient and the patient has nominated a near relative. This is a serious oversight with the potential for negative consequences for involuntarily detained people.

Finding 15: Section of 34.2(4) of the *Mental Health Act*, which provides that the director's notification duties are discharged by notifying the Public Guardian and Trustee of British Columbia (PGT) of a patient's involuntary admission where no near relative can be identified, establishes an unreasonable procedure for patients who are not PGT clients.

Recommendation 7: By January 1, 2020, the Ministry of Health and the health authorities develop and implement, in consultation with the Office of the Information and Privacy Commissioner and the Public Guardian and Trustee of British Columbia, an appropriate method for identifying, in a timely way, those involuntary patients who are clients of the Public Guardian and Trustee of British Columbia or who have private committees.

Recommendation 8: By November 1, 2019, government introduce legislation for consideration by the legislative assembly to amend the *Mental Health Act* to:

a. repeal section 34.2(4), which provides that a director's duty to notify a patient's near relative is discharged if a notice is sent to the Public Guardian and Trustee of British Columbia (PGT)

b. require the directors of designated facilities to identify patients who are clients of the PGT or who have a private committee and notify the PGT upon those patients' admission, transfer or renewal of detention

c. require the directors of designated facilities to notify any known representative under a Representation Agreement or attorney under an Enduring Power of Attorney upon those patients' admission, transfer or renewal of detention, and

d. provide that where there is no known near relative, representative, attorney or committee, and the patient is not a client of the PGT, the notice be provided to the independent rights advice body in accordance with the process described under Recommendation 21

ANALYSIS

Our investigation demonstrated that designated facilities generally do not comply with the procedural safeguards in the *Mental Health Act*. Of the 1,468 patient files we reviewed, only 412 – or 28 percent – contained the five forms required by the Act when a person is involuntarily admitted.[145]

Although the health authorities were legally required to send us copies of all requested forms, we recognize that some may have been unable to retrieve all completed forms due to poor records management practices. However, when we asked facilities why the forms had not been completed, they told us that it was generally an oversight by the responsible physician. In other cases, we were told that forms were not completed because patients were admitted to emergency departments for only a short time. Two health authorities told us it was their practice to refrain from completing Forms 13, 15 and 16 until after a second Form 4 was completed (meaning the patient had already been detained for up to 48 hours), despite the *Mental Health Act* requiring these forms to be completed immediately upon admission under a first Form 4 medical certificate.

As we have also highlighted, the way in which forms are completed falls short of acceptable standards. The failure to provide adequate reasons for involuntary admissions or renewals, the failure to adequately describe proposed treatment, and even the failure to sign and date Form 16s and ensure that they are sent to the designated recipients are all failures to comply with the procedural safeguards set out in the *Mental Health Act*.

> *"... ensuring that involuntary admissions are legally sound and procedurally fair helps to ensure that those who desperately need treatment receive it in a timely way."*

The poor compliance rates appear to reflect a prevailing view that completing the forms is secondary to providing psychiatric treatment. As we have emphasized throughout this report, one should not come at the expense of the other. To the contrary, ensuring that involuntary admissions are legally sound and procedurally fair helps to ensure that those who desperately need treatment receive it in a timely way.

[145] This is defined as at least one Form 4, Form 5, Form 13, Form 15 and Form 16. This does not mean that all of the forms were completed properly or completed on the day of admission. It also does not take into account cases where a second Form 4 was not completed, despite being legally required.

The involuntary admissions scheme under the *Mental Health Act* modifies individual rights that exist at common law – for example, the right of mentally capable adults to refuse medical treatment. It does so because society has also recognized that there is significant value in being able to provide psychiatric treatment to certain people with a mental disorder who are unable to seek treatment on their own. As with any government action, the way in which the *Mental Health Act* is administered must be considered in light of the values that are protected and upheld in the *Canadian Charter of Rights and Freedoms*. The Charter's recognition of rights to liberty and security of the person highlight the need for government to be particularly attentive to procedural steps that help to ensure that it only restricts individuals' rights when it is justified in doing so. In other words, whether or not a failure to complete the required forms constitutes a breach of the Charter in an individual case, the systemic failure to complete forms is inconsistent with Charter values.

As the court emphasized in *McCorkell*, the constitutionality of the entire system rests in part on the assumption that the substantive and procedural protections in the Act are being followed. Given the problems we have identified with the facilities' compliance with the admissions process, we cannot presume that the facilities consistently adhere to the requirements of the *Mental Health Act* and the *Canadian Charter of Rights and Freedoms*. Several of the recommendations we make in this report are therefore aimed at establishing mechanisms of oversight, accountability and advocacy that will allow designated facilities, health authorities and government to demonstrate that they consistently follow the processes that protect the rights of involuntary patients.

Finding 16: In June 2017, a number of directors of designated facilities repeatedly and consistently failed to follow the safeguards in the *Mental Health Act*, as evidenced by the lack of timely and adequate completion of Forms 4, 5, 6, 13, 15 and 16. The systemic failure to follow the procedural safeguards required by the *Mental Health Act* is incompatible with the protection of the values of individual liberty and autonomy articulated in the *Canadian Charter of Rights and Freedoms*.

Finding 17: The designated facilities have failed to establish adequate processes for ensuring that prescribed forms are completed as part of the involuntary admissions process.

Oversight and Accountability

In light of the extraordinary power of designated facilities to involuntarily admit, detain and treat psychiatric patients under the *Mental Health Act*, it is critical that there are mechanisms in place to hold the system accountable to patients and to the public as a whole.

International human rights laws emphasize the importance of accountability in the provision of mental health care. The *International Covenant on Economic, Social and Cultural Rights* (ICESCR), to which Canada is a signatory, provides for "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[146]

In 2017, the Special Rapporteur (an independent expert appointed by the United Nations Human Rights Council to report on article 12 of ICESCR) released a report to the Human Rights Council addressing the right

[146] *International Covenant on Economic, Social and Cultural Rights*, 19 December 1966, 993 UNTS 3, art 12 (entered into force 3 January 1976, accession by Canada 19 May 1976) [*ICESCR*].

to mental health.[147] The Special Rapporteur emphasized the importance of accountability in ensuring that human rights are observed in the mental health system. The report notes that accountability depends on:

- monitoring independent and non-independent review, such as by judicial, quasi-judicial, political and administrative bodies as well as by social accountability mechanisms
- remedies and redress

The report further states that "accountability provides an opportunity for rights holders to understand how duty bearers have discharged their duties and claim redress where rights are violated."[148] Mechanisms of accountability also serve a larger purpose, in that they demonstrate to patients, health-care professionals and the public that the rights and dignity of people with mental disorders are important and valued.

Currently, there is little oversight of, or accountability for, the extent to which designated facilities are complying with their legal obligations when they admit patients involuntarily.

Review panels exist under the *Mental Health Act* to consider whether patients met or continue to meet the criteria for admission under the Act. The Community Legal Assistance Society operates the Mental Health Law Program, which provides legal assistance before review panels for individuals who have been involuntarily detained. However, the review panels have no mandate to consider the absence of a required form or a failure to complete a form properly as a factor in their decision making.

Our office provides oversight of involuntary admissions under the *Mental Health Act* by receiving and investigating individual complaints, as highlighted by the examples used in this report.

A third method of oversight is the ability of patients or their families to challenge the validity of an admission and detention, often by retaining private legal counsel at their own expense. This remedy is not easy for patients to access, as it requires them to make a court application.

However, there is no meaningful, systematic and regular internal or external monitoring of the procedural safeguards in the involuntary admissions process.

Provincial Government Oversight and Accountability

In July 2017 government established the Ministry of Mental Health and Addictions separate from the Ministry of Health.[149] It became clear in the course of our investigation that the operational and policy repercussions of this change have yet to be fully worked out.

The Ministry of Mental Health and Addictions is responsible for "policy development, program evaluation and research in relation to mental health and addiction, including in relation to designated facilities within the meaning of the *Mental Health Act*."[150] In addition, the Ministry of Mental Health and Addictions has the power to establish, by regulation, provincial standards for the provision of mental health and addictions services by health authorities.[151] The ministry can also require a health authority to report on a matter related to certain "stewardship

[147] Dainius Puras, Special Rapporteur, Committee on Economic, Social and Cultural Rights, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 28 March 2017, A/HRC/35/21, 6-23 June 2017, Agenda item 3.
[148] *ICESCR*, 19 December 1966, 993 UNTS 3, art 12 (entered into force 3 January 1976, accession by Canada 19 May 1976).
[149] Order in Council 213/2017, 18 July 2017.
[150] Order in Council 213/2017, 18 July 2017.
[151] *Health Authorities Act*, R.S.B.C. 1996, c. 180, s. 3(1); Order in Council 213/2017, 18 July 2017.

purposes" in relation to mental health and addictions.[152] These purposes include conducting or facilitating research into health issues and monitoring or evaluating a health care body.[153]

In other words, the Ministry of Mental Health and Addictions can set standards for the delivery of mental health services by health authorities and can then require the health authorities to provide reports so that it can conduct research and monitor and evaluate the delivery of those mental health services. As of July 2018, the Ministry of Mental Health and Addictions had not exercised these powers with respect to setting standards for or researching, monitoring or evaluating the involuntary admissions process under the *Mental Health Act*.

Moreover, legislative responsibility for the *Mental Health Act* remains with the Ministry of Health.[154] A group within the Primary and Community Care Policy Division of the ministry is responsible for mental health and substance use.

The Ministry of Health monitors discharges from hospitals, including discharges of patients who had been involuntarily admitted under the *Mental Health Act,* to examine variances among regions. However, it does not monitor or audit compliance with the admissions procedures of the *Mental Health Act*. Further, the information that the Ministry of Health receives relates only to discharges from hospitals. Simply put, there is no body that monitors hospitals and other designated facilities to determine whether they are completing medical certificates for involuntary admissions, obtaining and documenting patients' consent (deemed or otherwise) to treatment, ensuring that renewals of detentions are completed on time and in appropriate circumstances, advising patients of their rights upon detention, and contacting near relatives and providing them with rights information.

> *"Currently, there is little oversight of or accountability for the extent to which designated facilities are complying with their legal obligations when they admit patients involuntarily."*

The overlapping and connected responsibilities of the Ministry of Health and the Ministry of Mental Health and Addictions mean that both ministries have a role in providing information to the public and in ensuring that health authorities and designated facilities administer the *Mental Health Act* in accordance with the law. As such, while we have made recommendations in accordance with the alignment of responsibilities outlined in the Order in Council,[155] we would expect the ministries to work together to the extent necessary to achieve full implementation.

Publicly Available Information about Involuntary Admissions

There is very little publicly available information about involuntary admissions in British Columbia and no information regarding compliance with admissions procedures. Community and legal groups have repeatedly criticized the lack of readily available statistical information about the number and length of detentions in the province, for specific facilities, geographic regions or health authorities. In its recent report, *Operating in*

[152] *Health Authorities Act,* R.S.B.C. 1996, c. 180.
[153] *Ministry of Health Act,* R.S.B.C. 1996, c. 288, s. 9.
[154] Order in Council 213/2017, 18 July 2017. The only sections of the *Mental Health Act* that are not the responsibility of the Ministry of Health are sections 24.1 and 24.2, which relate to the Mental Health Review Board and are the responsibility of the Ministry of Attorney General.
[155] Order in Council 213/2017, 18 July 2017.

Darkness: BC's Mental Health Act Detention System, the Community Legal Assistance Society observed:

> The health authorities and Ministry of Health do not track and publish the most basic information necessary to oversee *Mental Health Act* detentions and forced psychiatric treatment. The Ministry of Health does not have comprehensive and current data on straightforward components of the mental health detention system. . . . It is impossible to engage in an effective analysis of how the mental health detention system is operating in the absence of the information necessary to conduct an evaluation. The obvious conclusion to be drawn from the failure to track and monitor this data is that the health authorities and the Ministry of Health have not been engaging in oversight or evaluation of the system for mental health detention in BC.[156]

Similarly, in a 2011 paper that was adopted by the BC Civil Liberties Association, the author noted the "dearth of statistical information available on the mental health system."[157]

The lack of transparency around the involuntary admissions process is troubling. It allows the designated facilities and the health authorities to operate without any effective public oversight. The absence of statistical information impedes community groups, advocates and other external stakeholders from providing informed and effective feedback on the institutional mental health system.

Finding 18: The Ministry of Health and the health authorities acted unreasonably in failing to adequately monitor, audit and address designated facilities' compliance with the involuntary admissions procedures under the *Mental Health Act*.

Finding 19: The Ministry of Health's failure to make publicly available statistical and evaluative information about the extent to which designated facilities are complying with the procedural safeguards in relation to involuntary admissions and detentions under the *Mental Health Act* is unreasonable because it lacks the transparency required when the state is exercising extraordinary power over a vulnerable population.

Recommendation 9: By June 30, 2019, the Ministry of Health and the Ministry of Mental Health and Addictions work together with the health authorities to establish clear and consistent provincial standards aimed at achieving 100 percent compliance with the involuntary admissions procedures under the *Mental Health Act* through the timely and appropriate completion of all required forms.

Recommendation 10: By June 30, 2019, the Ministry of Mental Health and Addictions establish a regulation under section 3(1) of the *Health Authorities Act* to codify the standards developed in accordance with Recommendation 9.

[156] Community Legal Assistance Society, Operating in Darkness: BC's Mental Health Act Detention System, November 2017, 18-19, <https://d3n8a8pro7vhmx.cloudfront.net/clastest/pages/1794/attachments/original/1527278723/CLAS_Operating_in_Darkness_November_2017.pdf?1527278723>.

[157] Dr. Muriel Groves, "Suggested Changes to BC's Mental health System Regarding Involuntary Admission and Treatment in Non-Criminal Cases," BC Civil Liberties Association, February 2011, 2.

Recommendation 11: By June 30, 2020, June 30, 2021, and June 30, 2022, the Ministry of Mental Health and Addictions and the Ministry of Health review the effectiveness of the provincial standards developed in accordance with Recommendation 9 to achieve compliance with the involuntary admissions process under the *Mental Health Act*, and publicly report the results of each of their reviews, including the compliance rates for each health authority for the previous fiscal year.

Health Authority and Designated Facility Oversight and Accountability

Training for Decision Makers

An appropriate oversight and accountability mechanism must include a process for reviewing, assessing and, where necessary, providing training and direction to decision makers to improve the quality of reasons and information in the *Mental Health Act* forms. As we found in our investigation, the information in completed forms often fell below an acceptable standard. This was particularly the case for Forms 4 and 6, where the reasons provided to justify a person's detention were often illegible or inadequate. Similarly, Form 5s often lacked any details of treatment specific to a patient, meaning that neither the patient nor health-care professionals could rely on the form as a record of the treatment that the patient had consented to or that the director had authorized.

Given that there are more than 70 designated facilities in the province and thousands of involuntary admissions each year, the administration of the *Mental Health Act* is necessarily the responsibility of many different individuals, including facility directors, physicians and other health-care professionals. In this context, it is essential that decision makers have consistent training on how to properly exercise delegated decision-making authority and document, in a clear and legible fashion, reasons for decisions. Such training would help to ensure that decision makers are complying with the legislation and following a procedurally fair process in involuntary admissions.

The training materials that are developed will also need to be consistent with the provincial standards that will be developed and codified in accordance with Recommendations 9 and 10.

Recommendation 12: By September 30, 2019, the Ministry of Health, together with the health authorities, conduct a review of the training that is offered to directors, physicians and staff exercising authority under the involuntary admissions provisions of the *Mental Health Act*, and revise all training materials and policies and procedures to address the deficiencies identified in this report, including a focus on the substantive completion of medical certificates and consent for treatment forms.

Recommendation 13: By September 30, 2019, the Ministry of Health, together with the health authorities, develop and implement a mandatory training plan for all directors, physicians and other staff exercising authority under the involuntary admissions provisions of the *Mental Health Act*, and ensure that those individuals complete the revised training by March 31, 2020, and all new staff complete the training within one month of hire.

Records Management Processes

In carrying out our investigation, we found that the designated facilities often do not track and store records relating to involuntary admissions in a centralized way. The records of involuntary patients are classified

electronically only after they are discharged from the facility. This means that it can be difficult to locate and monitor the records of all involuntary patients during the course of their detention, increasing the risk that necessary steps under the *Mental Health Act* may be overlooked.

In response to our draft report, Island Health told us that it has made improvements to its records management processes. In particular, each facility now has standard regional chart packages that contain all forms required for the involuntary admissions process. Additionally, Victoria General Hospital and Nanaimo Regional General Hospital have implemented tracking tools to ensure that the correct forms are completed within the timelines under the *Mental Health Act*. Interior Health told us it was developing and implementing a system for electronic storage of *Mental Health Act* forms.

The recommendations below focus on the development and implementation of best practices for managing the records of involuntarily admitted patients within health authorities. If may also be useful for the Ministry of Health to be involved in facilitating a coordinated approach among health authorities to develop province-wide best practices for records management.

Finding 20: The failure of the designated facilities to appropriately track, file and store the forms of patients who are involuntarily admitted under the *Mental Health Act* is unreasonable because the forms constitute the legal authority to detain and treat the patients.

Recommendation 14: The health authorities establish a working group to address issues in relation to the storage, maintenance and tracking of *Mental Health Act* forms and, by January 1, 2020, identify and establish province-wide best practices for records management for involuntarily admitted patients.

Recommendation 15: Beginning immediately, the health authorities require the designated facilities to store and maintain *Mental Health Act* forms in a manner that makes them readily accessible to staff, physicians and patients.

Compliance Audits

As with the provincial government, the health authorities do not have standardized auditing procedures in place for *Mental Health Act* involuntary admissions, and most of the health authorities do not audit the involuntary admissions process at all.

Island Health told us that it intended to establish a defined auditing process but had not yet done so, and that reviews of the involuntary admissions process occurred at the "site level."

Vancouver Coastal Health also told us that auditing occurs at the site level, meaning each patient chart has a checklist attached that allows for daily tracking of forms and timelines under the Act. Vancouver Coastal Health indicated that it was in the process of updating its clinical information system to "ensure auditing and tracking processes" under the *Mental Health Act* are built into its clinical systems.

Interior Health told us that it audited compliance with *Mental Health Act* forms in 2012 and again in 2014. Internal auditors carried out the audits and the results were reported directly to the chief executive officer of the health authority. The audits revealed that the forms were not consistently completed or did not contain the appropriate authorizations, leading the auditors to conclude that some involuntary admissions and detentions were unauthorized. Interior Health told us it has largely implemented the recommendations that flowed from the audit results, and that it has no current plans to conduct a further audit of *Mental Health Act* processes.

While some health authorities have acknowledged the importance of auditing compliance with the involuntary admissions procedure, when we conducted our investigation none of the health authorities were consistently doing so. Moreover, the health authorities that had conducted audits did not have better overall completion rates for the *Mental Health Act* forms, suggesting that the audits had not resulted in meaningful changes to admissions processes.

In providing our office with the June 2017 records for BC Children's Hospital, representatives of the hospital and the Provincial Health Services Authority (PHSA) told us our investigation had led them to identify serious issues with respect to completion of *Mental Health Act* forms. They expressed surprise and concern about their own lack of compliance because they thought the hospital had solid processes in place.

In November 2017, BC Children's Hospital and the PHSA commenced proactive measures to identify instances of non-compliance, identify potential sources of non-compliance and strategize solutions aimed at reaching 100 percent compliance. When this report was drafted, strategies undertaken by BC Children's Hospital and the PHSA to improve appropriate completion of forms for involuntary admissions included:

- initiation of a *Mental Health Act* Steering Committee in December 2017 that meets monthly and is chaired by the Senior Medical Director to address all aspects of compliance with the *Mental Health Act* forms, including roles, responsibilities and training
- development of a *Mental Health Act* Forms Pathway outlining the necessary steps for staff and physicians to take in completing the required forms, to be implemented once tested and validated by the hospital's Mental Health Program
- development of draft work standards for the completion of *Mental Health Act* forms that indicate roles and responsibilities for all involved professionals, to be implemented once tested and validated by the hospital's Mental Health Program
- implementation of a *Mental Health Act* form audit that is completed in real time to catch omissions and errors and reviewed weekly by the Psychiatrist in Chief, with clinical nurse coordinators and physicians made responsible for corrective actions and audits continuing until the hospital reaches its goal of 100% compliance
- development and delivery of an education session with a link to the recorded session provided to all staff and physicians in the Mental Health Program who were unable to attend in person, and evaluation to determine whether further educational supports and materials are needed
- incorporation of a discussion on the certification status of each patient in the nursing rounds
- visual alerts used on each inpatient unit to track and record certification status and completion of all *Mental Health Act* forms
- completion of a script used for discussion with young children

BC Children's Hospital provided our office with its audit results for all 42 admissions between March 27, 2018, and June 14, 2018 (see Table 3). The audit results are promising and show significant improvement in compliance rates compared with the June 2017 compliance rates.

Table 3: BC Children's Hospital Audit Results, March 27–June 14, 2018, Admissions

	Form 4	Form 5	Form 13	Form 15	Form 16
Number of completed forms per total admissions	42/42	41/42	35/42	38/42	38/42
Percentage	100%	98%	83%	90%	90%

We commend BC Children's Hospital for its prompt and proactive response after becoming aware of the gaps in its compliance. BC Children's Hospital provides a concrete example of the benefits of auditing as a tool for quality improvement. The results of the hospital's internal audit demonstrate the extent to which important information can be missed when an authority fails to actively audit its compliance.

Government has an obligation to ensure that the use of the statutory power to involuntarily admit, detain and provide compulsory treatment to mentally disordered individuals is carried out lawfully. Government's duty is especially great because of the intrusive nature of the powers under the *Mental Health Act* and the vulnerability of the individuals the Act covers. Regular monitoring and auditing of the involuntary admissions procedures in the Act is a basic but critical step toward fostering compliance. We expect that the audit processes described in the following recommendations can and should be coordinated. In other words, the processes used to conduct the monthly audits at a facility level would then inform the quarterly audits.

Recommendation 16: By June 30, 2019, the health authorities establish audit procedures and begin auditing, on a quarterly basis, the designated facilities' compliance with the involuntary admissions form completion process and report the results of the audit to the Ministry of Health and the Ministry of Mental Health and Addictions.

Recommendation 17: By June 30, 2019, the health authorities establish procedures respecting monthly internal audits of the involuntary admissions form completion process, including in relation to timeliness and the content of the forms, for the designated facilities to implement by September 30, 2019. The audit process should be carried out by someone sufficiently senior to provide feedback to physicians and directors regarding compliance with the involuntary admissions process, including the adequacy of reasons on medical certificates and the adequacy of treatment descriptions on consent for treatment forms.

Recommendation 18: By March 31, 2020, the health authorities establish 100 percent compliance in form completion for the involuntary admissions process under the *Mental Health Act* as a yearly performance measure for each designated facility.

Recommendation 19: By March 31, 2021, the board of directors for each health authority establish a 100 percent rate of compliance in form completion for the involuntary admissions process under the *Mental Health Act* as a yearly performance measure for the chief executive officer of each health authority.

Recommendation 20: By March 31, 2020, the Ministry of Health update and reissue the *Guide to the Mental Health Act* to incorporate the changes made arising from this report and other changes.

Rights Advice for Involuntary Patients

The prevailing view in Canada is that involuntary admission and psychiatric treatment is sometimes necessary to provide for the health and well-being of people who suffer from mental disorders. The involuntary admission process established by the *Mental Health Act* can fulfill an important function for people with mental disorders and their loved ones. People who are involuntarily admitted and have close connections with friends and family may particularly benefit from the process under the Act because they have loved ones to advocate for their best interests.

Unfortunately, many people who are involuntarily detained do not have family who can or will advocate on their behalf. Even where patients do have family who are willing to assist them, the failure of facilities to notify nominated relatives – in addition to being a breach of the Act – has significant consequences for the detained individuals and their families. When a detained patient does not nominate a near relative, or when they nominate someone but the facility neglects to notify the relative, families may remain unaware of where their loved one is or what has happened to them. The detained person may be left unsupported and without anyone to advocate for their care or their legal rights.

Moreover, as we have highlighted in earlier sections of this report, a near relative who receives a Form 16 does not have any legal right to act on behalf of the patient. Instead, they can only act as an informal advocate for the patient. In some cases, they may not agree with the patient's wishes and refuse to advocate on their behalf or in their interests. An expansion of the nomination process to ensure that the Public Guardian and Trustee or private committee are notified in appropriate cases (as set out in our Recommendations 6 and 7, above) would go some way to addressing this gap.

More important to protecting and upholding the rights of all patients who are involuntarily admitted, however, is the implementation of a comprehensive and accessible rights advisor service. In the following sections, we describe how our investigation highlighted the need for such a service.

Existing Process for Provision of Rights Information

The director of every facility that admits and detains a person involuntarily under the *Mental Health Act* has an obligation under section 10 of the Charter to inform the patient of the reasons for their detention and of their right to retain and instruct counsel without delay.

The Act requires the director of the detaining facility to notify a patient of their legal rights, both orally and in writing using a Notification to Involuntary Patient of Rights under the *Mental Health Act* (Form 13), upon detention, renewal or transfer.

As described above, we found that the rate of compliance for the provision of rights information was poor: only 49 percent of patient files contained a Form 13 for the initial involuntary admission, and only 13 percent of those forms were completed on the same day as the first medical certificate.

In some cases where a Form 13 was not completed or was completed late, the patients may have been verbally notified of their rights. However, even in those cases, it is incumbent on the facilities to provide patients with information about their rights in writing, not only because the Act requires it but because patients may be incapable of understanding or retaining the information provided at the time of their admission. Even if a patient is admitted for only a short time, providing rights information needs to be a priority for staff at detaining facilities.

The failure of the detaining facilities to provide rights information in the prescribed form is not only a violation of the Act but also has broader implications for the lawfulness of those detentions, given the potential for violations of the patients' section 10 Charter rights. Detentions that violate section 10 of the Charter are illegal. Without a completed Form 13 on the patients' files, there is an absence of evidence that patients were provided with rights information, thereby increasing the risk that the patients were unlawfully detained.

The existing requirement for the director to provide rights information must, however, continue to be part of the *Mental Health Act*, as this is how the director complies with their obligations under section 10 of the Charter. As we have described in the previous sections, the Ministry of Health, health authorities and the directors of individual facilities need to monitor and improve compliance with those obligations. However, this process is not sufficient to adequately protect the rights of individuals who are involuntarily admitted. As our investigation found, the existing rights information process is limited in four key ways.

First, the information is not provided to the patient by an arm's-length or neutral body. Under the current model, the director is responsible for providing the patient with rights information. The director is also the person who exercises the authority to involuntarily admit and detain the patient. While the director must ensure that the patient is provided with information about their right to legal advice and their ability to challenge the validity of the detention, the director has also already concluded that the involuntary admission is appropriate and exercised their authority accordingly.

In practice, health-care professionals at the facilities – including directors, physicians, nurses and social workers – are responsible for notifying patients about their Charter rights as well as their rights under the *Mental Health Act*. These individuals are generally employed by or contracted to the designated facility that has detained the patient, or may themselves have exercised authority or delegated authority to detain the patient. The relationship between the person providing the rights information and the facility may influence the patient's willingness to ask questions, challenge the basis for the detention or seek advice.

Second, it does not provide for a patient who has questions or who, on receiving the rights information, asks for certain steps to be taken. The director's duties are completely discharged on providing the rights notification, and any further steps must be initiated by the patient. This is a heavy burden to place on individuals who are detained in a psychiatric facility and receiving treatment for a mental disorder.

Third, providing rights information is not a function assigned to a single person in many facilities. Thus, individuals providing the information may be unfamiliar with the

purpose of providing the information and might not be trained in or familiar with the rights notification role. Further, carrying out this responsibility may be well outside of their area of expertise or training.

Fourth, the notice that the director is required to provide to involuntary patients is limited to specific information: there is no obligation on the director, or any other entity, to provide patients with advice about the various avenues of legal recourse that are available to them and whether, given their particular circumstances, those avenues are likely to be successful.

The existing notification process needs to be complemented by a robust system of independent rights advisors who meet with patients soon after they have been involuntarily admitted and detained, assess the patient's circumstances and advise on remedies and options, and, where directed by the patient, resolve procedural matters or make referrals to legal counsel. In the next sections, we describe the history of approaches to rights advice in B.C. and then outline the necessary features of a rights advisor model for involuntary patients.

Independent Rights Advisor

In British Columbia, no independent entity exists to provide all involuntary patients with legal advice about their rights. B.C. is one of the few Canadian jurisdictions that does not have some form of rights advisor built into its mental health legislation.[158]

Currently, there is no independent rights advice body that provides legal advice to involuntary patients detained in 73 of the 74 designated facilities operated by the province.[159] The Forensic Psychiatric Services Commission funds the Community Legal Services Society's (CLAS) Mental Health Law Program to provide a limited form of independent legal advice to patients detained in the Forensic Psychiatric Institute. The only independent public entity that is regularly notified when people are detained under the Act is the Public Guardian and Trustee, and only for those people who do not have a known or nominated near relative. The majority of those patients are not PGT clients and, in such cases, the PGT has no authority or mandate to assist them.

> *"The existing notification process needs to be complemented by a robust system of independent rights advisors..."*

The absence of independent oversight and rights advice means that when the procedural safeguards in the Act are not observed, patients must pursue court proceedings in order to obtain a legal remedy. As noted earlier, the Mental Health Review Board can only consider whether, as of the date of the hearing, a person meets the criteria for involuntary admission under the Act, and not whether the initial admission was procedurally sound. To address breaches of the Act, patients must apply to the Supreme Court of British Columbia for a writ of habeas corpus or an order of discharge under section 33 of the *Mental Health Act*. However, many patients do not have the legal awareness or financial means necessary for pursuing these avenues. The significant barriers to accessing legal recourse are exacerbated when patients do not receive notification of their rights or where facilities have neglected to notify their near relative. In other words, those who experience a denial of their rights under the Act and the

[158] Provinces with a legislated rights advisor include Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, New Brunswick and Newfoundland and Labrador.
[159] We did not obtain information about the federally operated Regional Treatment Centre (Pacific).

Charter are less equipped to seek redress because the detaining facility did not inform them of their rights and how to exercise them.

The meaningful exercise of legal rights in the context of involuntary admissions requires access to legal representation. Further to a settlement of a constitutional challenge about the denial of legal representation,[160] the Attorney General increased legal aid funding to CLAS's Mental Health Law Program, which represents involuntary patients at review panel hearings.[161] However, review panels are barred from considering the lawfulness of initial detentions, and CLAS is not funded to represent involuntary patients who wish to challenge the validity of their detentions in court. While involuntary patients can apply for a legal aid lawyer to seek a court-ordered remedy, the Legal Services Society told us that it rarely, if ever, receives such applications and could not recall approving any.

The lack of applications for legal aid funding in relation to involuntary admissions underscores the need for a rights advisor who can assist people in identifying and accessing legal remedies. Navigating court proceedings is complex, time-consuming and costly – in many cases, the lack of legal representation will effectively bar involuntary patients from challenging the lawfulness and constitutionality of their detentions.

Historical Context

In the 1990s, the Legal Services Society funded CLAS's Mental Health Law Program to provide rights advice to patients at Riverview Hospital as well as to several psychiatric units in hospitals in the Lower Mainland. These facilities would notify the Mental Health Law Program when patients were detained.

In 1994, our office released *Listening: A Review of Riverview Hospital,* which outlined "what administrative fairness requires of a psychiatric hospital."[162] The report concluded that one way to offset the power imbalance between the detained individual and the detaining facility was through independent advice and advocacy. Among other things, the Ombudsman recommended that the Attorney General consult with the Legal Services Society to find ways of "expanding the availability of legal advocacy to patients, particularly those hospitalized outside the Lower Mainland."[163]

> *"The meaningful exercise of legal rights in the context of involuntary admissions requires access to legal representation."*

However, the recommended expansion of legal advocacy services did not occur. In 1998, as part of an investigation into the independent rights advice program, the Ombudsman wrote to the Deputy Minister of Health emphasizing the importance of independent advice in the circumstances of an involuntary detention:

> I believe there are several distinct advantages to having information on legal rights being provided by persons independent from clinical treatment personnel. First, I question the argument which was expressed to the ministry

[160] *Z.B. v. Her Majesty the Queen in Right of the Province of British Columbia,* Petition, Vancouver Registry, No. S-167325 (B.C.S.C.) filed 12 August 2016.
[161] BC Public Interest Advocacy Centre, "BC Woman's Charter challenge forces provincial government to provide legal representation to all people detained under the *Mental Health Act,*" news release, 3 February 2017.
[162] Ombudsman, Province of British Columbia, *Listening: A Review of Riverview Hospital,* Public Report No. 33, May 1994, 1–6 <https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2033%20Listening%20A%20review%20of%20Riverview%20Hospital.pdf>.
[163] Ombudsman, Province of British Columbia, *Listening: A Review of Riverview Hospital,* Public Report No. 33, May 1994, 11–13.

> during the course of its review, that clinical personnel are best placed to give information to involuntary patients on their legal rights because clinicians know the importance of, and can simultaneously encourage, compliance with psychiatric treatment. This is precisely the kind of conflict of roles with which we should be concerned. If rights information is to be effective in its function of legitimizing involuntary detention and treatment, it must be given in a neutral fashion, uncoloured by any interest in seeing the patient not exercise his or her rights. Second, I believe that by ensuring that information on rights is given independently, by persons trained for that specific purpose, the opportunity for holding rights advisors accountable for fulfilling this mandate in an appropriate way is maximized. Third, I believe this is the best way of ensuring equal provision of this service across the Province, a concern to which I referred to in Ombudsman Public Report No. 33, *Listening: A Review of Riverview Hospital* (1994). . . .[164]

The ministry did not agree that independent rights advice was necessary, and it was of the view that providing for the notification of rights delivered by or on behalf of the facility director and prescribing the form of rights notification was sufficient. Section 34 of the *Mental Health Act*, which requires rights information to be given to a patient using Form 13, was enacted in its current form on November 15, 1999.[165] The ministry expressed its confidence that the health authorities and designated facilities were well equipped to provide rights information to patients in accordance with the new statutory requirements:

> The Ministry believes that this procedure will improve the provision of rights information. It will also make facilities much more accountable. Through the *Guide to the Mental Health Act* and other mechanisms, the Ministry will impress upon health authorities and designated facilities the importance of providing rights information promptly and in accordance with the Charter and the Act.[166]

Unfortunately, 20 years later, the ministry's belief that enacting section 34 and the accompanying Form 13 would result in the prompt provision of rights information to detained patients has not been borne out. The evidence we obtained through this investigation demonstrates that designated facilities' compliance with the involuntary admissions procedure is inconsistent and inadequate. The procedural safeguards in the Act and the regulation are only of any use to the extent that they are put into practice. The failure to follow the statute and regulations calls into question the lawfulness of many of the involuntary detentions that we reviewed. Without an advocate who can independently assess the extent to which facilities are complying with these safeguards in individual cases, many patients are left on their own to identify and address these procedural shortcomings.

The 25th Anniversary Report of Ontario's Psychiatric Patient Advocate Office, released in 2018, outlines how a strong and skilled

[164] Ombudsman McCallum, letter to Deputy Minister of Health, 14 August 1998.
[165] *Mental Health Amendment Act,* 1998, s. 17, in force by B.C. Reg. 233/99.
[166] Assistant Deputy Minister Bayne, letter to Ombudsman McCallum, 13 November 1998.

rights advisor can assist with the "delicate balancing of rights" that is so important when treating people with mental illness:

> . . . the balance can be lost very quickly and individuals with a mental illness can lose their voice, their rights, and often their chance to receive optimal care unless they have skilled advocates and rights advisers acting on their behalf and on their instruction. Even the most loving family members and caring and skilled health professionals cannot replace an advocate acting for the individual. Without independent advocacy and access to rights protection mechanisms, individuals all too frequently have no voice and are lost in a system. And it is not just their civil rights that are compromised. Lack of a voice, lack of access to an independent advocate or rights adviser can easily result in less than optimal care, increased vulnerability, diminished quality of life, or the continued marginalization of the individual.[167]

A rights advisor service establishes an independent rights advisor to inform patients of their legal rights, and provide advice and advocacy. A rights advisor helps to ensure that involuntary detentions are lawful and that procedural safeguards are followed for all patients. This model has been adopted in other provinces across Canada. In the next section, we highlight some essential features of a rights advice service that should be implemented in British Columbia.

"The procedural safeguards in the Act and the regulation are only of any use to the extent that they are put into practice."

Necessary Features of a Rights Advisor Service

While the specific details of a rights advisor service need to be developed by government as part of its policy framework, we believe it is important to outline some key features of the model that will, in our view, create a robust and effective process through which patients can exercise their rights and seek appropriate remedies in relation to their involuntary admission and detention.

In order for a rights advisor to provide involuntary patients with timely, relevant information and assistance, the director of a facility would need to provide the rights advisor with prompt notice of each patient's admission, transfer and renewal. The rights advisor would need to have access to the patient's personal health information without the patient's consent. The director would have to facilitate private communication between the patient and the rights advisor. This communication would take place in person except in limited, exceptional circumstances.

In some cases, newly admitted patients may not have the capacity to understand the information being presented by the rights advisor. We note that the *Mental Health Act* requires the director to provide rights information (using the Form 13) on admission. If the person does not understand the information in the Form 13 at the time of their admission, the director has a continuing obligation to provide the information again as soon as the director considers the patient is capable of understanding it. Similarly, the rights advisor would have an ongoing obligation to follow up with patients to determine if they have stabilized to the point that they are able to understand the rights advice and provide direction on any next steps. Specific procedures for addressing

[167] Michael Bay, "Foreword" *Honouring the Past, Shaping the Future: 25 Years of Progress in Mental Health Advocacy and Rights Protection,* Psychiatric Patient Advocate Office, 25th Anniversary Report (Toronto: Queen's Printer, May 2018), ix <https://www.sse.gov.on.ca/mohltc/ppao/en/Documents/pub-ann-25.pdf>.

these circumstances could be developed as part of the overall policy framework.

The rights advisor would need to provide independent advice and advocacy. In practice, this means that the advisors would be independent of the facility, health authority and government generally. Their duty would be only to the patient and their role would be to act as a counterbalance to ensure that the patient's rights – which flow from both the Charter and the Act – are observed and can be meaningfully exercised. The advisor would provide information about the patient's status and options as an involuntary patient, advise about the best option given the patient's circumstances, and make referrals to legal counsel where appropriate or where requested by the patient. At the patient's direction and on their behalf, the advisor may seek to resolve procedural or other issues with the facility, but would not fulfill a general quality-assurance function for the facility.

For example, if a patient disagreed with or was concerned about a matter related to their treatment, the advisor would discuss with the patient their right to seek a second medical opinion. In addition, the rights advisor could communicate with the facility to ensure that the director was aware of the concern, had assessed it and had communicated appropriately with the patient about it.

We recommend that government mandate the Legal Services Society to deliver this rights advice service either directly or indirectly. As the body responsible for funding legal aid services in British Columbia, the Legal Services Society has existing accountability and governance structures in place that could be leveraged to ensure that the rights advisors are well trained and qualified to carry out their role and are properly accountable, including, where necessary, to a supervising lawyer.

At the same time, we note that there are already agencies in the province with significant expertise in providing advice and advocacy services to involuntarily admitted patients. Accordingly, the Legal Services Society may conclude that one of these existing organizations is best situated to carry out the functions of the independent rights advice body. Further, we note that legal advocates across the province may be well situated to play a role. These are matters for the Legal Services Society to determine.

Recommendation 21: By November 1, 2019, government mandate the Legal Services Society to deliver directly or through another body independent rights advice and advocacy to involuntarily admitted patients in all designated facilities, including introducing, for consideration by the legislative assembly, legislative changes to:

a. require directors of designated facilities to notify the independent rights advice body of every involuntary admission, transfer or renewal of detention in the province within 24 hours

b. provide the independent rights advice body with the power to obtain any patient records relating to the involuntary admissions procedure that may be prescribed under the *Mental Health Regulation*; and

c. require directors of designated facilities to ensure that each facility provides a method for facilitating private communication between involuntary patients and the rights advice body

Recommendation 22: By April 1, 2020, if passed by the legislative assembly, the legislation referred to in Recommendation 21 be brought into force.

Recommendation 23: By April 1, 2020, the Ministry of Attorney General provide funding to the Legal Services Society sufficient to allow the independent rights advice body to provide advice and advocacy services to involuntarily admitted patients in all designated facilities.

Recommendation 24: Within one year of the implementation of the rights advice service referred to in Recommendation 21, the Ministry of Attorney General review the amount of legal aid funding available for patients who wish to apply to the court to exercise legal rights arising from their involuntary admissions and detentions, and ensure that sufficient legal aid funding is provided on an ongoing basis for all patients who wish to make such applications and meet the usual financial eligibility criteria and assessment of prospects for success of the legal proceeding.

CONCLUSION

Moving forward, the Ministry of Health, the Ministry of Mental Health and Addictions, the health authorities and the designated facilities must work collaboratively to ensure that involuntary admissions and detentions under the *Mental Health Act* are carried out in accordance with the substantive and procedural safeguards in the Act and the rights enshrined in the *Canadian Charter of Rights and Freedoms*.

Involuntary patients are entitled to substantive, timely and well-documented information about the basis for their admissions and detentions, their right to a second medical opinion and their various rights of review. Additionally, they are entitled to sufficient information about any proposed treatment or course of treatment in order to be able to provide informed consent. Where a patient refuses treatment, any treatment they are prescribed must be duly authorized by the director. In an effort to achieve these outcomes, we have made a number of recommendations aimed at ensuring that the involuntary admissions process is carried out in accordance with the *Mental Health Act*, and that the facilities and health authorities are transparent and accountable in their efforts to achieve compliance.

While our recommendations regarding independent rights advice aim to increase accountability, they are also intended to ensure that some of the most vulnerable people in our society are treated with fairness and respect. In recommending that an independent body receive notice of all involuntary admissions in the province and provide rights advice to those individuals, we intend that people who are detained in the mental health system receive full and fair information about the circumstances of their detention and their rights. This information is of critical importance in helping people understand what is happening to them, even in circumstances where the person does not wish to challenge the involuntary admission. Where a question about the validity of an involuntary admission does arise, the affected individual will receive advice from a body with the capacity and expertise to provide further assistance and, where necessary, a referral to further legal advice.

Some of these recommendations can be implemented immediately or in the very near term, while others require changes to the *Mental Health Act* and may take some time to implement. All of these changes, if implemented, will help to achieve the balance that the legislature attempted to strike when it included substantive and procedural safeguards in the *Mental Health Act*, by ensuring that those safeguards are carefully observed every time a person is involuntarily detained. Providing necessary health care for people struggling with mental illness and ensuring that their fundamental rights to liberty and security of the person are observed must go hand in hand.

APPENDICES

Appendix A: Findings and Recommendations

Findings

Forms 4 and 6	
1	In June 2017, a number of directors of designated facilities admitted and detained people involuntarily under the *Mental Health Act* without first receiving: a. medical certificates in the prescribed Medical Certificate (Form 4), contrary to section 22 of the *Mental Health Act*, or b. medical certificates in the prescribed Form 4 that contained adequate information and reasons to demonstrate how the patients met the statutory criteria for involuntary admission
2	In June 2017, a number of directors of designated facilities acted contrary to section 24 of the *Mental Health Act* by renewing patients' involuntary admissions without first receiving completed renewal forms (Form 6) explaining how the patients met the statutory criteria for continued involuntary detention.

Form 5	
3	In June 2017, a number of directors of designated facilities acted contrary to the *Mental Health Act* and the *Mental Health Regulation* in failing to ensure that consent for treatment forms (Form 5) were completed for all involuntarily admitted patients before psychiatric treatment was provided to those patients.
4	In June 2017, a number of directors of designated facilities acted contrary to section 8 of the *Mental Health Act* in permitting the psychiatric treatment of involuntarily detained patients in circumstances where the patient objected to treatment and no Consent for Treatment (Form 5) was completed.

5	The University Hospital of Northern British Columbia acted improperly in failing to ensure that consent for treatment forms (Form 5) were completed for involuntary patients who were admitted under the *Mental Health Act,* in circumstances where it knew or should have known that the forms were not being completed as a matter of practice.
6	Except in circumstances where there is no alternative, the practice of having the director who authorizes treatment on behalf of an involuntary patient also act as the prescribing physician is unreasonable because it fails to provide for an adequate separation of duties.
7	In June 2017, a number of directors of designated facilities authorized psychiatric treatment of involuntarily detained patients in circumstances where the consent for treatment forms (Form 5s) did not include sufficient details about the nature of the proposed treatment to support the directors' authorization decisions.
8	In June 2017, a number of designated facilities followed an unreasonable process in using boilerplate language, including rubber stamps, to describe treatment in consent for treatment forms (Form 5), in that the descriptions failed to adequately identify the specific treatment proposed for individual patients.
9	In June 2017, a number of directors of designated facilities purported to authorize non-psychiatric medical treatment of involuntary patients through the use of a Consent for Treatment (Form 5), despite the lack of legal authority to do so.

Form 13	
10	In June 2017, a number of directors of designated facilities acted contrary to section 34 of the *Mental Health Act* in failing to provide patients, immediately or at all, with notice of their rights in the prescribed Notification to Involuntary Patient of Rights under the *Mental Health Act* (Form 13).

Forms 15 and 16	
11	In June 2017, a number of directors of designated facilities acted contrary to section 1 of the *Mental Health Act* and section 11(15) of the *Mental Health Regulation* in failing to ensure that patients were given an opportunity to nominate a near relative to be notified of their admission using the prescribed Nomination of Near Relative (Form 15).
12	In June 2017, a number of directors of designated facilities acted contrary to section 34.2 of the *Mental Health Act* in failing to ensure that notice of the patient's involuntary admission was provided, immediately or at all, to either a near relative or the Public Guardian and Trustee, using the prescribed Notification to Near Relative (Form 16).

13	The practice at the Forensic Psychiatric Institute and the Burnaby Centre for Mental Health and Addictions of not completing Nomination of Near Relative (Form 15) and Notification to Near Relative (Form 16) for patients who are involuntarily detained under the *Mental Health Act* is contrary to section 11(15) of the *Mental Health Regulation* and sections 1 and 34.2 of the *Mental Health Act*.
14	The failure of directors of designated facilities to take steps to confirm that notification to near relative forms (Form 16) were received by the addressees is unreasonable.
15	Section of 34.2(4) of the *Mental Health Act,* which provides that the director's notification duties are discharged by notifying the Public Guardian and Trustee of British Columbia (PGT) of a patient's involuntary admission where no near relative can be identified, establishes an unreasonable procedure for patients who are not PGT clients.

General	
16	In June 2017, a number of directors of designated facilities repeatedly and consistently failed to follow the safeguards in the *Mental Health Act,* as evidenced by the lack of timely and adequate completion of Forms 4, 5, 6, 13, 15 and 16. The systemic failure to follow the procedural safeguards required by the *Mental Health Act* is incompatible with the protection of the values of individual liberty and autonomy articulated in the *Canadian Charter of Rights and Freedoms*.
17	The designated facilities have failed to establish adequate processes for ensuring that prescribed forms are completed as part of the involuntary admissions process.
18	The Ministry of Health and the health authorities acted unreasonably in failing to adequately monitor, audit and address designated facilities' compliance with the involuntary admissions procedures under the *Mental Health Act*.
19	The Ministry of Health's failure to make publicly available statistical and evaluative information about the extent to which designated facilities are complying with the procedural safeguards in relation to involuntary admissions and detentions under the *Mental Health Act* is unreasonable because it lacks the transparency required when the state is exercising extraordinary power over a vulnerable population.
20	The failure of the designated facilities to appropriately track, file and store the forms of patients who are involuntarily admitted under the *Mental Health Act* is unreasonable because the forms constitute the legal authority to detain and treat the patients.

Recommendations

1	By September 30, 2019, the board of directors of Northern Health Authority: a. appoint an independent reviewer to produce a written report outlining the reasons for low Consent for Treatment (Form 5) compliance rates at the University Hospital of Northern British Columbia, and require the reviewer to provide the completed report to the board of directors, chief executive officer and the Ministry of Health b. in consultation with internal stakeholders and the Ministry of Health, approve a strategy to address the issues identified in the report c. work with internal stakeholders and the Ministry of Health to implement the resulting strategy, and d. ensure that the results of the monthly audits conducted in accordance with Recommendation 17 examine the effectiveness of the strategy in improving compliance
2	Beginning immediately, the health authorities require directors of designated facilities, and their delegates, to cease the practice of authorizing treatment in circumstances where they are also the treating physician, except in circumstances where there is no alternative.
3	Beginning immediately, the health authorities require all persons responsible for completing consent for treatment forms (Form 5) in the designated facilities to cease using boilerplate language to describe a proposed course of treatment in Form 5s and to tailor the description of treatment to specify the actual particularized treatment proposed for the individual patient.
4	Beginning immediately, the health authorities require the designated facilities to apply the policy guidance set out in the *Guide to the Mental Health Act* and require all persons responsible for completing consent for treatment forms (Form 5) to complete a new Form 5 when there is a significant change to a patient's treatment plan.
5	Beginning immediately, the health authorities: a. instruct the directors of designated facilities to cease purporting to authorize non-psychiatric treatment of involuntary patients by way of consent for treatment forms (Form 5), and b. instruct all staff that non-psychiatric treatment of involuntary patients can only be administered in accordance with Part 2 of the *Health Care (Consent) and Care Facility (Admission) Act* or the *Infants Act*
6	By January 1, 2020, the health authorities develop a process for implementation by the directors of designated facilities by February 1, 2020, to confirm receipt of each Notification to Near Relative (Form 16) by its addressee, and, if the form was not received, to issue a further Form 16 to another near relative of the patient.

7	By January 1, 2020, the Ministry of Health and the health authorities develop and implement, in consultation with the Office of the Information and Privacy Commissioner and the Public Guardian and Trustee of British Columbia, an appropriate method for identifying, in a timely way, those involuntary patients who are clients of the Public Guardian and Trustee of British Columbia or who have private committees.
8	By November 1, 2019, government introduce legislation for consideration by the legislative assembly to amend the *Mental Health Act* to: a. repeal section 34.2(4), which provides that a director's duty to notify a patient's near relative is discharged if a notice is sent to the Public Guardian and Trustee of British Columbia (PGT) b. require the directors of designated facilities to identify patients who are clients of the PGT or who have a private committee and notify the PGT upon those patients' admission, transfer or renewal of detention c. require the directors of designated facilities to notify any known representative under a Representation Agreement or attorney under an Enduring Power of Attorney upon those patients' admission, transfer or renewal of detention, and d. provide that where there is no known near relative, representative, attorney or committee, and the patient is not a client of the PGT, the notice be provided to the independent rights advice body in accordance with the process described under Recommendation 21
9	By June 30, 2019, the Ministry of Health and the Ministry of Mental Health and Addictions work together with the health authorities to establish clear and consistent provincial standards aimed at achieving 100 percent compliance with the involuntary admissions procedures under the *Mental Health Act* through the timely and appropriate completion of all required forms.
10	By June 30, 2019, the Ministry of Mental Health and Addictions establish a regulation under section 3(1) of the *Health Authorities Act* to codify the standards developed in accordance with Recommendation 9.
11	By June 30, 2020, June 30, 2021, and June 30, 2022, the Ministry of Mental Health and Addictions and the Ministry of Health review the effectiveness of the provincial standards developed in accordance with Recommendation 9 to achieve compliance with the involuntary admissions process under the *Mental Health Act,* and publicly report the results of each of their reviews, including the compliance rates for each health authority for the previous fiscal year.
12	By September 30, 2019, the Ministry of Health, together with the health authorities, conduct a review of the training that is offered to directors, physicians and staff exercising authority under the involuntary admissions provisions of the *Mental Health Act,* and revise all training materials and policies and procedures to address the deficiencies identified in this report, including a focus on the substantive completion of medical certificates and consent for treatment forms.

13	By September 30, 2019, the Ministry of Health, together with the health authorities, develop and implement a mandatory training plan for all directors, physicians and other staff exercising authority under the involuntary admissions provisions of the *Mental Health Act,* and ensure that those individuals complete the revised training by March 31, 2020, and all new staff complete the training within one month of hire.
14	The health authorities establish a working group to address issues in relation to the storage, maintenance and tracking of *Mental Health Act* forms and, by January 1, 2020, identify and establish province-wide best practices for records management for involuntarily admitted patients.
15	Beginning immediately, the health authorities require the designated facilities to store and maintain *Mental Health Act* forms in a manner that makes them readily accessible to staff, physicians and patients.
16	By June 30, 2019, the health authorities establish audit procedures and begin auditing, on a quarterly basis, the designated facilities' compliance with the involuntary admissions form completion process and report the results of the audit to the Ministry of Health and the Ministry of Mental Health and Addictions.
17	By June 30, 2019, the health authorities establish procedures respecting monthly internal audits of the involuntary admissions form completion process, including in relation to timeliness and the content of the forms, for the designated facilities to implement by September 30, 2019. The audit process should be carried out by someone sufficiently senior to provide feedback to physicians and directors regarding compliance with the involuntary admissions process, including the adequacy of reasons on medical certificates and the adequacy of treatment descriptions on consent for treatment forms.
18	By March 31, 2020, the health authorities establish 100 percent compliance in form completion for the involuntary admissions process under the *Mental Health Act* as a yearly performance measure for each designated facility.
19	By March 31, 2021, the board of directors for each health authority establish a 100 percent rate of compliance in form completion for the involuntary admissions process under the *Mental Health Act* as a yearly performance measure for the chief executive officer of each health authority.
20	By March 31, 2020, the Ministry of Health update and reissue the *Guide to the Mental Health Act* to incorporate the changes made arising from this report and other changes.

21	By November 1, 2019, government mandate the Legal Services Society to deliver directly or through another body independent rights advice and advocacy to involuntarily admitted patients in all designated facilities, including introducing, for consideration by the legislative assembly, legislative changes to: a. require directors of designated facilities to notify the independent rights advice body of every involuntary admission, transfer or renewal of detention in the province within 24 hours b. provide the independent rights advice body with the power to obtain any patient records relating to the involuntary admissions procedure that may be prescribed under the *Mental Health Regulation;* and c. require directors of designated facilities to ensure that each facility provides a method for facilitating private communication between involuntary patients and the rights advice body
22	By April 1, 2020, if passed by the legislative assembly, the legislation referred to in Recommendation 21 be brought into force.
23	By April 1, 2020, the Ministry of Attorney General provide funding to the Legal Services Society sufficient to allow the independent rights advice body to provide advice and advocacy services to involuntarily admitted patients in all designated facilities.
24	Within one year of the implementation of the rights advice service referred to in Recommendation 21, the Ministry of Attorney General review the amount of legal aid funding available for patients who wish to apply to the court to exercise legal rights arising from their involuntary admissions and detentions, and ensure that sufficient legal aid funding is provided on an ongoing basis for all patients who wish to make such applications and meet the usual financial eligibility criteria and assessment of prospects for success of the legal proceeding.

Appendix B: Authority Responses

BRITISH COLUMBIA

January 25, 2019

Mr. Jay Chalke, Ombudsperson
Office of the Ombudsperson
Province of British Columbia
947 Fort Street
Victoria, British Columbia
V8V 3K3

Attention: Mr. Chalke

Involuntary Admissions Report

Thank you for your letter of January 17, 2019, in which you provided the Ministry of Attorney General (the "Ministry") with revised findings and recommendations in relation to your Office's draft report on the involuntary admissions process under the *Mental Health Act.*

The Ministry appreciates the significant efforts of the Office of the Ombudsperson in preparing a report and proposing recommendations intended to improve the involuntary admissions process under the *Mental Health Act.*

Though the Ministry has not had an opportunity to review a final draft of the report, I have carefully considered recommendations 21-24, which are directed at this ministry. Having considered those recommendations, I confirm that the Ministry is supportive of the principles they identify, accepts their intent, and is prepared to take the actions set out below.

Recommendation 21: By November 1, 2019, government mandate the Legal Services Society to deliver directly, or through one or more other bodies, independent rights advice and advocacy to involuntarily admitted patients in all designated facilities, including introducing, for consideration by the legislative assembly, legislative changes to:

a) require directors of designated facilities to notify the independent rights advice body of every involuntary admission, transfer or renewal of detention in the province within 24 hours;

…/2

Ministry of Attorney General Office of the Deputy Attorney General
Mailing Address: PO Box 9290 Stn Prov Govt Victoria BC V8W 9J7
Telephone: 250-356-0149 Facsimile: 250-387-6224 Website: www.gov.bc.ca/justice

b) **provide the independent rights advice body with the power to obtain any patient records relating to the involuntary admissions procedure that may be prescribed under the *Mental Health Regulation*; and**

c) **require directors of designated facilities to ensure that each facility provides a method for facilitating private communication between involuntary patients and the rights advice body.**

Response: The Ministry is supportive of developing a service that provides independent rights advice and advocacy for involuntarily admitted patients in all designated facilities. As a service of this nature is not currently provided, the provision of this service is dependent upon the approval of Cabinet and the availability of funding. The Ministry is prepared to seek appropriate approvals with respect to legislation and funding from Cabinet and Treasury Board in order to develop and fund the services you are recommending government deliver.

In regard to the recommendation that government mandate the Legal Services Society (LSS) to deliver these services, either directly or indirectly, the Ministry will engage with LSS in the development of the above-noted service as LSS currently delivers legal aid services to involuntarily admitted patients. It is too early at this stage however to commit to the details of how the service will be delivered.

Recommendation 22: By April 1, 2020, if passed by the legislative assembly, the legislation referred to in Recommendation 21 be brought into force.

Response: As stated above in response to recommendation 21, the Ministry is prepared to seek the appropriate Cabinet approvals for legislative changes. If legislation is passed by the legislative assembly, the Ministry will follow the appropriate process for bringing that legislation into force if and when directed by Cabinet.

Recommendation 23: By April 1, 2020, the Ministry of Attorney General provide funding to the Legal Services Society sufficient to allow the independent rights advice body to provide advice and advocacy services to involuntarily admitted patients in all designated facilities.

Response: As stated above, the Ministry is prepared to seek the appropriate approvals from Cabinet and Treasury Board in order to fund a service that provides independent rights advice and advocacy for involuntarily admitted patients in all designated facilities.

…/3

Mr. Jay Chalke, Ombudsperson
Page 3

Recommendation 24: Within one year of the implementation of the rights advice service referred to in Recommendation 21, the Ministry of Attorney General review the amount of legal aid funding available for patients who wish to apply to the court to exercise legal rights arising from their involuntary admissions and detentions, and ensure that sufficient legal aid funding is provided on an ongoing basis for all patients who wish to make such applications and meet the usual financial eligibility criteria and assessment of prospects for success of the legal proceeding.

Response: The budget development process for LSS is an annual exercise, undertaken in alignment with government's priorities and fiscal plan. The demand for all services is reviewed and recommendations for funding are made accordingly. If there is an increase in demand for the services identified in this recommendation, it will be considered in the annual budget development exercise.

I appreciate the opportunity to review and respond to the revised recommendations. I trust the information provided above is of assistance to your office.

Sincerely,

Richard J. M. Fyfe, QC
Deputy Attorney General
Ministry of Attorney General

BRITISH COLUMBIA

January 25, 2019

1127838

Jay Chalke
Ombudsperson
Office of the Ombudsperson
947 Fort St
Victoria BC V8V 3K3

Dear Mr. Chalke:

The Ministry of Health ("the Ministry") would like to thank the Ombudsperson for the letter of January 17, 2019 enclosing the revised findings and recommendations in relation to your draft report on the involuntary admission process under the *Mental Health Act* (Attached for reference).

Though the Ministry has not had an opportunity to review a final draft of the report, I have carefully considered the recommendations directed to the Ministry and the Health Authorities and confirm that the Ministry is supportive of the principles they identify, accepts their intent, and is prepared to take the following actions.

The Ministry is supporting the Ministry of Mental Health and Addictions (MMHA) to establish a provincial Framework ("the Framework") that will provide guidance for quality improvement and compliance with legislation, policy, practice and standards which play a significant role in improving the quality and safety of patient care.

Consistent with the Framework, the Ministry in partnership with the MMHA and Health Authorities will develop and support the implementation of clear and consistent provincial operational standards aimed at achieving compliance with the involuntary admissions procedures under the *Mental Health Act* with respect to the timely and appropriate completion of all required forms.

Recommendations 1 to 7, 9, 11 to 20,

Response:

The Ministry will be undertaking the following actions:

- Developing and implementing provincial operational standards based on the MMHA Framework that:
    - Aims to achieve full compliance with completing appropriate *Mental Health Act* forms (Recommendation 1 and 9);

Ministry of Health Office of the Deputy Minister PO Box 9639 STN PROV GOVT Victoria BC V8W 9P1

- Clarifies that Directors appointed under the *Mental Health Act* will not be the treating physician, except where there is no alternative (Recommendation 2);
- Discontinues rubber stamping or boilerplate language and requires patient friendly language within the consent form (Form 5) for the purpose of documenting treatment (Recommendation 3);
- Clarifies within the consent form (Form 5) the definition of significant change to proposed treatment and when a new consent form is required to be completed (Recommendation 4);
- Identifies criteria with respect to when to apply the *Health Care (Consent) Care Facility (Admissions Act)* versus the *Mental Health Act* (Recommendation 5);
- Identifies a process for notification of a "Near Relative" based on best practices (Recommendation 6);
- Outlines a process for identifying involuntary patients who are clients of the Public Guardian and Trustee of British Columbia or patients who have private committees. This process will be completed in consultation with the Office of Information and Privacy and the Office of Public Guardian and Trustee of British Columbia (Recommendation 7);
- The Ministry of Health and the Ministry of Mental Health and Addictions will review the effectiveness of the provincial operational standards and identify a process and requirements for Health Authorities to audit designated facilities' compliance with the involuntary admissions forms completion process and report the results (Recommendation 11);
- Addresses training of persons exercising authority under the involuntary admission provisions of the *Mental Health Act* by revising all training materials and policies and procedures to address the deficiencies identified in the Report, focusing on substantive completion of medical certificate and consent to treatment forms (Recommendation 12 and 13);
- Identifies a process and establishes province-wide best practices for records management for involuntarily admitted patients in collaboration with Health Authorities (Recommendation 14 and 15);
- Identifies criteria, timelines and a process for Health Authorities to audit designated facilities' compliance with the involuntary admissions forms completion process, content of the forms, and report the results of the audit to the Ministry (Recommendation 16 and 17);
- Identifies a process and requirements for *Mental Health Act* form completion compliance for all involuntary admissions and establishes *Mental Health Act* form completion as an annual performance measure for the Health Authorities. (Recommendation 18 and 19).

Recommendation 8 – Amendment to the *Mental Health Act*

Response:

The Ministry will undertake a policy analysis in partnership with MMHA, Health Authorities and key stakeholders and determine whether legislative changes are needed versus development of policies, standards and or guidelines.

Recommendation 20 – Updated Guide

Response:

The ministry will update and re-issue the Guide to the *Mental Health Act* to reflect changes arising from the report.

The Ministry is committed to take appropriate steps as outlined above to ensure that patients involuntarily admitted under the *Mental Health Act* are admitted and detained in accordance with all the requirements of that Act.

We want to thank the Ombudsperson for undertaking the review and bringing the issues and concerns to our attention.

Sincerely,

for Jeri Collins

Stephen Brown
Deputy Minister

Attachment

January 25, 2019

Cliff # 1128250

Mr. Jay Chalke
Ombudsperson
Office of the Ombudsperson
947 Fort St
PO Box 9039 Stn Prov Govt
Victoria BC, V8V 9A5

Dear Mr. Chalke:

Thank you for your letter dated January 14, 2019, in which you provided the Ministry of Mental Health and Addictions (the "Ministry") with revised findings and recommendations in relation to your Office's draft report on the involuntary admissions process under the Mental Health Act.

The Ministry appreciates the significant efforts of the Office of the Ombudsperson in preparing a report and proposing recommendations intended to improve the involuntary admissions process under the Mental Health Act. The Ministry acknowledges the need to improve the quality of procedures when people are in crisis and at the point of involuntary admission. The establishment of the Ministry and its mandate has provided an opportunity for improved provincial oversight and accountability. As the Ministry's responses below indicate, we will continue to work collaboratively with Government partners to provide strategic and operational policies to improve program and service delivery to British Columbians.

Though the Ministry has not had an opportunity to review a final draft of the report, I have carefully considered recommendations #9, #10 and #11, which are directed at this Ministry. Having considered those recommendations set out below, I confirm that the Ministry is supportive of the principles they identify, accepts their intent, and is prepared to take the following actions.

Recommendation 9: By June 30, 2019, the Ministry of Health and the Ministry of Mental Health and Addictions work together with the health authorities to establish clear and consistent provincial standards aimed at achieving 100 percent compliance with the involuntary admissions procedures under the Mental Health Act through the timely and appropriate completion of all required forms.

Response:
The Ministry supports this recommendation. The Ministry is working with the Ministry of Health to establish clear and consistent provincial standards aimed at achieving 100% compliance with the involuntary admissions procedures under the Mental Health Act with

Ministry of Mental Health & Addictions Office of the Deputy Minister PO Box 9672 STN PROV GOVT Victoria BC V8W 9P6

respect to the timely and appropriate completion of all required forms. The Ministry will set the strategic direction and create an appropriate quality improvement framework (the "Framework") to support these standards, while the Ministry of Health will work with Health Authorities to develop and implement provincial standards. The Framework will provide guidance for quality improvement and compliance with legislation, policy, practice and standards which play a significant role in improving the quality and safety of patient care.

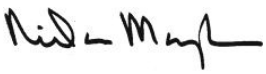
Recommendation 10: By June 30, 2019, the Minister of Mental Health and Addictions establish a regulation under section 3(1) of the Health Authorities Act to codify the standards developed in accordance with Recommendation 9.

Response:
The Ministry supports the intent of this recommendation. Once the Framework and standards are complete (recommendation #9), the Ministry will collaborate with Government partners to determine the most appropriate and effective mechanism, including potential regulatory amendments, to ensure compliance, transparency and accountability.

Recommendation 11: By June 30, 2020, June 30, 2021, and June 30, 2022, the Ministry of Mental Health and Addictions and the Ministry of Health review the effectiveness of the provincial standards developed in accordance with Recommendation 9 to achieve compliance with the involuntary admissions process under the Mental Health Act, and publicly report the results of each of their reviews, including the compliance rates for each health authority for the previous fiscal year.

Response:
The Ministry supports this recommendation.

Thank you again for outlining the opportunities for quality improvement and compliance with legislation, policy, practice and standards which play a significant role in improving the quality and safety of patient care.



Yours Sincerely,

Neilane Mayhew
Deputy Minister
Ministry of Mental Health and Addictions

Ministry of Mental Health & Addictions Office of the Deputy Minister PO Box 9672 STN PROV GOVT
Victoria BC V8W 9P6

fraserhealth Better health. Best in health care.

January 28, 2019

Mr. Jay Chalke
Ombudsperson
Province of British Columbia
947 Fort Street
PO Box 9039 Stn Prov Govt
Victoria, BC V8W 9A5

Dear Mr. Chalke:

Re: File SYS17-1004 – Involuntary Admissions under Mental Health Act

Thank you for your letter of January 15, 2019 summarizing the changes made to the Office of the Ombudsperson's report on the involuntary admissions process under the *Mental Health Act* in response to recommendations made by Fraser Health and other health authorities and agencies, and your subsequent letter of January 25, 2019 providing clarification on some additional queries from Fraser Health. We appreciate the willingness of the Office of the Ombudsperson to engage in dialogue on this topic and to incorporate the responses received into the final report.

Fraser Health is pleased to accept the revised recommendations as presented. We have appreciated the opportunity to review our practices and process, and remain committed to achieving 100 per cent compliance with regard to the procedural safeguards established by the *Mental Health Act* for the benefit and safety of our patients.

Sincerely,

Dr. Victoria Lee
President and Chief Executive Officer

VL/tls

Cc: Jim Sinclair, Board of Directors
Andy Libbiter, Executive Director, Mental Health and Substance Use
Denyse Houde, Clinical Director, Mental Health and Substance Use
Alexis Kerr, General Counsel

Fraser Health Authority
Office of the President and CEO

Suite 400, Central City Tower
13450 102nd Avenue
Surrey, BC
V3T 0H1 Canada

Tel (604) 587-4625
Fax (604) 587-4666
www.fraserhealth.ca

January 24, 2019

Jay Chalke, Ombudsperson
Province of British Columbia
947 Fort Street
POB 9039 Stn Prov Govt
Victoria BC V8W 9A5
Sent via email: ABockus-Vanin@bcombudsperson.ca

Ombudsperson File: SYS17-1004

Dear Mr. Chalke

This letter is in response to your correspondence dated January 15, 2019, in which you outlined and attached revised recommendations regarding the involuntary admissions process under the *Mental Health Act*.

Interior Health accepts your revised recommendations, and we commit to continue working with the Ministry of Health and Ministry of Mental Health & Addictions to assist with and implement the recommendations.

Sincerely,

Susan Brown
President & Chief Executive Officer

cc:
Mr. Doug Cochrane, Board Chair
Mr. Mal Griffin, VP Human Resources
Mr. Roger Parsonage, Executive Director NOK & EK
Ms. Patty Garrett, Director Risk Management
Mr. Tony Yip, Manager FOI, Privacy & Policy
Ms. Sandy da Silva, Director, Facility Standards and Compliance, MHSU

Bus: (250) 862-4205
Email: Susan.brownCEO@interiorhealth.ca
Web: www.interiorhealth.ca

INTERIOR HEALTH
Corporate Administration
505 Doyle Ave Kelowna BC V1Y 0C5

Excellent health and care, for everyone,
everywhere, every time.

island health

January 24, 2019 Cliff 19790

Mr. Jay Chalke
Ombudsperson
947 Fort Street
PO Box 9039 Stn Prov Govt
Victoria, BC V8W 9A5

Dear Mr. Chalke,

Thank you for your letter of January 15, 2019 regarding revisions to the findings and recommendations of your draft report on involuntary admissions under the *Mental Health Act*. We very much appreciate the time you have taken to discuss your findings with Island Health.

Island Health is dedicated to providing high quality care for individuals living with mental illness, and is committed to ensuring that the rights of those who are involuntarily admitted are safeguarded under the full protection afforded to them by legislation. We appreciate your acknowledgement of the work already underway in Island Health in this regard.

Your willingness to amend your report based on representations from Island Health is appreciated and Island Health is pleased to accept the report's revised recommendations.

We are committed to continuing to partner with the Ministry of Mental Health and Addictions, the Ministry of Health and the Ombudsperson's Office to implement this important report.

Once again, thank you for your commitment to the care and wellbeing of individuals living with mental illness.

Sincerely,

Kathy MacNeil
President and Chief Executive Officer
Island Health

cc. Ms. Leah Hollins, Board Chair
Ms. Cheryl Damstetter, Vice-President, Priority Populations & Initiatives

Executive Office
Located at: 2101 Richmond Road | Victoria, BC V8R 4R7 Canada
Mailing address: 1952 Bay Street | Victoria, BC V8R 1J8 Canada
Tel: 250-370-8699 | Fax: 250-370-8750
viha.ca

northern health
the northern way of caring

Board & Administration Office
#600 - 299 Victoria Street,
Prince George, BC V2L 5B8
Telephone: (250) 565-2922
www.northernhealth.ca

22 January 2019

Mr. Jay Chalke
Office of the Ombudsperson
947 Fort Street
PO Box 9039 Stn. Prov. Gov't.
Victoria BC V8W9A5

Dear: Mr. Chalke

Re: Involuntary Admissions Report

Thank you for providing the opportunity to make representations on your draft report, and for the thoughtful consideration you have given to the representations and concerns raised by Northern Health and the other health authorities.

We accept all recommendations as revised, and welcome the opportunity to collaborate with the other health authorities and the Ministry of Health to improve care and safeguarding of rights for a vulnerable population.

Sincerely,

Cathy Ulrich
President & Chief Executive Officer
Northern Health

cc. Ms. Colleen Nyce, Board Chair, Northern Health Authority

Provincial Health Services Authority
Province-wide solutions. Better health.

Carl Roy
PRESIDENT AND CEO

January 25, 2019

Mr. Jay Chalke
Ombudsperson
Province of British Columbia
947 Fort Street
PO Box 9039 Stn Prov Govt
Victoria, BC V8W 9A5

Dear Mr. Chalke:

Re: Involuntary Admissions Report

Thank you for your letter of January 15, 2019 and the opportunity to review the findings and recommendations to be contained in your report on the involuntary admissions process under the Mental Health Act.

On behalf of Provincial Health Services Authority (PHSA) and its designated facilities (the Forensic Psychiatric Hospital, the Burnaby Centre for Mental Health and Addiction, and BC Children's Hospital), I confirm that PHSA accepts the findings and recommendations in their entirety and will begin to implement the recommendations immediately.

We thank the Office of the Ombudsperson for your report on this important subject.

Sincerely,

Carl Roy
President & CEO

:jd

700 - 1380 Burrard Street, Vancouver, British Columbia V6Z 2H3 Canada – TEL 604 675.7400 FAX 604 708.2700 WEB www.phsa.ca

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Providence HEALTH CARE
How you want to be treated.

January 25, 2019

Mr. Jay Chalke
Office of the Ombudsperson
947 Fort Street
PO Box Stn Prov Govt
Victoria BC V8V 9A5

Dear Mr. Chalke,

RE: Involuntary Admissions Report

Thank you for the revised report and recommendations focused on the involuntary admissions process under the Mental Health Act.

On behalf of Vancouver Coastal Health Authority, Providence Health Care and the designated facilities we operate, this letter confirms our acceptance of the report's revised recommendations. Further, we would like to acknowledge our appreciation for the opportunity to provide feedback and appreciate the amended recommendations.

We are committed to working together to improve training, ensure oversight and accountability and provide rights advice for involuntarily admitted patients.

We look forward to continued discussion and collaboration as we implement the recommendations.

Sincerely,

Mary Ackenhusen
President and Chief Executive Officer
Vancouver Coastal Health
601 W. Broadway
Vancouver BC V5Z 4C2

Fiona Dalton
President & Chief Executive Officer
Providence Health Care
1081 Burrard Street
Vancouver BC V6Z 1Y6

cc: Yasmin Jetha, VP, Community Services
Monica McAlduff, Regional Director, MHSU
Dr. Lakshmi Yatham, Regional Medical Director, MHSU
Dr. Penny Ballem, Board Chair

Appendix C: Facilities Designated under the *Mental Health Act*[1]

Schedule A Facilities – Facilities Designated as Provincial Mental Health Facilities under Section 3(1)

Facility Name	Location	Operator	Involuntary Admissions in June 2017?[2]
The Alder Unit	Vancouver	Vancouver Coastal Health Authority (VCHA)	No
Arbutus Place	Langley	Fraser Health Authority (FHA)	Yes
Burnaby Centre for Mental Health and Addiction	Burnaby	Provincial Health Services Authority (PHSA)	Yes
Cara Centre	Kelowna	Interior Health Authority (IHA)	No
Connolly Lodge	Coquitlam	FHA	No
Cottonwood Lodge	Coquitlam	FHA	No
Cowichan Lodge	Duncan	Island Health Authority (Island Health)	No
Cypress Lodge	Coquitlam	FHA	No
Forensic Psychiatric Institute	Coquitlam	PHSA	Yes
Harbour House	Trail	IHA	No
Hillside Centre	Kamloops	IHA	No
Iris House	Prince George	Northern Health Authority (NHA)	No
Jack Ledger House	Victoria	Island Health	No
Maples Adolescent Treatment Centre	Burnaby	Ministry of Children and Family Development	No
Parkview[4]	Vancouver	Providence Health Care[3]	n/a
Provincial Assessment Centre for Community Living Services	Burnaby	Community Living BC	No
Riverview Hospital	Port Coquitlam	PHSA	n/a
Seven Oaks Tertiary Mental Health Facility	Victoria	Island Health	No
Seven Sisters Residence	Terrace	NHA	No
South Hills Centre	Kamloops	IHA	No
Sumac Place	Gibsons	VCHA	No
Tamarack Cottage	Cranbrook	IHA	No
Timber Creek	Surrey	FHA	No
Willow Pavilion	Vancouver	VCHA	No
Youth Forensic Psychiatric Services Inpatient Assessment Unit	Burnaby	Ministry of Children and Family Development	Yes

Schedule B Facilities – Hospitals Designated as Psychiatric Units under Section 3(2)

Facility	Location	Operator	Involuntary Admissions in June 2017?[2]
Abbotsford Regional Hospital and Cancer Centre	Abbotsford	FHA	Yes
British Columbia Children's Hospital	Vancouver	PHSA	Yes
British Columbia Women's Hospital and Health Care Centre	Vancouver	PHSA	No
Burnaby Hospital	Burnaby	FHA	Yes
Chilliwack General Hospital	Chilliwack	FHA	Yes
Cowichan District Hospital	Duncan	Island Health	Yes
Dawson Creek and District Hospital	Dawson Creek	NHA	Yes
East Kootenay Regional Hospital	Cranbrook	IHA	Yes
Fort St. John General Hospital	Fort St. John	NHA	Yes
G.F. Strong Centre	Vancouver	VCHA	No
Gorge Road Hospital[5]	Victoria	Island Health	No
Kelowna General Hospital	Kelowna	IHA	Yes
Kootenay Boundary Regional Hospital	Trail	IHA	Yes
Langley Memorial Hospital	Langley	FHA	Yes
Lions Gate Hospital	North Vancouver	VCHA	Yes
Mills Memorial Hospital	Terrace	NHA	Yes
Mount Saint Joseph Hospital	Vancouver	Providence Health Care[3]	Yes
Nanaimo Regional General Hospital	Nanaimo	Island Health	Yes
North Island Hospital Comox Valley[4]	Courtenay	Island Health	n/a
Peace Arch District Hospital	White Rock	FHA	Yes
Penticton Regional Hospital	Penticton	IHA	Yes
Powell River General Hospital	Powell River	VCHA	Yes
Prince Rupert Regional Hospital	Prince Rupert	NHA	Yes
Regional Treatment Centre (Pacific)	Abbotsford	Correctional Services of Canada	n/a
Richmond Hospital	Richmond	VCHA	Yes
Ridge Meadows Hospital and Health Care Centre	Maple Ridge	FHA	Yes
Royal Columbian Hospital	New Westminster	FHA	Yes
Royal Inland Hospital	Kamloops	IHA	Yes
Royal Jubilee Hospital	Victoria	Island Health	Yes
Sechelt Hospital/shíshálh Hospital	Sechelt	VCHA	Yes
St. Joseph's General Hospital[5]	Comox	Island Health	Yes
St. Paul's Hospital	Vancouver	Providence Health Care[3]	Yes
Surrey Memorial Hospital	Surrey	FHA	Yes

Facility	Location	Operator	Involuntary Admissions in June 2017?[2]
University of British Columbia Health Sciences Centre Hospital	Vancouver	VCHA	Yes
The University Hospital of Northern British Columbia	Prince George	NHA	Yes
Vancouver General Hospital	Vancouver	VCHA	Yes
Vernon Jubilee Hospital	Vernon	IHA	Yes
Victoria General Hospital	Victoria	Island Health	Yes
West Coast General Hospital	Port Alberni	Island Health	Yes

Schedule C Facilities – Hospitals Designated as Observation Units under Section 3(2)

Facility	Location	Operator	Involuntary Admissions in June 2017?[2]
Boundary Hospital	Grand Forks	IHA	No
Bulkley Valley District Hospital	Smithers	NHA	No
Cariboo Memorial Hospital	Williams Lake	IHA	No
Fort Nelson General Hospital	Fort Nelson	NHA	Yes
G.R. Baker Memorial Hospital	Quesnel	NHA	Yes
Haida Gwaii Hospital and Health Centre - Xaayda Gwaay Ngaaysdll Naay[4]	Village of Queen Charlotte	NHA	n/a
Kitimat General Hospital	Kitimat	NHA	Yes
Kootenay Lake Hospital	Nelson	IHA	No
Lady Minto Gulf Islands Hospital	Salt Spring Island	Island Health	Yes
Lakes District Hospital and Health Centre	Burns Lake	NHA	No
North Island Hospital – Campbell River and District[4]	Campbell River	Island Health	n/a
Port McNeill and District Hospital	Port McNeill	Island Health	Yes
Wrinch Memorial Hospital	Hazelton	NHA	Yes

1 The provincial government publishes the current list of facilities designated under the *Mental Health Act*, which is available at <https://www2.gov.bc.ca/gov/content/health/managing-your-health/mental-health-substance-use/mental-health-act>.
2 If an admission was a transfer from another facility and the patient was initially admitted prior to June 2017, we considered it out of scope. If the admission was a transfer from another facility and the initial admission occurred in June 2017, we attributed the admission to the first facility.
3 Providence Health Care is a non-profit organization that provides health care services in partnership with Vancouver Coastal Health Authority and the Provincial Health Services Authority.
4 The facility was not designated in June 2017 and therefore, not included in our investigation.
5 The facility was designated in June 2017, and therefore included in our investigation, but it has since had its designation rescinded.

Appendix D: Selected *Mental Health Act* forms

FORM 4
MENTAL HEALTH ACT
[Sections 22, 28, 29 and 42,
R.S.B.C. 1996, c. 288]

MEDICAL CERTIFICATE
(INVOLUNTARY ADMISSION)

I, _____ , M.D., certify that I examined
physician's name (please print)

_____ on _____ .
first and last name of person examined (please print) *dd / mm / yyyy*

In summary form, the reasons for my opinion are: (information may be obtained through interviews, observations and collateral sources)

1. In my opinion, this person:
   has a disorder of the mind that requires treatment and which seriously impairs the person's ability to react appropriately to his/her environment or to associate with others (section 1 of the *Mental Health Act*);

2. In my opinion, this person:
   (a) requires treatment in or through a designated facility; and
   (b) requires care, supervision and control in or through a designated facility to prevent his/her substantial mental or physical deterioration or for the protection of the person or for the protection of others; and
   (c) cannot suitably be admitted as a voluntary patient.

This person ☐ was ☐ was not brought to me by a police officer or constable under section 28 of the Act.

Note: if above space is insufficient, continue on back of form

Signed _____ _____
physician's signature *date of signature (dd / mm / yyyy)*

_____ _____
physician's address (please print) *telephone*

Note: This medical certificate, when duly signed, is authority for anyone to apprehend the person who is the subject of this certificate and to transport the person to a designated facility for admission and detention for a 48 hour period. If a second medical certificate is completed within that period, it provides authority to detain the person for one month from the date of admission under the first certificate.

If this is a first medical certificate, it becomes invalid on the 15th day after the date upon which the physician examined the person who is the subject of the certificate unless the person has been admitted on the basis of it.

HLTH 3504 Rev. 2005/06/01 (PINK)

FORM 5
MENTAL HEALTH ACT
[Sections 8 and 31, R.S.B.C. 1996, c. 288]

CONSENT FOR TREATMENT
(INVOLUNTARY PATIENT)

Note: Complete either **A** or **B**

A. I, _____, authorize the treatment described below.
first and last name of patient (please print)

B. I, _____, authorize the treatment described below
name of director or person authorized by the director (please print)

with respect to _____ at _____.
first and last name of patient *name of designated facility (please print)*

Description of treatment/course of treatment:

_____

_____

_____

_____

_____

_____

_____

_____

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

Complete either **A** or **B**

A. If signed by patient

_____
patient's signature

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

_____
witness' signature

_____
witness' first and last name (please print)

To the best of my judgment, the above-named patient was capable of understanding the nature of the above authorization at the time it was signed.

_____, M.D.
signature of physician

B. If not signed by patient

_____
signature

_____
name of director or person authorized by the director (please print)

_____
position/title

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

The above-named patient is an involuntary patient under section 22, 28, 29, 30, or 42 of the *Mental Health Act* and to the best of my judgment is incapable of appreciating the nature of treatment and/or his or her need for it, and is therefore incapable of giving consent.

_____, M.D.
signature of physician

HLTH 3505 Rev. 2005/06/01

FORM 6
MENTAL HEALTH ACT
[Section 24, R.S.B.C. 1996, c. 288]

MEDICAL REPORT ON EXAMINATION OF INVOLUNTARY PATIENT
(RENEWAL CERTIFICATE)

I, _____ , M.D., being a physician and the
name of physician (please print)

director of, ***or*** a physician authorized by the director of, _____
name of designated facility

certify that on _____ I examined _____
dd / mm / yyyy *first and last name of patient (please print)*

who on _____ was admitted as an involuntary patient to _____.
dd / mm / yyyy *name of designated facility*

On the basis of my examination, and having taken into consideration the requirements of section 24 (2.1)* of the *Mental Health Act*, I have formed the opinion that: (1) sections 22 (3) (a) (ii) and (c)** of the Act continue to describe the condition of the patient; and (2) that this patient's status as an involuntary patient should be renewed.

The patient's status as an involuntary patient is renewed for a period of up to _____.
number of month(s)

The patient must be examined again on or before _____ , the date on which this renewal
dd / mm / yyyy

expires. The reasons that lead me to form the above opinion are:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Note: if above space is insufficient, continue on back of form

_____ _____
signature of physician *dd / mm / yyyy*

Notes:

* Section 24 (2.1) requires that the physician's examination must include:

(a) consideration of all reasonably available evidence concerning the patient's history of mental disorder including (i) hospitalization for treatment, and (ii) compliance with treatment plans following hospitalization, and

(b) an assessment of whether there is significant risk that the patient, if discharged, will as a result of mental disorder fail to follow the treatment plan the director or physician considers necessary to minimize the possibility that the patient will again be detained under section 22.

** *Section 22 (3) of the Act states the following involuntary admission criteria:*
The patient is a person with a mental disorder who (i) requires treatment in or through a designated facility, (ii) requires care, supervision and control in or through a designated facility to prevent the patient's substantial mental or physical deterioration or for the protection of the patient or the protection of others, and (iii) cannot suitably be admitted as a voluntary patient.

HLTH 3506 Rev. 2005/06/01

FORM 13
MENTAL HEALTH ACT
[Section 34, R.S.B.C. 1996, c. 288]

NOTIFICATION TO INVOLUNTARY PATIENT OF RIGHTS UNDER THE *MENTAL HEALTH ACT*

The information in **bold** type must be read to the patient.

I am here to tell you about your legal rights under the *Mental Health Act* as an involuntary patient. I will read you a summary of these rights. You may ask me questions at any time. I will give you a copy of this form, which contains information for you to read.

You have the right:

1. **to know the name and location of this facility. It is** _____
   name of facility

   at _____
   location

2. **to know the reason why you are here. You have been admitted under the *Mental Health Act*, against your wishes, because a medical doctor is of the opinion that you meet the conditions required by the *Mental Health Act* for involuntary admission. (see *Reasons for Involuntary Admission*)**
3. **to contact a lawyer. (see *Contacting a Lawyer*)**
4. **to be examined regularly by a medical doctor to see if you still need to be an involuntary patient. (see *Renewal Certificates*)**
5. **to apply to the Review Panel for a hearing to decide if you should be discharged. (see *Review Panel*)**
6. **to apply to the court to ask a judge if your medical certificates are in order. A lawyer is normally required. (see *Judicial Review (Habeas Corpus)*)**
7. **to appeal to the court your medical doctor's decision to keep you in the facility. A lawyer is normally required. (see *Appeal to the Court*)**
8. **to request a second medical opinion on the appropriateness of your medical treatment. (see *Second Medical Opinion*)**

_____
name of patient (please print)

_____
patient's signature

_____
date signed (dd / mm / yyyy)

_____
name of person who provided information

Give the patient a blank copy and file the named copy in the chart

HLTH 3513 Rev. 2005/06/01

PAGE 1 OF 2

MORE INFORMATION

REASONS FOR INVOLUNTARY ADMISSION

A medical doctor signed a medical certificate for your involuntary admission because the doctor is of the opinion that

(a) you are a person with a mental disorder that seriously impairs your ability to react appropriately to your environment or associate with other people,

(b) you require psychiatric treatment in or through a designated facility,

(c) you should be in a designated facility to prevent your substantial mental or physical deterioration or to protect yourself or other people, and

(d) you cannot be suitably admitted as a voluntary patient.

The reasons why the medical doctor thinks you should be here are written on the medical certificate. You may have a copy of the medical certificate unless the hospital believes that this information will cause serious harm to you or cause harm to others.

As an involuntary patient, you do not have a choice about staying here. The staff may give you medication or other treatment for your mental disorder even if you do not want to take it.

CONTACTING A LAWYER

You may contact any lawyer or advocate you choose at any time.

RENEWAL CERTIFICATES

If a second medical certificate is completed within 48 hours of your admission, you may be required to stay in hospital for up to one month depending on your response to treatment. Before the end of the month a medical doctor must examine you and your involuntary certificate may be renewed, if necessary, for up to another month. After this, the certificates must be renewed at the end of three months and then every six months. *Every time a new certificate is filled out, you have the right to ask for a hearing by a review panel.*

REVIEW PANEL

You or someone on your behalf may apply to the review panel by filling in a Form 7, Application for Review Panel Hearing. This form is available in the nursing unit. The review panel must decide within 14 days to continue your hospitalization or discharge you. There is no cost. Information about how a reveiw panel works can be provided by your nurse or you can contact the Mental Health Law Program directly at (604) 685-3425 or toll free at 1-888-685-6222.

JUDICIAL REVIEW (HABEAS CORPUS)

You may ask the court to look at the documents used in your involuntary admission to see whether you should be kept in this facility. You will need a lawyer to assist you and there may be a cost.

APPEAL TO THE COURT

Your may ask the Supreme Court of British Columbia to decide whether you must continue to be an involuntary patient. You will need a lawyer to assist you and there may be a cost.

SECOND MEDICAL OPINION

At any time after the second medical certificate is completed, you, or a person on your behalf, may request a second medical opinion about the appropriateness of your medical treatment. The second opinion is NOT about about whether you should continue to be an involuntary patient. You may ask to be seen by a medical doctor of your choice or ask the director to pick a medical doctor. There may be a cost to you depending on the distance the doctor has to travel. *When the director receives the second opinion, the director does not have to change the treatment; it is only an opinion.*

HLTH 3513 Rev. 2005/06/01

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 a 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 Guardian and 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. 2005/06/01

FORM 16
MENTAL HEALTH ACT
[Section 34.2, R.S.B.C. 1996, c. 288]

NOTIFICATION TO NEAR RELATIVE
(ADMISSION OF INVOLUNTARY PATIENT OR PATIENT UNDER AGE 16)

This is to notify

_____,
name of near relative (please print)

_____,
address and phone number (please print)

being a near relative of _____ that on _____
name of patient (please print) *date (dd / mm / yyyy)*

the above patient was admitted and is being detained as ☐ an involuntary patient ***or as*** ☐ a patient under age 16
(tick off the statement which applies)

in _____, _____.
name of designated facility *address of designated facility*

RIGHTS INFORMATION

1. Duration of involuntary patient status

A patient who is an involuntary patient as a result of the completion of two medical certificates, under section 22 of the Act, may be detained for one month from the date of admission. If not already discharged, the patient must be discharged at the end of that month unless the authority for the patient's detention is renewed in accordance with section 24 of the Act.

2. Renewal certificate

An involuntary patient who has not been discharged has the right to be examined by a physician before the patient's medical certificate or renewal certificate expires, to determine whether the patient should be discharged. If the patient does not meet the criteria for continued treatment as an involuntary patient, the patient must be discharged or have his/her status changed to that of voluntary patient. If the physician determines that the patient continues to meet the criteria for involuntary admission, the physician must complete Form 6, Medical Report on Examination of Involuntary Patient (Renewal Certificate).

Section 24 of the Act provides that medical certificates may be renewed as follows:

- from the end of the first month, for 1 further month;
- for a further 3-month period following the end of the second month;
- from the end of this 3-month period, for a period of 6 months; or
- for further successive periods of 6 months.

In the case of a patient under age 16 admitted at the request of a parent or guardian under the Act, the same requirements for a medical examination and the same time periods apply. The physician must complete Form 3, Medical Report (Examination of a Person Under 16 Years of Age, Admitted at Request of Parent or Guardian) (Renewal Certificate).

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3. Review panel application by or on behalf of an involuntary patient

An involuntary patient, or a person acting on the patient's behalf, has the right, under section 25 of the Act, to request a review of the patient's detention. This must be done on Form 7, Application for Review Panel Hearing. The review panel office's address is listed at the end of this form.

If an application has been made for a review panel hearing, the patient and a near relative will be informed of the time and date of the hearing. The patient may name which near relative is to be notified. The near relative has the right to participate in the review process.

4. Review panel application by or on behalf of a patient under age 16

A patient under 16 years of age who was admitted to a designated facility by a parent or guardian, who asks to be discharged and whose request for discharge is not supported by the patient's parent or guardian, has the right under section 21 of the Act to request a review by a review panel. A person acting on the patient's behalf may also make the application.

If an application has been made for a review panel hearing, the patient and a near relative will be informed of the time and date of the hearing. The near relative has the right to participate in the review process.

5. Right to apply to the Supreme Court of British Columbia

The patient or someone acting on the patient's behalf may have the validity of the patient's admission and detention determined by way of an application (in the nature of *habeas corpus*) to the court under the *Judicial Review Procedure Act*. The patient or someone acting on the patient's behalf may also apply to the court under section 33 of the Act, to determine whether there is sufficient reason and authority for the medical certificate. Legal advice concerning these matters may be obtained from independent counsel or through the Legal Services Society or the Community Legal Services Society (CLAS).

The phone number of the local Legal Services Society office is _____.

The phone number for CLAS is _____.

6. Second medical opinion

Under section 31 of the Act, the patient, or a person acting on the patient's behalf, has the right to request a second medical opinion on the appropriateness of the patient's treatment. This must be done using Form 11, Request for Second Medical Opinion.

The right to request a second medical opinion does not apply to a patient under age 16 admitted at the request of a parent or guardian.

NOTE: If you are in agreement with the hospitalization of the above patient, you need not take any further action.

_____ *director's (or delegate's) signature*

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

_____ *director (or delegate) (please print)*

Mental Health Review Board
302 - 960 Quayside Drive
New Westminster BC V3M 6G2
Tel: 604 660-2325
Fax: 604 660-2403

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