British Columbia

MENTAL HEALTH REVIEW BOARD

Effective Date: 2020/01/31 (Amended 2024/01/02 - amendment in underline)

Title: Practice Direction – Case Note

This Practice Direction describes the procedures that must be followed by a facility preparing a case note to ensure a fair and timely hearing. Patients must know the evidence that will be presented at the hearing and have an opportunity to fairly challenge that evidence.

Guiding Principles:

The Mental Health Review Board [Board] honours the obligations and is guided by the principles contained in the *United Nations Convention on the Rights of Persons with Disabilities* and the values contained in the *Charter of Rights and Freedoms*.

Summary:

A case note is a written summary of the evidence a facility intends to present at a review panel hearing. During a hearing, the facility provides evidence to support the position that the patient continues to meet all of the criteria for involuntary detention under the *Mental Health Act* [*Act*].

The case note can contain observed facts and medical opinions. Medical opinions are inferences from the observed facts. Only medical experts are allowed to give medical opinion evidence. That is why the physician who authored the case note should present the evidence at the hearing. Review panels make decisions based on what evidence is presented at the hearing.

Direction:

Treating physician must provide a case note

The facility must ensure that the treating physician provides a case note before every review panel hearing. Additional members of a mental health team may provide a written summary of their evidence to supplement the physician's case note.

Case notes must address the four criteria set out in sections 22(3)(a)(ii) & (c) of the *Act*

Case notes to the review panel should provide a summary of relevant information to allow the panel to decide whether the patient continues to meet all four criteria for continued detention under the *Act*. There are four issues that must be decided at a review panel hearing:

1. Is the patient suffering from a disorder of the mind that requires psychiatric treatment and seriously impairs their ability to react appropriately to their environment or to associate with others?
2. Does the patient require psychiatric treatment in or through a designated facility?
3. Does the patient require care, supervision and control in or through a designated facility to prevent their substantial mental or physical deterioration or for their own protection or the

protection of others?
4. Can the patient not be suitably admitted as a voluntary patient?

At minimum, a case note must include the following information:

(a) the patient's current diagnosis;
(b) the patient's current treatment plan, including medications;
(c) a history of the patient's illness and hospitalizations;
(d) the patient's current level of functioning;
(e) present living situation, daily activities, family and other supports, and
(f) any other relevant information in support of each of the four criteria for continued detention and treatment. Please include a clear explanation of why the person cannot be admitted as a voluntary patient.

Acceptable forms of a case note

Where case notes were prepared for previous hearings, it is acceptable for the treating physician to update those notes with any changes or new information.

A psychiatric assessment, clinical consultation or discharge report may be submitted in place of a case note where the report addresses the four criteria and has been completed recently, or where it is provided with a case note that updates any new information since the report was completed.

Information referred to or relied on in a case note must be disclosed before the hearing

What to disclose to patients or their representatives

Facilities have a duty to disclose all relevant records in their possession and control to the patient or their representative before the hearing. Document disclosure is an ongoing obligation.

If a case note relies on or refers to specific documents or information, the facility must disclose this to the patient or their representative before the hearing.

Case notes should not, without reasonable explanation, contain any new information that has not been disclosed. More information about a facility's disclosure obligations can be found in Practice Direction: Disclosure.

What to disclose to the review panel

The facility must disclose the case note to the review panel. If the case presenter relies on any other documents as evidence during the hearing, those documents must be disclosed to the review panel as well. These documents will be marked as exhibits during the hearing.

Case notes must be disclosed before the hearing

The case note must be disclosed to the patient or their representative as early as possible and no later than 24 hours (excluding weekends and statutory holidays) before the start of the hearing. In exceptional circumstances – for example, in remote communities with limited access to physicians or in cases of last-minute patient transfers – the case note may be disclosed no later than 30 minutes before the start of the hearing. The case note must be disclosed to the panel before the start of the hearing.

When all or part of a hearing proceeds by electronic means, the facility must make every effort to disclose a copy of the case note to the Mental Health Review Board [Board] and any participant no later than 24 hours (excluding weekends and statutory holidays) before the scheduled hearing.

Failure to comply with case note requirement

A case note is a required document under the Board's *Rules of Practice and Procedure*. A facility that has not complied with this rule must be prepared to provide a reasonable explanation for the failure to comply, and the case presenter may not introduce the document as evidence at the hearing without permission of the panel. The review panel has the discretion to proceed with the hearing in the absence of a case note.

Diana Juricevic
Chair, Mental Health Review Board