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Interim Treatment Orders: Facilitating Treatment Pending Final Disposition of Treatment Capacity Appeals

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In *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, the Mental Health Commission of Canada has stated: "In any given year, one in five people in Canada experiences a mental health problem or illness, with a cost to the economy of well in excess of $50 billion".[1]

It is well established that the costs of mental illness are reflected not only in the lost productivity of the affected person but also in its impact on families, communities, and the health care system. Of the $50 billion total cited above, it is estimated that about $21.3 billion are direct costs to the health care system, including hospitalizations, physician visits, medication, and allied health professional and support staff.[2] One area affecting health care costs is the extended time spent in hospital by persons suffering from untreated mental illness while disputes related to the person's capacity to consent to treatment are pending before Ontario's Consent and Capacity Board ("CCB") and subsequently before the courts if a CCB decision is appealed.

In this article, the legal framework for determining a patient's capacity to consent to treatment and the manner in which that framework may affect the ability to commence treatment are explored, with consideration given to the perhaps underutilized provisions for obtaining a court order to initiate treatment pending the outcome of a treatment capacity appeal.

Ontario's Framework for Capacity to Consent to Treatment

The legal framework governing consent to treatment in Ontario is set out in the *Health Care Consent Act, 1996* [*HCCA*].[3] A health care provider is entitled to rely on the presumption that a person is capable of consenting to, or refusing, treatment unless there are reasonable grounds to believe that the person is incapable with respect to the proposed treatment.[4] In deciding whether a person is capable with respect to a specific treatment, the health care provider proposing the treatment must consider two things:

- Whether "the person is able to understand the information that is relevant to making a decision about the treatment", and

- Whether the person is "able to appreciate the reasonably foreseeable consequences of a decision or lack of decision".[5]

When a health care provider has found a patient who is admitted to a psychiatric facility for treatment of a mental disorder, incapable with respect to treatment decisions, Ontario's *Mental Health Act*[6] regulations require the attending physician to give the patient written notice of the incapacity finding and to ensure that a rights advisor has been notified of the finding.[7] Subsequent to the notice, a rights advisor must meet with the patient to explain the significance of the finding of incapacity and also the patient's right to apply to the CCB for a review of the finding.[8]

A finding of incapacity is made in relation to specific proposed treatment. The *HCCA* clearly states that treatment must not begin if the health care practitioner who has found the person incapable with respect to treatment learns that the patient intends to apply, or has applied, to the CCB for a review of the finding.[9] Even where the CCB confirms the finding of incapacity, treatment must not begin if the health care practitioner learns that the patient intends to appeal the decision. Further, treatment must not begin until the period for commencing the appeal has elapsed without an appeal being commenced, or if the appeal is started, until the appeal of the CCB's decision has been "finally disposed of".[10] An appeal is considered finally disposed of either when an appellate decision is rendered with no further routes of appeal being pursued or when all appeal routes have been exhausted. An appeal of a CCB decision is taken to the Superior Court of Justice, from which that court's decision may be appealed to the Court of Appeal and then to the Supreme Court of Canada. If an appeal is taken through all levels of court to the Supreme Court of Canada, years could elapse before an appeal is "finally disposed of".

While the *HCCA* requires CCB hearings to be convened within seven days of receipt of the application,[11] and appeals to be heard on the "earliest date compatible with its just disposition",[12] delays can arise on consent of the parties where scheduling difficulties are encountered or adjournments granted to deal with evidentiary and other issues. For appeals to the courts, delay in scheduling the hearing of the appeal may arise if an unrepresented patient is unable to take steps to "perfect" the appeal so that it is ready, from the court's perspective, to be scheduled.

Procedurally, perfecting an appeal requires certain steps. Upon receipt of a Notice of Appeal, the CCB is responsible for serving the parties (usually the patient and the physician who made the finding of incapacity) with the record of the appeal: a transcript of the CCB hearing and various documents, including the CCB's decision and Reasons for Decision, and any documents that were filed as exhibits at the hearing.[13]

The *HCCA* requires that (1) the appellant's *factum*, containing the facts on which the appellant relies and his or her legal argument as to why the appeal should be allowed, must be served on the other parties and filed with the court within 14 days of having been served with the transcript and appeal record, and (2) the respondent's (usually the physician) *factum* must be served and filed with the court 14 days after receipt of the appellant's *factum*, although there may be some relief granted from these timelines.[14] Many patient appellants are unrepresented by legal counsel, at least initially, and are not in a position, due to their illness and lack of legal training, to perfect an appeal by preparing a written *factum*.

In our experience, courts are increasingly sensitive to this issue and have taken steps to expedite the hearing of the appeal, including facilitating the appointment of legal counsel for the appellant patient. However, for the reasons set out above, it can still

take several months, and sometimes years, until an appeal is "finally disposed of".

Delays in Initiating Psychiatric Treatment Associated with Legal Review

In a 2002 study, researchers identified extensive delays in initiating psychiatric treatment for a significant number of patients at two Ontario psychiatric hospitals, whose capacity to consent to treatment was the subject of legal review.[15] Applications to the CCB and appeals of CCB decisions to the courts from 1990 to 1999 were considered. The researchers concluded that there were "serious clinical risks and substantial costs associated with delay in treating patients with acute psychiatric illness".[16]

Delays associated with applications to the CCB only, with no appeal to a court, ranged from 3 to 277 days, with an average 25-day delay.[17] Where the patient appealed to a court, the delay in starting treatment ranged from 55 to 721 days (almost two years), with an average of 253 days or almost seven months.[18]

The researchers in the 2002 Kelly *et al.* study opined that delay in initiating psychiatric treatment was linked to several significant deleterious effects:

- prolonged individual suffering of serious symptoms of acute major mental illness, such as auditory and visual hallucinations, paranoia, and delusions
- increased self-destructive behaviour
- increased assaultive behaviours by the patient
- increased use of seclusion and restraint to manage untreated symptoms
- poorer long-term prognosis associated with delays in initiating treatment
- deterioration of the therapeutic alliance
- creation of a non-therapeutic ward milieu
- demoralization and ethical dilemmas for health professionals
- the blocking of inpatient beds
- redirection of limited clinical resources to non-therapeutic activities
- paradoxically, the deprivation of liberty that results from withholding the treatment necessary to effect release from involuntary detention.[19]

As noted above, the Kelly *et al.* 2002 study looked at applications for review of incapacity findings from 1990 to 1999 in two Ontario psychiatric hospitals. In 2008, a similar study by Robert Solomon *et al.* looked at all Ontario psychiatric facilities to determine the total number of cases between 1990 and 2005, in which the courts overturned a finding of treatment incapacity or were required to address related issues.[20] This study also found that that the delays associated with appeals of capacity-related issues result in significant delays, "leaving untreated psychiatric patients to deteriorate in hospital", and identified similar serious harms for the untreated patients.[21]

There doesn't appear to be a more recent study following 2008; however, anecdotal evidence gleaned from discussions with psychiatrists practising in specialty psychiatric hospitals and Schedule 1 acute care facilities suggest that the significant clinical concerns expressed in the Kelly and Solomon studies have not diminished. In circumstances where acutely ill patients will substantially benefit from treatment pending the outcome of the appeal, the *HCCA* provides a mechanism to apply to court for an order authorizing treatment if certain criteria are met.

Criteria for a Court Order Authorizing Treatment Pending Resolution of a Capacity Appeal

While s. 18 of the *HCCA* prohibits the initiation of treatment pending the outcome of an appeal, s. 19

of the *HCCA* provides that treatment can be administered before the appeal is resolved, but only if the court to which the appeal is taken makes such an order, having been satisfied that certain criteria are met and the person's substitute decision has consented to the treatment.[22] Section 19(2) of the *HCCA* gives the court authority to make an order permitting treatment, provided the court is satisfied:

> (a) that,
>
> (i) the treatment will or is likely to improve substantially the condition of the person to whom it is to be administered, and the person's condition will not or is not likely to improve without treatment, or
>
> (ii) the person's condition will or is likely to deteriorate substantially, or to deteriorate rapidly, without the treatment, and the treatment will or is likely to prevent the deterioration or to reduce substantially its extent or its rate;
>
> (b) that the benefit the person is expected to obtain from the treatment outweighs the risk of harm to him or her;
>
> (c) that the treatment is the least restrictive and least intrusive treatment that meets the requirements of clauses (a) and (b); and
>
> (d) that the person's condition makes it necessary to administer the treatment before the final disposition of the appeal.[23]

There are very few reported decisions where the court has considered motions brought pursuant to s. 19. In part, this may be due to motions for interim treatment orders resulting in brief, handwritten endorsements indicating that the evidence supports or does not support the issuance of such an order. It may be that psychiatric facilities and treatment providers are reluctant to incur the legal costs that are required to apply to a court for intervention under s. 19(2). Finally, it may reflect the influence of a 2001 decision, *Gunn v. Koczerginski* [*Gunn*],[24] in which an interim treatment order application was denied on the grounds that the evidence before the court did not satisfy two of the four requirements for an interim order. First, the Superior Court in *Gunn* was not satisfied that the proposed treatment would substantially improve the patient's condition prior to the appeal, and second, it was not satisfied that the patient's condition made it necessary to impose the treatment before the disposition of the appeal.[25] In the court's view, the affidavit evidence of the attending physician suggested that earlier-rather-than-later treatment "may" be preferable in that the patient "may become more difficult to treat if not treated as soon as possible".[26] The court characterized this statement as too general and applicable to almost all psychiatric patients.

Finally, the court also considered the patient's wish not to take the prescribed medication in the context of the statutory test requiring that treatment be "necessary":

> Forcible treatment against [the patient's] will is a serious infringement of his right to self-determination, physical integrity, liberty and security of the person. It should only be undertaken if truly necessary and, even then, only with proper consideration and respect for these important personal rights [emphasis added].[27]

Subsequent reported decisions on motions for interim treatment orders often cite the *Gunn v. Koczerginski* decision and the need to find such an order "truly necessary" in the circumstances of the case at hand. Nonetheless, more recently, courts have allowed physicians' motions for interim treatment orders. In six out of seven reported decisions between 2009 and 2013, the court granted the attending physician's motion and issued interim treatment orders in whole or in part. In one case, the court found that the first three "clinical" criteria had been met, but did not allow the motion on the basis that the fourth criterion dealing with the necessity of the order had not been met. In that case, *L-S v. Menchions*, the judge assumed that the final disposition of the patient's appeal would take place approximately five weeks from when the motion was heard. The court concluded that even if the judge hearing the appeal reserved his/her decision, in all likelihood, the final decision would be rendered within two months.[28] The court did not expressly anticipate the possibility of further appeals.

In the other six cases, the court allowed the motion and issued an interim treatment order.[29] In all cases, the attending physicians submitted affidavit evidence in support of the motion, which the court found persuasive in demonstrating that the criteria for issuing an order had been met. The court considered the evidence in light of the criteria set out in s. 19(2). Examples of the accepted evidence on each criterion are as follows:

(a)(i) The treatment will or is likely to improve substantially the condition of the person to whom it is to be administered, and the person's condition will not or is not likely to improve without treatment.

- evidence that the patient has responded well to the proposed treatment in the past, including evidence of how the patient has functioned in the community when treated in the past, the likelihood that he or she would respond well if treated now, and whether the improvement will likely occur relatively quickly[30]

(ii) The person's condition will or is likely to deteriorate substantially, or to deteriorate rapidly, without the treatment, and the treatment will or is likely to prevent the deterioration or to reduce substantially its extent or its rate.

- evidence of the course of the patient's deterioration in the absence of medication, including, depending on the particular case, evidence of increased suicidality; increased aggressiveness towards others; increased need for higher levels of observation, seclusion, restraint, or placement in an intensive care unit; adverse or notable incidents involving assaultive or self-harming behaviours or damage to property[31]
- evidence that the patient's condition has progressively deteriorated without treatment, including evidence describing the patient's floridly psychotic symptoms and their impact on the patient, including as the case may be, evidence of extreme psychological stress, affective lability, volatility, intrusive behaviour, pressured speech, disorganized thinking, perceptual disturbances, delusions, significant psychosocial dysfunction, loss of independence, and cognitive dysfunction and delay in the patient's ability to be discharged from hospital[32]

(b) The benefit the person is expected to obtain from the treatment outweighs the risk of harm to him or her.

- evidence of how the improvement in the patient's condition once treatment is commenced will benefit the patient as compared to his or her untreated condition, including evidence, depending on the particular case, of amelioration of the patient's active symptoms of his or her illness, improvement in interpersonal relationships or self-care, increased likelihood of off-ward privileges on hospital grounds and in the community, or moving forward in the Ontario Review Board system (if a forensic patient), or a more timely discharge and reintegration into the community once treated[33]
- evidence of any harm related to the proposed treatment, such as side effects from the treatment, either anticipated or as experienced by the patient in the past if he or she has been on the same medication before[34]

(c) The treatment is the least restrictive and least intrusive treatment that meets the requirements of clauses (a) and (b).

- evidence that (1) the proposed treatment is the most appropriate treatment and there is no less restrictive or less intrusive treatment and that (2) without the proposed treatment, it is likely that more restrictive measures

will be required, such as physical and chemical restraints and seclusion[35]

(d) The person's condition makes it necessary to administer the treatment before the final disposition of the appeal.

- evidence that the patient's condition is such that the need for treatment is immediate and that the risks associated with lack of treatment cannot be addressed through emergency measures or otherwise wait for the disposition of the appeal[36]
- evidence may include the need to address an increased risk of suicidality or imminent threats to the physical health of the patient, such as refusal to eat due to psychotic paranoia[37]

A motion for an interim treatment order should be supported by affidavit evidence of the patient's attending psychiatrist. The list above includes evidence that was accepted by the court in the reported decisions we have reviewed. That evidence derives entirely from the particular facts of each case. Our review of the evidence should not be considered prescriptive; rather, it simply provides examples of evidence used in these cases.

The affidavit evidence in any particular case should be based on the clinical evidence of the patient in respect of whom the motion is being brought. It may be appropriate for the affidavit to attach exhibits, such as the Clinical Summary prepared for the patient's CCB hearing, the decision of which is under appeal, or excerpts from clinical notes relating to the patient that demonstrate the clinical condition of the patient. The attending physician's affidavit should also address whether the patient's substitute decision maker has consented to the proposed treatment, as substitute consent is a prerequisite for a s. 19 interim treatment order.

Conclusion

While the body of reported decisions on interim treatment orders is relatively small, the decisions are nonetheless instructive for assessing which cases are most likely to meet the statutory test for an interim treatment order. In our view, it is likely that applications for such orders will increase in the future, following the recent Court of Appeal decision, *P.S. v. Ontario*, which held that the provisions of the *Mental Health Act* dealing with involuntary committals of longer than six months violate s. 7 of the *Canadian Charter of Rights and Freedoms*[38] "by allowing for indeterminate detention without adequate procedural protections of the liberty interests of long-term patients".[39] As a remedy, the court set an upper limit of six months on involuntary admissions under the *Mental Health Act*, in part because the court found the powers of the Consent and Capacity Board procedurally inadequate to address the conditions of detention for long-term involuntary patients.[40] The court has suspended its ruling for one year in order to give the provincial legislature time to consider the decision and amend the legislation.

A full discussion of the implications of *P.S. v. Ontario* is beyond the scope of this article. However, if the Ontario government were to amend the *Mental Health Act* to limit involuntary admissions to six months, it would only increase the pressure to promptly resolve disputes about treatment capacity. Where appeals cannot be scheduled expeditiously, health care professionals involved in these matters may need to resort to motions for interim treatment orders with greater frequency in order to prepare for an earlier possible discharge.

In conclusion, it is appropriate to note again the oft-cited words of Justice Molloy in *Gunn v. Koczerginski*:

> Forcible treatment against [the patient's] will is a serious infringement of his right to self-determination, physical integrity, liberty and security of the person. It should only be undertaken if truly necessary and, even then, only with proper

> consideration and respect for these important personal rights.[41]

Justice Molloy's comments resonate with one of the purposes of the *HCCA*, that is, to "enhance the autonomy of persons for whom treatment is proposed … by allowing those who have been found to be incapable to apply to a tribunal for a review of the finding".[42] However, another expressly stated and equally important purpose is "to facilitate treatment … for persons lacking the capacity to make decisions" about treatment.[43] The criteria set out in s. 19 of the *HCCA*, which a court must apply before granting an interim treatment order, ensure that treatment may be initiated in what amounts to exigent clinical circumstances before treatment capacity is finally determined by appellate courts.

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2 Smetanin, ibid., 9–10.

3 *HCCA*, S.O. 1996, c. 2, Sched. A.

4 *Ibid.*, subs. 4(2) and (3).

5 *Ibid.*, s. 4(1).

6 R.S.O. 1990, c. M.7.

7 *General Regulation*, R.R.O.1990, Reg. 741, s. 15.

8 *Ibid.*, subs. 14(2).

9 *HCCA*, *supra* note 3, subs. 18(1).

10 *Ibid*., subs. 18(3).

11 *Ibid*., subs. 75(2).

12 *Ibid*., subs. 80(8).

13 *Ibid*., subs. 80(4).

14 *Ibid*., subs. 80(5), (6), and (7).

15 M. Kelly *et al*, "Treatment Delays for Involuntary Psychiatric Patients Associated with Reviews of Treatment Capacity", Can. J. Psychiatry 47 (2002): 181–185, p. 181 (hereinafter, the "Kelly *et al.* 2002 study").

16 *Ibid*., p. 181.

17 *Ibid*., p. 183.

18 *Ibid*., p. 184.

19 *Ibid*., p. 182.

20 R. Solomon *et al*, "Treatment Delayed – Liberty Denied", The Canadian Bar Review 87: 679–719 at p. 690 (hereinafter "Solomon *et al*.").

21 *Ibid*., p. 714.

22 *HCCA*, *supra* note 3, s. 19(1).

23 *Ibid.*, s. 19(2).

24 [2001] O.J. No. 4479, [2001] O.T.C. 839 (Ont. S.C.J.).

25 *Ibid.*, para. 7.

26 *Ibid*., para 12.

27 *Ibid.,* para. 8.

28 *L-S v. Menchions*, [2012] O.J. No. 2143, 2012 ONSC 2061, para. 13.

29 *S.R. v. Hutchinson*, [2009] O.J. No. 516, 177 A.C.W.S. (3d) 499 (Ont. S.C.) [*Hutchinson*]; *J.L. v. Howell*, [2012] O.J. No. 3597, 2012 ONSC 3415 [*Howell*]; *L.H. v. Hastings*, [2013] O.J. No. 2137, 2013 ONSC 2363 (Ont. S.C.) [*Hastings*]; *J.W. v. Baici,* [2013] O.J. No 6273, 2013 ONSC 4397 [*Baici*]; *K.B. v. Woodside* [2013] O.J. No 2879, 2013 ONSC 4041 [*Woodside*]; *A.H. v. Papatheodorou*, [2013] O.J. No. 5531, 2013 ONSC 7514 [*Papatheodorou*].

30 *Hutchinson*, *ibid.*, para 18; *Howell*, *ibid.*, para. 27; *Hastings*, *ibid.*, paras. 9–10, 30; *Woodside*, *ibid.*, paras 4–5; *Baici*, *ibid.*, paras. 8 and 10; *Papatheodorou*, *ibid.*, para. 9.

31 *Hutchinson*, *ibid.*, para. 20; *Howell*, *ibid*., para. 21; *Woodside*, *ibid*., at paras. 5, 7, and 12; *Baici*, *ibid.*, paras. 5 and 8; *Papatheodorou*, *ibid.*, paras. 11–13.

32 *Howell*, *ibid.*, paras. 22–26; *Hastings*, *ibid.*, paras. 15–21; *Baici*, *ibid.*, paras 11–12; *Papatheodorou*, *ibid.*, paras. 11–13.

33 *Howell*, *ibid.*, paras. 26–27; *Baici*, *ibid.*, paras. 8, 10, 13.

[34] *Hutchinson*, *ibid.*, paras. 22–23; *Hastings*, *ibid.*, para. 31; *Baici*, *ibid.*, para. 8.
[35] *Hutchinson*, *ibid.*, para. 26; *Hastings*, *ibid.*, para. 32; *Papatheodorou*, *ibid.*, paras. 17 and 20.
[36] *Hutchinson*, *ibid.*, para. 30.
[37] *Hastings*, *ibid.*, para. 33.
[38] *The Constitution Act, 1982*, Schedule B to the *Canada Act 1982 (UK)*, 1982, c. 11.
[39] *P.S. v. Ontario*, [2014] O.J. No. 6151, 2014 ONCA 900, para. 3.
[40]. *Ibid*., para. 202.
[41] *Supra* note 24, para. 8.
[42] *HCCA*, s*upra* note 3, s. 1.
[43] *Ibid.*

The Capacity to Consent to Treatment in Youth: A Retrospective Lens

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Evaluating a youth patient's capacity to consent to treatment often proves challenging for health care practitioners. Over the years, and in the course of my work as a child psychiatrist in hospitals, I have often been asked to help practitioners understand and assess this capacity of their young patients. In addition, as a psychiatrist member of the Consent and Capacity Board of Ontario ("CCB"), I have had the opportunity to observe the issues that have arisen for youth, their families, and the health care team in providing treatment in the context of the *Health Care Consent Act, 1996* [*HCCA*].[1]

The *HCCA* presumes that anyone of any age has the capacity to consent to treatment.[2] According to the *HCCA*, "capacity" is the ability to

- understand the information that is relevant to making a decision about treatment; and
- appreciate the reasonably foreseeable consequences of a decision or lack of decision.[3]

In addition, the *HCCA* prescribes a comprehensive process for navigating issues of capacity. Some practitioners assume there is a magic age for capacity before which it is assumed that a young patient is not "mature" enough to consent to treatment. However, maturity and capacity are not synonymous terms. Because adolescents reach social, emotional, and cognitive maturity at different rates, chronological age does not necessarily indicate maturity or capacity. It *may* be the case that a mature youth is also a capable youth but that is not always a given.

In 2010, I co-authored a paper aimed at establishing guidelines to assist practitioners in the clinical assessment of capacity to consent to treatment.[4] Unlike that paper, this article will focus on my own perspective on some of the key issues relating to capacity as well as issues that medical and related practitioners continue to face in this aspect of clinical work. These are my personal views on what has worked well and what has brought fresh challenges.

Supporting Autonomy in Young Patients

Over the years, one of the key themes for me has been how the *HCCA* and its processes can foster autonomy in youth patients, and how, as I will illustrate in the first of the vignettes that follow, the exercise of that autonomy can impact clinical outcomes.

By presuming capacity, the intention of the *HCCA* was to entrust the capable person, including the capable adolescent, with the legal right to make decisions about his or her treatment. It was believed that a capable adolescent who consented to treatment