2014 CarswellOnt 18804
Ontario Consent & Capacity Board

D. (L.), Re

2014 CarswellOnt 18804

In the Matter of The Mental Health Act R.S.O., 1990, c. M.7

In the Matter of the Health Care Consent Act S.O. 1996, chapter 2, schedule A, as amended

In the Matter of LD A patient at Trillium Health Partners Mississauga Site Mississauga, Ontario

C.A. Sylvester Presiding Member, J. Pellettier Member, J. Cutaia- Beales Member

Heard: November 17, 2014
Judgment: November 18, 2014
Docket: 14-3266-01, 14-3266-02

Counsel: MS, for herself
Ms A. Sultan, for Dr. Shafro
Mr. Siegel — amicus curiae

Subject: Public

Related Abridgment Classifications

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For all relevant Canadian Abridgment Classifications refer to highest level of case via History.

Headnote

Health law --- Consent and capacity — Involuntary status — Review of involuntary status

Health law --- Consent and capacity — Capacity — To consent to treatment

Table of Authorities

Cases considered by *C.A. Sylvester Presiding Member*:

Bartoszek v. Ontario (Consent & Capacity Board) (2002), 2002 CarswellOnt 3265 (Ont. S.C.J.) — considered

Neto v. Klukach (2004), 2004 CarswellOnt 546, [2004] O.T.C. 138, 12 Admin. L.R. (4th) 101 (Ont. S.C.J.) — followed

Starson v. Swayze (2003), 1 Admin. L.R. (4th) 1, 304 N.R. 326, 2003 CSC 32, 2003 SCC 32, 2003 CarswellOnt 2079, 2003 CarswellOnt 2080, [2003] 1 S.C.R. 722, 173 O.A.C. 210, 225 D.L.R. (4th) 385 (S.C.C.) — followed

Statutes considered:

Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A
s. 4(1) — considered

s. 4(2) — referred to

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

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Generally — referred to

s. 20(1.1) [en. 2000, c. 9, s. 7(2)] — considered

s. 20(5) — considered

s. 41(1) — considered

Regulations considered:

Mental Health Act, R.S.O. 1990, c. M.7
General, R.R.O. 1990, Reg. 741

Form 3 — referred to

Form 4 — referred to

Words and phrases considered:

”serious” bodily harm

”Serious” bodily harm means more than trifling.

likely

It should be noted that there must be a causal connection between the existence of mental disorder and the likelihood of the feared consequence. “Likely” in this context has been found to mean “probably”.

***Colleen A. Sylvester Presiding Member*:**

Purpose of the Hearing

1 LD was a patient at Trillium Health Partners - Mississauga Site, in Mississauga, Ontario. Her attending physicians had found her incapable to consent to certain treatment. The Board

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convened at LD's request to review her involuntary status and the finding of incapacity.

Dates of the Hearing, Decisions and Reasons

2 The hearing was held on November 17, 2014. The panel released its decisions on November 18, 2014. Reasons for Decisions were requested by Mr. Siegel, amicus curiae, and were released on December 4, 2014.

Legislation Considered

3 The *Mental Health Act, R.S.O. 1990* c. M.7, as amended including s. 20(5) and 39.

4 The *Health Care Consent Act, 1996* including s. 4 and 32.

Parties

5 LD, the patient

6 Dr. A. Shafro, the attending physician

Panel Members

7 Ms C. Sylvester, lawyer and presiding member

8 Dr. J. Pellettier, psychiatrist member

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9 Ms J. Cutaia-Beales, public member

Appearances

10 MS was self represented.

11 Dr. Shafro was represented by Ms A. Sultan, solicitor.

12 Mr. Siegel attended the hearing as amicus curiae.

Preliminary Matters

Self Representation

13 At the start of the Hearing, Mr. Siegel informed the Panel that LD had refused to speak with him and had walked away when he attempted to speak with her. A recess was held to allow Mr. Siegel to speak with LD and obtain instructions. After the recess, Mr. Siegel informed the Panel that LD had refused to answer his questions and informed him that she had changed her mind and no longer wanted Mr. Siegel to represent her.

14 Provided that LD had made an informed decision to represent herself, it was LD's right to be self represented before the CCB. A preliminary inquiry was held to determine if LD had made an informed decision to represent herself. The purpose of the Hearing, the procedures followed during the Hearing and consequences of the Board's decision were explained to LD. LD told the Panel that she understood. LD was informed that she had a right to be represented by a lawyer and that a lawyer could be arranged for her. LD stated that she understood.

15 The test for a finding of incapacity to make treatment decisions (Section 4 of the *Health Care Consent Act*) was read to LD. LD stated that she understood this test. Dr. Shafro indicated

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he was relying on the criteria contained in section 20(5) for LD's involuntary status. The test for involuntary status contained in section 20(5) was reviewed with LD. She stated that she understood.

16 LD then repeated that she wished to represent herself at the Hearing. She stated that she did not want a lawyer and was fully capable to represent herself. The Panel was satisfied that LD had made an informed choice to represent herself. Mr. Siegel agreed to remain at the hearing in the role of amicus curiae.

17 During Dr. Shafro's evidence, LD became very angry and left the Hearing. A recess was called to allow Mr. Siegel to explain to LD that she was welcome to return to the Hearing at any time, but that the Hearing would continue in her absence. Mr. Siegel informed the Panel that LD was emphatic that she did not wish to return to the Hearing and understood that the Hearing would continue in her absence. In his role as amicus curiae, Mr. Siegel cross examined Dr. Shafro and made submissions.

18 At the conclusion of Dr. Shafro's evidence, a recess was called to allow Mr. Siegel to speak to LD with respect to whether or not she wished to give evidence in the Hearing. After speaking with LD, Mr. Siegel informed the Panel that LD did not wish to return to the Hearing and that she had said all she had wanted to say.

Capacity to Consent to Treatment

19 The treatments at issue were antipsychotic medication, mood stabilizers and side effect medication.

Grounds for Involuntary Status

20 LD was an involuntary patient at Trillium Health Partners - Mississauga. She was detained under a Certificate of Involuntary Status (Form 3), issued on November 9, 2014. Dr. Shafro advised that he intended to rely on criteria contained in Box "A" which is s.20(5) of the

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Mental Health Act (MHA) for MS's involuntary status, namely, that she was at risk of causing serious bodily harm to another person and at risk of causing serious bodily harm to herself unless her detention continued otherwise complied with the criteria set out in s.20(5) (a) and (b) (the "Box A criteria").

The Evidence

21 The evidence at the hearing consisted of the oral testimony of Dr. Shafro together with four exhibits.

Introduction

22 LD was a 62 year old divorced woman who lived independently in her apartment and was supported by ODSP. She worked part-time delivering pamphlets for AA. LD had a history of trauma, with physical abuse caused by her father and sexual abuse.

23 LD was hospitalized from October 2, 2014 to October, 10, 2014. Coworkers called police because LD had not been to work for 3 days. Police found LD sleeping in her backyard and LD was brought to hospital by ambulance. At that time LD described being able to hear people plotting revenge against her from many blocks away and that these people were discussing killing her. She also believed that people from AA were trying to kill her as well as people behind a variety store were trying to stab her to death. LD reported that in the days prior to hospitalization she experienced a decreased need for sleep with increased energy, racing thoughts and pressured speech. LD left hospital against medical advice on October 10, 2014.

24 She was brought to hospital by police on November 8, 2014 after she had barricaded the entrance to her apartment building, claiming people were breaking into her apartment and stealing her belongings. A Form 3 Certificate of Involuntary Admission was issued on November 9, 2014. LD was found incapable to consent to treatment on November 10, 2014.

The Law

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Capacity to Consent to Treatment

25 Under the *Health Care Consent Act* (HCCA), a person is presumed to be capable to consent to treatment (s 4(2)) and the onus to establish otherwise in this case lay with Dr. Shafro. The test for capacity to consent to treatment is set forth in s. 4(1) of the HCCA, which states:

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

Involuntary Status

26 On any review of involuntary status under the *Mental Health Act*, the onus of proof at a Board hearing is always on the attending physician/health practitioner to prove the case. The standard of proof is proof on a balance of probabilities. The Board must be satisfied on the basis of cogent and compelling evidence that the physician's onus has been discharged. There is no onus whatsoever on the patient.

27 The said onus on the attending physician is to satisfy the Board that the conditions for involuntary status continue to be met at the time of the Board's hearing (s. 41(1) of the MHA). If this onus is discharged, the Board may make an Order confirming the patient's involuntary status. If the onus is not discharged, the Board is required by law to rescind the Certificate.

28 Section 20(5) of the MHA sets out what are commonly referred to as the "Box A Criteria" (because they appear in Box A of Forms 3 and 4) for involuntary detention. It states as follows: The attending physician shall complete a certificate of involuntary admission or a certificate of renewal if, after examining the patient, he or she is of the opinion both,

> (a) that the patient is suffering from mental disorder of a nature or quality that likely will result in,

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(i) serious bodily harm to the patient,

(ii) serious bodily harm to another person, or

(iii) serious physical impairment of the patient

unless the patient remains in the custody of a psychiatric facility; and

(b) That the patient is not suitable for admission or continuation as an informal or voluntary patient.

29 It should be noted that there must be a causal connection between the existence of mental disorder and the likelihood of the feared consequence. “Likely” in this context has been found to mean “probably”. “Serious” bodily harm means more than trifling.

30 A patient may be certified as involuntary either under subsection 20 (5) or under subsection 20 (1.1), or both.

Analysis

Incapacity to Consent to Treatment

Did the evidence establish that LD was unable to understand the information relevant to making a decision about the treatment in question?

31 This required the cognitive ability to process, retain and understand the relevant information. At Exhibit 2, Dr. Shafro wrote:

> I explained the diagnosis of schizoaffective disorder vs schizophrenia to [LD] on November 10, explaining the rationale (mood and psychotic symptoms as noted above), with the side effects, indications and alternatives to treatment, as well as consequences of both treatment and non-treatment. Difficult to determine whether or not [LD] would actually retain the information, as she categorically denies the indication for treatment, and wouldn’t comment on her knowledge of the medications that I communicated.

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32 In his oral evidence to the Panel, Dr. Shafro stated that LD was difficult to engage and that he did not know how much information she retained and that she may not have been listening during their discussions. Dr. Shafro stated that there was no indication that LD did not understand the information presented.

33 Dr. Shafro had the onus to show that LD did not have the ability to understand information. The evidence provided did not establish LD did not understand the relevant information. LD was deemed capable to understand the information and Dr. Shafro did not present evidence sufficient to displace this. The Panel was satisfied that MS was able to understand the information relevant to making a decision about the treatment in question.

Did the evidence establish that LD was unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision about the treatment in question?

34 The Board accepted Dr. Shafro's opinion that LD was not able to appreciate consequences of being treated or not being treated. Dr. Shafro's evidence showed that LD was not able to apply information to herself. LD did not believe that she was suffering from a mental illness or recognize that she was experiencing symptoms any condition.

35 Dr. Shafro told the Panel that the reasonably foreseeable consequences of not taking treatment would be that she would continue to suffer from paranoid delusions, auditory hallucinations and mood symptoms leading her to attempt suicide and place others in her building at risk. It was likely that her symptoms would continue to worsen without treatment, and the likelihood of harm to herself and others would also rise. Dr. Shafro stated that he met with LD daily and she was adamant that she did not require any treatment and that there would be no consequences to her without treatment.

36 LD did not believe she suffered from any delusions or hallucinations even as these were explained to her, with emphasis on the features that are physically impossible (eg that she could communicate with police on an ongoing basis without the use of a telephone, the limits of human hearing that prevented her from hearing conversations from great distances). She

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believed that others were plotting revenge against her for having them evicted from her apartment building two months ago. With LD's consent, doctors spoke with the superintendent of the apartment building who stated that there had been no evictions from the building in the past two years. Dr. Shafro stated that it was LD's psychotic symptoms that interfered with her ability to appreciate the relevant information, or accept the possibility that these were manifestations of a mental illness.

37 Dr. Shafro wrote in his Report of Consultation, dated November 10, 2014, at Exhibit 3: "When I met with her today she continued to show no insight into her illness stating, "I hear who is talking to me (not hearing voices)... [JM] is the reason I am here (a close friend of hers)... I do not hear voices. I am not paranoid schizophrenic. I won't take your pills...take your pills. You're railroading me." LD attributed her hospitalization to outside sources, and not to any manifestations of an illness, therefore she was unable to appreciate how medication could be of any benefit to her.

38 In the case of *Starson v. Swayze*, [2003] 1 S.C.R. 722 (S.C.C.) ("*Starson*"), the Supreme Court of Canada reviewed the law of capacity to consent to treatment. The issue was whether or not Professor Starson had capacity to consent to treatment of a mental disorder. Justice Major, writing for the majority, analysed capacity at paragraph 78:

> Capacity involves two criteria. First a person must be able to understand the information that is relevant to making a treatment decision. This requires the cognitive ability to process, retain and understand the relevant information. Second, a person must be able to appreciate the reasonably foreseeable consequences of a decision or lack of one. This requires the patient to be able to apply the relevant information to his or her circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof. Before turning to an analysis of the reviewing judge's decision, two important points regarding this statutory test require comment. First, a patient need not agree with the diagnosis of the attending physician in order to be able to apply the relevant information to her own circumstances. Psychiatry is not an exact science, and "capable but dissident interpretations of information" are to be expected. While a patient need not agree with a particular diagnosis, if it is demonstrated that he has a mental "condition", the patient must be able to recognize the possibility that he is affected by that condition.

39 *Neto v. Klukach*, [2004] O.J. No. 394 (Ont. S.C.J.), was a decision of the Ontario Superior Court of Justice dated February 10, 2004. In that decision, which was an appeal of a decision of

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the Board, Justice Day explained the second branch of the test for capacity (i.e. the ability to appreciate consequences) in light of *Starson* as follows:

> Chief Justice McLaughlin, in her dissenting judgment (but not dissenting on this point) quoted with approval three common indicators of a person's ability to meet the second branch of the test, set out by commentators such as B. F. Hoffman in The Law of Consent to Treatment in Ontario (2nd ed. 1997), at p. 18. One indicator is whether the person is able to acknowledge the fact that the condition for which treatment is recommended may affect him or her. A second indicator is whether the person is able to assess how the proposed treatment and alternatives, including no treatment could affect his or her quality of life. A third indicator is whether the person's choice is substantially based on a delusional belief.

40 In determining capacity, the court in Starson cautioned that capable individuals have the right to take risks and are presumed free to make decisions that are considered reasonable. The test is not whether the choice by the patient appears reasonable or wise, but whether the patient is capable, within the meaning of the statute of making the decision. The Board is not to inject its own personal values, judgments and priorities into the process. As Justice Harris stated in *Bartoszek v. Ontario (Consent & Capacity Board)*, [2002] O.J. No. 3800 (Ont. S.C.J.) at para 20, "it is mental capacity, not wisdom, that is at issue here. The appellant, Mrs. Bartozek carries with her, like all citizens, the right to be wrong."

41 The second branch assesses the ability to evaluate, not just understand, information. The patient must have an ability to appreciate the relevant information as it relates to him or her.

42 The Courts noted that the right to make one's own treatment decisions is a fundamental one that can only be displaced where it is established that a person lacks mental capacity to do so. The patient's "best interests" are not a consideration in determining the question of capacity to consent to treatment. Capable people have the right to take risks and to make mistakes. Further, the presence of mental disorder should never be equated with a lack of capacity.

43 LD did not see any consequences of not receiving treatment. She did not appreciate that without treatment, she was at risk of a decompensation in her mental state, requiring hospitalization.

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44 LD was not able to evaluate the possible benefits of treatment against the possible consequences of not accepting treatment. LD was not able to appreciate that there were possible benefits of the proposed treatment, and did not appreciate there were any consequences to her for not taking her prescribed medication. Although it was not necessary for LD to describe her mental condition as an illness or to otherwise characterize her condition in negative terms, LD's condition was such that she was unable to recognize that she was affected by the manifestations of her illness. She was unable to apply the relevant information to her circumstances and was unable to appreciate the consequences of her decision or lack of decision regarding treatment. LD did not appreciate the reasonably foreseeable consequences of not receiving treatment.

45 Capable people have the right to take risks and to make mistakes. The fact that LD did not want to accept proposed treatment did not render her incapable to make treatment decisions. In our view, this was a very different situation from the one found by the Supreme Court of Canada in *Starson*. In that case, the Court found, Professor Starson was effectively saying, "I know that the proposed treatment could help me with some symptoms that affect me, but I'd rather have those symptoms than the adverse effect of the treatment on my ability to think and carry out my work in the field of physics". In other words, the Court found, Professor Starson was able to appreciate the consequences of a decision. The fact that the decision to refuse treatment may have been unwise did not render him incapable.

46 LD did not recognize the symptoms that the medication was proposed to treat. She did not prefer to have the manifestations of illness over taking medication. The evidence taken as a whole amply supported Dr. Shafro's conclusions concerning LD's capacity. She was unable to evaluate information concerning the proposed treatment as it related to her own circumstances, a fact which rendered her incapable to make a decision concerning them.

Involuntary Status

Did the evidence establish that at the time of the hearing LD was suffering from Mental Disorder?

47 At Exhibit 2, Dr. Shafro wrote that "Patient suffers from either schizoaffective disorder, bipolar type or possibly schizophrenia, paranoid subtype (patient is an unreliable historian and thus it is difficult to determine a timeline for determination of schizophrenia, as well as the nature of her mood symptoms..." Dr. Shafro told the Panel that LD experienced both mood and

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psychotic symptoms of mental disorder. Dr. Shafro stated that the psychosis was not precipitated by marijuana abuse because despite being abstinent from marijuana while in hospital, her auditory hallucinations and paranoid delusions did not improve. Dr. Shafro stated that LD had seen a psychiatrist approximately 10 years ago and was treated with benzodiazepines. She had no psychiatric admissions to hospital prior to October 2014.

48 On October 3, 2014, LD was brought to hospital by ambulance. Coworkers had telephoned police because LD had not attended work for 3 days. At that time LD described auditory hallucinations from the police and others and claimed that she could hear people well outside her room talking about killing her. At that time she told Dr. Shafro that she had been hearing people talk about her negatively for a number of months. She also described paranoid delusions that people from AA were trying to kill her as well as people behind the variety store trying to stab her to death. She believed that these were 100% true and was unable to consider that these were symptoms of psychosis. Dr. Shafro wrote in Exhibit 3 that LD experienced paranoid delusions about being monitored by police and people trying to kill her. She described her friend as both a ring leader of the people trying to harm her and as someone trying to get her to seek help.

49 At that time she also described a number of mood symptoms with hypersomnia, decreased mood, interest, energy, concentration, psychomotor retardation as well as hypermanic periods with decreased need for sleep and increased energy, racing thoughts, pressured speech and irritability.

50 LD was brought to hospital by ambulance on November 8, 2014 after police were called because LD had barricaded the entrance to her apartment building. LD exhibited the same delusions and psychotic symptoms as during her hospitalization a month earlier.

51 Based on the foregoing, the Panel was satisfied that the evidence established that at the time of the Hearing, MS was suffering from mental disorder.

Did the evidence establish that LD's mental disorder was of a nature or quality that likely would result in serious bodily harm to another person unless she remained in hospital?

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52 The Panel found that it was likely LD would continue to act on her delusions and that others would inadvertently suffer serious bodily harm as a result. LD believed that her neighbours were stealing from her. She believed that she could hear them plotting revenge against her. She also believed that she was in communication with a police dispatcher through some sort of device, believing others should be able to hear it as well. Exhibit 3 described an incident in hospital where LD was observed responding to internal stimuli, "[LD] was actually responding to internal stimuli and yelled at some point "you are full of shit"-according to her - to the voice of Joe that was talking to her." It was also noted that LD was impulsive. During the Hearing, LD became angry at Dr. Shafro, left the Hearing and refused to return.

53 LD's delusions were worsening and were more entrenched this hospitalization as compared to her hospitalization one month ago. Dr. Shafro stated that LD's actions would become more extreme. During her last hospitalization, LD acknowledged that her delusional beliefs did not make logical sense. During the current hospitalization, LD was convinced that her delusional beliefs were factual and was unable to even consider the possibility that they were the manifestations of an illness. In October LD believed that others were stealing from her apartment, that "evicted" tenants wanted revenge against her, that she could hear others plotting against her from long distances and that she could communicate with the police through a device they had given her or through a speaker in her bed. In November she expressed these delusions as well as the belief that her CMHA worker was part of a conspiracy against her.

54 LD acted on her delusions. She felt unsafe in her apartment building. On November 8, 2014 LD barricaded the doorway to her apartment building. This caused a number of small children to be locked out of the apartment and unable to return to their homes.

55 Dr. Shafro told the Panel that LD stated that the "evicted, nosy neighbours" threatened to rob her apartment and that they had already robbed the apartment upstairs of hers. She believed that the owner of the building asked her to barricade the door to her apartment as well as the main door for the building. The owner had not asked her to do so. Dr. Shafro wrote at Exhibit 3 that on November 10, 2014 LD claimed to be the superintendant at her building and that she had received only a small pittance for acting in this capacity. In his Progress Note of November 11, Dr. Shafro wrote that LD clarified that she was being paid for certain tasks at the apartment building, she may not in fact be the superintendant.

56 At Exhibit 3, R. Habashi, medical student, for Dr. Miula wrote: "The superintendent of

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her apartment building called the police because she noted that [LD] started to barricade the apartment building front lobby door and threatened one of the neighbours". Dr. Shafro told the Panel that LD denied threatening her neighbours. There were no details of the threat provided to the Panel. As the Panel was not able to evaluate what was said, or the context of the "threat", it was not considered by us in reaching our decision.

57 LD had delusions involving others in her apartment building. She acted on those delusions. She contacted friends with respect to her delusions. She believed her CMHA worker was part of a conspiracy against her and no longer spoke to her. She had not intentionally put others in harm's way, but had barricaded the doorway to the building without regard to the safety of others. It was likely that she would continue to act on her delusions without regard to how those actions impacted others, resulting in serious physical harm to others. It was Dr. Shafro's opinion that there was a very clear risk of harm to others. He stated that it was quite likely that LD would cause serious bodily harm to another because her delusions were still present, LD had no insight to her illness and had not received treatment.

58 The Panel found that it was likely LD would continue to act on her delusions and that others would inadvertently suffer serious bodily harm as a result.

Did the evidence establish that LD's mental disorder was of a nature or quality that would likely result in serious bodily harm to herself unless she remained in the custody of a psychiatric facility?

59 Dr. Shafro told the Panel that his concerns regarding LD harming herself stemmed from the fact that on November 8, 2014 while being brought to hospital by police she threatened to kill herself via overdose of her medication. At the time LD made the statement to police she did not have access to her medication. LD had not repeated this threat. LD took no actions beyond making the statement.

60 Exhibit 3 contained a Report of Consultation dated November 8, 2014, written by R. Habashi, medical student for Dr. Miula. This Report stated: "The patient is not suicidal or homicidal".

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61 Based on the foregoing, the Panel was not satisfied that the evidence established that unless she remained in hospital LD was likely to suffer serious bodily harm.

Did the evidence establish that LD was not suitable for continuation as an informal or voluntary patient?

62 The *Mental Health Act* requires that a person be suitable for continuation as a voluntary patient, not merely that they state their intention to stay in hospital. On October 10, 2014 LD discharged herself from hospital against medical advice without medication or follow-up.

63 It was Dr. Shafro's opinion that if made voluntary, LD would again leave hospital against medical advice. He stated that LD would leave hospital at the earliest opportunity. He stated that LD frequently demanded to leave hospital. LD did not believe that she had any disorder or condition that required treatment.

64 In light of the above, the Panel was satisfied that LD was not suitable for continuation as an informal or voluntary patient.

Result

65 For the foregoing reasons, the Board upheld the finding that LD was incapable of consenting to treatment with anti-psychotic medications, mood stabilizers and side effect medication.

66 For the foregoing reasons, the Board determined that the requirements as set out in the *Mental Health Act* were met at the time of the hearing and LD's involuntary status was confirmed.

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