

TOPIC PRESENTED: “Mental Health Act in Ontario: *Legal Views on Capacity & Consent to Treatment in Ontario*”

Presentation	Company
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Key Words:

- Capacity;
- Consent;
- Informed Consent;
- Mental Health Act;
- Substitute Decisions Act;
- Health Care Consent Act;
- Material Risk.

1. The Legislation:

In Ontario, there are three main acts that deal with **consent** and **capacity**. These are: (a) The *Mental Health Act*, the *Health Care Consent Act*, and the *Substitute Decisions Act*. The roles played by these three legislative enactments are described in the table below:

Act	Description	Main Features
Mental Health Act	The Mental Health Act is mainly concerned with the powers and rights of: <ul style="list-style-type: none"> • Doctors; • Psychiatric facilities; and • Patients. 	The Mental Health Act sets out rules relating to: <ul style="list-style-type: none"> • Involuntary admissions; • How someone may be detained or otherwise kept at a psychiatric facility; • Who may have access to a patient's records; • How someone may gain access to a patient's records; • A patient's rights of appeal concerning decisions about: <ul style="list-style-type: none"> ○ Involuntary admissions; ○ Detention at a psychiatric facility; ○ Access to records; Etc.
Health Care Consent Act	The Health Care Consent Act primarily deals with: <ul style="list-style-type: none"> • Capacity; and • Consent. 	The Health Care Consent Act sets out the legal requirements for how a patient may be treated. It stipulates: <ul style="list-style-type: none"> • In order for the caregiver to pursue a course of treatment with a patient, the caregivers must establish <u>both</u>:

Act	Description	Main Features
		<ul style="list-style-type: none"> ○ CAPACITY: The patient is <i>capable</i> of granting consent to the treatment; and ○ CONSENT: The patient's consent must be <i>informed</i> consent. <ul style="list-style-type: none"> • The Act also provides that, if <i>informed consent</i> cannot be reasonably be obtained from the patient him or herself, then informed consent may be sought and obtained from a legally authorized <i>Substitute Decision Maker</i> ("SDM"). • The <u>only</u> exception to these requirements is <i>emergency care</i>.
Substitute Decisions Act	<p>The Substitute Decisions Act deals with <u>how decisions are to be made on a person's behalf</u>; and the appointment of:</p> <ul style="list-style-type: none"> • Powers of Attorney for Property; and • Powers of Attorney for Personal Care. 	<p>The Substitute Decisions Act sets out rules governing:</p> <ul style="list-style-type: none"> • The appointment of a SDM; • How a decision is to be made by someone on another person's behalf; • The powers of the SDM as to another person's property; and • The powers of the SDM as to another person's personal care. <p>Decisions about <u>personal care</u>, under the Act, includes decisions about:</p> <ul style="list-style-type: none"> • Admissions to facilities; • A proposed course of treatment; and • Personal assistance services.

2. The Relationship between Capacity and Consent:

While the notion of "informed consent" presents as one concept, implicit within it is a 2-step process. Obtaining informed consent requires the caregiver to engage in the following assessment-process, in the following order:

1. Is the patient capable of making a particular treatment-related decision?
2. If so, then has the patient been sufficiently informed about the proposed treatment?

The misconception that underlies **informed consent**, where a decision about treatment is received directly from the patient, is that it *automatically assumes* that the patient was **capable**. However, if the patient is not capable with respect to a particular form of treatment, then the consent given by that patient relating to that treatment-related decision is invalid. The result in such circumstances is that there never was informed consent.

This 2-step process to obtaining *informed consent* is discussed in greater detail below.

A. The First Step – Determining Whether a person is Capable:

(I) Who is Capable of Making a Decision about their Treatment?

All people 16 years of age or older are **presumed** to be capable of making informed decisions about their treatment. If there is any doubt as to a person's capacity, then a capacity assessment must be engaged in. It is critical to note that each treatment-related decision requires an assessment of capacity for that particular decision (unless the treatment is **emergency care**).

Sometimes it is plainly obvious that a person is incapable. However, appropriately documenting the assessment of someone's capacity is not just legally required, but also legally self-protective.

In the event that a legal / regulatory process is engaged, it is this initial step of *careful & accurate recordkeeping* that will largely determine the outcome of the regulatory process.

(II) How is Capacity (or the Lack of Capacity) Determined?

A person's capacity is determined by answering the 2 questions below:

Test for Determining Capacity

1. Does the person understand the relevant information about the proposed treatment?

~ AND ~

2. Does the person appreciate the likely consequences of either...?

- a. Consenting to the treatment;
- b. Refusing to consent to the treatment; or
- c. Making no decision about the treatment.

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- If the correct answer to **both** questions is "yes", then the person is capable of making the treatment-related decision.
 - However, if the answer to **either** question is "no", then the person is not capable of making the treatment-related decision.

Provided that the decision-making process is reasoned, appropriately thorough, and principled, then it will likely be legal. In unclear cases, it is good practice to get a *second opinion*.

(III) What Factors Are Relevant to Capacity Assessments?

The capacity assessor is better-equipped to prepare an appropriate capacity assessment if he or she is able to capably articulate the factors that went into the assessment. Such factors fall broadly into two categories:

- *Patient-specific*; and
- *Contextual*.

A list of suggested considerations for a capacity assessment is set out below. Obviously, these considerations may be highly relevant at one stage of treatment (such as on admission), and less relevant as treatment continues. Nevertheless, at each appropriate treatment-juncture, it is good practice to revisit the relevant factors relevant to the treatment-related decision. Just because a given form of treatment is being continued does not mean that the patient is still incapable.

Factor	Illustration
Communication	<ul style="list-style-type: none"> • The presence / absence of a pathway to communication is key... • Are you able to establish an <i>understood and agreed upon means</i> for communicating about the person's treatment? • Is the person is willing to communicate? • Do you understand the person? Does the person understand you? <p>Communication may take a variety of forms, and due consideration should include:</p> <ul style="list-style-type: none"> • The <u>language</u> in which the person is most proficient; • The person's <u>intellectual ability</u>; • The person's <u>emotional maturity</u>; • <u>Cultural factors</u> that may affect what otherwise appears to be a mutual understanding; • Whether <u>verbal communication or non-verbal</u> communication is relevant; and <p>... the fact that a patient's <u>spoken or written linguistic proficiency</u> does not automatically detract from his or her capacity.</p>
<i>Direct observation of the person</i>	How is the person acting? Is the person behaving in a delusional manner? Intoxicated? In withdrawal? Etc.
<i>Information from family or friends of the person</i>	The person engaged in irrational behaviour consistent with psychosis; the person had been taking drugs; the person was violent to others or him or herself; etc.
<i>Any events leading up to and surrounding the capacity assessment</i>	The person was seen by law enforcement to be intoxicated, withdrawn, self-harming, etc.
<i>Any psychiatric diagnoses and / or prognoses</i>	Schizophrenia, Bipolar Affective Disorder; Autism; the absence of any information about the person's psychiatric state; etc.
<i>Any personality disorders, including their effects</i>	The patient has anti-social personality disorder, and is attempting to influence the outcome of the capacity assessment by drug-seeking behaviour.

Factor	Illustration
<i>Substances / withdrawal from substances</i>	The person appeared to be drunk / high on arrest by law enforcement, and appeared to be in withdrawal while awaiting the capacity assessment.
Any other factors the caregiver considers reasonably relevant to the assessment of capacity (with emergency treatment being the sole exception to bypassing a capacity assessment)	

Appended to this paper as **Schedule “A”** is a Decision-Tree titled “Acquiring Informed Consent”, which provides an process-oriented approach for obtaining **informed consent**.

B. The Second Step – Obtaining Informed Consent:

Once a capacity assessment is completed, the caregiver must now ensure that any treatment-related decision (or lack thereof) is an *informed* choice.

(I) Who May Provide Informed Consent?

Informed consent may be received from the following persons:

- The patient him or herself – but *only if he or she is capable* of making the treatment-related decision;
- If the patient is not capable of making the treatment-related decision, then resort may be had to the following persons, in the following order of priority:
 1. A Court-appointed legal guardian;
 2. A Court-appointed person named as Power of Attorney for Personal Care;
 3. A Representative appointed by the Consent and Capacity Board;
 4. A spouse or partner;
 5. A child or parent;
 6. A parent with a right of access only;
 7. A brother or sister;
 8. Any other relative by blood or marriage; and
 9. A Treatment Decision Consultant from the Office of the Public Guardian and Trustee.
- In the case of **emergency treatment**, no consent is required.

(II) What Information Must Be Provided to the Patient (or his or her Proxy) in Order to Ensure that Informed Consent has been Obtained?

Once the caregiver has ascertained *whom* will be providing consent, the caregiver must then ensure that the patient / proxy is:

1. Informed of the relevant information about the treatment; and
2. Informed of the likely consequences of agreeing to, declining, or making no decision about the proposed treatment.

[**Note:** The steps followed in this process mirror the steps followed in the “Test for Determining Capacity”.]

The following table sets out the information that must be received by the patient / proxy.

Element	Issue Addressed	Elaboration
Nature of the Condition being Treated	What is the diagnosis or differential diagnosis?	---
Nature of the Treatment being Proposed	---	The nature of the treatment should be described with the above-noted cultural and communication-related factors in mind.
The Expected Benefits of the Treatment	What is the reasonably anticipated benefit of the treatment?	---
The Material Risks of the Treatment	What would a <i>reasonable person</i> in the same circumstances want to know in order to make a decision?	Just because an objective, “reasonable person” standard is employed, this does not mean that patient-specific circumstances are irrelevant. For example, if the patient’s faith system precludes blood transfusion, then the risk of a blood transfusion is something a “reasonable person in the same circumstances” would want to be aware of.
The Material Side Effects of the Treatment	(See above.)	(See above.)
Alternatives to the Treatment	What are the range of options available to the patient? Are they reasonable alternatives?	---
The Likely Consequences of NOT Having the Treatment	What would likely happen if the patient either: <ul style="list-style-type: none"> • Declined the treatment? OR; • Declined to make any decision at all? 	This analysis also relies on the notion of “materiality” and what is “reasonable in the circumstances”.

- The Notion of “Materiality”:

The notion of what is “material” is a judgment call. However, in arriving at a decision, the caregiver might find value in the following conceptualization of what constitutes a “material risk of harm”:

$$\frac{\text{[Degree of Harm]}}{\text{[Odds of Harm]}} = \text{Material Risk of Harm}$$

To illustrate how the above formula works, a patient might undergo a form of medication-oriented therapy, for example. The medication, X, carries with it a 1 in 1,000 chance of an adverse outcome (in the case of the drug, X, the adverse outcome is *suicide*). The **magnitude** of suicide – when compared against the odds of it occurring – suggests that this is a material risk. On the other hand, the medication, Y, has a 1 in 10 chance of an adverse outcome (in the case of the drug, X, the adverse outcome is *slight drowsiness*). This is likely not a material risk, although if the person is a cab-driver, for example, then it may constitute a material risk.

The caregiver must strive to arrive at a principled and reasoned assessment, in the particular circumstances of the person and proposed treatment, as to whether the risks are “material”.

- The Notion of “Best Interests”:

If there are *known wishes* that can be attributed to an incapable person for any given treatment, and these were expressed when the person was 16 years of age or older, then the treatment-related decisions should be made in a way that is compatible with these wishes.

However, if the incapable person’s wishes for care are not known, or are impossible to comply with, then the decision should be made in that person’s “best interests”. The “best interests” are informed by the expertise of the caregiver, but must still be reviewed with the incapable person’s proxy.

Consent & Capacity – Common Hazard Zones:

- A. **Treatment Junctures:** It should be recognized that the *presence* or *absence* of capacity must be considered each time a decision-making opportunity arises. Some patients may be incapable of consenting to most decisions, but are capable of making informed decisions at other times. The **absence of a decision by the patient does not mean that the patient was not capable at the time that he or she declined to make a decision** regarding his or her treatment.
- B. **False Assumptions:** A common mistake is determining that someone is incapable *on the basis of that person’s decision about their treatment*. This is a form of reasoning that focuses on the outcome – the patient’s **poor choice** – as opposed to his or her ability to make such a choice. Even choices made by someone against their best interests may still constitute legally valid decisions that must be adhered to. The “poor choice” may be incredibly strong evidence of a lack of capacity, but a “poor choice” does not automatically mean incapacity has been proven. A full assessment of capacity is still required.

- C. **Consent Forms**: Consent forms may be reassuring, but are only evidence of the consent form having been signed. It does not prove that the information on the form was understood, discussed, explained, or agreed to. Correlation in the patient's medical chart of the consent discussion should be made, with an appropriate focus on the material risks discussed.

Schedule “A” – Acquiring Informed Consent

