Involuntary treatment, consent and capacity considerations in substance use disorders:
A Canadian Perspective

May 8, 2025

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camh

Disclosures

None

This information is for educational purposes only. It should not be considered legal advice, and is not a substitute for legal advice in a given situation.

Objectives

1. To discuss the recent interest and discussion around involuntary treatment of substance use in Canada
2. To describe the legal criteria for involuntary hospitalization for substance use disorders in Canada
3. To relate recent work investigating incapacity findings in Canada with respect to substance use disorder treatment

1

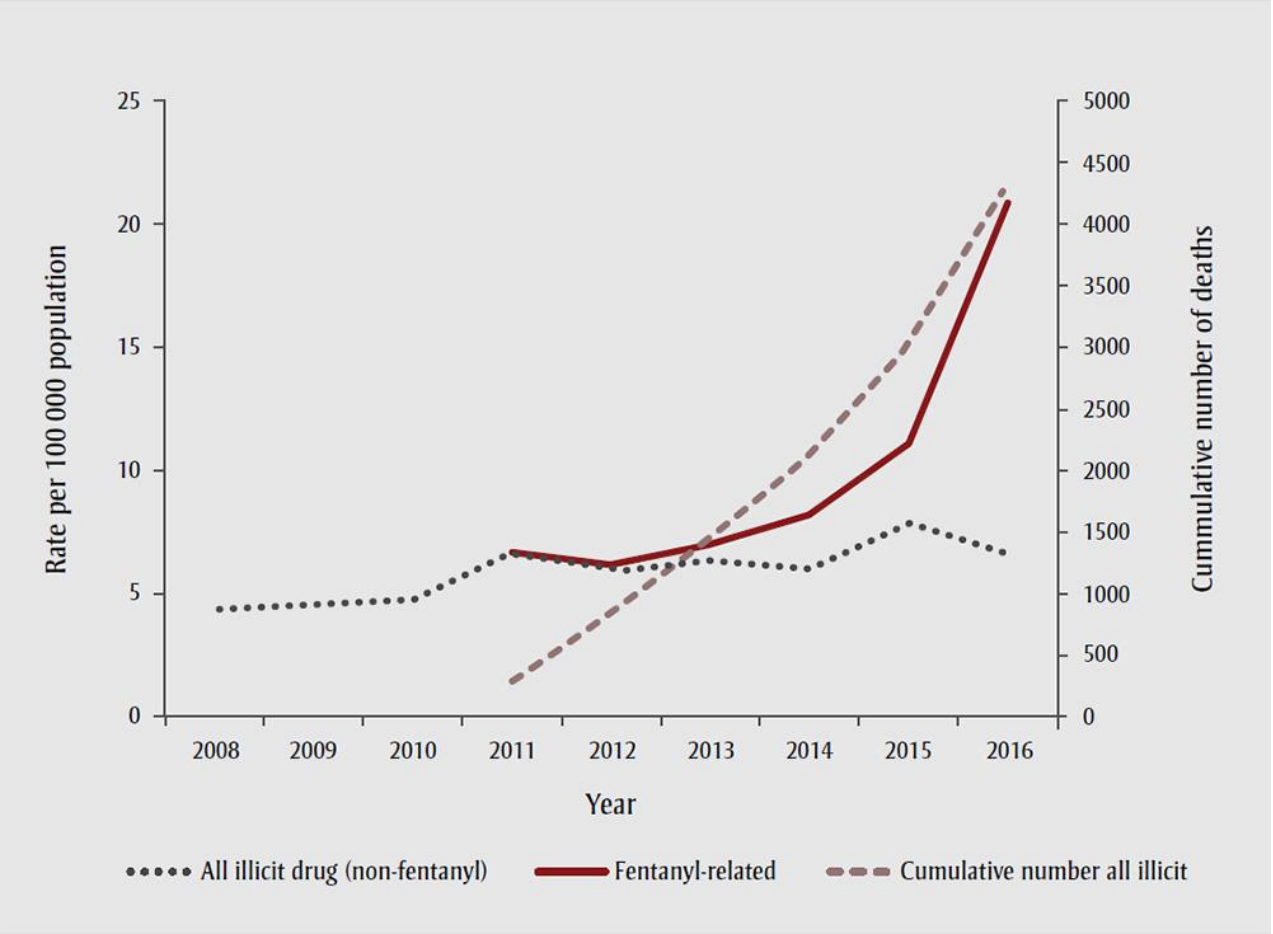
Involuntary Treatment for Substance Use Disorders

Hypothetical Case

"Steve" is a 35 year old man with severe stimulant use disorder, amphetamine type. He is on Ontario Works (social support), and would like to apply for disability. When using methamphetamine, he has severe psychosis and fears that law enforcement is conspiring to kill him. When he is in recovery, these symptoms largely subside. He was working until last year, when he lost his job due to frequent absences and one occasion of coming to work intoxicated. He has an apartment, but is at risk of losing it and received an eviction notice. Steve also uses fentanyl, although not regularly, but this has led to accidental overdoses. His father is advocating for him and trying to help him, but it has been challenging as Steve is hard to locate when using, paranoid and leaves treatment or hospital rapidly once symptoms improve. He has not attended outpatient treatment which he has been referred to.

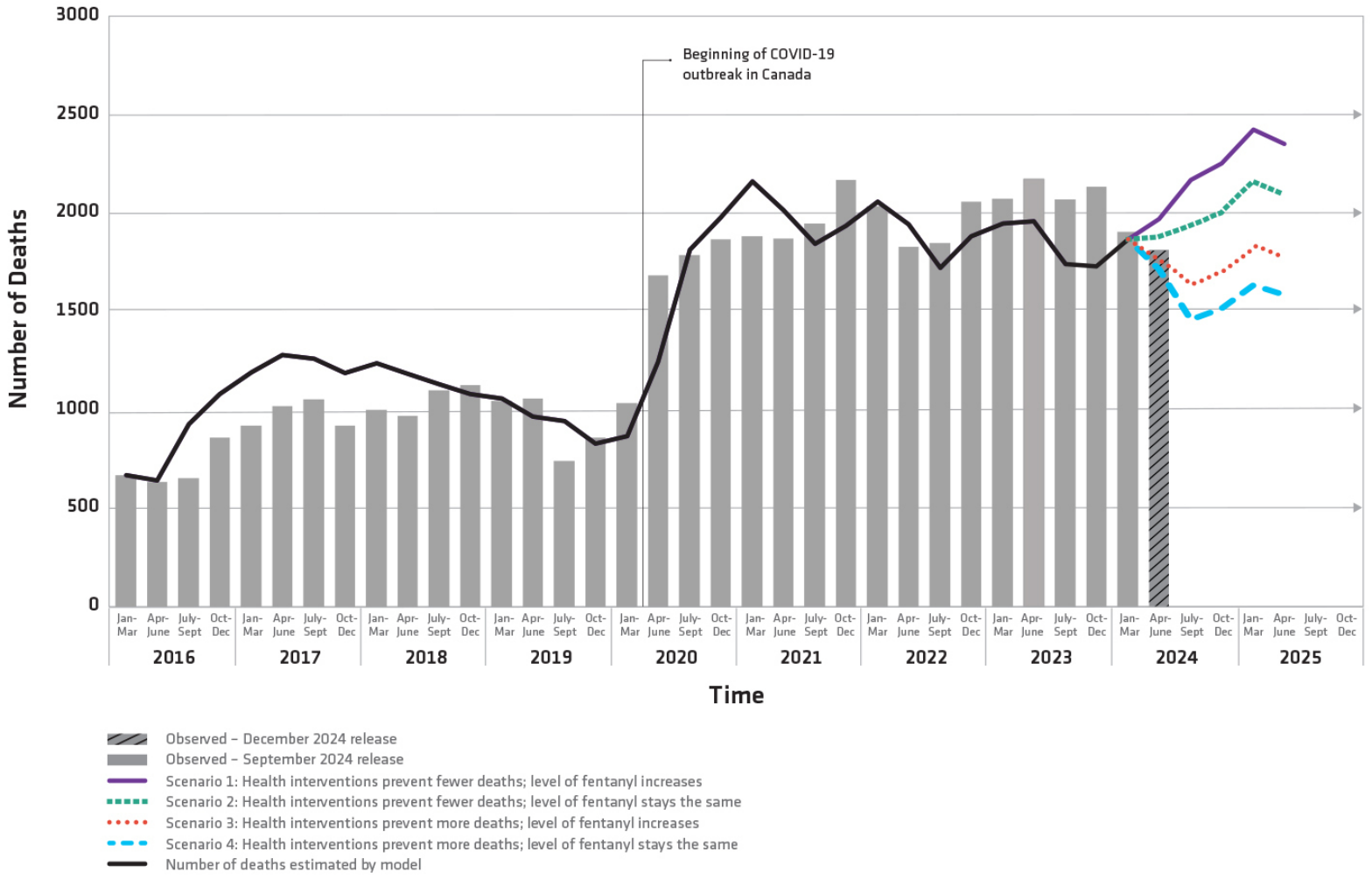
Steve comes into the ED intoxicated and agitated. He is brought in by police. He had barricaded himself in a Tim Horton's bathroom and was threatening. He tests positive for methamphetamine. Is he certifiable under Form 1 criteria?

Opioid Overdoses in Canada



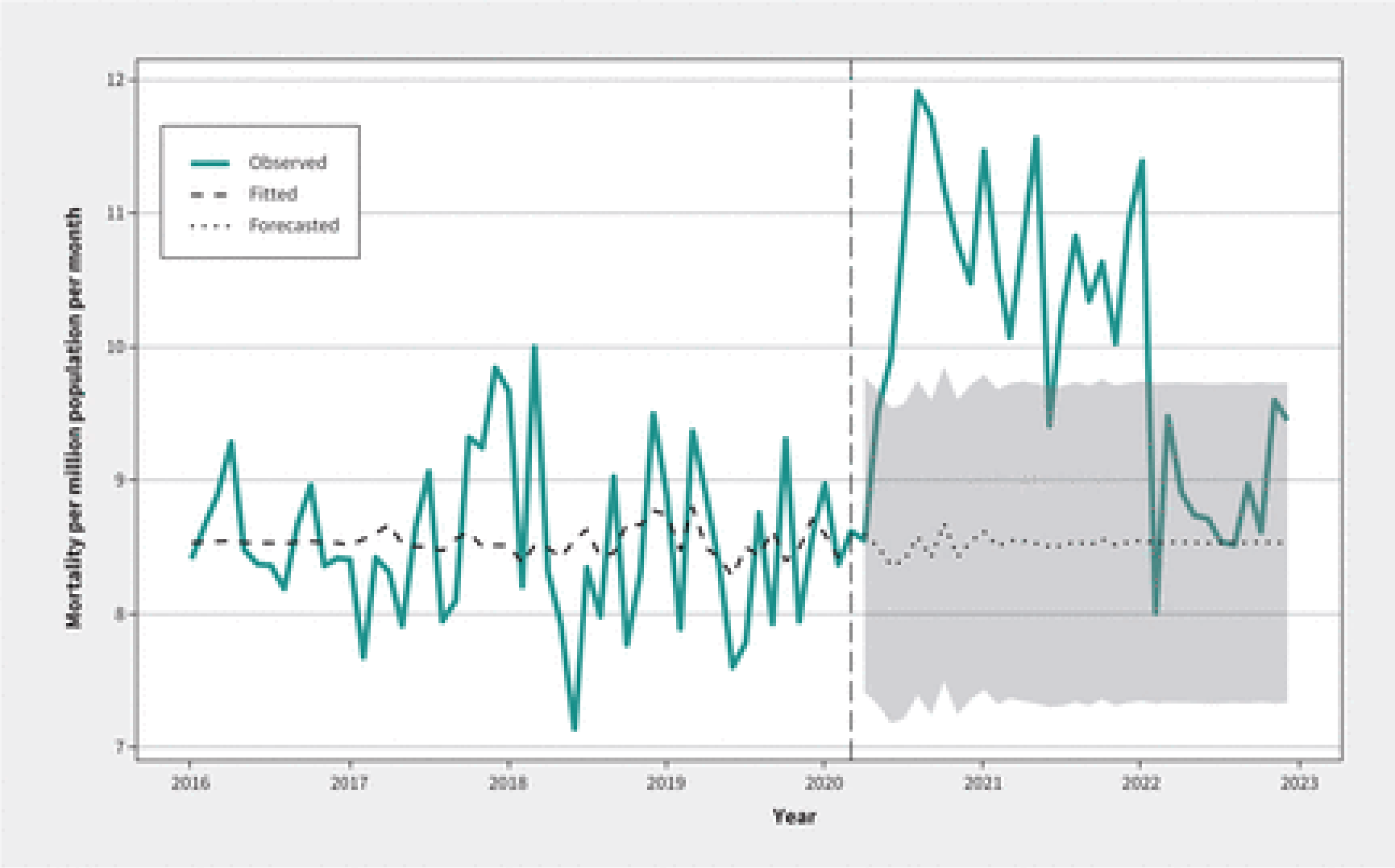
https://www.canada.ca/en/public-health/services/reports-publications/health-promotion-chronic-disease-prevention-canada-research-policy-practice/vol-38-no-6-2018/evidence-synthesis-opioid-crisis-canada-national-perspective.html

Opioid Overdoses in Canada



https://www.canada.ca/en/health-canada/services/opioids/data-surveillance-research/modelling.html

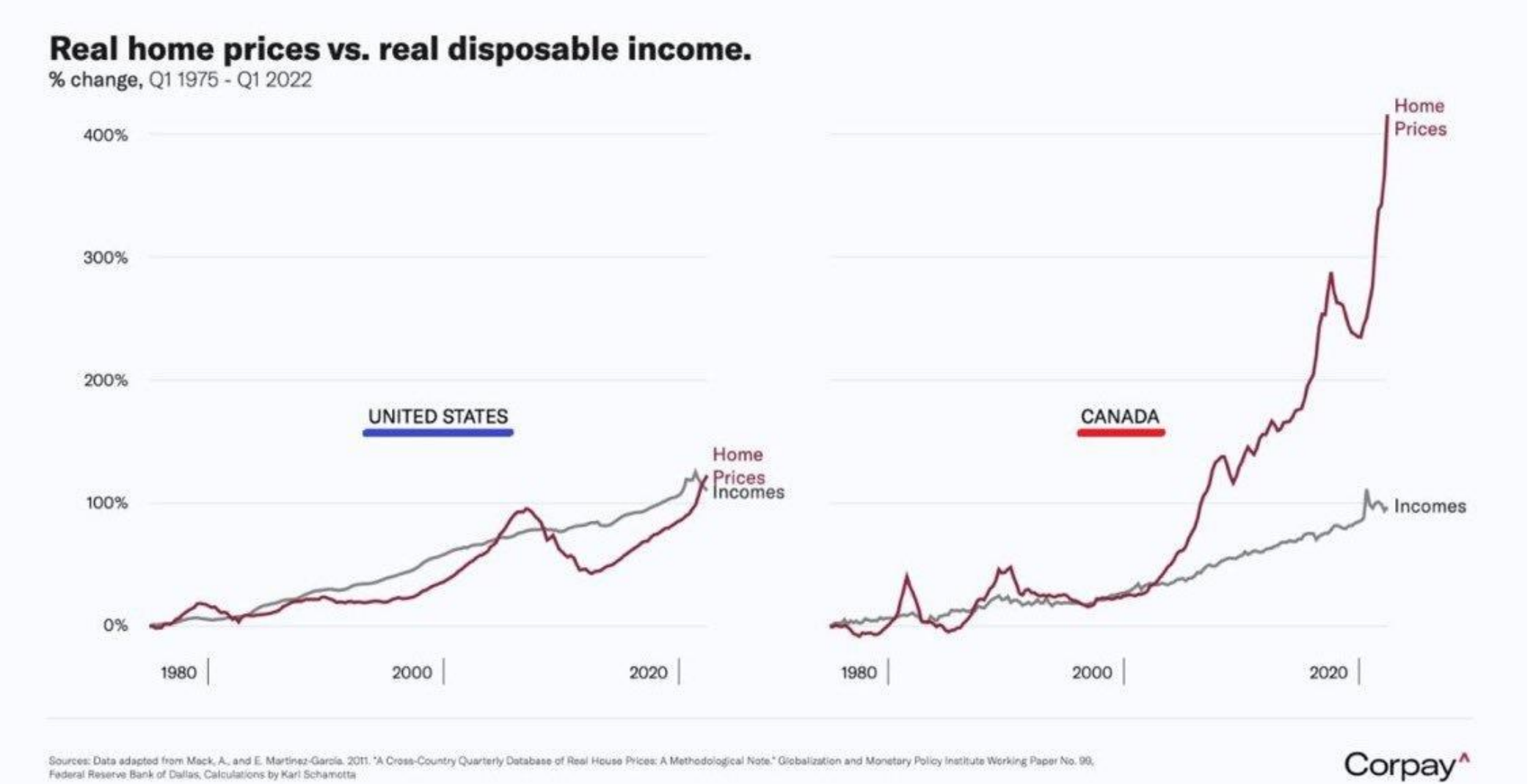
Observed and forecasted alcohol mortality



https://www.cmaj.ca/content/197/4/E87

CMAJVol. 197, Issue 43 Feb 2025

Housing Costs in Canada



https://shipshey.ca/wp-content/uploads/2023/02/housing-prices.jpg

Food Insecurity

Montreal

Rising demand at food banks seen as 'canary in the coal mine' for affordability crisis

'We need a government who is taking that seriously,' says head of Montreal's Depot Community Food Centre

Benjamin Shingler · CBC News · Posted: Apr 24, 2025 4:00 AM EDT | Last Updated: 6 hours ago

https://www.cbc.ca/news/canada/montreal/federal-election-food-ndg-depot-1.7516940

Encampments

In Thunder Bay, a divide over encampments weighs on voters

The northern Ontario city, like communities across the province, is grappling with what to do about the camps as an election looms

MARCUS GEE
PHOTOGRAPHY BY DAVID JACKSON
THE GLOBE AND MAIL
THUNDER BAY
PUBLISHED FEBRUARY 24, 2025

105 COMMENTS SHARE SAVE FOR LATER GIVE THIS ARTICLE

https://www.theglobeandmail.com/canada/article-in-thunder-bay-a-divide-over-encampments-weighs-on-voters/

Involuntary Treatment Proposal October 21, 2024

The Mayors passed a resolution (full motion here) which included requesting that the provincial government:

- Urgently review, consult on, and update the Mental Health Act and the Health Care Consent Act, neither of which address the current state of this crisis across the province.
- Implement Diversion Courts throughout the Province, and expand the scope and reach of these courts, with a focus on rehabilitation rather than punitive measures
- Along with the federal government, introduce legislation prohibiting open and public use of illicit drugs and public intoxication; and
- Review, consult on, and update the Trespass to Property Act with such a review to include but not be limited to options to assist communities in addressing aggressive or repetitive trespass ("repetitive trespass")

https://www.ontariobigcitymayors.ca/ontarios-big-city-mayors-are-calling-on-the-provincial-and-federal-governments-to-take-action-on-homelessness-mental-health-safety-and-addictions/

Involuntary treatment proposal in Alberta April 18, 2025

https://www.theglobeandmail.com/canada/alberta/article-albertas-ucp-exploring-sweeping-legislation-on-involuntary-treatment/

Alberta eyes legislation on involuntary treatment for some drug users

ALANNA SMITH › HEALTH REPORTER
PUBLISHED APRIL 18, 2023
UPDATED APRIL 19, 2023
FOR SUBSCRIBERS

This article was published more than 2 years ago. Some information may no longer be current.

Calgary police patrol the streets near the cities drug safe injection site in Calgary, on Feb. 21, 2019.
TODD KOROL/THE GLOBE AND MAIL

318 COMMENTS SHARE SAVE FOR LATER GIVE THIS ARTICLE

LISTEN TO THIS ARTICLE

The Alberta government is considering introducing a law that would broaden the circumstances under which people with severe drug addictions could be placed into treatment without their consent.

The legislation would be the first involuntary treatment law in Canada to target addiction specifically. Some jurisdictions, including Alberta, already use mental-health law to push people into drug treatment without court orders in exceptionally severe situations. But otherwise adult drug users can refuse help.

Ontario, May 1, 2025

Ontario to examine involuntary addiction treatment for people in jail, on parole, probation

Provincial government tabling large justice bill Thursday

Liam Casey and Allison Jones · The Canadian Press · Posted: May 01, 2025 11:18 AM EDT | Last Updated: May 1

Doug Downey holds a news conference at Queen's Park in Toronto on Oct. 24, 2023. (Nathan Denette/The Canadian Press)

Involuntary Treatment for People with Substance Use Disorders: What do we know?

- ❑ Most jurisdictions consider “mental disorder” to neither explicitly include nor exclude substance use disorders
- ❑ Substance use disorders have been found to satisfy certification criteria such as “serious bodily harm” and “serious physical impairment”
- ❑ Research on the benefits and harms of involuntary substance use treatment is limited

(Reid et al, CJEM 2020;22(5):629–632)

Involuntary Treatment for People with Substance Use Disorders: What do we know?

A systematic review from 2016 found:

- ❑ 9 quantitative studies were identified
- ❑ compulsory treatment ranged from long-term inpatient, community- treatment, group outpatient and prison-based treatment
- ❑ results were: no impact (33%), equivocal, without control (22%), negative (22%), positive (22%)
- ❑ compulsory treatment is a **broad term** and often **linked to the justice system**
- ❑ even within mandatory inpatient treatment, the **treatment** provided is broad (exercise, drug and health education, skills training), and the **outcomes** are broad (recidivism versus abstinence)

(Werb et al, Int J Drug Policy. 2016 February:28: 1–9)

Involuntary Treatment for People with Substance Use Disorders: What do we know?

A recent review specifically examined evidence for involuntary treatment in ***nonoffenders***:

Cooley et al, Canadian Journal of Addiction June 2023, Volume 14 (2), p 25–31

- ❑ there were limited Canadian studies/data
- ❑ a mandatory treatment program for high-risk alcohol users in Australia was expensive, not statistically found to be helpful, and discriminatory towards Indigenous patients
- ❑ a Norweigan study found that while both involuntary and voluntary treatment improved mental distress, the gains were only sustained in the voluntarily treated group

> "Overall, the data on involuntary treatment for adult nonoffenders with SUD suggests that voluntary treatment outperforms involuntary treatment. In addition, involuntary treatment gains are often lost at a greater rate after treatment completion than those seen for voluntary treatment, and involuntarily treated patients with SUD are at a higher risk of overdose after treatment."

Recent Systematic Review

- “Effectiveness of Involuntary Treatment for Individuals With Substance Use Disorders: A Systematic Review”
- The Canadian Journal of Addiction 14(4):p 6-18, December 2023.
- Most “treatment” was residential, but some was inpatient hospitalization, and it included medication, psychotherapy, 12-step programs and case management
- Outcomes were diverse (change in use, recidivism, retention in treatment)
- Only **7/22** studies comparing voluntary/involuntary treatment showed improvements, mainly for retention in treatment

“There is a lack of high-quality evidence to support or refute involuntary treatment for SUD. More research is needed to inform health policy.”

2

Involuntary Hospitalization Criteria

Pathways to psychiatric assessment

1. Booked/planned outpatient assessment

1. Voluntary presentation to an emergency department
   → Assessment and referral to psychiatry

1. Form 1 issued by a physician
   → Assessment and referral to psychiatry

2. Form 2 issued by Justice of the Peace
   → Assessment and referral to psychiatry

3. Apprehension by police under the *Mental Health Act*

Form 2 Criteria:

Justice of the peace's order for psychiatric examination

16 (1) Where information upon oath is brought before a justice of the peace that a person within the limits of the jurisdiction of the justice,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

and in addition based upon the information before him or her the justice of the peace has reasonable cause to believe that the person is apparently suffering from **mental disorder** of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

the justice of the peace may issue an order in the prescribed form for the examination of the person by a physician. R.S.O. 1990, c. M.7, s. 16 (1); 2000, c. 9, s. 4 (1).

- **Similar criteria based on a person's report to Justice of the peace**
- **Any person can apply for a form 2 (family, doctor, case worker, etc.)**

https://www.ontario.ca/laws/statute/90m07

Action by police, Mental Health Act

17 Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

and in addition the police officer is of the opinion that the person is apparently suffering from **mental disorder** of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

and that it would be dangerous to proceed under section 16, the police officer may take the person in custody to an appropriate place for examination by a physician. 2000, c. 9, s. 5.

- may occur after a “Wellness Check”, if staff are concerned about a patient

https://www.ontario.ca/laws/statute/90m07

Form 1 Criteria:

Apparently suffering from mental disorder

"Box A"

What happened?

What are the symptoms?

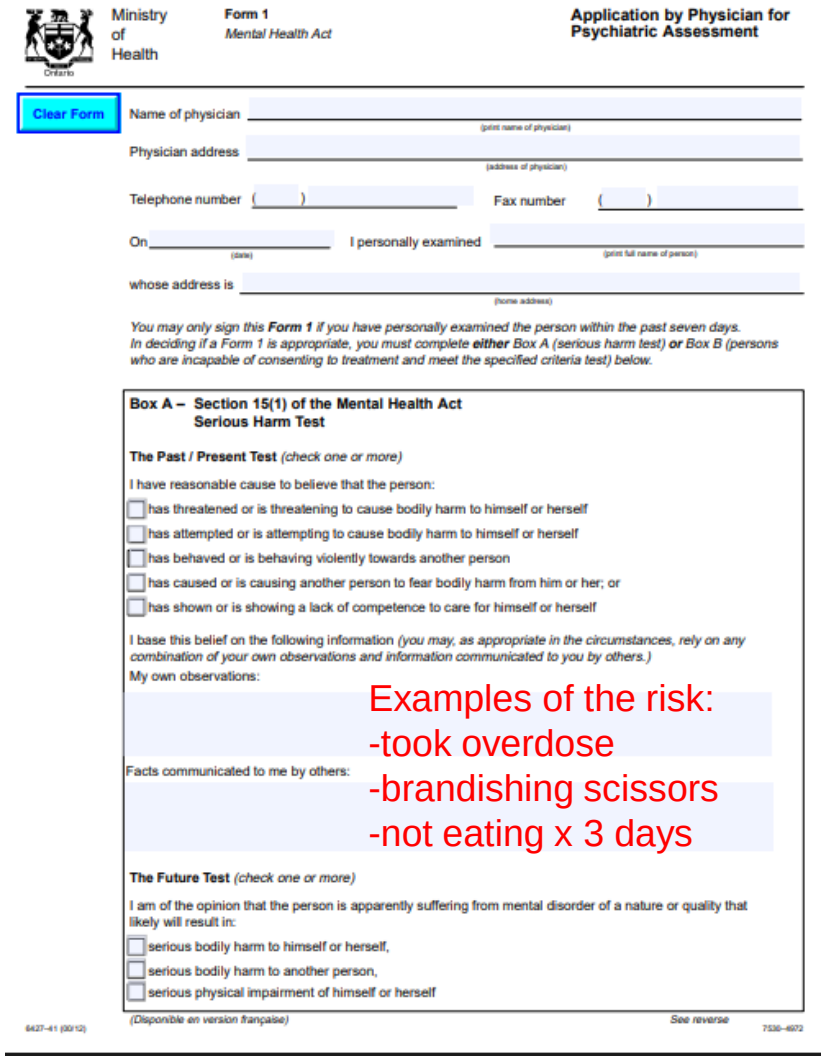
Past or present:	And future risk of:
• Threats or attempts to cause bodily harm to him/herself,	• Serious bodily harm to self,
• Violent behaviour towards another person or causing another person to fear bodily harm from him/her, or	• Serious bodily harm to others, or
• Lack of competence to care for self	• Serious physical impairment

OR

"Box B"

Less commonly used

- Previously received treatment for same or similar mental disorder of ongoing or recurrent nature
- Has shown clinical improvement
- Apparently incapable and SDM consent
- Likely to cause serious bodily harm to self or others, suffer serious physical impairment, or suffer substantial mental or physical deterioration



Ministry of Health

Form 1
Mental Health Act

Application by Physician for Psychiatric Assessment

Clear Form

Name of physician _____ (print name of physician)

Physician address _____ (address of physician)

Telephone number ( ) _____ Fax number ( ) _____

On _____ (date) I personally examined _____ (print full name of person)

whose address is _____ (home address)

*You may only sign this **Form 1** if you have personally examined the person within the past seven days.*
*In deciding if a Form 1 is appropriate, you must complete **either** Box A (serious harm test) **or** Box B (persons who are incapable of consenting to treatment and meet the specified criteria test) below.*

Box A – Section 15(1) of the Mental Health Act
Serious Harm Test

The Past / Present Test *(check one or more)*

I have reasonable cause to believe that the person:

- ☐ has threatened or is threatening to cause bodily harm to himself or herself
- ☐ has attempted or is attempting to cause bodily harm to himself or herself
- ☐ has behaved or is behaving violently towards another person
- ☐ has caused or is causing another person to fear bodily harm from him or her; or
- ☐ has shown or is showing a lack of competence to care for himself or herself

I base this belief on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated to me by others:

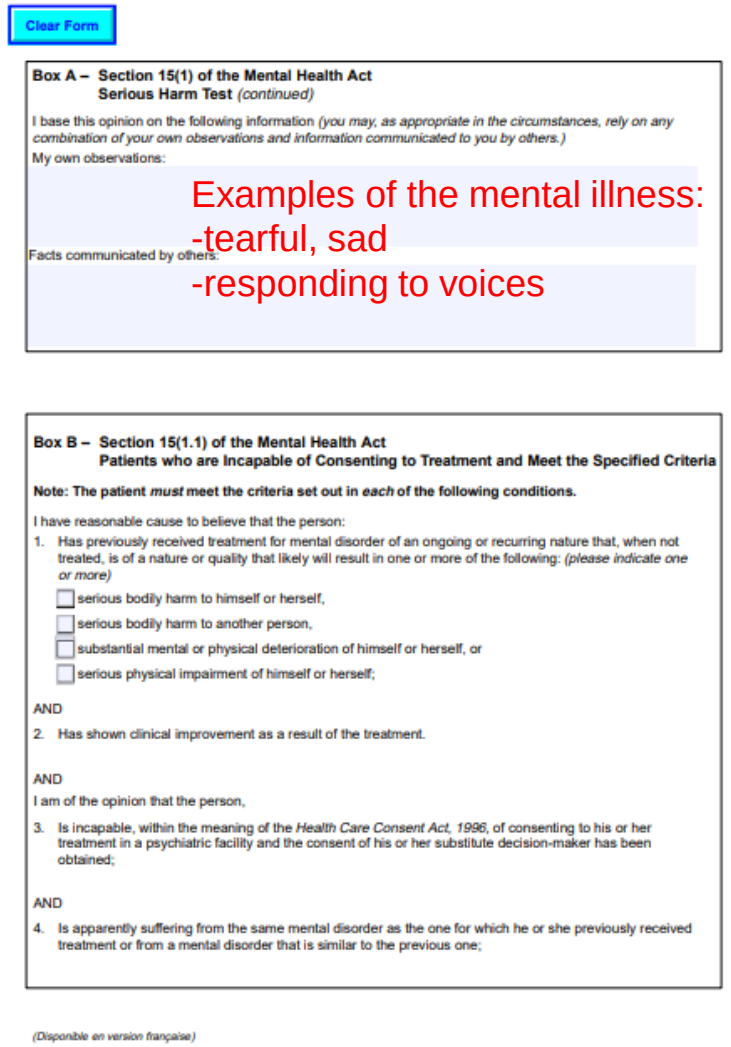
The Future Test *(check one or more)*

I am of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in:

- ☐ serious bodily harm to himself or herself,
- ☐ serious bodily harm to another person,
- ☐ serious physical impairment of himself or herself

6427–41 (00/12) *(Disponible en version française)* *See reverse* 7530–4972

Examples of the risk:
-took overdose
-brandishing scissors
-not eating x 3 days



Clear Form

Box A – Section 15(1) of the Mental Health Act
Serious Harm Test *(continued)*

I base this opinion on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated by others:

Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria

Note: The patient *must* meet the criteria set out in *each* of the following conditions.

I have reasonable cause to believe that the person:

1. Has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in one or more of the following: *(please indicate one or more)*
   - ☐ serious bodily harm to himself or herself,
   - ☐ serious bodily harm to another person,
   - ☐ substantial mental or physical deterioration of himself or herself, or
   - ☐ serious physical impairment of himself or herself;

AND

2. Has shown clinical improvement as a result of the treatment.

AND

I am of the opinion that the person,

3. Is incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained;

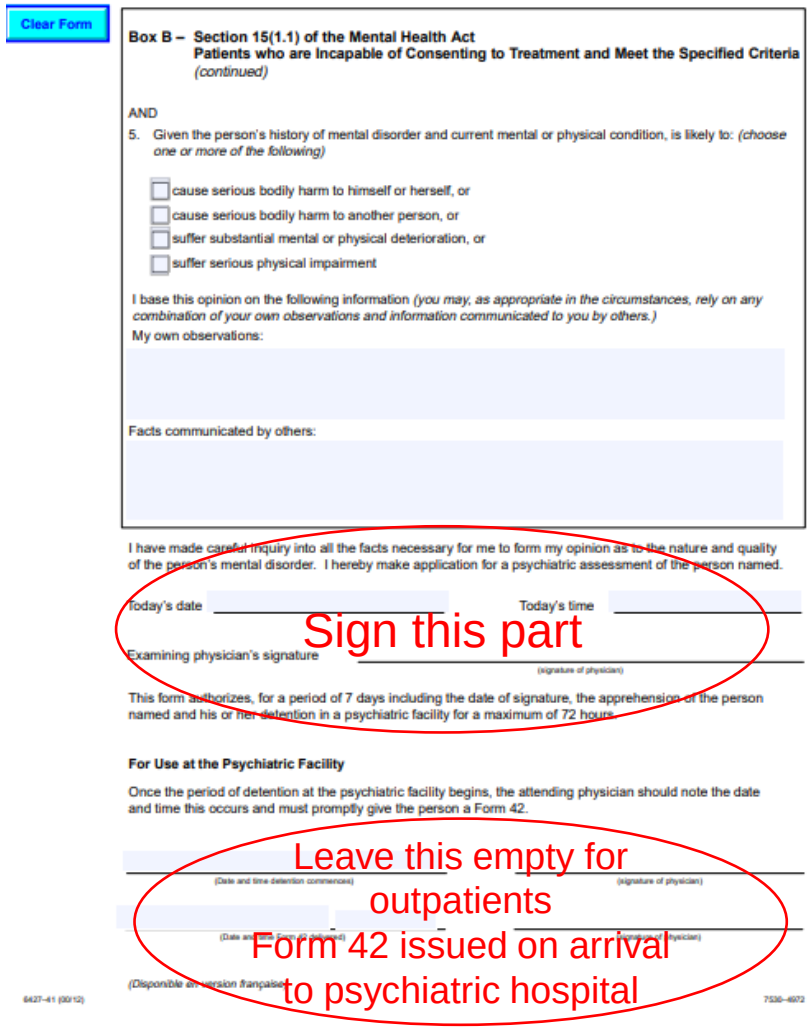
AND

4. Is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(Disponible en version française)

6427–41 (00/12)

Examples of the mental illness:
-tearful, sad
-responding to voices



Clear Form

Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria *(continued)*

AND

5. Given the person's history of mental disorder and current mental or physical condition, is likely to: *(choose one or more of the following)*
   - ☐ cause serious bodily harm to himself or herself, or
   - ☐ cause serious bodily harm to another person, or
   - ☐ suffer substantial mental or physical deterioration, or
   - ☐ suffer serious physical impairment

I base this opinion on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated by others:

I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder. I hereby make application for a psychiatric assessment of the person named.

Today's date _____ Today's time _____

Examining physician's signature _____ (signature of physician)

This form authorizes, for a period of 7 days including the date of signature, the apprehension of the person named and his or her detention in a psychiatric facility for a maximum of 72 hours.

For Use at the Psychiatric Facility

Once the period of detention at the psychiatric facility begins, the attending physician should note the date and time this occurs and must promptly give the person a Form 42.

_____ (Date and time detention commences) _____ (signature of physician)

_____ (Date and time Form 42 delivered) _____ (signature of physician)

(Disponible en version française)

6427–41 (00/12) 7530–4972

Sign this part

Leave this empty for outpatients
Form 42 issued on arrival to psychiatric hospital

Form 1 Process

Person assessed by physician

If criteria are met, sign Form 1 within 7 days

Police then have 7 days to apprehend the person

Form 1 - Application by Physician for Psychiatric Assessment

Authority to:

- **Take person forthwith to psychiatric facility; and**
- **detain for up to 72 hours**

Procedural Requirements

- ✓ **Sources of information must be clear**
- ✓ **Document date and time of detention start**
- ✓ **Form 42 (Notice to Person) must be provided forthwith *upon arrival at Schedule 1 (or immediately upon completion of Form 1 if already at facility)***

Three options upon assessment

1) Discharge

2) Admit as voluntary or informal patient

- ✓ **Obtain and document patient/SDM's agreement**
- ✓ **If informal pt 12-15 yo, Form 27**

3) Form 3 – Certificate of Involuntary Admission

Hypothetical Case

Steve spends three days in hospital under a form 1. He is no longer agitated or threatening anyone or himself. He is caring for himself appropriately. He wants to leave. He has some mild paranoia, but it is vague, and his symptoms of psychosis have clearly improved. Could he be certified under a form 3?

Involuntary Detention – Form 3/4/4A

“Box A” Criteria (*MHA* s. 20(5))

Not suitable to be voluntary or informal patient

Suffering from mental disorder of a nature or quality that likely will result in:

- Serious bodily harm to others
- Serious bodily harm to self
- Serious physical impairment

Unless remains in the custody of a psychiatric facility

Involuntary Detention – Form 3/4/4A

"Box B" Criteria (*MHA* s. 20(1.1))

1) Not suitable to be voluntary or informal patient

2) Found **incapable of consenting to treatment** and **SDM consent** obtained

3) **Previously received treatment** for mental disorder of ongoing/recurring nature that when not treated will likely result in:

- Serious bodily harm to others
- Serious bodily harm to self
- Serious physical impairment
- **Substantial mental or physical deterioration**

4) Shown **clinical improvement** as a result of the treatment

5) Currently suffering from **same or similar mental disorder**

6) Given history and current condition, like to

- Cause serious bodily harm to self or others

Form 3/4/4A Process

Form 3 – Certificate of Involuntary Admission

Authority to detain for two weeks

- Completed by a <u>different physician</u> than Form 1
- Patient must be voluntary/informal/Form 1
- Right to apply to CCB

Form 4 – Certificate of Renewal

- Authority to detain for one month less a day
- Right to apply to CCB with each renewal

Form 4 2nd Renewal

- Authority to detain for two months less a day

Form 4 3rd Renewal

- Authority to detain for three months less a day

Form 4A – Certificate of Continuation

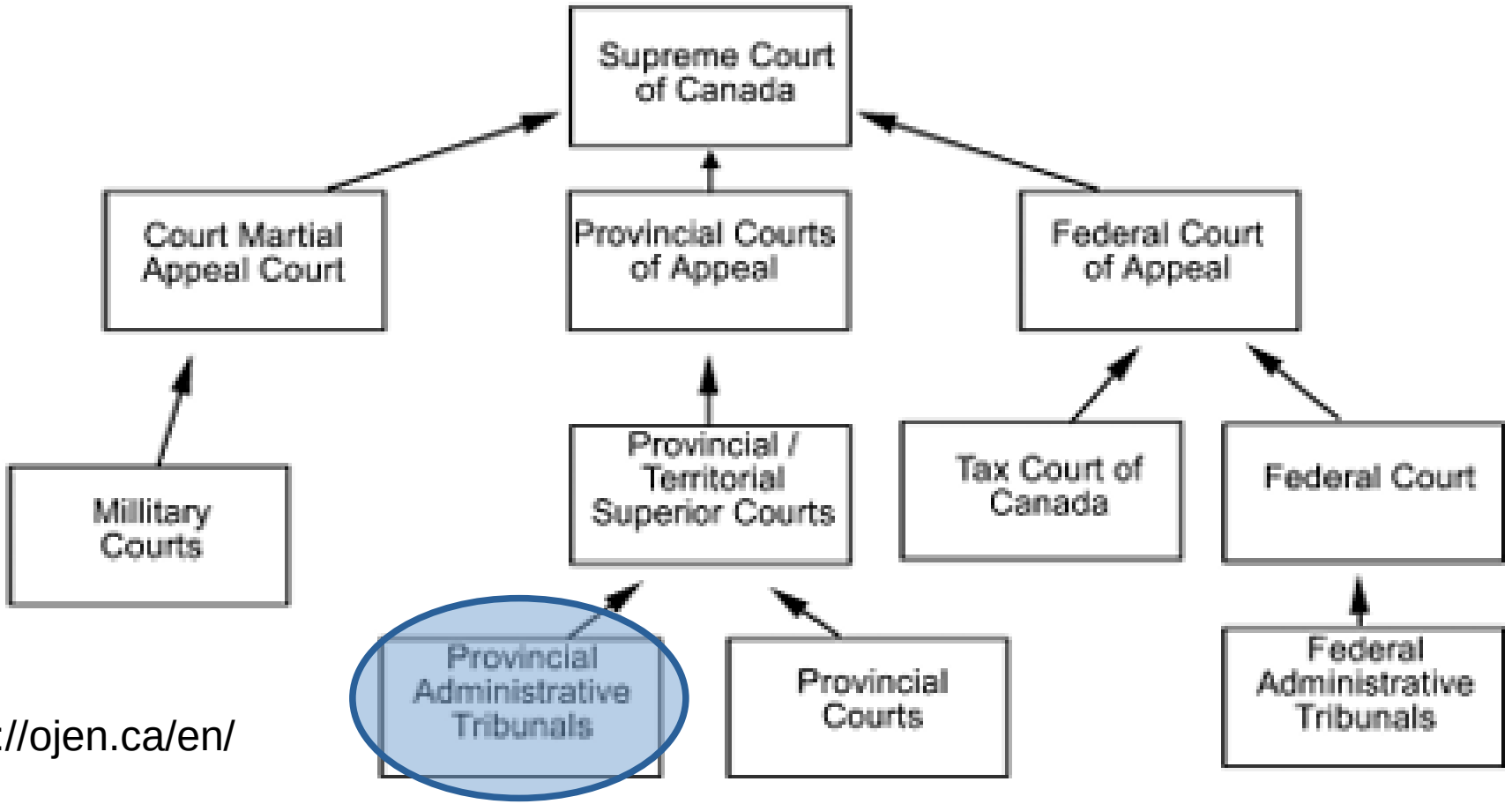
- Authority to detain for three months less a day
- <u>Mandatory</u> CCB Hearing on first Form 4A and <u>every fourth</u> Form 4A thereafter
- Opportunity for Form 51 (Application to the Board for Orders Under s 41.1)

Form 1 is the basis of all of this

Procedural Requirements for each Form 3/4/4A

- ✓ **Filing and Review** with Officer in Charge – fax Form 3/4/4A AND Form 30 to Health Records BEFORE expiry of previous Form
- ✓ **Form 30** (Notice to Patient) must be provided – original to patient, copy to Health Records
- ✓ Request **Rights Advice**. Patient must receive Rights Advice promptly. Form 50 (Confirmation of Rights Advice) required

Ontario Justice Education Network
Handout: Structure of the Courts in Canada



https://ojen.ca/en/

Cases considered by the Consent and Capacity Board

AJ - 2021

AJ was diagnosed with substance use disorder, which was the basis of her involuntary hospitalization.

AJ's history included a pattern of substance-seeking behaviour and ingestion of large quantities of prescription medications, which had resulted in overdose and hospitalization.

The Board found AJ's mental disorder was likely cause serious bodily harm to herself, either intentionally or unintentionally, unless she were detained in hospital. They cited AJ's overdose history, car accidents in the context of substance use, hospitalization, and ingestion of antifreeze as evidence supporting this ground.

The Board confirmed AJ's involuntary status on the Box A criteria of serious bodily harm to herself.

AJ (Re), 2021 CanLII 61415 (ON CCB).

FP - 2021

FP was diagnosed with schizophrenia, however, he was admitted to hospital for the purpose of treating his addiction to fentanyl. At the time of the hearing, FP's schizophrenia was managed by a CTO:

- The Board found that FP "was sufficiently addicted," and suffered consequences as a result, that his use of these drugs constituted a "disease or disability of the mind"
- The Board noted the context of fentanyl use and resulting deaths across Canada, and cited the specific nature of that drug as a particular concern.
- The Board accepted that FP was addicted to fentanyl and had no desire to treat his addiction and "further serious physical impairment was probable, death was possible"

However, FP's involuntary status was overturned on the basis that **he agreed to stay in hospital as a voluntary patient.**

FP (Re), 2021 CanLII 53197 (ON CCB)

AH - 2022

AH was diagnosed with schizoaffective disorder bipolar subtype and substance use disorder

The Board's Reasons identify a constellation of risk factors arising from AH's mental conditions, including substance use:

- AH had a long-standing history of stimulant use, but experienced mania and psychosis absent substances
- In finding AH was likely to suffer serious physical impairment due to her mental condition, the Board cited her: poor insight, non-adherence to treatment, refusal of medical investigations, history of sexual exploitation and substance use, along with other factors

While the Board found that any one risk factor in AH's case may not have established a likelihood of serious physical impairment, the risks, when considered in their totality, satisfied this criteria under the *Act*.

Involuntary status confirmed on Box A – risk of serious physical impairment

AH (Re), 2022 CanLII 64985 (ON CCB),

Case reports: Di Paola et al, The Canadian Journal of Addiction 14(1):p 22-25, March 2023.

- three reports of patients in their early 20s to late 50s
- all patients were **capable with respect to treatment**

Case 1: male in his 50s, 30-year history of alcohol use, 26-52 oz a day at admission
- suspected Wernicke's encephalopathy, with ataxia and confusion
- initially admitted for 4 days, then an additional 4 days involuntarily
- started anticraving medications and connected to care, cognition improved

Case 2: female in 20s, severe opioid use disorder, emotional dysregulation
-held on a form 1 after escalating use, not engaging in assessment or safety planning
-3 day admission which allowed stabilization and engagement in care

Case 3: male in early 30s, opioid and methamphetamine use disorders
-long period of recovery followed by severe relapse to opioids and stimulants
-multiple admissions to ED, malnourished, decline in functioning
-involuntarily admitted for 17 days, then an additional 8 days voluntarily
"The patient stated that this decision was beneficial and necessary."

Involuntary Treatment:
When should we (if we can), and to what end?

acute → Form 1 (up to 72h) → ***subacute*** → Form 3 (up to 14 days) → ***chronic*** → ? Residential treatment (21 days – 1 year)

Form 1 criteria may apply to safety concerns related to acute intoxication or withdrawal: harm to self, others or failure to care for self.

Concurrent Primary Psychiatric Disorder

If there is a separate or related mental health diagnosis such as psychosis, Form 3 criteria could be fulfilled, **but this may be <u>underused</u>**.*

NO concurrent Primary Psychiatric Disorder

This is the major controversy – Form 3 criteria for the substance use as a primary diagnosis.

Where? How?
In a concurrent mental health and substance use treatment facility?
Involuntarily?

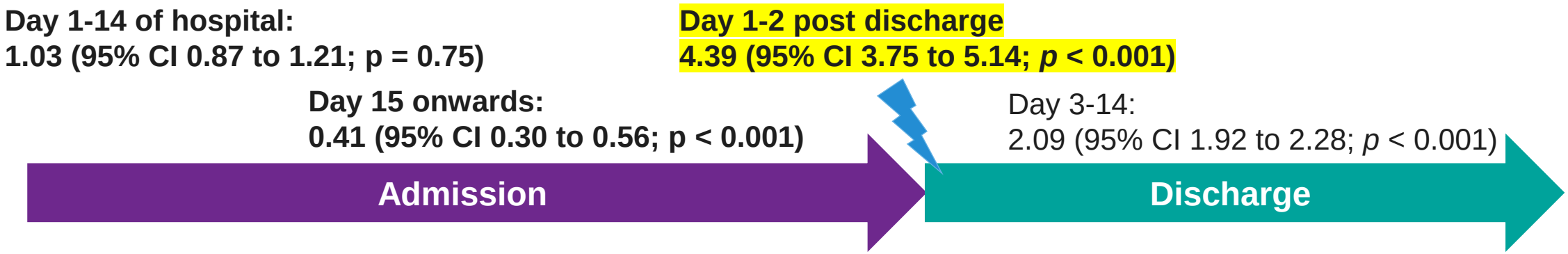
"The Red Fish Healing Centre is designated as a provincial mental health facility under Schedule A of the BC Mental Health Act which articulates the rules and regulations for admission and detention of patients"

Being a frequent ED user (5+ visits) for substance use makes it **less likely (13.8%) that a person receives a psychiatric hospitalization vs. no SUD ED visits (34.4%). (Urbanoski K, et al. Emerg Med J 2018;35:220–225.)*

http://www.bcmhsus.ca/Documents/Inpatient_Model_of_Care_120821_online.pdf

Intersections of law and clinical practice: Complexity, nuance and trends

- ❑ Historically, much of the discussion was around **alcohol use**, which is still a leading cause of substance use morbidity and mortality
- ❑ Even within opioid use disorder, secular trends (**fentanyl**) and scientific understanding have changed substantially over the last decade
- ❑ Treatment with opioid agonists (methadone, buprenorphine and newer agents) is by far the most effective and life-saving treatment for opioid use disorder, compared to residential treatment (Wakeman, *JAMA Network Open.* 2020)
- ❑ Discharge from any controlled environment, **including hospital** is a high risk time in terms of relapse and overdose:



Lewer D, Eastwood B, White M, Brothers TD, McCusker M, Copeland C, et al. (2021) Fatal opioid overdoses during and shortly after hospital admissions in England: A case-crossover study. PLoS Med 18(10): e1003759.

…to what end?

- There are lengthy wait times for publicly funded residential programs
  - **100 days is the average wait for adult residential treatment (2022) in Ontario -** https://amho.ca/wp-content/uploads/AMHO_BudgetSubmission_2022_FINAL.pdf
- Applications to residential programs require intake assessments → **this has just changed!**
- Sub-specialty services are not available in the majority of the province/country
- If there no possibility of acute (<14 day) admission voluntarily to residential care, what is the ethical basis of certification for substance use disorder without acute concurrent disorders? Is it reasonable to use certification as a resource for the reason that it may be the *only* available resource?
- **PWUD (people who use drugs) included in a qualitative survey reported, "Participants did not endorse the use of involuntary care, instead emphasizing significant changes were needed to address shortcomings of the wider voluntary care system."**
  - Chau et al (2021). The perspectives of people who use drugs regarding short term involuntary substance use care for severe substance use disorders. *International Journal of Drug Policy, 97*(103208).

More Questions

- Defining the correct research question:
  - Is it ethical?
- Would involuntary treatment target and harm First Nations communities? (Kisely et all, Australian & New Zealand Journal of Psychiatry, 2024. 58(12): 1017-1019
- What is the *treatment* we are proposing?
    - Even among “residential”, what does this mean?
    - Work? Farming? CBT? Service? Spiritual?
  - What is the duration of the treatment?
  - Who is the population we are proposing it for?
    - Adults vs. Youth, Justice vs. non-justice

Brightshores Health System

About Brightshores | Patients & Visitors | Services | Careers | Physicians | Volunteering | Research

Services > Mental Health & Addiction Services

Services

- Ambulatory Care
- Autism Spectrum Disorder Clinic
- Cardiac Rehab Program
- Cardiology Services
- Complex Continuing Care
- Critical Care Unit
- Diabetes Grey Bruce
- Dialysis
- Emergency Department
- Brightshores Cancer Centre

Mental Health & Addiction Services

Brightshores Mental Health & Addiction Services Expansion – Wellness & Recovery Centre

https://www.brightshores.ca/mental-health-addiction-services/

The Bigger Picture

- Do we need to change the law, or *use* the laws we have?
- To use the laws we have, do we need more beds?
- If people are seeking voluntary care, but face long wait lists, are these barriers we can and must reduce first?
- Is it only residential treatment we should focus on, or also comprehensive, integrated outpatient mental health and substance use services?
- How do we consider mandated treatment for a capable versus incapable person...?
- The IDAT program in New South Whales treats approximately 60 people a year, and prioritizes individuals without decision-making capacity (Kisely et all, Australian & New Zealand Journal of Psychiatry, 2024. 58(12): 1017-1019).

Hypothetical Case

Steve leaves the hospital and is now receiving treatment at a RAAM clinic. The staff identify that he has been using fentanyl intermittently for the past few months. He does not use daily and has had several accidental overdoses. Due to the risk of overdose, they discuss buprenorphine with him, but he says, "I have to start at 11 mg, that's my Angel number, I can't start at a lower dose". Is he capable with respect to opioid agonist therapy? What if he isn't?

3

Consent and capacity with respect to substance use treatment

Capacity and Consent to Treatment: An intertwined issue

- Today's discussion is focused on involuntary treatment, but inevitably this relates to capacity to consent to treatment in a number of ways:
  - "Box B" criteria for incapable patients
  - Capacity with respect to treatment for primary mental disorder versus substance use disorders
  - The potential use of Community Treatment Orders for people with substance use disorders as a less restrictive or coercive measure than hospitalization or coercive residential treatment

- Tension about how the legal test of capacity (*Starson v. Swayze*) applies in populations such as youth that have impaired capacity due to substance use, intoxication, overdose, and possibly developmental considerations
  - Goodyear, T. *et al*. (2023). Autonomy and (In)Capacity to Consent in Adolescent Substance Use Treatment and Care. *Journal of Adolescent Health, 72*(2) 179-181.

Decision-making capacity – legal overview

Is **presumed** (*HCCA* s. 4) ***unless you know otherwise**

Is **time specific** (*HCCA* s. 15)

Is **task specific**

- Treatment vs Finances vs. Admission to long-term care facility

Is **treatment specific** (*HCCA s. 15*)

- Antipsychotics vs. mood stabilizers
- Diabetes management vs. cancer
- Heart surgery vs. Tylenol for headache

Is **functional**

- Diagnosis does not indicate incapacity

Consent and Capacity to make *treatment* decisions

- Capacity to consent to treatment is defined in the *Health Care Consent Act* (HCCA): https://www.ontario.ca/laws/statute/96h02
- Who assesses it: "A health practitioner who proposes a treatment" must determine if the person is capable
- The capable person **or** the incapable person's substitute decision maker (if the patient is incapable) has the legal right to make decisions about treatment
  - Exception for emergencies
- Substitute decision makers are determined by the hierarchy in the act
- Prior capable wishes (versus best interest) is prioritized

Legal test of capacity for treatment

Ontario's *Health Care Consent Act* defines capacity with respect to treatment as follows:

"A person is capable with respect to a treatment...if the person is able to understand the information that is relevant to making a decision about the treatment…,

…and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."

- ❑ capacity is specific to the treatment
- ❑ ***"Best Interest" or consideration of outcomes is not part of this definition***
- ❑ consent must be obtained **prior** to starting a treatment (except in emergencies) from the capable person, or incapable person's substitute decision maker
- ❑ any inpatient or outpatient can contest a finding of incapacity, with respect to any treatment by requesting a hearing of the Consent and Capacity Board

Aid to Capacity Evaluation tool: Dr. E. Etchells

https://www.cmpa-acpm.ca/static-assets/pdf/education-and-events/resident-symposium/aid_to_capacity_evaluation-e.pdf

EXAMPLES OF SCORING

1. Able to Understand Medical Problem		
Sample Questions	**Sample Responses**	**Suggested Scoring**
What problem are you having right now?	*My foot hurts. I can't walk.*	YES
What problem are you having right now? Do you have a foot problem?	*I don't know.* *Yes, I can't walk.*	UNSURE
What is your most serious medical problem right now?	*I don't know.*	NO

Findings of Incapacity (Treatment) - Process

Finding of incapacity is made for:

- an **inpatient in Schedule 1 facility**
- **≥14 y.o.**, **AND**
- the treatment is **for a mental disorder:**

√ **Form 33**

√ **Rights advice**

√ Right to apply to the **CCB**

Finding of incapacity is made for:

- **<14 y.o.**,
- **outpatient,**
- **inpatient in non-Schedule 1**, **OR**
- the treatment for **anything other than a mental disorder**

√ No Form 33

√ **Physician/Health practitioner provides rights advice** and documents same

√ Right to apply to the **CCB**

Finding of Incapacity – Medical/Community

STEP 1: Documenting the Assessment

1) The *specific treatments* for which the client has been found incapable (recall that capacity is treatment specific);

2) A consideration of each branch of the capacity test and whether s/he passes or fails:

Does the client have *the ability* to understand the information provided to him/her; and

Does the client have *the ability* to appreciate the reasonably foreseeable consequences of a decision or lack of decision regarding the treatment?

3) What information has been given to the client, including:

Nature of the treatment

Risks and benefits of same

Possible side effects/negative outcomes

Alternatives

4) The responses s/he gives to that information;

5) Whether the inability to understand/appreciate is due to a mental disorder (broadly defined as any disease or disability of the mind);

6) That the healthcare practitioner has provided Rights Advice (see next slide).

Finding of Incapacity – Medical/Community

STEP 2: Providing Rights Advice to the Client

According to the CPSO, delivering **Rights Advice** involves;

1) Informing the incapable patient of the finding and that a SDM will assist them in understanding the proposed treatment and will be responsible for making the final decision;

2) If the patient disagrees with the finding, advising that patient that s/he can apply to the CCB for a review of the finding;

3) If the patient disagrees with the involvement of the current SDM, advising the patient s/he can apply to the CCB to appoint a different SDM; and

4) If the patient wishes to exercise either of the option in (2) or (3), taking reasonable steps to assist the patient in making an application to the CCB.

Who Is the SDM?
HCCA s. 20

Guardian of the Person

Attorney for Personal Care

Representative appointed by Consent and Capacity Board

Spouse or Partner

Custodial parent (or CAS) or child

Parent with right of access only

Brother or sister

Any other relative

Public Guardian and Trustee

CCB Reasons and Addictions Treatment: A Review

- ❑ Review of all CCB Reasons for Decision publicly reported on CanLII in Ontario (**10,463**) *****
- ❑ Not all hearings are reported, e.g. in the 2020/2021 fiscal year **only 12.4% of CCB hearings were reported**
- ❑ Only **71** reported CCB Reasons included the key words "methadone", "buprenorphine", "Suboxone", "opioid agonist", "opioid replacement" or "naltrexone" (the hearing was not necessarily regarding capacity whatsoever)
- ❑ In comparison, **5016** included "schizophrenia", **7148** included "antipsychotic" or "anti-psychotic" and **525** included "surgery"
- ❑ Only **6** CCB Reasons specifically reference a determination of capacity with respect to addictions treatment, and only **1** found a patient being incapable with respect to opioid replacement therapy

AM (*Re*), 2019 CanLII 46829 (ON CCB)

43 year old man detained under the Ontario Review Board, with a history of aggression related to requesting escalating doses of methadone.

"For the foregoing reasons, it was determined that AM was not capable respecting treatment with antipsychotic medications (oral and injectable); anti-anxiety medications; and opioid replacement therapy. It was not necessary to specify blood work and EKG testing as they were ancillary to said treatments; and as such included."

*****_The Consent and Capacity Board (CCB) publishes all Reasons for Decision issued by the CCB since June 1, 2003 on the Canadian Legal Information Institute (CanLII) website: https://www.canlii.org/en/on/onccb/index.html. Some Reasons issued before June 1, 2003 are also available on CanLII. Note that Reasons for Decision are only issued if one of the parties to a CCB hearings makes a request for reasons for a decision, within 30 days after the hearing ends._

See also: Hauck TS, Goud R, Warner M, et al. Capacity to Consent to Treatment of Substance Use Disorders at Ontario's Consent and Capacity Board: A Review of Past Reported Decisions. *The Canadian Journal of Psychiatry*. 2024;69(10):781-783.

CCB Reasons for Decisions for Incapacity to Substance Use Treatment

Decision	Patient	Site	Incapacity Finding	
AK (Re) #26051 2016	57 M	St. Joseph's Healthcare Hamilton - Charlton Campus	Yes (including naltrexone)	Patient with history of schizophrenia, SUD and brain injury, and previously on methadone. Involuntary status upheld and incapacity towards bloodwork, APs, mood stabilizers, BZs, cogentin for side effects and naltrexone.
AM (Re) #52835 2015	40 M	CAMH	Yes (APs, anxiolytics, anti-cholinergics)	Patient with history of SCZ and OUD, previously found capable to consent to methadone and gabapentin. CCB upheld incapacity towards treatment with APs, anxiolytics and anticholinergic medications.
AM (Re) #28874 2020	53 M	Owen Sound, Ontario	Yes (capable to naltrexone and CTO)	Patient with SCZ and on a CTO, previously found capable to consent towards naltrexone treatment for AUD. CCB confirmed CTO renewal and incapacity towards APs and the CTP.
JG (Re) #138886 2021	62 W	Mount Sinai Hospital	No	Patient with history of major neurocognitive disorder, taking anti-craving medication for AUD. Previously found incapable to consent to ADs only. Involuntary status was revoked. There was discussion that the finding of incapacity around anti-craving medication was unclear: **"The panel also had some difficulty finding whether there was a finding of incapacity related to the anti-craving medication."**
RB (Re) #120998 2018	37 M	Waypoint Centre for Mental Health	Yes (APs and MS)	Patient with history of SCZ and previously found treatment capable with regards to methadone. Incapacity towards APs and mood stabilizers was upheld.

Consent and Capacity: Implications and Future Considerations

- ❑ Methamphetamine use has been escalating in North America as part of a “twindemic”
- ❑ Methamphetamine use increased from 0.3% of population (USA) in 2015 to 0.9% in 2021
- ❑ Between 2015 and 2017, methamphetamine use tripled among people using heroin (9.0% to 30.2%)
- ❑ Stimulant use can lead to persistent psychosis in individuals concurrently using opioids, particularly fentanyl
- ❑ A recent study from British Colombia found that, “Among people with a mental illness, the highest overdose mortality rates were among those with schizophrenia and other psychotic disorders (2.7, 95% CI = 2.3–3.3)” (Keen et al, *Addiction* 2022)
- ❑ There are many reasons why a patient may be incapable with respect to addictions treatment such as OAT, including psychotic disorders, traumatic or anoxic brain injury, neurocognitive disorder, or neurodevelopmental disorders

→How does this impact care in an ACT setting, as opioid overdose becomes a major source of mortality?

→How does it impact care if 100% of ACTs are over-capacity? (https://ontarioactassociation.com/resources/)

→ What are the implications for a CTO if a patient is incapable with respect to OAT such as buprenorphine extended-release?

https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf
https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf

Conclusions

- ❑ Acute, subacute and long-term residential treatment settings are different and have different considerations
- ❑ Acute treatment on an involuntary basis in hospital can be utilized in some cases pursuant to provisions of Ontario's *Mental Health Act*
- ❑ Involuntary subacute treatment has been provided in some circumstances to individuals with primary substance use disorders, and merits further exploration
- ❑ Long-term treatment (residential) is a very different ethical and legal consideration, with limited evidence to support involuntary long-term treatment and ongoing work needed in the following areas:
  - ❑ ethical considerations and legislative changes
  - ❑ ongoing research and outcome studies
  - ❑ consideration of resource limitations and logistical possibilities
- ❑ Capacity and consent have had limited attention in addictions treatment, but are important considerations given the risks of treatments and the substantial risks of mortality if treatment is not received

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Questions?

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This information is for educational purposes only. It should not be considered legal advice, and is not a substitute for legal advice in a given situation.