MOCK HEARING OF THE CONSENT AND CAPACITY BOARD OF ONTARIO

FINDING OF INCAPACITY TO MAKE TREATMENT DECISIONS
And
INVOLUNTARY ADMISSION TO A PSYCHIATRIC FACILITY

Filmed and Funded Jointly
By the
Consent and Capacity Board of Ontario
And
The Ottawa Hospital,
Social Work Department

The Ottawa Hospital, Mock Hearing Committee

Chair: Elda Lansfield MSW, RSW
Member: Pierre-Paul Filion MSW, RSW
Member: Brian Wilson MSW, RSW

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Introduction

This video of a mock hearing of the Consent and Capacity Board was filmed jointly by a group of social workers from The Ottawa Hospital and members of the Capacity Board (CCB) of Ontario with the support and assistance of Dr. Yoland Charbonneau and Mr. Mark Handelman. This video is intended to help educate health professionals who are preparing to participate in a Hearing held by the CCB. The video shows the process and procedures followed at all CCB hearings. The documents that accompany the video will provide additional information on these procedures and on the process of preparing for a hearing.

The mock hearing depicted in this video reviews a finding of incapacity to make treatment decisions and an involuntary admission to a psychiatric facility. The health practitioner in this video is a hospital based psychiatrist.

To further prepare anyone who is presenting before the CCB and to make the video a more useful tool, a toolkit has been provided in addition to the video. This toolkit contains documents that we hope will further explain CCB procedures and practice. It also contains the mock documents submitted by the health practitioner during the mock hearing. These "mock" documents are intended to give the viewer of the video examples of the type of documentation that can be given into evidence.

The first document in the toolkit is the Order of the Hearing. All CCB hearings follow the same process. This document summarizes the steps that will be followed during the Hearing. The second document is a collection of teaching points. It includes those points discussed by the narrator in the video and other information that will help the viewer prepare for and participate in the Hearing.

The Ottawa Hospital, Mock Hearing Committee

Chair: Elda Lansfield MSW, RSW
Member: Pierre-Paul Filion MSW, RSW
Member: Brian Wilson MSW, RSW

GENERAL ORDER OF THE HEARING

PRELIMINARY MATTERS

Presiding Member's Opening Remarks:

1. Explains the purpose and nature of the hearing
2. Introduces the parties to the Hearing and CCB members
3. Lists documents that were provided to the Board as evidence
4. Explains the process of the Hearing
5. Asks if there are any preliminary or procedural matters and deals with them

THE HEARING

1. Health practitioners present evidence first (i.e. introduce the patient, brief review of clinical summary)
2. Patient or patient's lawyer may question the health practitioner
3. Board members may question health practitioner
4. Health practitioner calls and questions witnesses
5. Patient (if not represented by counsel) or patient's lawyer questions health practitioner's witnesses
6. Board members may question health practitioner's witnesses
7. Patient or patient's lawyer may call and question witnesses
8. Health practitioner may question patient/lawyer's witnesses
9. Board members may question lawyer's witnesses

CLOSING SUBMISSIONS

- Closing submissions are presented starting with the health practitioner

CLOSING THE HEARING

- Presiding member thanks everyone for attending and reminds them that the decision of the Board will be faxed to them within 24 hours. The presiding member also reminds the parties that they have the right to request Reasons for the decision.

TESTS

Test for: Capacity to Make Treatment Decisions

This test, as stated in the *Health Care Consent Act,* defines "capacity." The health practitioner must demonstrate that on the day of the Hearing the patient lacks these abilities, as related to the definition of capacity, and is therefore incapable of making treatment, admission or personal assistance decisions.

The CCB hearing is held to determine if the finding of incapacity meets the test stated in the legislation. The definition of "capacity" is found in the *Health Care Consent Act,* section 4 (1):

> 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.

Test for: Involuntary Admission to a Psychiatric Facility

This test is found in the *Mental Health Act.* After the attending physician has observed and examined a person who is the subject of an application for assessment (Form 1) under section 15 of the *Mental Health Act,* or who is already a voluntary patient the physician will proceed as follows:

20.(1)(c) shall admit the person as an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission if the attending physician is of the opinion that the conditions set out in subsection (1.1) or (5) are met.

20. (1.1) Conditions for Involuntary Admission for Incapable Patients (Box B of Form 3 or 4):

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 that the patient,

(a) 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 serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person;

(b) has shown clinical improvement as a result of the treatment;

(c) is 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;

(d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment;

(e) has been found 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

(f) is not suitable for admission or continuation as an informal or voluntary patient. 2000, c. 9, s. 7 (2).

20. (5) Conditions for Involuntary Admission that <u>do not</u> require the Patient to be Incapable of Making Treatment Decisions (Box A of Form 3 or 4):

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,

(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.

Note: Other subsections of section 20 deal with the procedural aspects of a person's admission as an involuntary patient, such as filing the Form 3 or 4 with the Officer in Charge. Physicians; remember to have the Officer in Charge sign and date these forms.

TEACHING POINTS

The Hearing Process:

- The Ontario Consent and Capacity Board will convene a Hearing within 7 days of receiving the application. The Hearing takes place in a location that is mutually convenient to the parties, usually in a hospital, community centre, care facility or CCAC office, but sometimes at the home of the person found incapable. If the Applicant is a patient in a psychiatric facility or the mental health unit of a general hospital, that is where the Hearing will be convened.

- The law gives the patient's lawyer the right to review all medical and other records without the patient's consent.

- A Board that is reviewing a finding of incapacity to make a treatment decision and/or involuntary admission typically consists of three members: a psychiatrist member, a public member and a presiding member, who is always a lawyer.

- The role of the presiding member is to "preside", which means controlling the Hearing by ensuring that the rules and procedures that govern a Hearing are followed. This can include describing the Hearing process at its beginning, ensuring the parties call and question witnesses in the right order, maintaining order, safety and security and ruling on evidentiary and procedural issues--after consulting with his or her fellow adjudicators where necessary. The presiding member will also sign and fax the Decision and write Reasons when requested.

- Each presiding member will conduct the opening process of a CCB Hearing in a somewhat different fashion. This video intends to illustrate the general practice.

- Rules found in the legislation govern who may attend a Hearing. Parties are those people who are entitled to attend the Hearing, who receive notice of a Hearing, who are entitled to appeal a Board decision and who are entitled to request and receive reasons for a Board decision. Who is a party to a hearing depends on the type of application submitted to the Board. The people (parties) depicted in this video are the person applying for the review, his lawyer and the attending physician.
- At the beginning of the Hearing the presiding member asks if there are any preliminary matters to be dealt with. "Preliminary matters" are procedural issues that might result in a decision (finding of incapacity or involuntary admission) being revoked as it is procedurally invalid. This review of procedural issues can also lead to some evidence not being admitted or to an adjournment of the Hearing.

- CCB hearings are open to the public unless restrictions are imposed by the Board. A party is entitled to bring witnesses to the Hearing. Parties may request that witnesses be excluded from parts of the Hearing, until they give evidence.

- It is the job of a patient's lawyer to challenge the finding of incapacity and/or the involuntary admission. The lawyer's first opportunity to do that is when he/she questions the health practitioner. The lawyer will do what he/she can to challenge the health practitioner's evidence. The lawyer is follows the patient's instructions.

- When deciding how to conduct yourself at the Hearing, which witnesses to call, which documents to submit and what questions to ask, **remember the test** relevant to your Hearing and use common sense.

- **Physicians: It is recommended that the clinical summary template provided by the CCB be used and submitted as evidence. This template is designed to help you present the evidence required to provide validity to your findings. This template can be found on the Board's website at http://www.ccboard.on.ca**

- When the health practitioner presents his/her evidence, the health practitioner should begin with a brief introduction of the patient. This will help orient the patient to the Hearing and assist the Board in getting to know this patient and their current situation. The health practitioner refers to the clinical summary at this point in the Hearing. Preparing a detailed clinical summary saves time and ensures that the health practitioner will not miss any important evidence. It also decreases the possibility of affronting the patient's dignity with sensitive oral evidence that may be embarrassing or offensive to the patient.

- The health practitioner's presentation of evidence is the first opportunity to demonstrate that the test for a finding of incapacity to make treatment decisions and involuntary admission (or any test relevant to your Hearing) has been met. In the video the health practitioner demonstrates that the test has been met by submitting written evidence, providing oral evidence and witness testimony. **Know the legal definition of your test(s)** as the Board will only consider evidence related to the test when making their decision.

- After the health practitioner gives evidence, the patient's lawyer and the Board may question the health practitioner.

- If a lawyer asks a health practitioner for information about a patient's case, in advance of a Hearing, the health practitioner should confirm that this lawyer is representing the patient.

Evidence, Exhibits and Witnesses:

- Evidence that demonstrates that the test has been met must be presented during the Hearing. Many forms of evidence can be submitted. It may include witness testimony, expert knowledge (i.e. research findings, diagnostic information and rational, medication usage, lab results, ER physician reports), photos, and documents. Evidence other than oral testimony from witnesses may be entered by the Board as "exhibits." Exhibits may include: clinical summary, notes from the patient's hospital record, a family physician report or letter, reports and assessments from any health discipline, police report(s), and letters from family, friends and neighbours.

- The health practitioner's clinical summary may be supported by other evidence in the form of oral testimony or written evidence. For example, a report from the police officers who brought the patient to hospital will likely show the type of behaviour to anticipate if the patient left hospital too early. Or, a nurse's entry in the patient's chart will show patient's ongoing aggressive behaviour or delusional state.

- Health Practitioners should make all documents intended to be used as evidence available to all the parties (or their legal representatives) at least 15 minutes before the Hearing is scheduled to begin. Copies of these documents should also be available to all Board Members (3 copies, one for each Member).

- In weighing the evidence the Board must decide if it was sufficiently **cogent**, **compelling** and **credible**. Evidence is cogent if it is detailed, logical and well reasoned. It is compelling if it tends to prove the party's case. It is credible if it has the ring of truth and is believable.

  Example:
  The statement, "Jane is violent" is not cogent because it is too vague. However an assessment that states that Jane is violent and is supported with: "Jane attacked her mother last Tuesday with a steak knife when she asked Jane to help clear the table." The mother needed 12 stitches to her neck and cheek." is cogent. It is also compelling because it demonstrates the likelihood that Jane will cause serious bodily harm to another person (of course, it does not, by itself, establish that the harm is the result of mental disorder.). It is also credible because it is supported by the injury Jane's mother suffered. In this particular case the violence is an objective fact that was independently proven.

  The Board largely trusts the opinions of health professionals because they are trained observers and trained note takers. A nurse's note, for example, supporting the physician's evidence is therefore often valuable because the author is a trained and objective observer. A note that reads, "Jane didn't sleep at all last night" does not tell us much. Though it is credible, it is neither cogent nor compelling. However a note that states, "Jane was up all night, crouched on the window sill, insisting it be opened so she could fly away. She said she wouldn't be hurt if she exited through the window because Jesus was in her and would protect her. When I tried to offer her PRN medication, she spat at me, called me an agent of the devil and screamed that there was nothing wrong with her. Since she was not hurting herself or anyone else (the window is barred and shatterproof glass), we decided not to force medication upon her" is cogent, compelling and credible: it tends to prove what is likely to happen to Jane if she left hospital.

- Hearsay evidence, information that is told to you by others, can be admitted but is of less weight than that offered by the person who has first hand knowledge of events. At Board hearings, hearsay evidence is admissible and the Board will decide how much weight to give it, based upon how cogent, compelling and credible it is.

- The patient has the right but **is not** obliged to testify.

- The health practitioner may call witnesses to support his/her findings but is not obliged to do this. Many types of witnesses can be called: nurses, family members, friends, any type of health care provider, family physician, neighbours, etc.

- The health practitioner may educate the witness in advance of the Hearing about the CCB hearing process, the nature of the test and the need to provide facts over emotion. The health practitioner **may not** tell the witness what answers to give, but can tell the witness what questions to expect.

- The witness should be asked to provide information about the nature of their relationship with the patient. The witness may be asked questions such as: How long has the witness known the patient? How do you know the patient? What problems has the witness observed? When did the problem start and how often did it occur? It is the details of the problems, which constitutes evidence, not the emotional impact of the problems.

- Witnesses often find testifying at the Hearing emotionally difficult. They worry about damaging their relationship with the patient as they are asked to present information that the patient can perceive as humiliating. Helping the witness to deal with their emotions prior to the Hearing can be beneficial for the Hearing and the witness.

- A witness must be sure to give all pertinent information when testifying, as this is the only opportunity to provide information. Health Practitioners, encourage a witness to organize the information they wish to present prior to the Hearing.

- The health practitioner, patient (or their lawyer) or Board members may cross examine any witness.

Board Issues and Needs:

- The Hearing reporter must have access to a power outlet and for safety reasons should be seated away from the patient, preferably at one end of the table.

- The Hearing room should be selected and set up with everyone's safety and the importance of the Hearing in mind (spacious, table to accommodate all members on one side and all parties on the other, enough space and chairs for witness, etc.).

- For the overall safety and comfort of the patient the following should be considered:

    - The patient should be seated so that they have easy access to the room exit.
    - Water should be made available to the parties and Board Members.
    - An orderly should be present when there is concern for safety or aggression.
    - The patient is entitled to be in street clothes rather than a hospital gown.

SUMMARY FOR CONSENT AND CAPACITY BOARD (CCB)

The following summary has been prepared to assist physicians appearing before the Consent and Capacity Board. The summary is recommended as a useful tool for hearings. It is not intended to replace the physician's presentation to the Board. Physicians are reminded to distribute the completed summary and any relevant documents and materials to the patient and to his/her counsel before the commencement of the Hearing.

Patient's Name: Arthur William MacKenzie IV

Date of Birth: January 7, 1984

Personal Background (i.e., health status, current/most recent address, education, employment, etc.:

- Very thin; has lost 25 pounds in last 8 weeks
- Lived with parents
- Was working on Masters Degree until 2 years ago, no employment or schooling since
- Guarded, paranoid, possible audio hallucinations, undetermined delusional structure

Hearing Date: February 29, 2008

Current Applications to the Board: Form 16, Form A

Date and Circumstances regarding Most Recent Admission and Discharge (if applicable):

William's most recent admission, his second, was to this facility from December 15 to December 23, 2007, the day the Board rescinded the Form 3 then in effect.
Admission took place after William reported to his mother that he and the family dog both heard warnings from William's great, great uncle (who has been dead for decades) that William's mother was planning to poison him. When his mother did not accept that statement with the sincerity William thought it was entitled to, William began screaming at his mother, accusing her of trying to poison him. He became very threatening and she called police, who brought William back to this facility based upon their observations of him and what his mother said.
Previous Board did not think patient likely to harm self or others. Patient denied illness, left hospital AMA.

Number of Previous Admissions:

The current admission is William's third to this facility. No indication he has been in other facilities.
First admission was September 2006, when William announced he was not returning to complete his Masters degree because one of the professors hated him due to political decisions William's great uncle made. Got into an argument with his mother, threatened her, mother called police. When Form 1 expired there were no grounds for certification. However William did need further treatment and he was asked to remain in hospital. He refused and left hospital.

Current Plan of Treatment, including Medication:

Currently administering antipsychotic medications, trying to find one to which patient responds. No side effects observed though patient complains of them. Keep patient in hospital until he regains weight recently lost, becomes mentally stable and less guarded.

Classes of Medication and/or Plan of Treatment for which the patient has been found incapable, if applicable:

Antipsychotics, side effect medications

I. INVOLUNTARY STATUS: BOX A

(Section 20(5) and 20(8) *Mental Health Act*)

Please comment on the evidence which supports the requirements for involuntary admission:

Conditions for Involuntary Admission:

Section 20(5):

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,

(i) serious bodily harm to the patient:

Supporting evidence:

(ii) serious bodily harm to another person, or

Supporting evidence:

Patient's mother reports he has threatened her, become verbally abusive, invading of her personal space. Three of those many occurrences have resulted in his hospitalization, when police officers agreed that he was dangerous to his family, brought him to this facility.

(iii) serious physical impairment of the patient,

Supporting evidence:

In the past 8 weeks, William has been increasingly guarded at home, spending almost all his time in his room. He will not eat with his family. His mother believes William sneaks out in the middle of the night to purchase food, but is unsure what he eats as he has no access to any money.

William's weight on discharge in December was 145 pounds. He refused to let us weigh him during this admission but it is clear to staff who treated him in December that he has lost significant weight since then.

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.

Supporting evidence:

William does not believe he is ill and therefore sees no reason to stay in hospital. As a voluntary patient, he would leave, which is what he did the prior two admissions.

Section 20(8):

□ Form 3 or 4 filed with Officer in Charge **Yes**

□ Form 3 or 4 reviewed forthwith by Officer in Charge or Delegate **Yes—see note and initials on Form by OIC delegate.**

II. INVOLUNTARY STATUS: BOX B
(Section 20(1.1) and 20(8) *Mental Health Act)*

Please comment on the evidence which supports the requirements for involuntary admission:

Conditions for Involuntary Admission:

Section 20(1.1):

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 that:

(a) the patient 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 serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person;

Supporting evidence:

Patient has been treated with oral antipsychotic medication since the start of his current admission—he was assessed as incapable on admission and did not file Form A for 4 days.

Patient's illness (paranoid schizophrenia) is a delusional condition in which the patient perceives that others are "out to get him." Without treatment, the victims of this disease retaliate against their "persecutors," or themselves become seriously physically impaired, or suffer substantial mental or physical deterioration.

(b) the patient has shown clinical improvement as a result of the treatment;

Supporting evidence:

With treatment during this admission, patient has become less guarded, appears less suspicious, has not been observed responding to internal stimuli as he did on previous 2 admissions. Accepted a visit from his mother February 27th, was civil with her.

(c) the patient is 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;

Supporting evidence:

Both of William's previous hospitalizations, he was diagnosed as being in the prodromal stages of paranoid schizophrenia. He was treated with controlled environment of hospitalization, having refused medication.

(d) given the patient's history of mental disorder and current mental or physical condition, the patient is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment;

Supporting evidence:

See evidence of bodily harm, serious physical impairment under Box A.

Without ongoing treatment, symptoms will reassert themselves. He will become more guarded, aggressive toward parents and continue to lose weight to the point of malnutrition and possible starvation.

(e) the patient has been found 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

Supporting evidence:

I assessed William's capacity February 20, found him incapable—rights advice provided same day; William's mother (father unavailable) agreed to be SDM, consented to his treatment—see consent in his clinical record.

(f) the patient is not suitable for admission or continuation as an informal or voluntary patient. 2000, c. 9, s. 7 (2).

Supporting evidence:

William does not recognize that he is delusional or paranoid, does not see that his weight loss could be dangerous and therefore sees no reason to be in hospital. If voluntary, he will leave—again.

Section 20(8):

□ Form 3 or 4 filed with Officer in Charge **Yes**

□ Form 3 or 4 reviewed forthwith by Officer in Charge or Delegate **Yes**

III. CAPACITY TO CONSENT TO TREATMENT (Section 4 *Health Care Consent Act*)

Date of the finding of incapacity: February 20, 2008

Proposed Plan of Treatment, including medication: (use class of drug not the specific medication)

Antipsychotic medications and side effect medications if indicated.

Section 4**(1):**

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,

Supporting evidence:

William is a very smart gentleman. His mother advises that he received scholarships to university. I have no doubt of his ability to understand this information.

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

Supporting evidence:

Though William understands information about schizophrenia and its treatment, because of the illness itself, he cannot recognize that he suffers from it. He cannot discern the objective manifestations of his illness (such as hearing voices, being guarded and irate, threatening his mother) and therefore lacks the ability to appreciate that, absent treatment, his mental condition will substantially deteriorate, he will become dangerous to his loved ones and himself suffer serious physical impairment and substantial mental deterioration.

Completed By: *Dr. Armand St. Jean*

Date: February 28, 2008

RN Note to be included in document brief:

February 29, 2008: Approached patient prior to CCB hearing to discuss eating breakfast and hoping to weigh him prior to the Hearing. In a quiet and angry voice the patient called the writer a “heinous bitch” and then stated “You are just trying to put those poisons in my body, like my mother”. The patient then walked quickly down the hall. Approached the patient in his room a few minutes later to further discuss this issue. William did not respond. He only glared at the writer and abruptly left the room kicking the open door and the way out. PRN was offered and accepted but the patient refused to discuss the incident.

February 22, 2008

Dear Dr. St. Jean

My son William has now been admitted to the hospital for psychiatric treatment for the third time since 2006. I implore you Dr. St. Jean to not allow him this time to trick you or the hospital staff in believing that his condition is not serious. He may put on airs at the hospital or sweet talk the nurses but I assure you that William is a very sick boy and should not be allowed this time to return home. His father and I are very concerned about his mental health. William has clearly lost touch with reality.

As you know William has again accused me of trying to poison him. He has been doing this on and off consistently since his first admission in 2006. He is so paranoid in thinking that I am poisoning his food that he refuses to eat anything I serve at home. He use to weigh 145 lbs but now he is down to only 120 lbs. We assume he is getting some food outside of our home but it can't be very much. He has no money to buy food with. Not only does he not eat with us any more but he has become a hermit. He never leaves his room in the basement and yells at his father and me to get out if we go down to talk to him or see how he is doing. He is always on the internet looking at God knows what. While he was sleeping one night I went down to his room and saw that he had left his computer on. The internet site he had logged into talked about aliens visiting earth and receiving communications from outer space. I really don't think that William is thinking straight. He has no friends that visit him and seems to live in a world of his own. Sometimes we even hear him talking down in his room. He doesn't have a phone in his room so we can't see who he could possibly be speaking to.

Dr. St. Jean we would like our son to have a normal life. Despite the threats he makes towards us we love him and are very worried about him. You can't possibly imagine what it is like to have your son think his parents are trying to kill him. Nothing could be further from the truth. There is no reasoning with him either. He just won't let us talk to him or listen to anything we say to show him that we love him and only want good things for him. He immediately starts yelling and going on about our wanting to get rid of him. When this time he said he was going to kill us before we got to kill him, we got scared and felt we had no choice but to call the police on him.

Please Dr. St. Jean, don't allow our son to be released from hospital this time until he gets the help that he needs. We cannot continue to live like this with his delusions and constant threats. Please help him for God's sake. He obviously needs psychiatric treatment. Why can't everyone see this? I trust and pray that you will do the right thing and keep him at the hospital this time for treatment.

Sincerely,

Janice McKenzie

POLICE MENTAL HEALTH TEMPLATE

Name:	*Sgt. Friday*	Cadre number:	12345	Date (yyyy/mm/dd)	2008/02/22

Name of Subject:	*Arthur William MacKenzie*
Type of dispatched call:	*Mental Health*
Who contacted police:	*Mother*
Case number:	123456-7

Check all boxes that apply

APPEARANCE / BEHAVIOUR					
General		**Hygiene**		**Activity**	
Cooperative / Polite		Dirty		Slow	
Rude	x	Body Odour		Agitated	x
Maintains Eye Contact		Malnourished	x	Restless / Fidgety	
Proper Clothing		Clean		Abnormal movements	

THINKING							
Disorganized Thinking		**Abnormal Speech**		***Odd Beliefs***		**Hallucinations**	
None		Rapid		Paranoid	x	Voices	
Mild		Loud/Swearing	x	Grandiose		Visions	
Moderate	x	Few words		Bizarre	x	Abnormal sensations	
Severe		Other		Other		Other	
Describe Other:							

MOOD		Rapid change of mood			
Sad		Angry	x	Anxious	
Happy		Mood not appropriate for situation		Flat	

ORIENTATION (Ask and record responses)							
Day:		Month:		Year:		Location:	

DWELLING					
Food in Fridge	x	Rotten food		Clean	
Dirty		Disorganized	x	Fire Hazard	

COMMENTS:
Lives with mother, two previous admits to hospital (psy).
Threatening mother "will kill her before she kills me"

ALCOHOL USE	Admitted:		Suspected:	
Comments / Quantity:				

DRUG USE	Admitted:		Suspected:	x
Drug Type:	Cocaine:		Marijuana:	x	Other:	

DANGER ISSUES:					
Active to Self		**Active to Others**		**Passive to Self**	
Suicidal Thoughts		Homicidal *threat*	x	Poor Self Care	
Self Mutilation		Aggressive	x	Poor Judgment	
Suicidal Act		Weapons present		Clothing inappropriate for weather	

MEDICAL INFORMATION				
Family Doctor:	*none*			
Hospital associated with:				
Psychiatrist:	*None -- refused*			
Other Professional Agency:				
Are they taking medications?	Yes:		No: x	*refused*
Pharmacy name and number:				
Name of medication:				

ACTION:		
No action		
Follow up with Professional (name):		
Arrested / Charge		
Voluntary to Hospital		
MHA Section 17	x	
Form		

Ministry of Health

Ontario

Form 3
Mental Health Act

Certificate of Involuntary Admission

Name of patient ARTHUR WILLIAM MACKENZIE
(print name of patient)

Name of physician ARMAND ST JEAN
(print name of physician)

Name of psychiatric facility THE OTTAWA HOSPITAL
(name of psychiatric facility)

Date of examination FEBRUARY 23, 2008
(date)

I hereby certify that the following three pieces of information are correct:

1. I personally examined the patient on the date set out above.
2. I am of the opinion that the patient named above is not suitable for voluntary or informal status.
3. Complete one or more boxes as appropriate.
   - ☐ I am of the opinion that the patient named above meets the criteria set out in Box A. *(please complete Box A below)*
   - ☐ I am of the opinion that the patient named above meets each of the criteria set out in Box B. *(please complete Box B below)*

Box A – Risk of Serious Harm

Note: Check one or more boxes as appropriate.

The patient is suffering from mental disorder of a nature or quality that likely will result in:

- ☐ serious bodily harm to the patient,
- ☑ serious bodily harm to another person
- ☐ serious physical impairment of the patient

unless he or she remains in the custody of a psychiatric facility.

Box B – Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria

Note: The patient *must* meet *all* of the following five criteria.

1. The patient has been found 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.
2. The patient 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 the patient,
   - ☑ serious bodily harm to another person,
   - ☑ substantial mental or physical deterioration of the patient, or
   - ☐ serious physical impairment of the patient;

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See reverse.

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Box B – Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria *(continued)*

3. The patient has shown clinical improvement as a result of the treatment.

4. The patient is 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.

5. Given the person's history of mental disorder and current mental or physical condition, is likely to: *(please indicate one or more)*

- ☐ 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

Feb 23/08
(Date of signature)

(signature of attending physician)

Notes

1) This certificate is valid for *14 calendar days*, including the day upon which it was signed.

2) The following actions must be taken promptly after this form is signed:

a) The signing physician must give the patient a properly executed Form 30 notice and notify a rights adviser.

b) The rights adviser must meet with the patient and explain to him or her the significance of the certificate and the right to have it reviewed by the Consent and Capacity Board.

Filed with Officer in Charge
and received by delegate
Feb 23/08 [illegible]

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