REPRESENTING A CLIENT WHO HAS A MENTAL HEALTH ISSUE BEFORE THE
CONSENT AND CAPACITY BOARD

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October, 2007*

*This paper is an updated version of a paper delivered at the training seminar for lawyers organized jointly by LAO, the LSUC and the OBA in anticipation of Bill 68, in Nov. 2000

INTRODUCTION

This Paper

This paper is meant to give guidance to practitioners beginning representation of clients with serious mental health issues before the Consent and Capacity Board. It reflects the author’s personal experience in representing probably now several thousand clients with such challenges in the last twelve years. The scope of the paper is general in the sense that specific legal issues before the Board which confront our client population are not addressed, except to illustrate a practice suggestion. A great deal has change in this practice area since this paper was originally published in November of 2000. For one thing, there are now many resources available to new practitioners, including our book, available through Buttherworths, LexisNexis, “A Guide to Consent and Capacity Law in Ontario” by D’Arcy Hiltz and Anita Szigeti, which was first published in 1995 and has been updated annually since. This volume includes the applicable legislation and commentary about each statute as well as the Rules of Practice of the Consent and Capacity Board and commentary on it. In addition, LAO has produced two conferences on the issue of representing individuals with mental health issues at the tribunal level. On October 1, 2005, LAO
held a conference entitled “Defending the Mentally Ill in Criminal Court---Everything you wanted to know but were afraid to ask”, which touches on CCB and ORB proceedings and is available on DVD from LAO. More specific to the CCB, LAO held a conference entitled “Nuts and Bolts of Consent and Capacity Law and Appearances Before the Consent and Capacity Board, on December 5 and 6, 2005, also available on DVD. This latter course, which is accompanied by print or electronic materials is now required to be viewed if you wish to join LAO’s Consent and Capacity panel. LAO has also enacted specific standards of practice for those wishing to join the panel, so if you are looking to be issued a legal aid certificate in this area, you’ll have to fulfill the requirements, which are posted to LAO’s website in the “Information for Lawyers” section, under practice standards.

The Author

My experience in representing clients with mental health problems has consisted of representation before the Consent and Capacity Board, the Ontario Review Board (which reviews forensic mental health clients’ annual dispositions where a verdict of “unfit to stand trial” or “not criminally responsible by reason of mental disorder” has been rendered by a court in relation to a criminal charge), and the Ontario Human Rights Commission. I also do appeals from the ORB to the Ontario Court of Appeal, where I am one of five lawyers on its Amicus panel and frequently act therefore as friend of that court. I will sometimes act as Amicus in appeals from CCB matters to the Superior Court of Justice and also as counsel on such appeals. My practice has evolved to the point that these and a handful of other administrative law litigation matters, all involving the seriously mentally ill, have comprised the entirety of my practice within my partnership with one other lawyer, who also acts as counsel at CCB hearings.

Having said this, my experience is just that. Every client who faces a situation in which her liberty has been restricted because of mental illness faces a wide range of challenges. Just as each client reacts differently to her own situation, counsel often experience representing this clientele in
vastly different ways. I have chosen to write this paper simply to give you a flavour of what you may expect in representing this extraordinarily vulnerable client population. I encourage you to contact practitioners in this area for assistance or support whenever you need it, and to join our legal committee for ongoing education on complex legal issues which arise in this practice area with some regularity.

The Mental Health Legal Committee

When I first started practising mental health law in 1995, there were almost no resources to turn to for assistance. There is no periodical or journal published, for instance, chronicling cases before the Consent and Capacity Board, or appeals from the Board. Although cases of the CCB are now available on CanLii, a free website of jurisprudence, and briefly were available on QuickLaw, in 1995 there was nothing. The CCB itself did not have its website up, which now provides another great resource (www.ccboard.on.ca). The organization of lawyers and community legal workers who advocate for persons with serious mental health problems, which I chaired for 10 years (1997 to 2007) and is now under the guidance of Acting Chair, Marshall Swadron (the Swadron firm has a website and Marshall may be reached through it), was founded in February of 1997, to afford practitioners a forum in which they could share cases and information, and provide support to one another in assisting our clients before the CCB and the ORB, particularly. The organization is voluntary in membership, there are currently no fees charged, and we meet about once every month. An application for membership may be obtained from the Swadron firm online (contact Mercedes Perez) and may be forwarded to their offices. I believe that the formation of this group has led to increased levels of advocacy before the two tribunals affecting the legal rights of our clients, and it also serves to provide a supportive collegial environment for young lawyers in this practice area. I encourage you to join us and we welcome your participation.
Why Practise Mental Health Law Litigation?

Once you have represented a client before the Consent and Capacity Board, I expect you will know whether this is the right fit for you and why. Almost all counsel I know can recall their first mental health law client and those who have stayed within the mental health bar also remember a real sense of exhilaration about their first case. The right reasons to take on this particular work rest on your commitment to the fundamental civil rights of all citizens to autonomy and self-determination in how and where they choose to live their lives, what they will accept is done to their bodies and what they may conversely refuse, and a passion for advocating to protect the legal rights of vulnerable persons. A poor reason to enter into this practice area would be your desire to earn a living wage or your desire to win more cases than you will lose. Ninety-eight percent of your mental health law clients will be legally aided, and probably more than ninety percent of your clients will lose their hearing on the issue of their treatment capacity, for instance. (If you’re interested in specific statistics, the CCB may be able to provide some.)

I have practised in a number of different areas (from Bay Street to commercial real estate litigation for developers, to family law and insurance litigation, just to name a few) since I graduated law school in 1990; throughout my practice, I have never met a group of practitioners as uniquely dedicated and competent as the mental health bar. This is true of those counsel who act for doctors and hospitals at Consent and Capacity Board hearings (most of the time) as it is of counsel to patients. There are ten attributes of good counsel for persons with mental health problems, which I identify as: intelligent, fearless, advocate, compassionate, patient, non-judgmental, strong, fair, professional and prepared. Trying to turn this into a mnemonic for you I came up with “painfcsfpp” which is ultimately not that helpful. The pain part, however, is relevant. As the saying goes, “no pain, no gain.” In practising mental health law, you will find that the experience can be the most rewarding litigation experience of your career; at the same time, the
demands of representing this clientele in the context of proceedings of the Board can be extremely stressful.

In short, you will want to practise mental health law if you enjoy the complexity of the legislative regime and the resulting intellectual challenges and if you find that your personal satisfaction in advocating for a marginalized population outweighs the stresses of economic hardship and regular devaluation of your efforts by your client’s family members, physicians, hospital staff, often your own client, and sometimes the Board. I have found that caffeine and nicotine are not my only vices; my addiction to adrenalin has kept me relatively immersed in this practice area, because of the incredible personal satisfaction I derive from doing a good job for my client (whether or not she will ever appreciate the effort.) And while I am not prone to being an emotional person as a rule, I have found that on occasion I have been moved to tears (sometimes during the course of a hearing) by the incredible vulnerability of my clients, and the often surprising and endearing kindness that psychiatric inpatients will show each other within the context of their confinement. It has been my experience that I had learned more in the first few years I practised in this area about human nature, good and bad, and indeed about myself, than I had been able to glean from the rest of my life experience up to that point (of course I’ve since had children, and nothing changes your life faster than all that, but apart from having children of one’s own, mental health law is the next most interesting life experience I’ve had). If any of this peaks your interest, I encourage you to use your formidable power as a lawyer and your skills as an advocate, to join the mental health bar. Or (apparently) have kids. Or do both!

THE CLIENT POPULATION

Mental Illness

In representing persons with serious mental illness, a general understanding of the nature of psychiatric conditions and the psycho-social stressors faced by this population is useful. Your
education in this regard need not be formal; over time you will develop an uncanny familiarity with various diagnoses (schizophrenia, schizoaffective disorder, bipolar affective disorder (I and II) formerly known as manic depressive illness, depression, and dissociative identity disorder (formerly known as multiple personality disorder), to name those most commonly encountered in consent and capacity matters. There is a range of personality disorders and conduct disorders as well as sexual paraphilias, paedophilia and so on, most of which one encounters in the forensic mental health stream. Additionally, you may encounter various degenerative or cognitive dysfunctions such as Alzheimer’s or other dementias, particularly in the context of representing the elderly, and eating disorders or acute suicidality mainly in the context of adolescent mental health clients. You will also develop a rapid facility in recounting serious, often irreversible and debilitating side-effects of long term antipsychotic (neuroleptic) treatment, such as “tardive dyskinesia” (“TD”) or “extra-pyramidal symptoms (“EPS”), dystonias, neuroleptic malignant syndrome (“NMS”). While you certainly do not need to be a psychiatrist to function effectively as counsel to the patient before the Board (though some lawyers are trained in a related field), some basic background understanding of formal psychiatric disorders, their conventional treatment and benefits as well as side-effects of those treatments, is certainly going to enhance your level of advocacy for your client both within and outside of the context of the hearings.

Your Experience and Understanding of Mental Health Issues

While many would suggest that family members of the seriously mentally ill always advocate forced treatment and psychiatric hospitalization, it has always struck me as interesting that most counsel who act to protect the legal rights of this clientele also have close family members who suffer from major mental disorders. Many have faced difficult challenges in respect of their own mental health. My experience which has proved useful in this area consists of pre-med undergraduate training in physiology, psychology and philosophy, the fact that my mother is a physician, and my own personal struggles with a formal diagnosis of Post Traumatic
Stress Disorder. Probably more immediately relevant, however, were the many years I spent volunteering as a Distress Centre (suicide hotline) telephone counsellor, and attending to the calls from people with serious mental health issues, mainly during overnight shifts, when our clients tend to be awake, and tend to experience crises.

An excellent general resource, to get you thinking about the issues your client may need you to address, is journalist Scott Simmie’s Atkinson Fellowship series published in the Toronto Star in October, 1998, which is available through the Atkinson Foundation (TorStar) in bound format. This thirteen part series, called “Out of Mind: Atkinson Fellowship Investigation Into Mental Health” confronts homelessness, poverty, adverse effects of psychiatric medications, the myth of dangerousness, hospital downsizing, deinstitutionalization of the mentally ill, the debate in political arenas about legislative reform in mental health, and other pressing and relevant topics, with real sensitivity to the concerns of our clientele. (Web site: atkinsonfdn.on.ca)

What to Expect – Empathic Communication With Your Client

However you come by your experience, you will need to have a genuine sensitivity to your client’s general quality of life as well as the current crisis she is facing, which is often multi-faceted. While one in four people can be expected to experience a serious mental illness during our life time (according to the Canadian Mental Health Association’s statistics), which means that mental illness does not target a particular race, gender or income level, the diagnosis of mental illness often results in poverty for most of our clients. Your client will more often than not find herself without (decent) housing, with low or no income source, without employment, and generally without supportive or accessible family or other psycho-social supports. It is rare that one of my clients will have access to a telephone, and almost never will she have her own phone line. This, first of all, makes communication with your client, when not in hospital, a challenge in terms of the logistics alone.
Sometimes your client will have her own cellular telephone, however rare this is, and in that case, you can generally expect to be bombarded with telephone messages. In understanding psychiatric diagnoses, you will find that representing the so-called “hypomanic” or “manic” client is often the most challenging as well as rewarding. Also, you will quickly learn that a twenty-five message limit on your office voice mail is a good thing, because your client will often need to speak to you about that many times a day, and always on an urgent basis. These are some of the demands of a mental health law practice that can threaten your own mental health, frankly, and yet when you understand the client’s concerns, usually about medication, you can effectively work to safeguard their own decision making process.

For instance, the right of the manic patient to sustain a certain level of hypomania which the person finds enhances his creativity or mental prowess really cannot be ignored. When I first wrote this paper I referenced in this context what I thought was an interesting little case I had then recently argued in the Superior Court of Justice (known as Professor Starson v. Dr. Ian Swayze and Dr. Paul Posner at the time), a decision of Madam Justice Anne Molloy released November 26, 1999, which made this point rather eloquently. Ultimately, the case was appealed by the physicians to the Supreme Court of Canada, after the Appellant (my client) succeeded at the Court of Appeal level as well. The case, now known as Starson v. Swayze, has pretty much gone on to be the seminal case in this area of law, at least in relation to issues of treatment capacity, but also insofar as elucidating the standard of review applicable to appeals from this Board. For our purposes here, the case stands for the point that mental capacity exists where there is not compelling evidence to indicate that the person does not appreciate the reasonably foreseeable consequences of refusing treatment. It is a strong pronouncement in favour of safeguarding an individual’s right to refuse treatment notwithstanding that there may well be consensus among health practitioners that the best interest of the patient dictates administration of, as happened to be the case here, mood stabilizing medications. Her Honour Molloy’s decision ultimately got upheld
in its entirety and I encourage you to read it as well as reading the ultimate ruling of the Supreme Court. If nothing else, this case is certainly a useful tool in litigation before the Board.

UNDERSTANDING YOUR ROLE AS COUNSEL

Best Interests vs. Client Instructed Advocacy

The fundamental tension in this practice area arises because what is in your client’s best interest from a clinical or therapeutic perspective is nearly always something that is contrary to your client’s wishes. You must never confuse your role as the person’s lawyer to the point that you forget what client instructed advocacy means. You are there to do what your client tells you to do regardless of your own personal belief as to what you think the person should do. Your client is under enormous pressure often from her family, always from the treatment team, sometimes from boarding house operators and other service providers, to “comply” with the prescribed medication regimen and to stay in hospital if those are the issues being litigated. You are often the first person to really listen to your client and take her instructions. You cannot waiver from this approach. If you hear from family members who want you to sympathize with their position, you can certainly express your understanding of their frustration and concerns; but you must never forget who your client is. And you must refrain from passing judgment on your client’s choices, however unreasonable you believe those choices might be.

There are many stereotypes of the seriously mentally ill person embedded in society’s approach to these folks. In the media mental illness is commonly linked to violence, sometimes it is thought to result in cognitive impairment, and many presume that symptomatic mental illness renders an individual incapable to function sufficiently to meet his basic daily needs. All of these prejudices and presumptions are false in that they do not apply to any class of people in any general sense. Just because a person has a diagnosis of a serious mental disorder, the person is not stupid,
the person is not deaf, the person is not going to hurt you, and the person may well be capable to make her own decisions about a whole host of issues, including her own treatment of the mental disorder, managing her own property or financial affairs, making Powers of Attorney for Personal Care or Property, deciding who they want to represent them at hearings, and/or any combination of these things, again simply by way of example.

The point is that when you agree to represent a person with a mental health problem, you undertake to leave your own biases and prejudices outside of your interaction with your client.

Is the Client Competent to Instruct Counsel?

Of all things complicated in this area of legal practice, blissfully your client’s competence to instruct you is the one thing never in issue. By provisions of the Health Care Consent Act, section 81.(1) (b) your client is deemed competent to instruct counsel in the context of her application or whenever she is a party to proceedings of the Consent and Capacity Board, where other determinations of your client’s capacity are in issue before the Board.

The Fearless Advocate

Our Rules of Professional Conduct prescribe the following obligation for lawyers acting as advocates:

Rule 4.01(1)

“When acting as an advocate, a lawyer shall represent the client resolutely and honourably within the limits of the law while treating the tribunal with candour, fairness, courtesy and respect.” The commentary to this rule further provides: “The lawyer has a duty to the client to raise fearlessly every issue, advance every argument, and ask every question, however distasteful, which the lawyer thinks will help the client’s case and to endeavour to obtain for the client the
benefit of every remedy and defence authorized by law....In adversary proceedings the lawyer’s function as advocate is openly and necessarily partisan. Accordingly, the lawyer is not obliged [with some exceptions noted eg. Crown disclosure] to assist an adversary or advance matters derogatory to the client’s case........When acting as an advocate, a lawyer should refrain from expressing the lawyer’s personal opinions on the merits of a client’s case.”

I cannot think of a context outside of mental health legal advocacy where this Rule of Professional Conduct is more necessary or compelling. It bears repeating to yourself each time you agree to undertake legal advocacy for a client who is facing a restriction or loss of liberty or autonomy, or other infringement of basic civil or legal rights, simply because of mental illness.

KNOWING THE LAW

Resources

Before you agree to act for a person with mental health issues, you need to have a solid understanding of the incredibly complex legislative scheme governing your client’s rights in the consent and capacity arena. My law partner, D’Arcy Hiltz, and I determined in 2005 to publish a book in this area, because there simply was not anything out there by way of textual material to assist a practitioner in appearing before the Consent and Capacity Board. While there was a consolidated volume of some of the legislation, entitled “Consent and Capacity Legislation”, available from Canada Law Book, and published annually, we found that it contained pieces of legislation we never used, such as the Public Hospitals Act, which added additional bulk, but no added value in terms of commentary or jurisprudence. We therefore created our own book, “A Guide to Consent and Capacity Law in Ontario” (available from LexisNexis Butterworths and updated annually), which is designed with only practice before the CCB in mind. It contains all the relevant statutes and no others, and provides commentary including reference to jurisprudence as an introduction to each piece of legislation. I strongly recommend, daunting as it may seem, reviewing the provisions of the Mental Health Act, the Health Care Consent Act, and
the Substitute Decisions Act, at the very least (all of these and some other statutes are reproduced in their entirety in our text book.) Other helpful resources are information sheets for clients (parties to the Board hearings) available through offices (or website) of the Consent and Capacity Board, public legal education pamphlets available from Community Legal Education Ontario, from the Advocacy Centre for the Elderly, and patients’ rights brochures available from the Psychiatric Patient Advocate Office.

There are also now some helpful text books available on forensic mental health law, including some by Justice Richard Schneider (Irwin Law books) and by Riun Shandler and Joan Barret (through Carswell). In spring of 2008, I am hoping to have published another text on Mental Disorder Law also through LexisNexis Butterworths, co-authored with Madam Justice Maureen Forestell and some other colleagues and practitioners. The focus in these textual materials is the intersection of the criminal law and mental health issues, both in the criminal courts and before the Ontario Review Board, and apart from one volume by Justice Schneider (the Annotated Mental Health Statutes, also through Irwin Law books), none will reference civil mental health legislation, as far as I know, though ours might touch upon it (we’ll see, this paper anticipates the publication of that text, but you never know).

To get some sense of our clients’ objections to psychiatric medications, you may wish to consult any one or a number of books by Dr. Peter Breggin, a self-described “anti-psychiatry” psychiatrist who runs the “Centre for the Study of Psychiatry” in Bethesda, Maryland, U.S.A. One of his books, co-authored by University of Montreal Social Work Professor Dr. David Cohen is entitled “Your Drug May Be Your Problem: How and Why to Stop Taking Psychiatric Medications” I obtained from amazon.com on the Internet. I also recommend having easy access to basic administrative law and constitutional law text books because in your day to day practice it certainly helps to have a good grounding in the principles of natural justice and fairness in the constitutional/administrative law context, quite apart from the specific provisions of the Statutory
Powers Procedures Act (the SPPA) which applies to the CCB and which you will certainly employ before the Board. The Board also has its own Rules of Practice (reproduced in their entirety and with commentary in our CCB text book), with which you must become familiar.

Also helpful are the former Continuing Legal Education publications of the LSUC on mental health legal issues. The Conference for which I initially wrote this paper was hosted by the OBA, the LSUC and LAO in November of 2000, and the conference materials, including a DVD of the 8 hour event are probably still available. The law has changed since then, though the conference was put on in anticipation of the very changes brought about by Bill 68 (also known as “Brian’s Law”) which have now been enacted. There were some really useful papers prepared especially for that conference, which were made available in the conference binder. LAO now requires you to have attended either that conference or the 2005 update by ACE in order to become a member of the CCB panel of LAO. I highly recommend renting or buying the DVDs of the ACE conference of 2005 (there are 8 DVDs). Both conference include a mock hearing of a CCB proceeding. LAO requires now that you attend at least one CCB hearing before doing your own, and I think this is really wise.

I also actually own a pocket sized copy of the DSM IV, which is the North American diagnostic and statistical manual, used in psychiatric diagnosis of major mental disorders, as well as the current year (always!) copy of the CPS (Compendium of Pharmaceuticals and Specialties), which I find helpful in learning about medications my clients receive. This may be overkill and certainly isn’t necessary, but if you are going to consult these manuals, in order to be of any use to you they must be current, as psychiatric diagnoses and medications change exceedingly rapidly from year to year.
When the Call Comes

Your first contact on a mental health law file will generally come from a Rights Advisor, seeking counsel for her client, most often a patient in a psychiatric facility. Bill 68 expanded the scope of mental health legislation into the community, however, so your client may not be an inpatient at all at the relevant time. When your client is on a Community Treatment Order (CTO), this presents special challenges altogether, in large part because your client will be difficult to locate and communications become very tricky. I’ll try to address this special circumstance as it comes up. For now, let’s focus on the routine call.

Rights advisors’ obligations are prescribed in Regulations to the Mental Health Act. In all situations where your client’s legal status has been changed (from voluntary to involuntary psychiatric patient or from capable to incapable person with respect to psychiatric treatment or management of her property), a rights advisor is required to attend with the client and advise her of the option of applying to the Board. When a Rights Advisor calls you, such an application has been made by the client. There are some exceptions to this rule, including determinations of incapacity with respect to medical (as opposed to psychiatric) treatment, admission to a long term care facility, or capacity with respect to personal assistance services, once a resident in a long term care facility or when a capacity assessor attends with your client in the community; in those situations, the physician, assessor or evaluator is meant to provide the subject of the assessment or evaluation with the required “rights advice.” Sometimes your client will contact you directly. Unfortunately, there remains the occasional where rights advice in the particular general hospitals with psychiatric services is a duty of existing employees of the hospital who generally resent the additional work required of them. As opposed to rights advisors employed by the PPAO who now provide the service to clients within Ontario’s ten major psychiatric hospitals (previously known as the “provincial psychiatric hospitals”, of which only the Mental Health Centre, Penetanguishene remains as a provincial institution—the rest have been divested into private ownership) including the CAMH’s and to most general hospitals with psychiatric wards, rights
advisors in general hospitals often refuse to take an application for legal aid from your client, in which case you need to do this yourself (special mental health application forms for Consent and Capacity Board representation are available through your local Area office of Legal Aid Ontario.) There will be other occasions when you may have to assist the client in completing the application to LAO, including for clients on CTOs. Unfortunately, rights advice is statutorily mandated to be provided to individuals when they are notified of an “intent to issue or renew a CTO” as opposed to when the CTO has been issued or renewed. Therefore, when the Rights Adviser sees the client, they cannot apply to the Board for a review of the CTO, and can only be referred to you to assist in doing this once the CTO has been issued or renewed in relation to the patient/client. By then, the individual is generally discharged from Hospital, which makes getting access to their record, and to them, difficult. The client may live with her Substitute-Decision-Maker, who won’t put your calls through, will open your mail, and impede the client’s access to counsel, for instance. And the Hospital will require your client’s consent to disclosure of their personal health information, which means finding the client to sign all these forms. The Hospital doesn’t have the right to ask for these forms if your client has an application before the Board, but good luck explaining this to them (s. 76 of the HCCA, see below). Back to the rights advice call.

I try to extract as much information as possible from the Rights Advisor regarding my client’s application to the Board, during this first call about the client. I will want to know when a Certificate of Involuntary Admission or its Continuation, or a Finding of Incapacity, was made in respect of my client, by whom, and when the application to the Board was completed and forwarded to the Board. I will ask for the telephone number where I can reach the client, the nursing station on the unit, the direct telephone number of the attending physician for my client, and whether a legal aid application has been taken from the client as well as whether there is likely to be an issue as to the client’s eligibility for legal aid. Sometimes a rights advisor will want to tell you her opinion of the client’s clinical situation, something I generally try to discourage for fear of developing a bias in relating to my client. On the other hand, sometimes Rights Advisors have
spent a great deal of time with your client already, and will have some special concerns of your client to relay to you or other helpful information. It never hurts to listen, unless for some reason the rights advisor is being disparaging of your client, which does not happen when the rights advice is provided through the PPAO (therefore it’ll rarely ever happen these days, though it was very common before the PPAO started to provide services in general hospitals).

It is absolutely imperative that you do not agree to represent a client before the Consent and Capacity Board unless you are able to devote on average 10-20 hours in preparation for the hearing prior to the scheduled date of the hearing. The hearing will be scheduled within seven days of the application being received by the Board. Often, by the time the Rights Advisor reaches you, the hearing has been scheduled, often for the next day or two days after you get the first call. Subject to consent of all the parties, you may be able to adjourn the matter, but remember your client’s liberty interests are at stake, and your client may want you to proceed as soon as possible. The reverse is often the case when treatment is in issue, because treatment cannot be commenced while your client’s application to the Board to review her capacity to make decisions about treatment for a mental disorder is pending; however, in those cases you are less likely to get the attending physician to agree to an adjournment, as he will want to commence treating your client as soon as possible.

The exception to scheduling imperatives (in practice, not by law, which still requires the hearing to start within seven days of the receipt of the application), in my view, is the CTO hearing where your client is in the community. It is often physically impossible to prepare for a CTO hearing within 7 days, given that you need to find the client, meet with the client, get consent forms signed by the client, request access to records of the hospital where the client was before the CTO was issued, to the ACT (Assertive Community Treatment) team records if an ACT team is supervising the client in the community pursuant to the CTO, and to the files of the CTO co-ordinator (i.e. All the legal forms around the CTO, of which there are many inexplicably
numbered ones---eg. Form 49 Notice of Intent to Issue or Renew a CTO, Form 50, Confirmation of Rights Advice re: the Form 49, Form 45 (the CTO itself), Form 46 Notice to the Person of the Issuance of the CTO, Form 48, the client’s application or Notice to the Board to schedule a mandatory Hearing (on 2\textsuperscript{nd}, 4\textsuperscript{th}, etc. renewals of the CTO) and finally the Form 47, Order for Examination of the subject of the CTO (when the person fails to comply, the issuing physician can order the person returned to the physician for an examination). Very complicated. Generally physicians agree to have CTO hearings commence outside of the seven day limitation period, and while your client’s liberty is restricted by ongoing enforcement of the CTO pending the hearing, they are at least generally not detained in hospital for the duration. A long delay is still not justifiable, but a week or two I find is necessary.

If you are not prepared or able to take the client on, you may want to make the caller aware of the Advocacy Centre for the Elderly (if the matter concerns a senior), of Justice for Youth and Children (about adolescents), or feel free to forward the call to members of the Mental Health Legal Committee (or the Acting Chair) if the request is representation for clients anywhere within the Province. The local office of the Psychiatric Patient Advocate Office or its head offices can also probably refer clients to a list of lawyers who practise in the area. Additionally, as you know, Legal Aid Ontario maintains a list of lawyers who are trained in consent and capacity litigation, and the local Area Office may be helpful in referring the client or Rights Advisor to a lawyer in their area.

**Steps to Take Once You Have Agreed to Represent the Client**

I first contact the Board to see whether the application has been received by the Board and when.

It is important to confirm your retainer with the Board as your name may not appear on the application that has already been received by the Board. It is generally important that you endeavour to get a hearing date as soon as possible, even sooner than the seven day maximum
prescribed by the legislation, if you can, whenever involuntary admission is an issue (for one thing, days in hospital are used to establish eligibility criteria for CTOs, so the longer your client is in the hospital, the more likely they become a candidate for a CTO on this admission or a future one.)

The Board will provide you with a written Notice of Hearing as soon as the time, date and place of the hearing have been scheduled. Hearings are generally held at the hospital where your client is detained. However, if the client is on a CTO or otherwise living in the community, I have found that the client will ask the Board to hold the hearing at the offices of the Board (in Toronto this is at 151 Bloor Street West) or in another neutral place, since they don’t want to return to the hospital which had detained them. Doctors will want the hearing in the hospital or at their own office where they see the patient. I tend to encourage the Board to do what the patient/client wishes, and they have been very accommodating in this regard.

I then call the client to tell her when I am coming to meet with her. It is also a good idea to let the ward know when you will come by so that they can ensure your client is there to meet with you when you arrive. Often in general hospitals, you will be asked to review the clinical records on the unit, so staff should be aware that you’re expecting to see the charts and that you may need to make some copies of relevant parts of your client’s records. You should be aware that many hospitals now chart (particularly nurses, but also physicians and consult reports) on computer.

There may be no printed hard copies on the actual chart, in which case you’ll have to ask for access to the computer to review the notes and also to print up copies if you need them.

**Your First Meeting With Your Client**

I will always meet with my client before I review her clinical charts and records. This is important to safeguard your objectivity about the story your client is about to tell you. When you meet with your client you will employ a host of skills you never before knew you had in communicating clearly, exercising diplomacy, listening empathically, and addressing unexpected situations with unflinching calm.
Clear Communication

In communicating with your client, you have to remember that sometimes your voice is not the only one she is hearing. This is not meant to be mocking the person in any way; it is a simple fact. One of the most useful things I learned about clients’ needs was the result of trying an exercise intended to mimic what it may be like to hear voices (or “auditory hallucinations”.) Try responding to simple questions put to you by a friend (“how was your day? What did you have for dinner last night? and so forth) while another friend whispers rapidly in your ear, a continual stream of rather unpleasant and derogatory things (“You’re a worthless, useless person, you should probably kill yourself, you are a burden to your family, everyone hates you” etc.). I found that my responses to the questions being asked of me were halting, I had a great deal of difficulty focussing on what was being said to me as I kept being distracted by the voices I heard whispering in my ear. I also tried to push the person whispering to me away, something you may observe your clients doing, although obviously no one is there to be pushed away. When your client is experiencing such hallucinations, raising your voice just a touch, and speaking slowly and clearly is helpful. You may have to repeat your question or information on a number of occasions. My initial client interview is often longer than two hours, and I often have to give my clients breaks to smoke or take a rest during the interview. Incidentally, this is not as easy as it used to be. When I first wrote this paper in 2000, all psych wards had, by law I believe, access to smoking rooms for the patients on the units. Now, none do. In fact, certain facilities have outlawed smoking on their entire grounds. Whitby Mental Health Centre is an example of this latter approach. If you speak to doctors and patients alike about this, you’ll find that taking away the occasional pleasure of a coffee and a cigarette break for our clients has been a huge blow to their quality of life. Smoking decreases side-effects of anti-psychotic meds, so they actually feel sicker for having to go without their ciggies, or so they report to me. And battles over this ensue.

Due to side-effects of anti-psychotic or mood stabilizing medications, your client is often restless (this could also be due to the fact of being confined), sometimes slurring her speech, may
exhibit tremors or other strange involuntary movements and may have blurred vision, making it very difficult for her to read anything you give her, including your business card. I write my phone number in big block numbers on the back of my cards, and actually used to distribute a brightly coloured pen with my phone number on it (something some of my colleagues found shameless self-promotion) but which I found the clients never misplaced and actually enjoyed. I do tend to check with nursing staff before I give anything, including my promotional pens to clients, as sometimes they are not permitted to have “sharps” and on occasion this is for good reason, namely to prevent self injury or physical harm to other clients or staff.

If your client is obviously delusional (for instance she believes she is the Queen and isn’t), a good approach is to bypass discussion about that particular aspect of things, by neither feeding into nor challenging the delusion. There is absolutely no point is asking to see the client’s driver’s license only to point out: “Hey, this does not say Elizabeth the Second, Queen of England, but suggests you are Jane Doe, how do you explain that, huh?!”; it also does not further matters in this case to ask to be knighted by your client. I sometimes suggest to the client that I am pleased she has shared that information with me, but the Board doesn’t particularly need to hear about that, as the issues are really about whether she poses any real risk of harm to herself, as the case may be, and it may be best to keep her activities as Queen between us as solicitor-client privileged information. Rarely, but on occasion, this approach solves the need to go down this path with the client, and allows us to focus on preparing for the hearing. As in every other type of litigation, you are not to encourage or support your client’s intention to mislead the Board or lie; on the other hand, it is perfectly acceptable to assist your client in determining what is central to her case and what she should therefore expect to give evidence about at the Board, if she chooses to give evidence at all.

**Ground to Cover in Your First Meeting**

At minimum, you need to **give** your client the following information:
a) What the hearing is about (reviewing the client’s legal status in certain cases);
b) What the hearing is not about (issues properly within the physician’s discretion);
c) What the Board does and cannot do (their jurisdiction and decision making power);
d) Who the Board members are: psychiatrist, lawyer and community person, usually;
e) Where the hearing will be and when;
f) General process of the hearing and that there will be a court reporter making a record;
g) What the doctor’s onus is and that there is no obligation on your client to prove anything;
h) That your client has the right to attend but does not have to do so;
i) That your client has the right to call witnesses or lead evidence, but does not have to;
j) That you are there to assist the client in reaching her goal, whatever that may be, and that you will be asking the attending physician questions on your client’s behalf.

You will need to get the following information from your client:

a) her story as to why she is in hospital (or if on a CTO, why and how that came to be) etc. but also enough information about the client so you have some sense of who she is (education history, marital status, living accommodations, income source, family relationships, any conditions which need to be accommodated by you and/or the Board, for instance a language barrier (the Board will arrange an interpreter for your client if she needs one and you advise the Board about this.)

b) contact names and numbers for anyone who the client believes may be willing to support her position at the hearing and could become a witness or offer a letter or other documentation which may help your client’s case; sometimes your client will suggest that another patient on the ward would help out; I have been generally loathe to subject another patient, who is not my client, to the stresses of testifying at a hearing, but again, this is a personal choice to be decided between you and the client. I discourage this approach as much as possible. If your client does insist and the co-patient, other client, agrees to testify, you must ensure the Board does not ask the witness inappropriate questions about the
witness’s own history or medication issues over and above what is reasonable about the nature of the friendship / relationship and putting it in context.

c) clear instructions about what the client hopes to accomplish by applying to the Board (often your client is simply looking for certain privileges or increases in those privileges); I am of the view that if your client is willing to stay in hospital and simply wants passes, your client should be a voluntary patient and the doctor should be convinced, either in negotiations or by decision of the Board, to change your client’s status to that of a voluntary patient, for example. Some other counsel feel you can negotiate getting those privileges and then advise the Board your client has withdrawn her application without prejudice to her right to reapply should she choose to do so later. It’s entirely up to the client how you will proceed, and as with any other litigation matter, you cannot consent to anything or make any representation to the Board or to the attending physician, unless your client consents herself or authorizes you to take that specific step. This bears repeating, as the vulnerability of this clientele essentially poses a grave risk of abuse for them, including by unscrupulous counsel, though blissfully there is very little of this kind of exploitation currently, to the best of my knowledge.

d) Whether your client consents to you making contact with their doctor(s) or their family members or other supportive contacts or service providers in the community, or former counsel in mental health matters, as you prepare for the hearing.

e) Get copies of whatever documents your client has received regarding her legal status (your client is entitled to written notice whenever her legal status has been changed; however, just because your client does not retain a copy does not necessarily mean she didn’t get one, although you do need to know whether she remembers getting anything.)

_Do Not Pass Judgment on Your Client’s Story_
In your very first meeting with your client, it is absolutely crucial that you keep an open mind. On one occasion, my client (a senior) had been found not capable to manage her property. In my initial interview with her, she told me that she did not pay rent, owned her home, did not have a mortgage on the home, and that she did not pay taxes. I pretty much concluded she was likely not capable to manage her own financial affairs. In speaking with her son, however, I discovered that she lived in a part of the city where seniors could defer their taxes until their home is sold (or their estate sells the home) which is what my client had chosen to do. In fact, she paid no taxes.

In another case, a young man told me that his admission to a psychiatric ward was due to his mother’s psychiatric problems, because she suffered from something known as Munchausen’s Syndrome; he alleged that his mother had attended before a Justice of the Peace to suggest that my client was violent due to mental disorder, when in fact he neither suffered a mental disorder, nor had ever been violent. I was pretty sceptical, as my client had by this time been detained by psychiatrists at this hospital, for almost two weeks. In the course of my representation of this client, he produced the judicial pronouncements in his parents’ divorce proceedings which dated back to when my client was six years old. According to those documents, my client’s mother had been admitting my client to psychiatric wards since he was six months old, stating he was “schizophrenic.” The Judge in the custody battles felt that it was not my client, but rather his mother, who suffered from serious psychological if not psychiatric illness. Although my client told his treating physicians these things, it was not until the matter got before the Board, that he was able to walk free from the psychiatric facility.

No matter how unwell your client is, if not everything they tell you is true, at least some of their story will in all likelihood be capable of being corroborated somehow. The trick you learn through experience, is separating some fanciful things from those anecdotes based in reality. It helps to remember that the onus at Board hearings is always on the doctor to prove his case on an enhanced balance of probabilities, so that if your client’s version of things is not independently
verified, it is often one person’s information against another’s. You should suggest that any ambiguity in the evidence be resolved in your client’s favour. It is also useful to understand that many things your client says while in hospital will be “pathologized” in that setting; ie. while the client may have told the doctor that she has an education as a physician or lawyer etc., the clinical information regarding your client may state something like: “Patient claims to be a doctor.” In fact, I have had both doctors and lawyers as clients, often trained as such in other countries, or not having recently practised in Ontario, but absolutely telling the truth in terms of their education, or many other things whose veracity is questioned by the treatment team or institution.

Your Client’s Clinical Records (now called “personal health information” under PHIPA)*

*The Personal Health Information Privacy Act came into force since I initially wrote this paper. It changes the language from “clinical records” to “personal health information” and makes the rules for access to and disclosure of personal health information uniform to all health care settings. It is complicated legislation (included in full with commentary in our text book), and because the new language is so cumbersome, I have chosen not to change it for purposes of this paper. But when you read “records”, just think “record of personal health information held by the health information custodian” etc.

Access to Records

Accessing your client’s clinical records may prove problematic in some contexts. If you encounter obstacles in reviewing your client’s records or in making copies at nominal or no cost to you, rely on s. 76 of the Health Care Consent Act. You have an automatic right of access to your client’s records in preparing for a hearing of the Board and the argument can be made that copies should be available to you at low or no cost. If you still encounter difficulties, you might suggest the clinical records department or ward clerk call the Board to confirm your authority to view and copy the record. Failing that, you can ask the Board to sign a Summons to Witness document
wherein you subpoena the hospital administration or their representative together with the records and make your pitch for disclosure to the Board. You will get this Order. You should make sure that you have been provided with access to all your client’s charts and records, including former hospitalizations at the same facility and any documentation which may be contained outside the clinical charts and records, if there is such a file. In the context of Community Treatment Orders, you may have to attend at all the facilities where your client has been a patient in the preceding three years, and you may also have to access various outpatient records for the relevant time period, in addition to any current charts or records.

**What to Look for in the Clinical Records**

**a) “Technical” Requirements: Are All the Forms In Order?**

It’s your job to ensure that all the formal requirements in completing the relevant forms have been followed by the attending physicians. This requires a careful review of all legal forms, in particular, though you absolutely must review the entire record. On two occasions, the Board has had to point out to me that my client’s name appeared nowhere on the relevant form seeking to detain my client or find her not capable to manage her property. I wish I had found those particular flaws myself. You need to make sure that not only the relevant legal forms depriving your client of some right, but also the formal written notice of that change in legal status, have been completed in the appropriate time frame, by the appropriate person, and delivered to your client as prescribed by law. You also should be able to confirm by reviewing the record whether a Rights Advisor attended or was contacted to see your client promptly following the completion of any of those forms which require rights advice to follow. Failure to comply with these requirements may allow you to bring a motion leading to absence of jurisdiction for the Board, thereby restoring your client’s voluntary status or capacity, as the case may be. Of particular note is the requirement of the Officer in Charge of the psychiatric facility to receive as filed and to review the certification
forms of your client (s. 20(1)(c) and 20(8) of the MHA). Evidence of the filing and review should be available on the chart, and often isn’t, leading to good results, i.e. Rescinded certificates of involuntary admission for your client.

Where your client’s liberty or autonomy is being restricted or removed as a result of a physician completing a single form, I am of the view that these are absolutely vital issues to canvass as preliminary matters before the Board. Physicians sometimes tend to object to this approach, as overly “technical”. In one case, a physician who had signed a Form 1 application for a psychiatric assessment in respect of my client, without examining the client, stormed out on me at a hearing shouting “this is the OJ Simpson trial .....she’s going to get the patient off on a technicality”. The Board happened to agree with me that conducting an examination before completing the Form 1 is a key element of the process, required by law, and as such the subsequent Form 3 involuntary admission form was invalid, leaving the Board (as it ruled at that time) without jurisdiction to review my client’s application to the Board; this was a good result for the client, who was in that case, free to go. These days, under the same circumstances, the Board is more likely to rescind the certificate than to decline jurisdiction, though some members of the Board still refuse to do this. It’s a debate that is too complex to get into in this paper, but is canvassed again at length in our book.

In the context of the Community Treatment Order, it is imperative that you bring such preliminary motions seeking to “strike the forms” wherever you have a reasonable chance of success. Given that the criteria for a CTO include two prior hospitalizations as a “patient” in a psychiatric facility or a cumulative 30 days or longer as a “patient” in the last three years, if you can succeed in the Board holding they are without jurisdiction in respect of a Form 3, you can hopefully argue (or try to anyway) that your client was never a “patient” on that admission.

b) Substantive Issues in the Records
You actually need to review your client’s charts not once, but at least twice. First just after you meet with your client for the first time, and then again as close to the time of hearing as possible (I try to do this immediately prior to the time of the hearing on the date of hearing.) Your client’s mental state can change rapidly, which can cut both ways. You may think you are in great shape for a hearing, not knowing that on the day of the hearing your client punched a co-patient in the head, and is currently in locked seclusion in four point restraints. Conversely you may have a sense that the case is lost, when your client has substantially improved in the last couple of days, and has been exercising new privileges, going off the ward for hours at a time without incident, or may be willing to continue as a voluntary patient.

The most useful part of psychiatric charting is often not the attending physician’s notes (which, predictably and cliched as this is to say, are generally illegible as well as brief) but the nursing notes (often listed under “clinical” or “progress” notes), which tend to be easier to read and much more detailed in describing your client’s mental status, her interaction with other patients, and general concerns. The general rule is that if behaviour is not charted, it did not happen. At the hearing doctors will refer to all kinds of things which were never charted; knowing there is no charting of an incident being described is sometimes as useful as things you may find in the record. Getting copies of the nursing notes is often helpful, because the entire record will not be made an exhibit at the hearing (as a general rule), and the doctor will have the original record available to him when responding to questions. Your cross-examination will be helped by having a good idea of what is in the notes, and being able to put specific notations in the charts to the attending physician during your cross-examination.

Your Second Meeting With Your Client

Upon returning to see your client, you are now in a position to tell the client what the attending physician will be relying on to support his position to either detain or treat your client, as the case may be. You should get your client to respond to each issue raised by your review of the
records. Together you can then develop a strategy for approaching the hearing, pick your strongest points, and proceed to formulate a “theory of your case.”

Do not leave this interview without knowing whether you or your client will be contacting witnesses, whether the client has other documents she would like you to enter as exhibits at the hearing, and that she knows how to get a hold of you between now and the hearing.

At this time, I usually canvass with the client what she may wear to the hearing. Often staff will insist the client must wear hospital gowns to a hearing; something I will not allow. I take the position that if the client is considered an AWOL risk, for instance, that is the type of thing that must be demonstrated to the Board, before the client should become the only person in the hearing wearing hospital gowns. On one occasion I suggested we should all gown, which somehow resulted in the attending physician allowing my client to wear her street clothes. If this seems like it might be an issue, the best time to have this conversation with the staff is in advance of the hearing.

**Preparing for the Hearing**

I have found that contacting the attending physician is of varying degrees of utility to me. Some doctors refuse to talk to you, ask if you’re going to pay them for their time on the phone, and other miserable excuses which are inappropriate in the context of such a hearing. Your client has the right to know what is going to be argued by the attending physician, and you have a right to receive any documentation sought to be relied upon “prior to the commencement of the hearing.” Some physicians are absolutely wonderful to work with, however, in that they understand the importance of the hearing process, and try to work on an acceptable resolution, wherever possible. Making the first call is at least worth the effort. At least you know what you’re dealing with when you show up with your client for the hearing.

It is helpful to compile a short list of important dates and other significant information on a single sheet of paper (or on your laptop computer) in preparation for the hearing. This list should
minimally include your client’s diagnosis, medication regimen, the date of this and the most recent admission, the dates of relevant forms being completed and by whom, a short summary of the history of your client’s hospitalization. Although there is absolutely no obligation on you to help the attending physician flesh out these details, if he doesn’t know them, you can sometimes sit around at a hearing for long tortured minutes while they flip through the chart, and they will in fact eventually unearth this information, since that’s where you got it. However, on occasion, it is actually useful to demonstrate to the Board how little the attending physician knows about your client or their course in hospital.

If you possibly can, without having heard the evidence, it may be useful to think about and plan out your submissions based on your theory of the case. I used to do this when I was first practising in this area, and now tend to wing it, which is a shame, as taking the time to write my thoughts down probably made me somewhat more coherent in the early days. Drafting your submissions will also force you to revisit the relevant legislative provisions, confirming the onus on the physician, something that is easy to forget, and vital to remember and repeat in submissions.

The Day of the Hearing

It’s ill-advised to show up for the hearing only moments before the scheduled time for the hearing. Your client may need your assistance on the day of hearing in a variety of interesting ways. I once had a client who was conservatively dressed and perfectly presentable when I met with her the night before the hearing. Imagine my surprise when I went to get her on the day of the hearing half an hour before the hearing, and found her wearing a tight spandex orange mini-dress which was drawn under her breasts (as she was pregnant); her only visible item of clothing above the waist was a lacy bra. She had also died her hair a peroxide blonde and had smeared most of her face with bright red lipstick (I later discovered my client had a crush on a member of the Board she had hoped would come out to hear her case). I immediately began scavenging the floor for decent clothing and eventually had to borrow a dress from a co-patient. I also had to approach the situation with the utmost of diplomacy. On another occasion, my client told me he couldn’t come
to the hearing, which was to be held in another building, because he had no shoes. He had been homeless, prior to admission, and the staff had requested funding for this fellow to get new shoes, but that funding hadn’t arrived. Again, we borrowed shoes from a co-patient who blissfully also had size 13 feet. You cannot rely on staff to turn their mind to these kinds of things. Your client’s physical comfort and her basic needs in getting to the hearing so that her dignity is preserved, are entirely your responsibility.

Your client also can’t be relied upon necessarily to either remember your earlier meeting or to tell you anything resembling what they told you in that meeting. Particularly in the case of brain-injured clients, their short term memory may be impaired to the point that they will have absolutely no recollection of your earlier meeting. I had one client who, during the hearing, asked me why I was putting her in a nursing home, literally every five minutes during the hearing. At these times I would reassure her that I was advocating for her to go home, and she would settle down each time. So, arriving early to go over your client’s evidence with her is always a good idea.

At the Hearing

Your Client’s (and Your) Experience at the Hearing

Personally, hearings of this Board are probably my favourite forum in which to appear as counsel to the patient. For me, the relative informality of the administrative law process, combined with the opportunity to cross-examine “expert” witnesses (psychiatrists), and the nature of my role in advocating for vulnerable people, is the ultimate combination of things I like to do. It also is a good fit for my own personal skill set. I happen to have a good memory in the short term for lots of medical and other information (though I forget entire years out of my life), I enjoy the challenge of thinking on my feet when unexpected situations arise, and I particularly enjoy forcing physicians who have such power over my client, to justify their decision to take legal rights away from my client. I generally find the hearing process is therapeutic for my client, notwithstanding
the opinion of many physicians to the contrary; you will often hear physicians objecting to what they perceive is a profoundly anti-therapeutic impact of the hearing on the physician-patient relationship. In my experience, the hearing is what everyone makes of it. If anyone has a bad attitude, the process can indeed harm all kinds of relationships, and result in not much use to the client. On the other hand, mutual respect between the professionals present, and mutual respect for the client before the Board, when coupled with a panel of Board members who have cultivated what can only be described as a talent in adjudicating in this area, can converge to result in a rather wonderful hearing process for the client. Win or lose, they will have had their “day in court.”

Again, your client’s physical and emotional state and needs are your responsibility. Your client may have trouble sitting through the hearing without a break, either for a smoke, or simply because the hearing is stressful and they need a break. The Board will tend to sit until the hearing is completed, and sometimes we forget to take a break for lunch, dinner, or any other important call of nature. You have to remember that your client’s medications may make their mouth very dry, and in any event that they need to drink and eat; they will sometimes forget to tell you or be intimidated into failing to say anything about their basic physical needs. The client may also risk being excluded from the hearing if they act out in unduly disruptive ways; you should do whatever you can to calm your client so this does not happen, if your client wishes to be present for the duration of the hearing.

It’s important that you advise your client that she can return to her room while the attending physician or her family members are giving evidence. In my experience, my clients get the most understandably agitated when their family are called to give evidence “against them” by the attending physician.

Family members are also the trickiest to cross-examine, because they are usually exceedingly emotional. They are in a difficult situation, no doubt frustrated and upset about watching their loved one deteriorate in the community to the point of hospitalization. Family relationships can be irreparably harmed during these hearings if you are not careful. I admit to
losing it a bit with some family members sometimes, and not always when they deserved it. As a general rule, it’s better to go gentle on the family member, if for no other reason than because in these cases you really do get more flies with honey. Incidentally, while the physician may be disturbed by how long the hearing is taking, the Board may want you to move on from your line of questioning and so on, it is generally family members who resent your presence more than anyone. I once got asked by my client’s sister, during her evidence, if I was planning to attend her sister’s funeral after I got her out of hospital. You are more often than not the family’s enemy. When my client allows me to speak to the family prior to the hearing, I take a minute to explain my role as advocate for the client based on her instructions, so they are not surprised by this during the conduct of the hearing.

Documentary Evidence Admitted at the Hearing

Sometimes family may not attend, but will deliver a letter to the physician which will be admitted by the Board. The Board is entitled to receive hearsay evidence, attributing to it only the weight that is appropriate. In CTO hearings and hearings under the expanded committal criteria, where your client is considered not capable to consent to her own treatment “in a psychiatric facility” and the consent of the SDM has been obtained, you may wish to explore whether that consent has been given in accordance with the HCCA (in the case of the CTO, the language of the Act requires this). In the absence of the SDM as witness at such hearings, you have two choices. Argue that the physician has not established these pre-requisites are met, or summons the SDM to testify about prior capable wishes and so on, in an effort to find out if the consent that was given was indeed lawful.
The attending physician may present you with a clinical summary to be admitted into evidence, just prior to the hearing. You should request a few minutes to review this document before the Board members read the summary. You should already be familiar with most of what is contained in the summary unless one of you or the attending physician is completely misdirected in preparing for the hearing, but there are certain things to watch for, which are not properly to go to the Board. One good example is the propensity of some physicians to include excerpted lines or paragraphs if not pages or the entire set of the Reasons for Decision of a previous Board panel dealing with the same issue in respect of your client. Your client is entitled to a fresh hearing (and I often argue, without statutory basis, for a fresh panel of members altogether), and the Board hearing the matter on the date in question should be wholly independent, with no knowledge of a prior hearing. This is a general rule. The legal concept of issue estoppel or res judicata is not practically capable of being invoked in most of the Board’s proceedings; a fuller discussion of this issue is out of the scope of this paper, but elsewhere merits further examination.

If your client has documents you wish to file on her behalf, try to get them in through the attending physician, in case your client either chooses not to testify, or the doctor does not meet his onus, and your recommendation to the client (which she may accept) is that she not give evidence. You will not know what to recommend until the doctor has completed his case.

**Cross-Examining the Attending Physician**

My best advice is to cross-examine the physician on every criterion within the criteria for an involuntary admission or finding of incapacity, where you have any real chance of undermining the physician’s case (which usually means fewer areas of questioning than there are in total.) Again, CTO hearings and expanded committal criteria hearings (the so-called Box B criteria / hearings) give rise to dozens of specific requirements (literally) within each Community Treatment Order, for example, so these hearings are obviously going to take longer than the
average 1-2 hour hearing before the Board. In cross-examining the physician, remember that you are your client’s fearless advocate obligated to raise every issue which could get your client the desired result in law. The subject of your efforts often becomes very agitated, which sometimes works in your favour, as the time the attending physician threw my client’s clinical records at me in response to one of my questions, which I believe did not fortify her position before the Board. On the other hand, the Board can lose its patience with you as well, which is never pretty, and you risk losing your client’s confidence.

Your Client’s Evidence

If you don’t believe the attending physician has met his onus of providing clear, cogent and compelling evidence to prove his case on a balance of civil probabilities, you may advise your client against giving her own evidence. More often than not, your client has a lot invested in giving evidence, from an emotional perspective, wanting to respond to what she sees as unfounded allegations of all kinds, whether or not you think those allegations are critical. Most often, your client is going to want to tell the Board that she is not mentally ill, something that in fact basically never assists your client’s chances of success before the Board. If, in the face of your advice to the contrary, she chooses to testify anyway, you have to assist her as much as possible, to keep focussed on the issues before the Board. I do a pathetic job in leading my client through her evidence because I don’t want to appear as disrespectful of my client, which means I often let her sink herself in the process of giving her evidence. There is a balance to be struck here, which I have not found. I generally advise my client to testify in matters where capacity is in issue, nonetheless, as opposed to involuntary admissions, because the Board will have a hard time finding your client capable when they have only heard the attending physician’s evidence. Of course, your client’s evidence may do more harm than good. This is the client’s decision, and I always ask for a few minutes to consult with my client before it is her turn to provide evidence.

The client is not a compellable witness before the Board. On occasion, when your client does not attend the hearing, the Board may want to go and visit your client on the unit. I generally
come prepared with instructions about whether or not my client would like to receive such a visit, and if not, I register my displeasure and disagreement with the Board (this tends to happen in mandatory hearing situations respecting chronically institutionalized clients where the Board has not seen the client in about one year.)

Sometimes your client fires you just before or during the hearing, for apparently idiosyncratic reasons, though not always. One time my client became convinced I was exhibiting an aura indicating I was in the process of metamorphosing into a witch, another time I had asked questions of the physician regarding my client’s allegations of sexual abuse against her father, and this legitimately upset the client to the point that she did not wish me to continue representing her. In these situations, you must immediately advise the Board that you no longer have instructions to represent the client. They may ask you to stay to assist the Board, although they also have the power to Order the Office of the Public Guardian and Trustee to make arrangements for other counsel to represent your client if your client is or may be incapable, where the client does not appear to wish to retain other or any counsel. There is some recent jurisprudence to suggest that the Board also has the power to appoint Amicus for the patient/applicant or ask you to stay on as “friend of the Board” to assist your former client by letting the client self-represent but helping the client and/or the Board with the law, or in some other informal fashion as the hearing panel deems most appropriate.

**Submissions**

The Board will invite submissions from the attending physician (or his counsel, representation of physicians before the Board has been rare to date but is expected to be on the rise in the context of the new legislation) after all the evidence has been presented. Most doctors don’t use this opportunity at all or certainly don’t take full advantage of it. It is my practice to make submissions on almost all occasions. For one thing, it’s one of the only times your client can hear you say something on their behalf, as opposed to ask questions, and they need to hear that you are
fighting for them. Generally speaking, my clients tend to remember my submissions more than anything else about the hearing. These closing statements are also your best and last chance to convince the Board to decide in your client’s favour. I tend to review the onus on the physician, the evidence I want the Board to remember, and my theory of the case. Sometimes, rarely, I present appellate level cases or other decisions of the Board (which do not bind this panel of the Board of course) which may be directly on point. At this time I usually also request Written Reasons for the Decision of the Board. Some members of the Board will request that you contact the Board after the close of the hearing to request Reasons, but this is just to buy them more time to write them, and there’s nothing in the legislation that prevents the request from being made at the hearing. Members of the Board may also request that you consent to Reasons being delivered later than two business days after the request is made; however, since the statutory obligation is a mandatory one, arguably your client does not have the ability to waive the requirement. Certainly you do not have the authority to consent without your client’s instruction. Remember that the time lines for appeal are seven days for filing the Notice of Appeal from the date of the Decision, not the Reasons, so if you want to be able to advise your client about the merits of an appeal in a meaningful fashion, you need to see those Reasons as soon as possible. Where there is a dissenting opinion in a Decision, the Board is supposed to show you who dissented, on the face of the Decision, but sometimes they do not do this, and the only way you find out is by reading the Reasons. Similarly, mistakes can happen, and on a couple of occasions the Decision has appeared to have gone against my client, but upon review of the Reasons, we discovered that the panel agreed with us and the client should have been released.

**Decision and Reasons for Decision of the Board**

The Board is obligated to provide its decision within 24 hours from the time the hearing concluded, and if requested, they are to produce their written Reasons for the Decision within 48 hours of the request being made. These are statutory requirements. If your client has not received the decision within 24 hours, call the Board and ask them to ensure that staff get the decision to
your client. If you call and start harassing staff about this, they will give you all kinds of reasons to avoid delivering the decision to the client, like the doctor has to approve it first, etc. The fact is that the hospital cannot interfere with communications from the Board to your client; I have found it useful to request the presiding member at the hearing to make this clear to the attending physician, in cases where a revocation of the certificate of involuntary admission results from the hearing, and staff at the hospital really don’t want the client to know she is free to go.

The chances of your client succeeding before the Board, sadly, are slim. As I understand it, the provincial average success rate of your client regarding treatment capacity applications is perhaps 10% (90% of the time the Board confirms the physician’s determination that your client is not capable) and on an involuntary admission hearing your client’s chances are probably even worse, meaning that more than 90% of the time, your client’s involuntary status will be confirmed.

I have no way of knowing whether I’m an effective advocate for my clients at these hearings. One of the frustrating things about these hearings is that more often than not, the Reasons for the Decision of the Board do not convey any sense that you were even there for your client, other than the recitals indicating the applicant was represented by legal counsel, you. Except on rare occasions when family members who testified at the hearing and were unduly abusive of me, I have never seen the Board comment on my work for the client, or whether any of my arguments were of any assistance. In terms of results obtained for clients, I once compiled my own list of statistics. In retrospect, when I look at those numbers I realize it was during a very lucky stretch, when I must have felt encouraged enough by the results to conduct this little survey. Of thirty-three clients I represented before the Board in a five month period in spring-summer 1999, on 15 occasions my client’s involuntary status was changed to voluntary prior to the hearing (this will happen about half the time in any event), my client was successful in 10 decisions received from the Board and unsuccessful in 10 other issues (some files had two or more issues). This apparently meant a 50-50 win/lose ration, and a 72% victory rate if you include the Form 5s (change to voluntary status.) I wish I could say this is typical. I can say that I have won all but a very few financial capacity issues, mainly because physicians habitually err in finding my client
not capable to manage her finances simply because she made “unreasonable” expenditures, which is not the legal test for “capacity.” I have won very few treatment capacity issues. On involuntary admission hearings, even where we succeed, I often receive one dissenting opinion. Where my client did succeed in an involuntary admission hearing, it was generally either because the risk of serious physical impairment had not been shown to be “imminent” (something no longer available under the new legislation which removes the requirement of imminence in ground (c) of s. 15 (1) and s. 20 (1) of the MHA) or because it had not been shown that my client was not suitable to be continued as a voluntary patient (of course, under the CTO, your client would be ill-advised to stay as a voluntary patient, and you can no longer recommend this course of action without also explaining how continuing as a voluntary patient prejudices your client in future in qualifying her as a candidate for a CTO).

These days winning involuntary admission hearings is easier if only the traditional, danger-based criteria are relied upon by the physician (the so-called Box A criteria). I am aware of only a couple of CCB decisions rescinding an involuntary admission completed on Box B criteria (ie, where risk of substantial physical or mental deterioration is the criterion for certification selected).

**Appeals**

You have only seven days to file an appeal of the decision of the Board to the Superior Court of Justice. This is such a narrow window that Legal Aid almost always authorizes an opinion letter to be delivered on the merits as well as filing the Notice of Appeal in the client’s name only. In involuntary admission cases, I do not recommend appeals unless the client is on a third or subsequent Continuation of the Certificate of Involuntary admission, because the time lines in the legislation when weighed against the length of time it will take your client to get to court mean that your client would probably get “another kick at the can” before the Board faster than she would have the appeal heard in the courts. On the other hand, though I am not certain that this has been tried, one could argue that CTOs are treatment (definitely the underlying Community
Treatment Plan is defined as “treatment” for purposes of the HCCA) and they are therefore stayed pending appeal, so it may well be that all our clients who oppose the notion of a CTO as it would apply to them, could benefit from serving and filing an appeal to the Superior Court of Justice. Of course counsel opposite will argue against this, opposing you being her job.

SAFEGUARDING YOUR OWN MENTAL HEALTH

I have found that I both need and have an infinite amount of patience for my clients. However, the predictable result of this kind of emotional energy spent at work is that my tolerance level for things going wrong vis a vis my family, friends, other colleagues or the Board (on occasion) is strained, probably the first sign (just after a complete loss of one’s sense of humour) of burn-out. Professional burn-out in this practice area is a real and substantial risk. I wish I had an easy solution for the problem. What I can say is that it helps to have others around who know what you are going through (like an office mate instead of working in complete isolation) and that having colleagues (such as the members of the Mental Health Legal Committee) to consult with on legal and non-legal issues alike, has been of invaluable assistance to me personally. If your own physical or mental health suffers because of overwork etc., you’re not going to be much use even to your clients, never mind your spouse or loved ones. No doubt this is a troubling concern in all practice areas, but in mental health law, burn-out is something you must be vigilant about. Subject to this proviso, I welcome you to the rewarding, exciting, always challenging practice of mental health law! I hope this paper is of assistance to you.