Deciding who decides: the assessment of mental capacity in Canada

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This report provides an overview of my trip to Canada during July and August 2011, funded by the Winston Churchill Memorial Trust. The main aim of the trip was to learn more about how the legal framework for people whose decision making capacity is impaired works in practice in two jurisdictions (Ontario and Saskatchewan) to help inform the process of law reform in Northern Ireland.

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Aims and background

In Northern Ireland a new legal framework for people who have impaired decision making capacity is being planned – the Mental Capacity (Health, Welfare and Finance) Bill. In most jurisdictions, including within the rest of the UK, there are separate laws covering mental health and mental capacity. In Northern Ireland it is proposed that there will be no longer be a separate law for people with mental health problems and the Mental Capacity Bill will apply to everyone who has impaired decision making capacity. This approach would be unique but some states in Canada have elements of it.

The main aim of this project is therefore to learn how the assessment of capacity works in practice, especially when it is a gateway criterion for compulsory intervention. The other aims reflect components of this process and they are to:

- Observe and learn how professionals in two jurisdictions in Canada assess mental capacity;
- Explore any issues raised by having mental capacity as a criterion for compulsory intervention;
- Learn how professionals are trained to assess mental capacity and identify any standardised tools used to support these assessments;
- Discuss the use of advance statements and decisions;
- Experience how assessments of capacity are considered by an independent body and identify any practice issues with the review process;
- Meet with a range of organisations, including those representing the views of service users and carers, to discuss their views on the strengths and any difficulties with the assessment of mental capacity; and
- Identify strategies for evaluating the implementation of capacity based law.

Under the Ontario Mental Health Act, although a person who has capacity can be hospitalised, under the Health Care and Consent Act intervention requires their consent, or if they do not have capacity, the consent of their substitute decision-maker. The assessment of capacity can be reviewed by an independent tribunal, the Consent and Capacity Board. In Saskatchewan, mental capacity is one of several gateway criteria for compulsory admission.

In Northern Ireland the proposed use of capacity as the gateway criterion for all compulsory intervention, including detention for mental health care, is a world-first and so it is important to learn from other jurisdictions that have aspects of this approach. This report is intended to help inform the Department of Health, Social Services and Public Safety's ongoing process of drafting the Bill and the Code of Practice for Northern Ireland. It could also contribute to the planning process for the training of professionals in the assessment of capacity under the new framework.

Itinerary

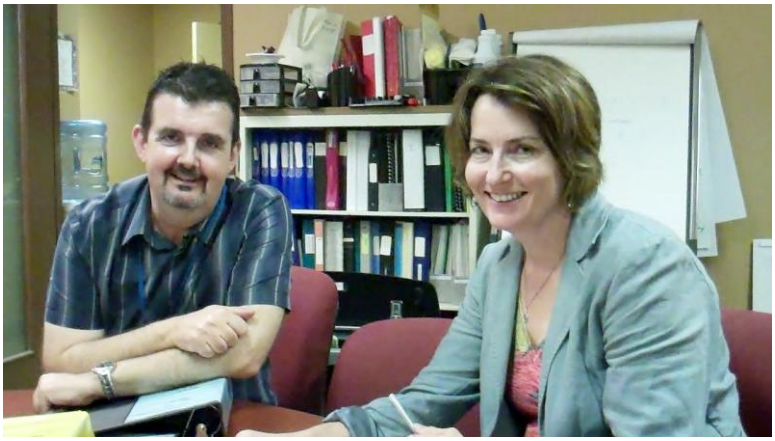
24th July - Belfast to Ottawa, Ontario
10th August – Ottawa to London, Ontario
20th August – London to Regina, Saskatchewan
30th August – Regina to Belfast.

Visits in Ottawa, Ontario

Ann-Marie O'Brien, Project Manager, Women's Health Program, Royal Ottawa Mental Health Centre. Ann-Marie helped me with my Fellowship application, provided a comprehensive overview of the legal framework in Ontario and facilitated my visits in Ottawa. Many of my visits were in or associated with the Royal Ottawa Mental Health Centre.

- Consent and Capacity Board Hearings. During my time in Ottawa it was possible for me to attend three Consent and Capacity Board hearings, one by teleconference, in the Royal Ottawa Mental Health Centre (ROMHC).
- Case Presentation and Ethics Discussion lead by Dr. Jean-Marie Ribeyre, Psychiatrist, ROMHC. Dr. Ribeyre addressed some of the complexities around compulsion and capacity and was also the Psychiatrist in two the Consent and Capacity Board hearings I attended.
- Alison Freeland, Associate Chief of Psychiatry, ROMHC, and Director of Undergraduate Education for Department of Psychiatry**,** University of Ottawa, was able to provide clinical, management and academic perspectives on the training for and assessment of capacity.
- Susan Farrell, Clinical Psychologist and Clinical Director for the Community Mental Health Program, Royal Ottawa Mental Health Group and Clinical Professor at the University of Ottawa, discussed the capacity issues involved across the community mental health teams and enabled me to observe the following team meetings.
- Assertive Community Treatment Team (Catherine Street), I attended their daily team meeting which included discussion of capacity issues related to finances and substitute decision makers, and consideration of Community Treatment Orders.
- Dual Diagnosis Team meeting. In this context dual diagnosis refers to mental health problems and learning disability (referred to as intellectual disability in Canada where learning disability relates more to what in the UK would be called specific learning difficulties (e.g. dyslexia). The term for the UK use of dual diagnosis (mental health problems and substance misuse) is co-occurring disorders. This team provides a specialist consultation service and their discussions explicitly considered capacity.
- Psychiatric Outreach Team provides mental health support to people who are homeless. This also involves consideration of capacity issues and the need for compulsory intervention at times.
- Dr Donna Lougheed, Psychiatrist with the Dual Diagnosis and Psychiatric Outreach Teams also met with me separately and highlighted some of the complexities involved in practice, for example when there are capacity issues and needs relating to mental health problems, physical health problems, intellectual disabilities and homelessness.
- Kelly Kilbreath, Community Treatment Order Co-ordinator, explained how the initiation, review and renewal of CTOs works in Ontario. Her role involves ensuring the legal criteria are met and providing advice on the appropriateness of a CTO and what is proposed to include within it.
- Susan Farrell also organised a meeting for me to present to the Community Mental Health Program the proposed law for Northern Ireland and to obtain feedback from practitioners about the proposals and to compare them with the current framework in Ontario.

- Assertive Community Treatment Team (Bank Street). I was also able to attend the Bank Street ACT Team meeting and then meet with the Team Leader, James McDonnell and Robin Pow, Director Patient Care Services, Community Mental Health Program (pictured below).

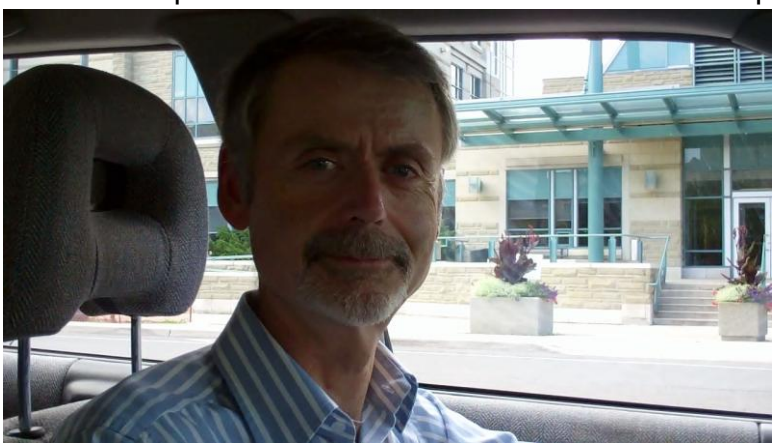


- In addition to the Royal Ottawa Mental Health Care Group service providers I visited I also met with representatives of the Centre for Addition and Mental Health (CAMH). Alfred Cormier, System Planning Consultant, Bernadette Wren, Director of Mental Health Services, Wendy Brown, Community Mental Health and Addictions Counsellor (all pictured below), and Mike Haswell, Triage Nurse for CAMH – not in the photograph as he joined us by teleconference from Toronto.

- I also met with Bernard Starkman who works for Health Canada and is on the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada. He is currently engaged with the debates about the relationship between mental health services and the criminal justice system and how law and policy should provide a framework for children and young people.
- My final visit in Ottawa was with Wendy Heffern from the Mental Health Commission who is currently working on a draft Mental Health Strategy for Canada to be released early in 2012.

Visits in London, Ontario

My visits in London were facilitated by Dr Richard O'Reilly, Psychiatrist and Director of Research, Regional Mental Health Care, London and Professor of Psychiatry, University of Western Ontario (picture below). Dr O'Reilly has written extensively about the debates and complexities involved in mental health and capacity laws.



My first visit in London was with Robin Rundle Drake, a Patient Advocate in with the Psychiatric Patient Advocate Office based in but independent of Regional Mental Health Care London (both pictured below). One of the roles of the Psychiatric Patient Advocate Office is provide rights advice to anyone who comes under the powers of the Mental Health Act. This role is a duty under s59 of the Act.

- My next visit in London was with Marne Wedlake who is the Research/Information Coordinator and a Mental Health Public Educator with the London-Middlesex Branch of the Canadian Mental Health Association. We discussed the central importance of involving service users and carers in the process of law reform and, in parallel, addressing the wider issues of stigma, discrimination and social exclusion.
- Cathy Plyley and Joe Skufca (pictured below) are the Community Treatment Order Co-ordinators for Regional Mental Health Care, London. They were able to provide a comprehensive overview of how CTOs work in practice including: the process from referral through renewal; considerations about what should be contained in the CTO and the importance of wording; how non-compliance is responded to; and the crucial importance of ensuring sufficient involvement and education for everyone who may be involved from as early as possible.

- During my time in London I was able to meet with Dr O'Reilly, who had facilitated my other visits, several times. These meetings included discussing the legislation in Ontario as well as accompanying him as he presented lectures to junior doctors on mental health law and schizophrenia and to his Assertive Community Treatment (ACT) Team meeting in Strathroy, a rural area outside London.
- In Strathroy I was able to speak with the ACT team co-ordinator, Joseph Bhasker, and several of the Team's multi-disciplinary staff. During their team meeting they used video-conferencing with an in-patient unit team to discuss the care plan for one of their service users who is currently in hospital.
- Dr O'Reilly also arranged for me to meet with Dr Varinder Dua, another psychiatrist working in London who is using CTOs in practice. Dr Dua discussed the processes and practice issues involved.
- My final visit in London was with Michael Petrenko, Executive Director of the London-Middlesex Branch of the Canadian Mental Health Association. Michael discussed the process of change within mental health law, policy and practice. He referred to a range of initiatives that have had a positive impact including at the Provincial Government and national Government levels.

Visits in Regina, Saskatchewan

- My first visit in Regina was with Jamie Petty (who also facilitated my other visits in Regina), Lorne Sier and Bruce McKee (pictured below) who have responsibility for mental health law and policy within the Saskatchewan Ministry of Health. They were able to provide an overview of the law, the Mental Health Services Act 1984, and its subsequent amendments. They also discussed some of the related practice issues and the possible further amendments they are considering.

- I also met with Dave Nelson (below), Executive Director of the Saskatchewan Division of the Canadian Mental Health Association. Our discussion covered possible changes to the law as well as the wider policy and societal issues.

- My next meeting was with Dr Dhanapal Natarajan, Department Head and Chief Psychiatrist, Regina Qu'Appelle Health Region. We met in his office in Regina General Hospital. An important issue we covered was the assessment of the capacity criteria for compulsion within the Saskatchewan mental health law.

- My final visits in Regina were all in the community mental health clinic in Regina. There I was able to speak with Terry Nielson, the Intake Program Manager, who discussed how the various components of the community mental health services work in practice. I also met with Dr Kumar, a consultant psychiatrist who discussed the relationship between insight and capacity. My final meeting on the trip was with Marlin Marynick (pictured below), a psychiatric nurse who works with the crisis response team. Marlin described his crisis work which involves responding to a wide range of issues and working closely with a range of other agencies. This work also involves using compulsory powers under mental health law and Marlin discussed how this works in practice and some of the complexity involved.

Findings: the laws

As part of planning this trip a number of key issues and debates relevant to the development of the new law in Northern Ireland had been identified. There were: the definition and assessment of mental capacity; rights advice and advocacy; community powers (Community Treatment Orders); advance planning; application to the criminal Justice System; application to children and young people; and review and appeal processes. The findings are therefore organised using these issues and present the relevant law in Canada, the proposed law for Northern Ireland and any recommendations arising from this comparison. The relevant laws are listed below before getting into the more detailed issues:

Relevant laws

The legal framework in Ontario is provided through three main laws which cover different aspects of substitute decision making for people who are incapable of making the relevant decision:

Ontario.ca

Ontario

ServiceOntario
e-Laws

PRINT ACCESSIBILITY

Français

Substitute Decisions Act, 1992

S.O. 1992, CHAPTER 30

Consolidation Period: From January 1, 2011 to the e-Laws currency date.

Last amendment: 2009, c. 33, Sched. 18, s. 33.

Ontario.ca

Ontario

ServiceOntario
e-Laws

PRINT ACCESSIBILITY

Français

Health Care Consent Act, 1996

S.O. 1996, CHAPTER 2
SCHEDULE A

Consolidation Period: From July 1, 2010 to the e-Laws currency date.

Last amendment: 2010, c. 1, Sched. 9.

The mental health law in Ontario is also of relevance:

Ontario.ca

Ontario

ServiceOntario
e-Laws

PRINT ACCESSIBILITY

Français

Mental Health Act

R.S.O. 1990, CHAPTER M.7

Consolidation Period: From May 18, 2010 to the e-Laws currency date.

Last amendment: 2010, c. 1, Sched. 17.

In Saskatchewan my focus was on their Mental Health Service Act but the Health Care Directives and Substitute Health Care Decision Makers Act was also relevant.

The Health Care Directives and Substitute Health Care Decision Makers Act

being

Chapter H-0.001 of the *Statutes of Saskatchewan, 1997* (effective September 1, 1997) as amended by the *Statutes of Saskatchewan*, 2000, c.A-5.3; and 2004, c.65.

The Mental Health Services Act

being

Chapter M-13.1* of the *Statutes of Saskatchewan, 1984-85-86* (effective April 1, 1986) as amended by the *Statutes of Saskatchewan*, 1989-90, c.54; 1992, c.A-24.1; 1993, c.59; 1996, c.9 and 17; 1997, c.12; 2002, c.R-8.2; and 2004, c.L-16.1.

As mentioned, in Northern Ireland the proposed law is the Mental Capacity (Health, Welfare and Finance) Bill. The most recent public statement of what will be in the Bill was for an equality impact assessment in 2010 and so this is where the Northern Ireland sections are taken from.

Definitions and assessment of mental capacity

In Ontario under the Health Care Consent Act (s.4(1)) capacity is defined as:

> **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. 1996, c. 2, Sched. A, s. 4 (1).

Under the Substitute Decisions Act the definition is the same:

> **Incapacity to manage property**
> **6.** A person is incapable of managing property if the person is not able to understand information that is relevant to making a decision in the management of his or her property, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 1992, c. 30, s. 6.

Incapacity for personal care
45. A person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 1992, c. 30, s. 45; 1996, c. 2, s. 29.

Under the Mental Health Act in Ontario the conditions for involuntary admission (s.20) are that:

(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 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).

There is an important issue with the legal framework in Ontario because a person who is detained under the Mental Health Act can only be treated against their will in an emergency, to enable them to be fit for trial or if they are incapable and their substitute decision-maker had given consent. It the person has been detained and is appealing against the finding that they are incapable of consenting to treatment then treatment can only be forced in an emergency or to enable them to be fit for trial. The appeal process can take a very long time, in one case which went to the Supreme Court, it took seven years. Although this situation applies to a relatively small number of people it does appear to create considerable difficulties and distress for them, in-patient staff and other people on the ward.

In Saskatchewan, under the Mental Health Services Act, the grounds for compulsory admission include some consideration of capacity (s.24.2.ii):

> **24**(2) Every certificate issued for the purposes of this section is to be in the prescribed form and is to:
> (a) state that the physician has examined the person named in the certificate within the immediately preceding 72 hours and that, on the basis of the examination and any other pertinent facts regarding the person or the person's condition that have been communicated to the physician, he has probable cause to believe that:
> (i) the person is suffering from a mental disorder as a result of which he is in need of treatment or care and supervision which can be provided only in an in-patient facility;
> **(ii) as a result of the mental disorder the person is unable to fully understand and to make an informed decision regarding his need for treatment or care and supervision**; and
> (iii) as a result of the mental disorder, the person is likely to cause harm to himself or to others or to suffer substantial mental or physical deterioration if he is not detained in an in-patient facility;

The *Health Care Directives and Substitute Health Care Decision Makers Act* defines capacity as:

> **2**(1) In this Act:
> (b) **"capacity"** means the ability:
> (i) to understand information relevant to a health care decision respecting a proposed treatment;
> (ii) to appreciate the reasonably foreseeable consequences of making or not making a health care decision respecting a proposed treatment; and
> (iii) to communicate a health care decision on a proposed treatment;

The proposal for Northern Ireland is that is, closely following the Mental Capacity Act 2005 for England and Wales there should be a two stage process of assessing capacity:

> the first being diagnostic: that a person has **an impairment of, or disturbance in, the functioning of the mind or brain**. The second stage is a functional test, which considers if, as a result of the impairment or disturbance, the individual can **understand** the information needed to make a decision and, if required, the person must be assisted in that understanding. The person should be able to **retain** the information at least long enough to make the decision. The person should be able to **use and weigh** the information in order to make the decision and finally the person should be able to **communicate** the information and again, every assistance must be given.

So, in Ontario capacity is the ability to understand and appreciate; in Saskatchewan it is the ability to understand, appreciate and communicate; and the proposal in

Northern Ireland is that it is the ability to understand, retain, use and weigh and communicate.

In terms of who assesses capacity and how, in Ontario, under the HCCA, for treatment decisions, it is the practitioner who proposes the treatment, under the Substitute Decisions Act it is specially trained Capacity Assessors and under the Mental Health Act it is doctors. There are specific guidelines for Capacity Assessors under the Substitute Decisions Act - see http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacity.asp.

In Saskatchewan it is also the treatment provide under the Health Care Directives and Substitute Health Care Decision Makers Act and doctor under the Mental Health Services Act. In some of my discussions with practitioners in Saskatchewan the capacity criterion under the Mental Health Services Act was sometimes referred to as the insight criterion which is an interesting interpretation of the law.

In Northern Ireland it is proposed that at the routine level capacity will be assessed by those intervening and at the serious level by a GP and Approved Social Worker.

Rights advice and advocacy

In Ontario, any decision to involuntarily intervene under the Mental Health Act or that they are incapable of make a specific decision under the Health Care and Consent Act and/or Substitute Decisions Act triggers independent rights advice. This is usually provided through the Psychiatric Patient Advocate Office that also provides instructed and non-instructed advocacy services.

In Saskatchewan you should also be informed of the reasons for compulsory intervention, you can contact a lawyer and receive a copy of the form enabling intervention. There are also Official Representatives who visit people who are being treated, transferred or ordered to receive ECT against their will. They are slsdo notified if a person is being examined against their will or placed under a CTO. People are also able to contact the Official Representatives.

In Northern Ireland there has been discussion about the right to advocacy but it is not yet clear if this will be available to all or only those subject to serious levels of interventions and it is also not yet decided how this will be provided.

Community powers (Community Treatment Orders)

The grounds for CTOs in both Ontario and Saskatchewan appear relatively complex. In Ontario you may be placed on a CTO if:

- in the last three years, the person has been an inpatient in a psychiatric facility two times or more or for a total of at least 30 days, or has been on a CTO; and,

- a community treatment plan has been developed; and,
- the physician has examined the person in the 72 hours before the plan is entered into and believes :
- because of his or her mental illness, the person needs continuing treatment or care and continuing supervision, if he or she lives in the community; and,
- if the person isn't an inpatient in a psychiatric facility, that he or she meets the conditions for assessment; and,
- if the person doesn't get continuing treatment or care and continuing supervision while living in the community, he or she is likely, because of mental illness, to cause serious bodily harm to himself or herself or to someone else, or suffer substantial mental or physical deterioration or serious physical impairment; and,
- the person is able to comply with the plan; and,
- the treatment or care and supervision are available in the community; and,
- the physician has consulted with the health practitioners or other persons proposed to be named in the plan; and,
- the physician is satisfied that the person subject to the order and his or her substitute decision-maker (if any) have consulted with a rights adviser and been told about their legal rights; and,
- the person or his or her substitute consents to the plan.

In Saskatchewan the criteria are that your psychiatrist may place you under a CTO if:

- you have a mental disorder and need treatment and supervision in the community and you do not need to be in hospital;
- in the last two years you have been hospitalized for psychiatric treatment against your will for 60 or more days **OR** you have had three or more separate admissions;
- your mental disorder will probably make you harm yourself or others, or make your illness get worse if you are not treated;
- the services which you need are available in the community;
- your mental disorder keeps you from understanding that you need treatment and supervision, so that you cannot make an informed decision;
- you are able to co-operate with the CTO. If a second doctor examines you and supports a CTO written by your psychiatrist, you must comply with the order. You must then follow prescribed medical treatment and attend appointments with your psychiatrist or case manager.

So, in both jurisdictions the grounds for CTOs include previous admissions. In Ontario they are consent based – by you or, if you are incapable of consenting your substitute decision maker, and in Saskatchewan there you have to be unable to make an informed decision about your need for treatment and supervision.

In Northern Ireland, intervention will be enabled across settings and it does not appear that there will be different criteria, thresholds and safeguards for community settings.

Advance planning

The law in Ontario allows for people to state, when they have the capacity to do so, what decisions they wish to be made when they no longer retain this capacity. This is through the Health Care and Consent Act and the Substitute Decisions Act. The Health Care Consent Act s.21(1) states:

> **21.** (1) A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:
> 1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
> 2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests. 1996, c. 2, Sched. A, s. 21 (1).

The Substitute Decisions Act s.66(3) allows for other decisions to be made:

> (3) The guardian shall make decisions on the incapable person's behalf to which the *Health Care Consent Act, 1996* does not apply in accordance with the following principles:
> 1. If the guardian knows of a wish or instruction applicable to the circumstances that the incapable person expressed while capable, the guardian shall make the decision in accordance with the wish or instruction.
> 2. The guardian shall use reasonable diligence in ascertaining whether there are such wishes or instructions.
> 3. A later wish or instruction expressed while capable prevails over an earlier wish or instruction.
> 4. If the guardian does not know of a wish or instruction applicable to the circumstances that the incapable person expressed while capable, or if it is impossible to make the decision in accordance with the wish or instruction, the guardian shall make the decision in the incapable person's best interests. 1992, c. 30, s. 66 (3); 1996, c. 2, s. 43 (2).

For these wishes to be legally binding, however, they have to be in the form of a power of attorney for personal care or 'Ulysses Contract' under s.50 of the Substitute Decisions Act. This has to be a written document which names a substitute decision maker and is witnessed by two people.

In Saskatchewan the *Health Care Directives and Substitute Health Care Decision Makers Act* enables people to make health care directives to give instructions for the medical treatment they wish to receive if they become unable to make the relevant

decisions. The directive has to be in writing, dated and signed by the person and one witness.

In Northern Ireland it is proposed that advance statements of wishes (not legally binding) should be included within the new law but that the existing power to make a legally binding advance decision (advance refusal of a specific intervention) should continue to be in the common law.

Criminal Justice System

In Ontario people may be detained for mental health assessment and treatment under the Criminal Code (Part XX.1) but crucially, the Health Care Consent Act still applies as stated in s.25 of the Mental Health Act:

> **25.** Any person who is detained in a psychiatric facility under Part XX.1 of the *Criminal Code* (Canada) may be restrained, observed and examined under this Act and provided with treatment under the *Health Care Consent Act, 1996*. 2000, c. 9, s. 8.

This part of the Criminal Code also applies in Saskatchewan as included in their Mental Health Services Act s.23:

> **23.** Subject to the regulations, a person who is suffering from a mental disorder may be admitted to an in-patient facility and detained there:
> (a) under an order pursuant to Part XX.1 of the *Criminal Code* (Canada);
> (b) on an order of the Commissioner of the Correctional Service of Canada in the case of transfer of the person from a penitentiary.

In Northern Ireland there is ongoing debate whether the proposed capacity gateway to compulsory intervention should also apply to those in the criminal justice system or whether a set aside is needed in cases where there is a high level of concern about public safety.

Children and young people

In Ontario there is a presumption of capacity for everyone regardless of age so a child's capacity to consent to treatment must be assessed. S.4(2)of the Health Care and Consent Act states:

> (2) A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services. 1996, c. 2, Sched. A, s. 4 (2).

The Mental Health Act also applies to children but there are some age restrictions in the Substitute Decisions Act, so for example, the Act applies to decisions about personal care for people who are 16 or over and the substitute decision maker must be 18 or over.

In Saskatchewan the Mental Health Services Act applies to all ages but you have to be 16 or over to make a Health Care Directive and to be a proxy or substitute decision maker you have to be 18 or over.

In Northern Ireland it is intended that the new law applies to people of 16 and over but there is ongoing debate and the position in Ontario should be considered.

Review and appeal processes

In Saskatchewan the review process under the Mental Health Service Act is very similar to the current Mental Health Review Tribunal system in Northern Ireland. It has three person review panels with the possibility of appeal to a higher court (the Queen's Bench). People can also appeal to the Court of the Queen's Bench if there are concerns about the arrangements, proxies and/or nearest relatives under the *Health Care Directives and Substitute Health Care Decision Makers Act*.

Ontario has a Consent and Capacity Board (www.ccboard.on.ca) system that could provide a progressive and flexible model for the review and appeal processes under the new law in Northern Ireland. It covers issues relating a range of laws including capacity, consent, involuntary intervention under the Mental Health Act and substitute decision making. Most of its work relates to intervention under the Mental Health Act and reviews of decisions about capacity under the Health Care and Consent Act. Hearings are usually held within a week of an application being received and can be one, three or sometimes five person hearings. Teleconferencing can also be used if necessary. Within the Consent and Capacity Board's website is a link to an online module which is a great introduction to how the system works: http://machealth.ca/programs/ccb/default.aspx.

There are a range of possibilities for what the system for review and appeal could be in Northern Ireland and the Consent and Capacity Board could provide an excellent model.

Conclusion and dissemination

There are some clear and useful lessons from the legal frameworks in Ontario and Saskatchewan for how the proposed law in Northern Ireland could be developed and implemented:

- Mental capacity can be used as a gateway criterion for intervention across a range of decision making. This is perhaps most clearly demonstrated by the Health Care and Consent Act in Ontario and by the inclusion of a capacity criterion in the Mental Health Services Act in Saskatchewan. The concerns identified in discussion with practitioners were more in relation to the interpretation of the threshold for capacity/incapacity and this reinforces the importance of extensive training and clear guidance for the how the law should be implemented.
- The definitions of capacity used in Canada are similar to what is proposed for Northern Ireland. There is some concern in Northern Ireland that this

definition is too wide and could greatly increase the scope of compulsion but in the Canadian jurisdictions this has not been the case.

- The legal frameworks in these jurisdictions have developed over time and so there are a range of laws to cover different aspects of decision making. This means that the legal framework is at times difficult for people, including professionals, to have a comprehensive understanding. Providing a comprehensive framework in one law for Northern Ireland may avoid some of these difficulties but there will still be a need to make the new law as clear, simple and accessible as possible.
- In Ontario there is specific training and guidance for those who assess capacity under the Substitute Decisions Act which could be a useful model. The use of structured forms also ensures that the assessment of capacity consistently addresses all aspects of the definition. Standardised tests do not appear to be routinely used but should still be considered to assist in this assessment process.
- The criteria for Community Treatment Orders are much tighter than what is proposed for Northern Ireland. This may explain why the use of Community Treatment Orders in these jurisdictions has not followed the usual international trend of increasing over time and so these criteria should be considered.
- There are also very strict criteria for the equivalent of advance decisions and, perhaps partly as a result, they do not seem to be widely used in either Ontario or Saskatchewan.
- The application of the Health Care and Consent Act across settings, including the criminal justice system, suggests that the proposed law for Northern Ireland could apply to the criminal justice system without the public safety set aside that is being considered.
- The application of the Health Care and Consent Act to children also suggests that the Northern Ireland law could apply to children.
- The Consent and Capacity Board in Ontario provides an excellent model for how the review and appeal processes under the new law could be provided.

In addition to this report being placed on the Winston Churchill Memorial Trust website, the findings and conclusions will be disseminated through correspondence and discussion with those who are working on the new law, through formal presentations at Queen's University Belfast, and through an academic journal article. This was a great opportunity for learning and hopefully some of the findings contained in this report will provide useful information for the development and implementation of the Mental Capacity (Health, Welfare and Finance) Bill in Northern Ireland.

Gavin Davidson
Lecturer in social work