



Holding Risk with Care: Form 1 Decision-Making in Family Medicine

PANELISTS

Brooke Smith • Dr. Sean Moore

WITH

Dr. Chase McMurren • Dr. Stephanie Zhou

Ontario College of
Family Physicians  *Thriving Family Physicians
in a Healthy Ontario*

 Family & Community Medicine
UNIVERSITY OF TORONTO

**Mental Health
and Addictions**

May 27, 2026

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Your community,
Your X (Twitter)
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name & topic(s) of interest to
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Your Panelists: Disclosures

Brooke Smith

Relationships with financial sponsors (including honoraria):

- CoP Speaker - OCFP Practising Well
- Gowling WLG

Dr. Sean Moore

Relationships with financial sponsors (including honoraria):

- Honoraria for speaking at CAEP /OCFP /SRPC /OMA / ICEM / ACEP / NOSMU / UofT
- SRPC National Advanced Skills and Training Program (grant)
- Physician and Chief of Staff Lake of the Woods District Hospital, CritiCall, Ontario Health
Co-Lead EM
- Ornge Lead for Mental Health Transport

Disclosures

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Relationships with financial sponsors (including honoraria):

- Ontario College of Family Physicians – Practising Well Scientific Planning Committee
- University of Toronto
- College of Physicians and Surgeons of Ontario
- Ontario Medical Association
- Medical Psychotherapy Association Canada
- Centre for Effective Practice

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Relationships with financial sponsors (including honoraria):

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- Ontario Medical Association – Honoraria for practice management lectures
- Department of Family and Community Medicine (University of Toronto), Dept of Medical Imaging, Dept of Ob/Gyn for practice management lectures
- Toronto Public Health – Board of Directors Member
- McMaster University, Queen's University, McGill University, Toronto Metropolitan University, OntarioMD & Dr. Bill, Canadian Society of Allergy & Immunology, Canadian Fertility & Andrology Society, and Women in Academic Medicine - Honoraria for teaching financial literacy, billing, and practice management.

Mitigating Bias

Disclosure of financial support



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Potential conflicts



N/A

Mitigating potential bias



The Scientific Planning Committee (SPC) has control over the choice of topics and speakers.

Content has been developed according to the standards and expectations of the Mainpro+ certification program.

The program content was reviewed by the SPC.

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The Practising Well CoP is certified for self-learning credits!

Earn **1-credit-per-hour** for reviewing the recording and resources from **past CoP sessions**. The self-learning program is certified for up to 63 Mainpro+ credits.



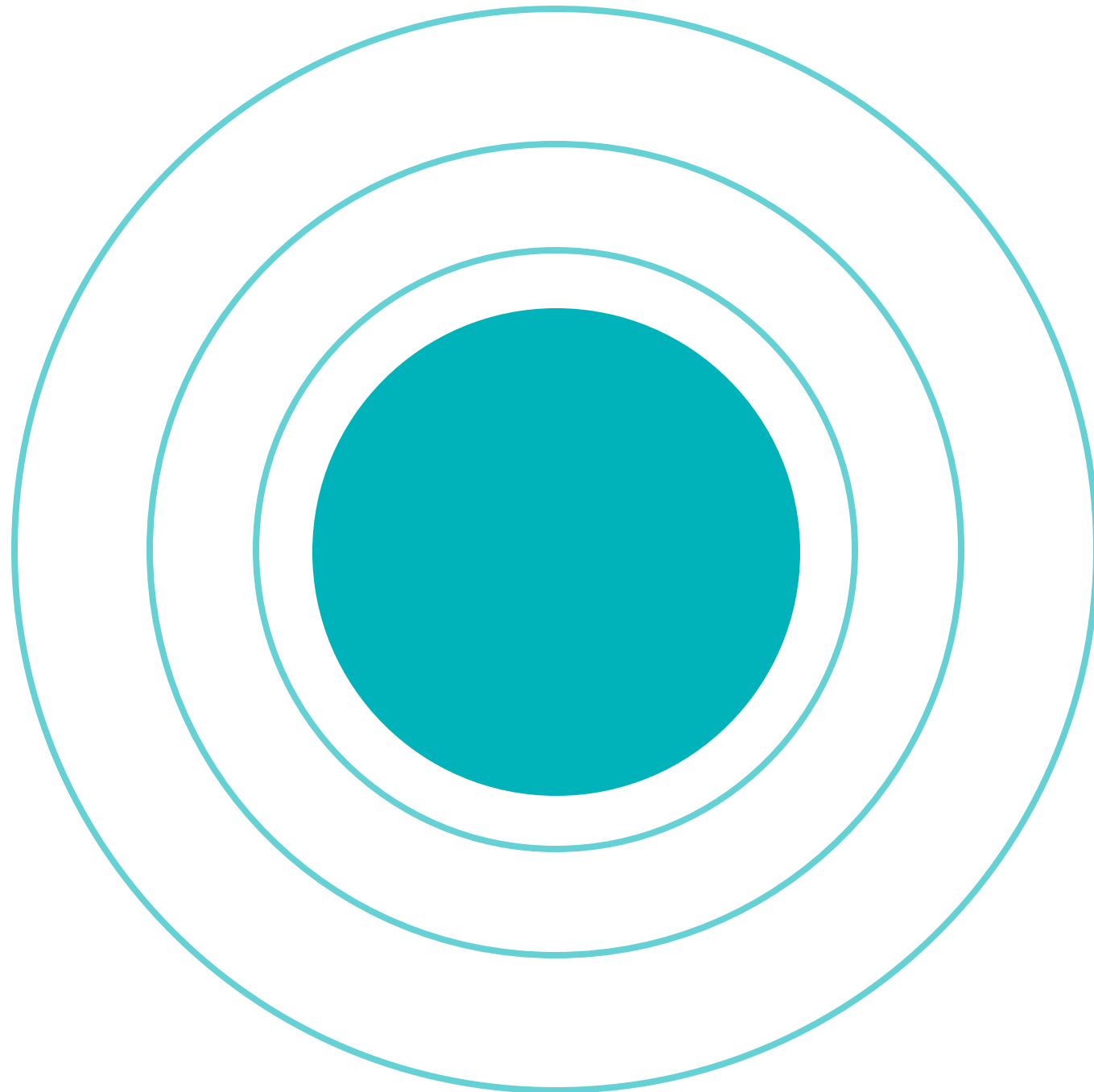
**Learn More and
Participate**

Land Acknowledgement

We acknowledge that the lands on which we are hosting this meeting include the traditional territories of many nations.

The OCFP and DFCEM recognizes that the many injustices experienced by the Indigenous Peoples of what we now call Canada continue to affect their health and well-being. The OCFP and DFCEM respects that Indigenous people have rich cultural and traditional practices that have been known to improve health outcomes.

I invite all of us to reflect on the territories you are calling in from as we commit ourselves to gaining knowledge; forging a new, culturally safe relationship; and contributing to reconciliation.



Your Panelists



Brooke Smith

Dr. Sean Moore

Holding Risk with Care: Form 1 Decision-Making in Family Medicine



APPLICATION BY A PHYSICIAN FOR PSYCHIATRIC ASSESSMENT (FORM 1)

ONTARIO COLLEGE OF FAMILY PHYSICIANS – MAY 27, 2026

FORM 1 AND ITS CRITERIA

- **A Form 1 application is made under section 15 of the *Mental Health Act* of Ontario.**
 - Leads to an involuntary admission for psychiatric assessment at a psychiatric facility for up to 72 hours.
- **The physician making a Form 1 application must have (1) personally examined the person within the past 7 days. Such examination can take place in a physician's office, or via videoconference or telephone. The physician must also have (2) made a careful inquiry into all the facts necessary to form an opinion as to the nature and quality of the mental disorder of the person.**
 - The physician making an application need not be a psychiatrist.
 - The physician is entitled to rely on the reports of others about the person but must distinguish between their own observations and third person reports.
- **1 of 2 criteria to meet: Box A or Box B.**

BOX A VS BOX B CRITERIA

- **Box A - Serious Harm Test:** where a physician examines a person and has reasonable cause to believe that the person,
 - a) Has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
 - b) Has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; **or**
 - c) Has shown or is showing a lack of competence to care for himself or herself,
 - **and**, if in addition, the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that will likely result in,
 - a) Serious bodily harm to the person;
 - b) Serious bodily harm to another person; **or**
 - c) Serious physical impairment of the person,

the physician may apply in the prescribed form for a psychiatric assessment of the person.

 - **Note:** not all of the behaviour criteria that are set out in a, b, and c must be met. It is sufficient to only find that one has been met.
- **Box B – Future Harm Test:** where a person has previously received treatment for a recurring or ongoing mental disorder and is incapable of consenting to psychiatric treatment.

REASONABLE CAUSE (MENTAL HEALTH ACT CONTEXT)

- **Reasonable cause under Box A:**
 - Deference is accorded to a doctor considering a Form 1 application as to what information is necessary to give reasonable cause for belief, and for an opinion under the Box A and Box B tests respectively. There is no specific set of criteria for what qualifies as “reasonable cause”, so long as the physician examination is conducted and the physician has used their professional judgment to base their opinion (*Dr. X v Everson*, 2013 ONSC 6134 at para 90).

SERIOUS BODILY HARM AND SERIOUS PHYSICAL IMPAIRMENT (MENTAL HEALTH ACT CONTEXT)

- **Serious Bodily Harm:**
 - Any hurt or injury, whether physical or psychological, that substantially interferes with the health or well-being of the individual (*Baig v Maldeniya*, 2019 ONSC 2045 at paras 7 – 10).
- **Serious Physical Impairment:**
 - Situations where a patient, due to a mental disorder, has failed to attend to the activities of daily living (e.g. eating, sleeping), failed to seek medical attention or treatment, lived in inadequate housing without adequate support, exposed himself to danger, been manipulated by others, etc (*JA (Re)* 2005 Can LII 56613 (ONCCB)).

FORM 42 – WRITTEN NOTICE OF REASONS

- **A Form 42 gives written notice of the detention and sets out the reasons, as well as the fact that the person has the right to retain and instruct counsel without delay.**
- **If a patient's detention begins at the psychiatric facility, a Form 42 must be delivered.**
- **If a Form 1 is not issued in a psychiatric facility (i.e., issued in a physician's office instead), a Form 42 is not required.**
 - However, it may be good practice to keep copies of a Form 42 readily accessible in a physician's office and deliver it with the execution of a Form 1. A person's detention without written notice may be found unlawful in certain circumstances and render the Form 1 void.

ALTERNATE ROUTES – FORM 2 AND POLICE APPREHENSION

FORM 2 – ALTERNATE ROUTE

- **A Form 2 provides another route to assess persons at risk of harm and may be used by concerned family members or other people who have come into contact with a person who they believe requires mental health care.**
 - Any person can appear before a justice of the peace and provide sworn information that there is a person that meets either the Box A or Box B criteria. The justice of the peace may issue an order for the examination of the person by a physician.
 - The sworn information may be oral or written, and is under oath. It can include documents and other relevant materials for the justice's determination as to whether the criteria are met.
 - If an order is made, local police will take the person into custody at an "appropriate place" for the physician examination – which may be at a physician's office, a hospital emergency department, or any other appropriate facility. It is common for the physician's Form 2 examination to lead to a Form 1 application for psychiatric assessment.

POLICE APPREHENSION – ALTERNATE ROUTE

- **A physician can tell the family to get a Form 2 (through court order), but if there is an emergency or a dangerous situation, a physician or family member can call the police.**
- **In these circumstances, a police officer may apprehend a person, without a Form or an order if the officer has reasonable or probable grounds to believe that a person is acting or has acted in a disorderly manner and that person meets the Box A criteria.**

LEGAL RISKS

- The most important thing is to act in good faith and prioritize safety.
 - If your professional opinion is that the criteria has been met, proceed with the Form 1 application.
 - Any legal risk is lower when you proceed with the Form 1 in good faith and with safety considerations. Erring on the side of caution and using your professional judgment is the best way to avoid larger legal repercussions.


THANK YOU

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GOWLING WLG

Your Panelists



Brooke Smith

Dr. Sean Moore

Holding Risk with Care: Form 1 Decision-Making in Family Medicine

ER / Rural Generalists

- 12 physicians total with locum support
- See 6-8 day present with suicidality
- 28% of the surrounding populations attempt suicide 41% of teenage girls attempt.
- Up to 50% report visiting health care professional with suicidality
- We only place approximately 1-2 patients per day on Form 1
- Strange Rules around removing Form 1





ED Visits - 1,634
Unique Patients - 1,194

Length of Stay - 90th Percentile

All ED Registrations
8 hours 1 minute (↓)
Disposition to Left ED (admitted)
19 hours 40 minutes (↓)
Triage to Initial Assessment
Physician - 4 hours 35 minutes (↓)
NP - 2 hours 34 minutes (↓)



Rostered w/ Primary Care
Yes - 52%

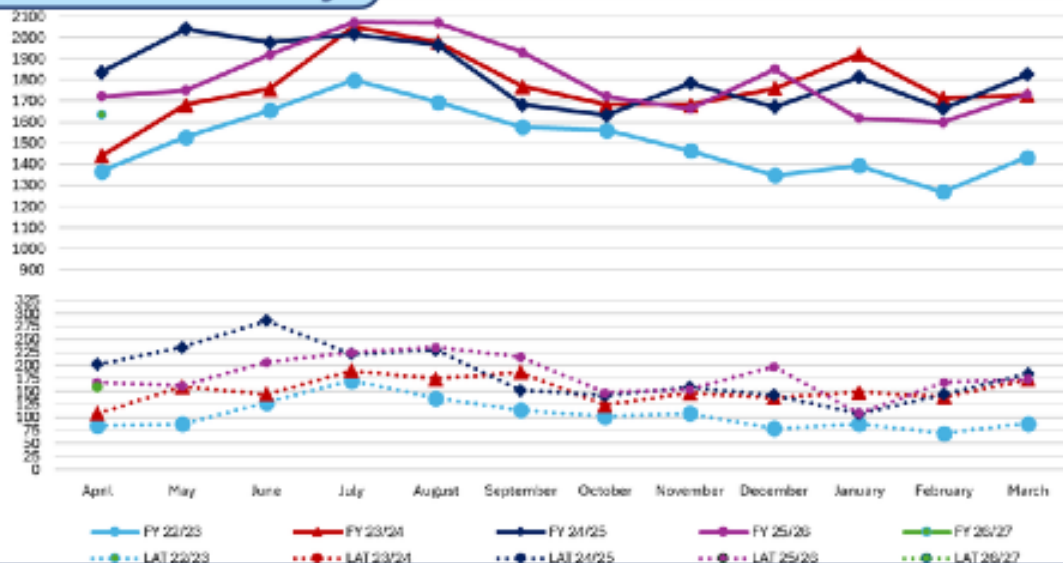
ED Coverage

Regular Shifts:
Locum - 31%
Local - 69%
Backup hours - 21
Overtime hours - 57.5
Swing shift hours - 106.25
Average hours per day - 30h 9m

Patients with Repeat Visits 217
Total Repeat Visits 657

1. Mental and behavioural disorders due to use of alcohol - 67
2. IV treatments - 41
3. Attention to surgical dressings and sutures - 22

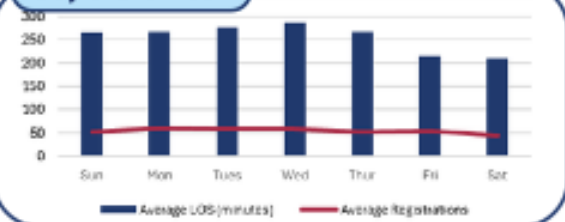
ED Visits and Left After Triage



CTAS Distribution



Day of the Week



Top 13 Primary Diagnoses

1. Mental and behavioural disorders due to use of alcohol (withdrawal state, acute intoxication, harmful use) - 83
2. Chest pain - 56
3. Other chemotherapy (IV treatments) - 42
4. Urinary tract infection - 36
5. Other and unspecified abdominal pain - 36
6. Pneumonia - 34
7. Acute upper respiratory infection - 27
8. Attention to surgical dressings and sutures - 26
9. Otitis media - 22
10. Gastroenteritis and colitis - 22
11. Acute pharyngitis - 18
12. Cellulitis of lower limb - 17
13. Headache - 15

**#1 Diagnosis:
Mental Health with
SUD**

**Have another MH
dashboard to get
more granularity**



Emergency Department Mental Health and Addictions 2025/26



ED Visits

2,069

MHA Primary Only

MHA Patients with Repeat Visits

303

MHA Patients with 10+ Visits

25

Access to Primary Care

Yes: 810 (39%)

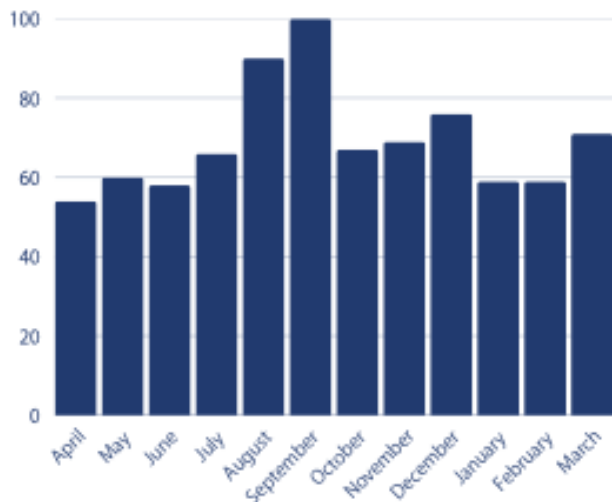
No: 1041 (50%)

Other: 218 (11%)

Top 5 MHA Primary Diagnoses

1. Mental and behavioural disorders due to use of alcohol, withdrawal state - 349
2. Mental and behavioural disorders due to use of alcohol, acute intoxication - 337
3. Mental and behavioural disorders due to use of alcohol, harmful use - 207
4. Mental and behavioural disorders due to use of alcohol, dependence syndrome - 146
5. Anxiety disorder, unspecified - 138

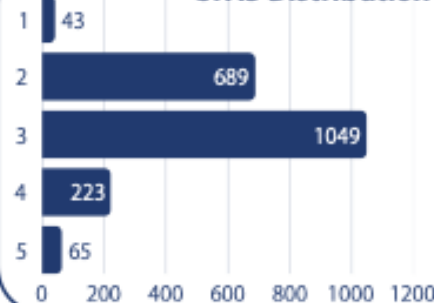
Social Worker Intake in the ED



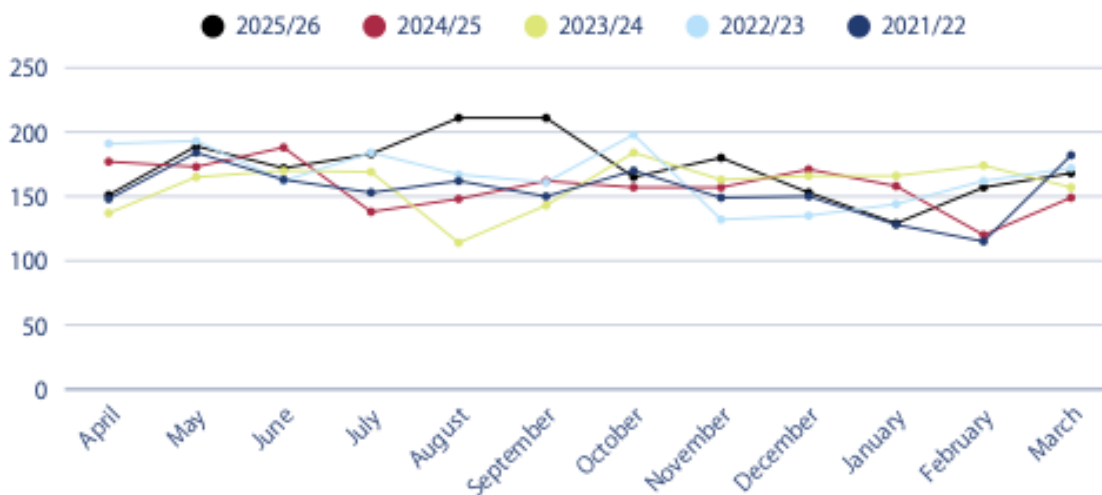
Average Length of Stay:

5 hours 41 minutes

CTAS Distribution



ED-MHA Visits per Month



Source - CHI: CACS Codes B170 and B216

Average 6 per day with most with concurrent disorder

60% no primary care.

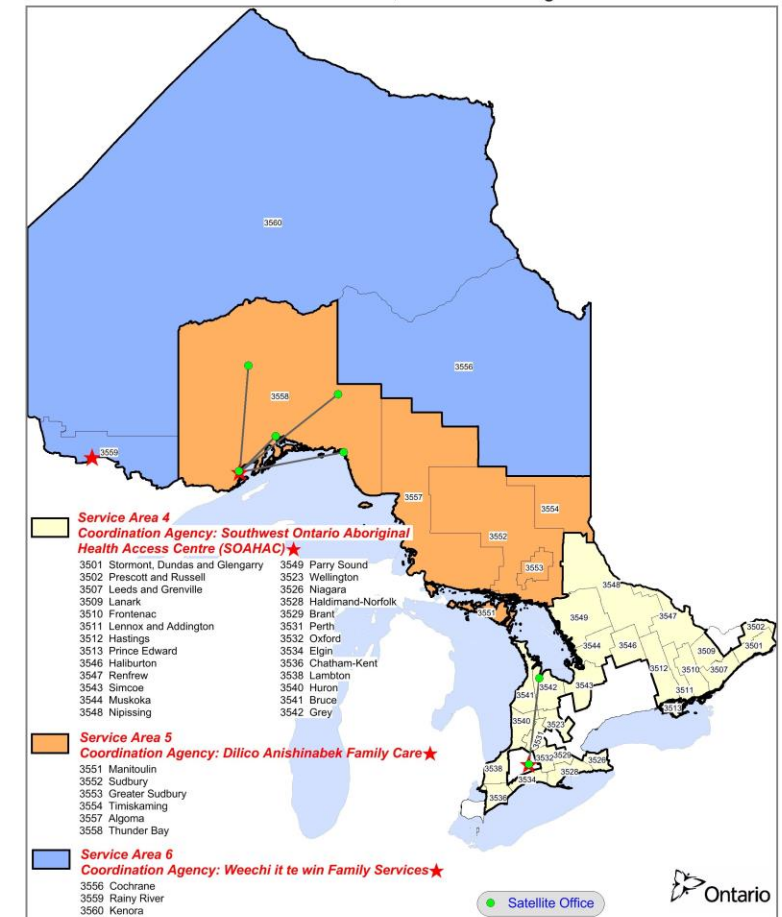
Of 2000 visits: 25 patients with more than 10 / year

303 patients with “more than 1”

Air Medical Transport of Mental Health Patients

- Many of our communities do not have access to mental health services locally
- Kenora schedule 1 serves a geographical area larger than France staffed by 2 psychiatrists
- 1300 km Fort Severn to Kenora
- Telehealth Services not ubiquitous and still not consistent with Ontario Law.

Tele-Mental Health Service Areas 4, 5 and 6 - Aboriginal and First Nations



Dedicated Mental Health Aircrafts

- 2 SA Carrier Aircrafts - Based in Thunder Bay
- 9AM-9PM / day 7 days per week January 2022
- We accept around 100 on Form 1 / year by mental health airplane, many more Orange dedicated ACP
- PCP, Mental Health Nurse, Security
- Stocked for safe transport, including sedation, antipsychotic medications, and typical meds to address side effects, unforeseen reactions, etc



Mental Health Emergency Transport and Telepsychiatry

Dr Sean Moore^{†§}, Dr Chien-Shun Chen[†], and Dr Bruce Sawadsky^{†§}
[†]NOSM University, [‡]University of Toronto, [§]Ornge Transport

Abstract

Introduction: Over the past decades, emergency mental health care services in Ontario have been centralized, resulting in challenges to accessing appropriate, timely and safe psychiatric consultation and hospitalization. Little data is available in the published literature around best practices in emergency mental health transport, emergency telepsychiatry, or logistical solutions for system planning. Advocacy and desired commitments around these issues have been outlined by the Truth and Reconciliation Commission of Canada: Calls to Action¹, the Canadian Patient Safety Institute's "Canadian Quality & Patient Safety Framework", and SRPC & CPIC Rural Roadmap Implementation Committee's "Call to Action: An Approach to Patient Transfers for Those Living in Rural and Remote Communities in Canada."

Methods: We aimed to establish benchmarks and initial data collection for mental health transfers and emergency mental health care consultations in Northwestern Ontario. We collected anonymized data from Ornge transports over a 4-year period, as well as recent data from the Regional Mental Health Team (RMHAT) telepsychiatry program. In order to set up a pilot project for a mental health transport team, we utilized this data and engaged a multidisciplinary team to establish an optimal structure for assessment and transport of patients needing emergency mental health care services including utilization projections and cost benefit analysis of various provider mix, base location, and hours of operation. For the telepsychiatry RMHAT program, data was collected regarding the communities utilizing the service and the need for transport vs helping the patients remain in their communities.

Results: Baseline data revealed significant challenges to timely transport of patients from rural and remote communities. Ornge decision support reviewed data to model multiple possible base locations, operation times, and team compositions for optimizing access to care. It was determined that a team composed of a mental health nurse, a primary care paramedic, and a security guard working 12-hour shifts from noon to midnight based in Thunder Bay would optimize timeliness and safety for mental health transports in Northern Ontario.

Conclusions: Clear gaps and improvement opportunities were found for both implementation of telepsychiatry and a dedicated mental health transport team. Through consultation with patients and health care providers serving rural and remote communities and by building on the frameworks established by advocates for safe and equitable care, we have been able to establish benchmarks and metrics to inform decision makers with practical solutions for the challenges facing those providing emergency mental health care and the leadership involved in high-level planning and programming.



Introduction

1 in 5 Canadians will have a mental health problem in any given year. Across Canada, mental health services have undergone substantial centralization, and rural, remote and Indigenous Canadians are frequently transported to distant urban facilities for emergency mental health services or when there is a need for inpatient hospitalization. Those requiring transfer from their home communities often face significant barriers to equitable care and frequently encounter complex logistical challenges.

The innovations undertaken and described here were built on the principles and foundations of the Truth and Reconciliation Commission of Canada: "Calls to Action", the Canadian Patient Safety Institute's "Canadian Quality & Patient Safety Framework", and the SRPC & CPIC Rural Roadmap Implementation Committee's "Call to Action: Approach to Patient Transfers for Those Living in Rural and Remote Canada". Through data collection and intentional choices made to meet the goals set out by these organizations and approaches, mental health service and transportation have been improved for the patients of rural, remote and Indigenous communities in Northwestern Ontario.

Truth and Reconciliation Commission of Canada

Call to Action 19 states: "We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services."

Our innovations directly aim to establish improved access to psychiatric assessment and to provide timely care and transport in addition to challenging our institutions and governments to establish benchmarks and data collection in order to provide progress reports and long-term trends.

Goals Guiding the Mental Health Transfer Program Principles & Initial Data

Patient-Centered Care: Patients and communities need to be consulted and involved in providing input into the care provided and be involved in the support of decisions and priorities of programming. Ornge Transport and Lake of the Woods District Hospital both involve patient representatives and care providers stakeholders in strategic planning, program development and governance for the provision of mental health services.

Safe care: Health services are safe and free from preventable harm. Rural Canadians should expect and receive safe care that reflects careful planning to match the patient needs with provider skills to optimize utilization. The team members had appropriate training and orientation to transport medicine and mental health emergencies. All of the medical directives and protocols were developed in conjunction with regional psychiatrists at the receiving hospital and based on current best practices. Ornge required a standardized agitation risk assessment involving direct communication between transport physicians prior to every transport. Risk assessment for every transport call, quality assurance committee oversight and incident reporting programs are in place for both the transport and the hospital-based telepsychiatry services.

Equitable care: Leadership across health professions, health care institutions and governments must address disadvantages, including those related to systemic racism, experienced by those living in rural and remote communities in order for them to receive an equitable standard of care. This is the area of focus of our innovation. Baseline data with ongoing collection of metrics focused on the timeliness and availability of emergency mental health care delivery to patients from rural, remote and Indigenous communities allows improvements and requires to be assessed for program changes in this area.

Accessible care: People have timely and equitable access to quality health services. Guidelines for coordinated rural patient transfers must be based on indicators and data agreed upon by stakeholders, including rural and Indigenous communities.

Appropriate care: Care is evidence-based and people-centred. All those involved in the coordination of patient transfers must be competent in providing culturally safe care. The paramedics, physicians and nurses at Ornge all underwent mandatory medical education sessions, cultural safety training and recruitment focused on an anti-racism lens. The same is true at the Regional Mental Health Assessment team at Lake of the Woods District Hospital. Where appropriate, we aimed to leverage the use of virtual care options to provide urgent and overnight regional specialist psychiatric consultations, reducing the need for transfer by 85% for those in our program.

Integrated care: Health services are continuous and well-coordinated, promoting smooth transitions. By eliminating the need to have "medical clearance" done in a third community, and asking for this to be done at the Schedule 1 facility emergency department for patients presenting to remote nursing stations, we reduced the need for multiple flights prior to being assessed at a psychiatric facility.

Key Performance Indicators and Baseline Data

KPIs for this program included:
 Aircraft availability & Aircraft time to wheels up when assigned
 Call received time to transport team arrival at sending hospital for 50% of calls
 Number of transports needing escalation to advanced care or critical care teams (those calls where on-site triage or risk assessment failed)
 Number of requests for mental health transfers NOT serviced by MHA and why (out of scope needs such as running antitile for overdose/intoxication)

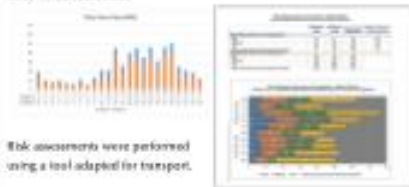
Dedicated Mental Health Transport Team Results

Choice of Crew was determined by analyzing multiple crew configurations to best match patient needs and safety considerations for the risk level of patients deemed appropriate for transfer by a dedicated Mental Health Transport Team. The most efficient team composition was determined to be the combination of mental health nurse, paramedic and security guard.

Location of Base: Triangulation data for optimal position of base for the Mental Health Transfer Team was done using historical flight data for mental health transports and multiple assumption scenarios.



Time of Calls for Mental Health Transports: Ornge Decision support determined the optimal hours for the crew to be operated based on historical call times for requests for transfer to maximize efficiency and time to care. Additional data establishes the case mix anticipated by level of risk identified.



Risk assessments were performed using a tool adapted for transport.



Regional Mental Health Assessment Team

The Regional Mental Health Assessment Team (RMHAT) is a multidisciplinary team at Lake of the Woods District Hospital in Kenora, Ontario that leverages virtual care modalities to provide timely, high-quality, evidence-based, patient-centred care collaboratively with our regional emergency department partners throughout Northwestern Ontario. RMHAT greatly improves access to specialized psychiatric care in remote and rural communities in Northwestern Ontario, reduces transfers born outside of Kenora to a Schedule 1 psychiatric bed, facilitates timely discharge from the regional emergency department, reduces system costs by reducing patient transfer, admission, and length of stay, and enhances provider, patient, and family satisfaction with care closer to home.

RMHAT Preliminary Results: Over the period from October 1, 2022 to February 14, 2023 the RMHAT team assessed 90 cases from rural and remote surrounding communities. Of these, 70 of 90 (78%) patients safely underwent consultations in their home community without the need for transfer. 75% of these cases were first consults and the remainder involved giving advice on patients being cared for by the surrounding Ontario community hospitals within 250km of Lake of the Woods District Hospital. Further collection of data will enhance these preliminary results to assess the long-term safety, appropriateness, and efficiency of this model.



Conclusions

Clear gaps and improvement opportunities were found for both implementation of telepsychiatry and a dedicated mental health transport team. Through consultation with patients and health care providers serving rural and remote communities and by building on the frameworks established by advocates for safe and equitable care, we have been able to set benchmarks and metrics to inform decision makers with practical solutions for the challenges facing those providing emergency mental health care and the leadership involved in high-level planning and programming.

References

1. Truth and Reconciliation Commission of Canada. "Truth and Reconciliation Commission of Canada: Calls to Action." <https://www25.gc.ca/13066531-10166666-0000-0001-0000-000000000000> accessed April 19, 2023.
2. Canadian Patient Safety Institute and Health Services Organization. "The Canadian Quality and Patient Safety Framework for Health Services." Ottawa, ON: Canadian Patient Safety Institute and Health Services Organization; 2020. Available from <https://www.cpsimethods.com/en/Canadian-Quality-and-Patient-Safety-Framework-for-Health-Services> [Accessed April 19, 2023].
3. Rural Road Map Implementation Committee. "Call to Action: An Approach to Patient Transfers for Those Living in Rural and Remote Communities in Canada." Ottawa, ON: College of Family Physicians of Canada and the Society of Rural Physicians of Canada; 2021.

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Resources

Tools



Links to resources shared today will be sent to participants following the session.

Tools and Resources

Resource Type	
Guidelines	OHA BLG Mental Health and the Law Information Guide- Application for Psychiatric Assessment
Practice Resources	Form 1- Application by Physician for Psychiatric Assessment CMPA- Help & Advice

Resources

Education



Upcoming Community of Practice Events



Medical Fitness to Drive: When & How to Report

June 24th
8:00am – 9:00am



[Register Now](#)



ADHD in Primary Care: Meeting Growing Demand with Practical Tools

July 22nd
8:00am – 9:00am



[Register Now](#)



Clinical Application of the Long-Term Care (LTC) Fracture Prevention Recommendations for Frail Older Adults

At the end of this session, participants will be able to:

- Assess fracture risk using Fracture Risk Scale
- Apply evidence-based recommendations for fracture prevention in LTC
- Recognize challenges and barriers to implement the recommendations and use enablers.

May 27, 2026 | 12 PM – 1PM | Zoom

Free to attend. This one-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada and the Ontario Chapter for up to 1 Mainpro+ credit.



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learn more

[Registration now open](#)

Upcoming Changing the Way We Work Community of Practice

Infectious Disease & The Colon Cancer Check (CCC) Program
with Drs. Daniel Warshafsky & Aisha Lofters

June 5, 2026
8:00am – 9:00am

[Register Now](#)



The Changing the Way We Work Community of Practice for Ontario Family Physicians is a one-credit-per-hour Group Learning program that has been certified for up to a total of 32 credits.

Osteoporosis and Fracture Prevention Workshop

What you'll gain:

- A **practical toolkit** with resources and video content to support you in your practice.
- **Expert insights** from facilitators sharing the latest updates from the 2023 clinical practice guideline.
- A **collaborative learning experience** designed specifically for family physicians.

July 15, 2026 | 9:00 AM- 12:00 PM

\$195 + HST

Take advantage of this opportunity to earn up to
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learn more

Mentorship Program - Connect with a Peer Guide!

Interested in continuing your learning journey while prioritizing your own well-being?

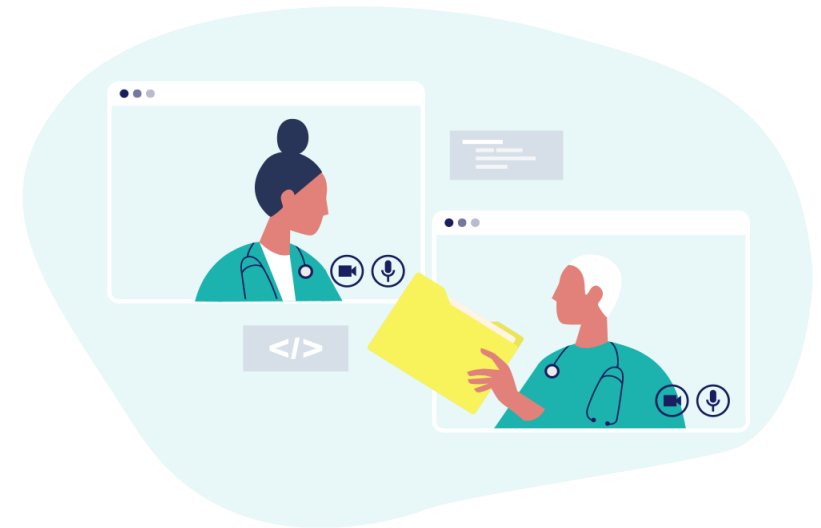
Connect with another family physician through OCFP's one-to-one mentorship program for educational support on topics related to physician wellness, mental health, chronic pain and substance use disorders.

Examples of topics Peer Learners have explored:

- Guidance for setting boundaries/work-life balance
- Managing chronic pain and long-term use of opioids



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[Peer Connect](#)



practisingwell@ocfp.on.ca