Psychiatric Malpractice Claims Guide

2026 Edition

The plaintiffs comprehensive guide to navigating Psychiatric Malpractice in

Atlantic Canada

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Understanding Psychiatry and Psychiatric Practice in Canada

Psychiatry is a medical specialty with powers, responsibilities, and potential for liability that are distinct from all other mental health professions. Understanding what a psychiatrist is, and what makes a malpractice claim against a psychiatrist legally distinctive, is the starting point for evaluating any potential legal claim.

What a Psychiatrist Is and What They Can Do

A psychiatrist is a medical doctor (MD) who has completed medical school and a residency in psychiatry, typically of at least five years duration. Psychiatrists are the only mental health professionals in Canada who can prescribe and manage psychiatric medication. They diagnose and treat mental health disorders using both biological and psychological interventions, may provide psychotherapy, and conduct clinical assessments.

Critically, psychiatrists also hold authority that no other mental health professional possesses: the power to admit a patient to a psychiatric facility as an involuntary patient under provincial mental health legislation, to deprive a person of their liberty for psychiatric treatment without their consent. This authority is exercised through a formal certification process governed by each province's mental health legislation and is addressed in detail in Sections 5 and 6.

Because they are physicians, psychiatrists are regulated by the provincial college of physicians and surgeons in their province. They are held to the same standard of care applicable to any physician, with additional expertise expected in the specialized area of psychiatry. The Canadian Psychiatric Association is the national professional body representing psychiatrists in Canada.

Why Psychiatric Malpractice Is Legally Distinct

Psychiatric malpractice encompasses a range of liability exposure that goes beyond that of other mental health practitioners:

- Psychiatrists carry prescribing liability: they can cause harm through medication, wrong drug, wrong dose, failure to monitor, dangerous drug interactions, failure to disclose material risks.
- Psychiatrists have the statutory authority to deprive a person of their liberty through involuntary admission. Exercising that authority when the legal criteria are not met, or failing to exercise it when a competent practitioner should have, are both independently actionable.
- Claims against psychiatrists are defended by the Canadian Medical Protective Association (CMPA), one of the most experienced and well-resourced medical defence organizations in the world.
- The body of Canadian case law on psychiatric malpractice is more developed than for other mental health professions, providing a defined framework for both plaintiffs and defendants.

A peer-reviewed study examining forty-five years of civil litigation against Canadian psychiatrists found that in 75% of cases, courts ruled in favour of the defendant psychiatrist, underscoring that not every adverse outcome in psychiatric care constitutes negligence. Documentation, obtaining second opinions, and adherence to clinical guidelines were consistently identified as protective factors in cases that were successfully defended.

Who Regulates Psychiatrists in Atlantic Canada?

Psychiatrists are regulated as physicians in all Canadian provinces. In Atlantic Canada, each province has a college of physicians and surgeons that governs the conduct of all licensed physicians, including psychiatrists. Complaints about a psychiatrist's professional conduct can be filed with the relevant college in the province where the treatment occurred.

Nova Scotia

Psychiatrists in Nova Scotia are regulated by the College of Physicians and Surgeons of Nova Scotia (CPSNS). The CPSNS sets standards of practice, investigates complaints, and can discipline members including by imposing conditions on practice or revoking a licence.

New Brunswick

Psychiatrists in New Brunswick are regulated by the College of Physicians and Surgeons of New Brunswick (CPSNB).

Prince Edward Island

Psychiatrists in Prince Edward Island are regulated by the College of Physicians and Surgeons of Prince Edward Island (CPSPEI).

Newfoundland and Labrador

Psychiatrists in Newfoundland and Labrador are regulated by the College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL).

The Canadian Medical Protective Association (CMPA)

The CMPA is a physician-funded organization that provides legal representation and covers damage awards for physician members facing malpractice claims. Virtually all practising psychiatrists in Atlantic Canada are CMPA members. Plaintiffs in psychiatric malpractice cases should be aware that the CMPA is one of the most experienced and well-resourced medical defence organizations in the world. This is not a reason not to pursue a legitimate claim, but it is a reason to ensure your legal counsel has specific experience in medical malpractice litigation.

Duty of Care in the Psychiatric Relationship

The duty of care in psychiatry is shaped by the same general principles as medical malpractice law, but it takes on distinctive dimensions because of the unique nature of psychiatric treatment and the special powers that psychiatrists hold.

How the Duty of Care Is Established

A duty of care arises when a physician-patient relationship is established. In the psychiatric context, this can arise from a single assessment, an emergency department consultation, a referral intake, or an ongoing treatment relationship. Once the relationship is established, the psychiatrist owes the patient a duty to provide care that meets the standard of a reasonably competent psychiatrist in the same circumstances.

The Ontario Court of Appeal in Ahmed v Stefaniu, 2006 CanLII 34973 (ON CA), the leading Canadian case on psychiatric negligence and the duty of care to third parties, confirmed that the standard requires an "honest and intelligent exercise of judgment" and that negligence is not established simply because the outcome was poor. What is required is that a competent psychiatrist, applying the accepted body of knowledge in the field, would have made a materially different decision.

The Duty to Warn: Obligations to Third Parties

One of the most consequential aspects of psychiatric law is the duty to warn, the obligation that arises when a patient communicates an intention or credible threat to harm an identifiable person. The foundational Canadian case is Wenden v Trikha, 1991 CanLII 13111 (AB QB), which established that a hospital and psychiatrist who become aware that a patient presents a serious danger to a third party may owe a duty of care to take reasonable steps to protect that person.

Ahmed v Stefaniu extended this principle dramatically. In that case, a psychiatrist

changed a patient's status from involuntary to voluntary; the patient left hospital and approximately two months later murdered his sister. The victim's family sued the psychiatrist. A jury found the psychiatrist negligent, and the Ontario Court of Appeal dismissed the appeal. The Supreme Court of Canada denied leave to appeal. The case confirmed that a duty of care can extend to identifiable third parties where harm is foreseeable, and that the decision to change a patient's involuntary status must be made with appropriate clinical rigour and documentation.

The Canadian Psychiatric Association has published a position paper on the duty to protect, acknowledging an ethical and potentially legal obligation to act when a credible and serious threat to an identifiable person is disclosed.

Confidentiality and Its Limits

Confidentiality applies in the psychiatric relationship as it does in all therapeutic relationships, but the exceptions are particularly significant in psychiatry because of the clinical situations psychiatrists routinely face:

- Where the patient presents a credible and imminent risk of serious harm to an identifiable third party (duty to warn / duty to protect).
- Where the patient presents a serious and imminent risk of suicide or serious self-harm requiring emergency intervention.
- Where a court order or provincial mental health legislation requires or authorizes disclosure.
- Where the patient has explicitly authorized disclosure.

Psychiatric records can be ordered disclosed in civil proceedings including custody disputes, personal injury litigation, and employment claims. If you are involved in legal proceedings and your psychiatric records may be relevant, seek legal advice on their protection promptly. This is a distinct legal issue from any malpractice claim you may be considering.

The Fiduciary Dimension of Psychiatric Care

The psychiatric relationship carries fiduciary dimensions, particularly where a patient has been admitted involuntarily or where the power imbalance of the relationship is at its most pronounced. Exploitation of that relationship for the psychiatrist's own purposes, including sexual misconduct, may ground a claim in both negligence and breach of fiduciary duty. Breach of fiduciary duty allows courts to consider the full extent of the harm caused by the exploitation of trust, including harm that may be difficult to frame purely in negligence terms.

Common Grounds for Malpractice Claims Against Psychiatrists

The following are the most common categories of psychiatric malpractice claims in Canada, drawing on a peer-reviewed study of forty-five years of civil litigation against Canadian psychiatrists and the relevant body of Canadian case law.

Sexual Misconduct and Boundary Violations

Sexual misconduct between a psychiatrist and a patient is a fundamental breach of professional and ethical duty and one of the most serious categories of psychiatric malpractice. The power imbalance in psychiatric care, which is especially pronounced in inpatient settings where the patient may be involuntary, makes any sexual relationship between a psychiatrist and a current patient an inherently coercive act.

Sexual contact with a current patient is prohibited without exception under the codes of ethics and professional standards of all provincial colleges of physicians and surgeons. Many jurisdictions also prohibit sexual contact with former patients within a defined period after treatment ends.

How these claims arise in practice:

- Sexual contact during the course of treatment, including in inpatient settings.

- Gradual “grooming” of patients through increasingly personal and non-clinical communication before physical contact occurs.
- Sexual communication by text, email, or social media.
- A psychiatrist “terminating” a therapeutic relationship for the purpose of pursuing a sexual relationship, without a genuine clinical basis for termination.

Evidence in these cases frequently includes session notes, text and email records, regulatory college disciplinary findings (which are not binding on civil courts but are powerful supporting evidence), and the testimony of the patient.

Failure to Manage Suicide Risk

Failure to appropriately assess, document, and respond to suicide risk is one of the most common and most frequently litigated grounds for psychiatric malpractice in Canada. The research on civil litigation against Canadian psychiatrists found that inpatient cases involving patient suicides were associated with the most successful claims against practitioners.

The standard of care does not require psychiatrists to prevent all suicides. Courts have accepted that suicide risk assessment is inherently uncertain and that a psychiatrist exercising an honest and intelligent clinical judgment, even one that turns out to be wrong, may not be liable. What is required is a documented, structured, and clinically defensible assessment and response process.

How negligence commonly arises:

- Failing to conduct or document a structured suicide risk assessment for a patient who has disclosed ideation, stated intent, or a history of attempts.
- Discharging a patient from inpatient care without adequate documented risk assessment or a safety plan.
- Failing to follow up with a patient who missed an appointment after expressing serious ideation.
- Changing a patient's status from involuntary to voluntary without adequate reassessment of the risk factors that led to the original certification.
- Using a “no-harm contract” as a substitute for clinical assessment and intervention, a practice that is not recognized as an adequate risk management strategy.
- Failing to involve family or support persons in safety planning when clinically appropriate and with the patient's consent.

- Failing to document the basis for clinical decisions about risk level, including the information available at the time and the reasoning applied.

Documentation is central to defending, and to succeeding on, suicide risk claims. A chart showing no recorded risk assessment in sessions where ideation was discussed is a significant evidentiary problem for a psychiatrist defending a malpractice claim.

Failure to Warn: Third-Party Harm

Where a patient communicates an intention to harm an identifiable person and the threat is serious and credible, the psychiatrist has an obligation to take reasonable steps to protect that person. This may require warning the potential victim, contacting police, or taking steps to prevent the patient from accessing the means to carry out the threatened harm.

Ahmed v Stefaniu illustrates how demanding this standard can be in practice. The psychiatrist in that case had obtained second opinions and was nonetheless found negligent, because the jury accepted that the patient's clinical picture, properly assessed, did not support the change in status that was made. This underscores that the obligation is not simply to go through the motions of consultation, but to exercise genuine clinical judgment and document it thoroughly.

How negligence commonly arises:

- Ignoring explicit verbal threats made in session without documenting them or taking any protective action.
- Treating a threat as hypothetical or venting without clinical assessment of credibility and imminence.
- Discharging or releasing a patient known to be dangerous to a specific person without warning that person or notifying police.
- Changing a patient's status from involuntary to voluntary without adequate clinical reassessment of the risk factors that led to the original certification.

Misdiagnosis and Failure to Diagnose

Psychiatric misdiagnosis claims are among the more difficult to succeed on in Canada, because diagnostic uncertainty is inherent in psychiatric practice and courts are generally reluctant to second-guess clinical judgments made in good faith.

However, where a diagnostic failure leads to a patient receiving inappropriate treatment, being denied treatment they needed, or being harmed by interventions that would not have been applied with a correct diagnosis, a claim may be available.

How negligence commonly arises:

- Treating a patient for a condition they do not have, causing harm through the treatment itself, particularly relevant where the treatment involves medication that would not otherwise have been prescribed.
- Failing to diagnose a serious condition that required immediate intervention, leading to deterioration or harm.
- Failing to refer a patient to an appropriate specialist when the presentation was outside the psychiatrist's area of competence.
- Making a diagnosis without adequate assessment, based on partial or incomplete history.
- Applying a diagnosis that carries significant and lasting consequences, such as a personality disorder diagnosis, without the evidence-based assessment required to support it.

What distinguishes actionable misdiagnosis from a recognized diagnostic error is whether a competent psychiatrist with the same information would have reached the same conclusion. Expert evidence is required to establish the standard of diagnostic care and whether it was met.

Negligent Prescribing

Because psychiatrists are the only mental health professionals who prescribe medication, they face an additional category of liability that does not apply to psychologists, counsellors, or social workers. Psychiatric medication errors mirror the general pharmaceutical negligence principles discussed in other guides in this series, but with particular patterns common to this specialty.

How negligence commonly arises:

- Prescribing a medication without adequate assessment of the patient's medical history, existing medications, or contraindications.
- Failing to monitor for known and serious side effects, including metabolic changes, cardiac effects, elevated prolactin, or tardive dyskinesia in patients on long-term antipsychotic medications.
- Failing to disclose material risks of medication to the patient, including the risks of physical dependence with benzodiazepines, weight gain and metabolic effects with certain antipsychotics, or the risk of withdrawal effects if medication is stopped suddenly.
- Abrupt discontinuation of a medication that requires tapering, causing withdrawal effects or clinical deterioration.
- Prescribing excessive doses, or combinations of medications that interact in ways that cause harm.
- Failing to reassess a medication plan as the patient's clinical situation changes over time, including failing to monitor for the emergence of new side effects or the loss of therapeutic effect.
- Prescribing a medication to a patient whose physical health status contraindicated it, without adequate investigation.

Health Canada approves psychiatric medications for specific indications. Off-label prescribing, using a medication for a purpose not listed in its approved indications, is not automatically negligent, but it requires that the clinical rationale be sound, documented, and communicated to the patient.

The CMPA's Medico-Legal Handbook for Physicians in Canada addresses informed consent in prescribing and is the standard reference for the obligations of Canadian physicians when prescribing medication. A psychiatrist who fails to disclose the material risks of a medication before prescribing it may be found to have not obtained valid informed consent, independently of any question of whether the drug itself was appropriate.

Premature Termination and Abandonment

Therapeutic abandonment in the psychiatric context occurs when a psychiatrist ends a clinical relationship without adequate notice, without facilitating transition to another provider, and in circumstances where the abrupt termination causes harm. This is particularly serious for patients with active safety concerns, those who are receiving inpatient care, or those for whom the psychiatric relationship is the primary clinical anchor.

The standard of care requires that a psychiatrist who ends a clinical relationship:

- Provides reasonable notice where the clinical situation permits.
- Discusses the termination with the patient and explains the reasons for it.
- Provides referrals or recommendations for ongoing psychiatric care.
- Ensures continuity of medication management and does not discontinue ongoing prescriptions without adequate transition arrangements.
- Ensures continuity of care for patients with active risk factors, including suicide risk.

Failure to Refer or Consult

A psychiatrist who fails to obtain consultation or a second opinion when managing a complex or deteriorating patient may be found to have breached the standard of care. The research on Canadian psychiatric malpractice consistently identifies the absence of second opinions and timely consultation as a risk factor in adverse outcomes. Conversely, obtaining and documenting second opinions was among the most important protective factors in cases that were successfully defended.

How negligence commonly arises:

- Failing to obtain a second psychiatric opinion before making a significant clinical decision, such as changing an involuntary patient's status to voluntary, discharging a patient with known risk factors, or commencing an unusual or complex medication regimen.
- Failing to refer a patient to another specialist (neurologist, internist, or addiction medicine specialist) when the clinical picture raises medical questions outside the psychiatrist's area of competence.
- Failing to obtain supervision or consultation when a case becomes complex,

deteriorates unexpectedly, or raises clinical questions that the treating psychiatrist has not previously encountered.

Wrongful Commitment and Failure to Commit: Lawsuits Arising from Involuntary Admission Decisions

Among the most distinctive and consequential aspects of psychiatric malpractice law is the liability that can arise from involuntary admission decisions. Psychiatrists, and, in some circumstances, other physicians, hold authority under provincial mental health legislation to certify a person as an involuntary patient. This power carries significant legal consequences in both directions.

The Legal Framework for Involuntary Psychiatric Admission in Canada

Every province in Atlantic Canada has mental health legislation that authorizes the involuntary admission and detention of individuals who meet specific statutory criteria. While the precise criteria and procedures vary between provinces (addressed in detail in Section 6), the general framework is common across jurisdictions:

- The person must have a mental disorder as defined by the applicable legislation.
- The mental disorder must give rise to a specified level of risk to the person or others, or a specified likelihood of serious deterioration.
- Voluntary admission must be unsuitable or unavailable.
- Psychiatric treatment must be necessary and available in the facility.

These criteria reflect the balance the law strikes between individual liberty and the protection of the person and of others. The criteria must all be met before involuntary admission is legally justified. A certification that does not meet the statutory threshold is unlawful.

The Canadian Charter of Rights and Freedoms protects individuals against arbitrary detention (section 9) and against being deprived of liberty except in accordance with the principles of fundamental justice (section 7). Involuntary psychiatric detention is an exercise of state power over individual liberty. Where it is exercised without a lawful basis, it is actionable both in tort and potentially as a breach of Charter-protected rights.

Wrongful Hospitalization: How a Lawsuit Arises

Wrongful hospitalization, also called wrongful commitment or false imprisonment by certification, occurs when a physician certifies a patient as involuntary without the statutory criteria being met. This is a form of false imprisonment and is actionable as both a tort and, in appropriate cases, a breach of the patient's Charter rights.

The statutory criteria for involuntary admission require a finding that the person has a mental disorder, presents a specified level of risk of harm to themselves or others or of deterioration, and that less restrictive alternatives are insufficient. Certification without an adequate clinical basis is actionable.

How wrongful hospitalization claims arise in practice:

- Certifying a patient whose presentation does not meet the statutory definition of mental disorder, for example, certifying a person in a temporary situational crisis, or a person under the influence of substances, without establishing an underlying mental disorder.
- Certifying a patient who does not pose a sufficient level of risk to themselves or others, and who does not meet the deterioration criterion, at the time of the certification.
- Certifying a patient who is capable of making their own treatment decisions and who could be managed as a voluntary patient.
- Continuing to hold a patient as involuntary beyond the authorized period without completing the required renewal documentation, or completing renewal certificates without conducting the required clinical reassessment of the patient.
- Certifying a patient based on inadequate or inaccurate clinical information, for

example, relying solely on a family member's account without directly examining the patient.

Damages for wrongful hospitalization include compensation for the deprivation of liberty itself, which Canadian courts have recognized as a significant and independently compensable harm, as well as psychological harm, lost wages, and any physical consequences of the detention or of treatment administered without a lawful basis.

Failure to Hospitalize: How a Lawsuit Arises

Conversely, a decision not to certify a patient who subsequently harms themselves or an identifiable third party may give rise to a claim where the clinical information available at the time should have led a competent psychiatrist to conclude that the statutory threshold for involuntary admission was met.

Ahmed v Stefaniu is the leading Canadian case on this question. In that case, the psychiatrist changed a patient's status from involuntary to voluntary. The patient subsequently murdered his sister. The court found the psychiatrist negligent, not for having made an incorrect prediction about human behaviour (an inherently uncertain exercise), but for having made a decision to change the patient's status without adequate clinical reassessment and documentation of the ongoing risk factors.

The standard applied in failure to hospitalize cases is not whether the psychiatrist made the correct prediction about what the patient would do. It is whether the process by which they made the decision was clinically defensible and adequately documented. A psychiatrist who conducted a thorough, documented risk assessment and reached a reasonable conclusion in good faith is in a substantially stronger position than one whose decision-making is undocumented or inconsistent with the clinical record.

How failure to hospitalize claims arise:

- Discharging or de-certifying a patient who presents to an emergency department with suicidal ideation and a specific plan, without adequate assessment or a documented safety plan.
- Changing a patient's status from involuntary to voluntary when the clinical risk factors that justified the original certification remain present and have not been

adequately re-evaluated.

- Failing to initiate the certification process for a patient who presents with clear statutory grounds for involuntary admission, with the result that the patient causes harm to themselves or others.
- Discharging a patient from hospital or changing their status based on pressure from the patient, family members, or institutional capacity constraints rather than clinical assessment.

The Certification Process Across Atlantic Canada: A Province-by-Province Guide

Each Atlantic province has its own mental health legislation governing the involuntary admission of psychiatric patients. The authorized forms, holding periods, review mechanisms, and precise statutory criteria differ between jurisdictions. This section provides a detailed guide to each province's process, with references to provincial government health authorities and to the authoritative legislation for each province.

LEGAL NOTE: This section describes the legal framework that governs involuntary admission in each province. If you believe you or a family member was wrongfully committed, or that a failure to commit resulted in preventable harm, consult a lawyer. The legal analysis of whether the statutory criteria were met in a specific case is a fact-specific inquiry that requires both clinical and legal expertise.

Nova Scotia: Involuntary Psychiatric Treatment Act (IPTA)

Nova Scotia's Involuntary Psychiatric Treatment Act (IPTA), SNS 2005, c 42 (as amended to 2024), governs the involuntary admission and treatment of patients in Nova Scotia's psychiatric facilities. The Act came into force on July 3, 2007, replacing

the involuntary admission provisions previously contained in the Hospitals Act. The IPTA Regulations were significantly amended effective August 13, 2024, introducing updated patient-centred definitions of capacity, clarifications to form language, new duties for medical professionals, explicit obligations for substitute decision-makers, and expanded powers for the IPTA Review Board. An overview and the official forms are published by the Government of Nova Scotia.

Criteria for Involuntary Admission

Under section 17 of the IPTA, a psychiatrist may declare a person an involuntary patient if the psychiatrist is of the opinion that the person:

- Has a mental disorder, defined as a substantial disorder of behaviour, thought, mood, perception, orientation or memory that severely impairs judgment, behaviour, capacity to recognize reality, or ability to meet the ordinary demands of life, in respect of which psychiatric treatment is advisable;
- Is likely to cause harm to themselves or others, or will suffer serious physical impairment or serious mental deterioration, or both, if not detained;
- Requires treatment in a psychiatric facility;
- Does not have the capacity to make admission and treatment decisions; and
- Cannot be suitably treated as a voluntary patient.

The 2024 regulatory amendments added a further consideration: whether, in the preceding 2 years, the person has been detained in a psychiatric facility for 60 days or more, detained on two or more separate occasions, or been the subject of a community treatment order. This history is a relevant factor in the assessment of the involuntary admission criteria.

The Certification Process and Forms

The Nova Scotia IPTA uses a numbered form system. Each form serves a specific step in the involuntary admission and ongoing review process. The forms are set out in the Involuntary Psychiatric Treatment Regulations and are available on the Nova Scotia government website.

Form 1, Detainment of Voluntary Patient

Issued by a member of the treatment staff to detain a voluntary patient who is requesting discharge and who staff believe may meet the criteria for involuntary admission. This form allows the patient to be held temporarily while a physician is

contacted to conduct a medical examination.

Form 2, Certificate for Involuntary Psychiatric Assessment, Part 1 (Section 9, IPTA)
Completed by a physician who has conducted a medical examination of the person within the previous 72 hours. Two Form 2 certificates from two separate physicians, or one Form 2 and one Form 3, are required to initiate a Declaration of Involuntary Admission (Form 4). A person cannot be taken into custody or detained solely on the basis of a Form 2.

Form 3, Certificate for Involuntary Psychiatric Assessment, Part 2
Completed by the same physician who signed a Form 2, in cases where compelling circumstances make it impractical to obtain a second Form 2 from another physician. Allows the involuntary assessment to proceed with a single physician's certificate in urgent circumstances.

Form 4, Declaration of Involuntary Admission (Sections 17, 18 and 19, IPTA)
Completed and signed by a psychiatrist who has personally examined the patient. This is the primary certification document that admits the person as an involuntary inpatient. A completed Form 4 authorizes detention for not more than 30 days.

Form 5, Declaration of Renewal of Involuntary Admission (Section 21, IPTA)
Completed by a psychiatrist to renew the patient's involuntary inpatient status beyond the period authorized by the preceding Form 4 or Form 5. A new Form 5 must be completed for each renewal. The patient must continue to meet all of the section 17 criteria at the time of each renewal.

Form 8, Certificate of Leave
Authorizes an involuntary patient to be absent from the facility subject to specified conditions. A certificate of leave may be issued for up to 180 days under subsection 43(1) of the Act.

Form 9, Community Treatment Order (CTO)
A psychiatrist may issue a community treatment order for an eligible involuntary patient, allowing the patient to receive treatment in the community rather than remain in the psychiatric facility. The CTO requires the consent of the patient's substitute decision-maker and is based on legislated eligibility criteria.

Holding Periods Under the IPTA

The IPTA establishes an escalating framework of detention periods:

- **Initial involuntary admission under Form 4:** Not more than 30 days.
- **First renewal (Form 5):** Must be completed before the Form 4 expires (within 30 days of the initial admission). Valid for up to 30 additional days.
- **Second renewal (Form 5):** Must be completed before the first Form 5 expires. Valid for up to 60 additional days.
- **Third renewal (Form 5):** Must be completed before the second Form 5 expires. Valid for up to 90 additional days.
- **Fourth and subsequent renewals (Form 5):** Valid for up to 90 additional days each. There is no absolute limit on the number of renewals that may be issued if the patient continues to meet the section 17 criteria at each reassessment.

At each renewal, the psychiatrist must reassess the patient and confirm that all section 17 criteria continue to be met. A renewal completed without the required clinical reassessment is a procedural irregularity that may support a wrongful hospitalization claim.

Court and Police Authority to Initiate the Process

An involuntary psychiatric assessment can also be ordered by a Family Court judge (on application by any person) or initiated by a peace officer. A court order under the IPTA is valid for 7 days and authorizes a peace officer to take the person for a medical examination. If the person refuses the initial examination or to attend for it, an order for examination can be obtained through this process.

Review Rights: The IPTA Review Board

Involuntary admissions and community treatment orders are reviewed by the Involuntary Psychiatric Treatment Act Review Board at mandatory intervals. The Review Board is a legislated body. Each hearing panel includes at minimum a lawyer, a psychiatrist, and a lay person. A patient may also apply for a Review Board hearing at any time, independently of the mandatory review schedule. The Review Board must complete a mandatory hearing within 21 days of an application.

The 2024 regulatory amendments expanded the Review Board's powers, including the ability to arrange for the patient to be examined by a second psychiatrist who has not been involved in the patient's case. Nova Scotia Health publishes information on patient rights under the IPTA.

New Brunswick: Mental Health Act (RSNB 1973, c M-10)

New Brunswick's Mental Health Act, RSNB 1973, c M-10 (as amended), governs the involuntary admission and treatment of patients in New Brunswick. New Brunswick's process differs structurally from Nova Scotia's: while initial detention is authorized by any physician through an examination certificate, the formal involuntary admission itself requires a tribunal hearing, making the New Brunswick system more rights-protective at the point of admission than some other provinces. The Government of New Brunswick publishes information on involuntary hospitalization and the prescribed Mental Health Act forms.

Criteria for Involuntary Admission

Under the New Brunswick Mental Health Act, a person may be involuntarily admitted where a physician or psychiatrist is of the opinion that:

- The person is suffering from a mental disorder; and
- The mental disorder puts the person or others at substantial risk of imminent physical or psychological harm; and
- Hospitalization is required in the interests of the person or others.

The Certification Process and Forms

New Brunswick's certification process has two distinct stages, initial detention and formal involuntary admission by tribunal order, and uses a form system prescribed by the Minister under the Act.

Examination Certificate (Initial Detention)

Any physician who examines a person and determines they may be suffering from a mental disorder requiring hospitalization in the interests of the person or others may complete an examination certificate. This certificate gives authority to detain the person for up to 72 hours for the purposes of observation, examination, assessment, and routine clinical medical treatment.

Psychiatric Assessment Within 72 Hours

Within the 72-hour detention period, an attending psychiatrist must assess the patient and make one of three decisions: release the person if further observation or treatment is no longer deemed necessary; admit the person as a voluntary patient; or file an application to a tribunal for involuntary admission, and where applicable,

request authority to administer routine clinical medical treatment without the patient's consent.

Tribunal Application (Involuntary Admission)

If the psychiatrist determines that involuntary admission is warranted, they must file an application with a review tribunal. This tribunal process at the point of admission is a structurally distinctive feature of New Brunswick's system, and provides an independent review that occurs before formal involuntary status is established. A psychiatric patient advocate contacts the detained person during the 72-hour period to explain their rights and the tribunal process.

Certificate of Detention (Post-Tribunal)

If the tribunal orders involuntary admission, a certificate of detention is issued on the prescribed form. This is the document that formally authorizes the patient's involuntary status.

Form 15, Application by Attending Psychiatrist for Third or Subsequent Certificate of Detention

From the third renewal onward, the attending psychiatrist must apply to the Review Board for issuance of the certificate, rather than issuing it unilaterally. This is a significant additional safeguard at the point of extended detention.

Other Key Forms in the New Brunswick System

- **Form 10** - Application to Review Board for Inquiry into Whether Consent Should Be Given on Behalf of an Involuntary Patient.
- **Form 16** - Notice of Change to Voluntary Status.
- **Form 17** - Application for Inquiry with Respect to Disclosure of a Clinical Record.
- **Form 21** - Application for Approval by Review Board for Order to Transfer to a Psychiatric Facility in Another Jurisdiction.
- **Form 23 / Form 24** - Applications for authority to administer routine clinical medical treatment without the patient's consent.
- **Form 25** - Certificate of Attending Psychiatrist.

Holding Periods Under the New Brunswick Mental Health Act

The New Brunswick Mental Health Act provides the following escalating framework of holding periods following a tribunal order for involuntary admission (section 13):

- **Initial detention under the tribunal order:** Not more than 1 month from the date of the order.
- **First certificate of detention:** Valid for not more than 1 additional month after the period authorized by the tribunal order.
- **Second certificate of detention:** Valid for not more than 2 additional months from the date of expiration of the first certificate.
- **Third and subsequent certificates of detention:** Each valid for not more than 3 additional months from the date of expiration of the last certificate. From the third certificate onward, the certificate is issued by the Review Board on the application of the attending psychiatrist (Form 15), rather than by the psychiatrist directly.

When the authorized period of detention has expired and a further certificate of detention has not been issued, the involuntary patient is deemed to become a voluntary patient and must be informed in writing of their changed status and their right to leave the psychiatric facility.

The Role of the Psychiatric Patient Advocate

A distinctive feature of New Brunswick's system is the Psychiatric Patient Advocate service. An advocate contacts every person detained under the 72-hour examination certificate to provide information about their rights and to explain what to expect during that period. Where the psychiatrist applies for involuntary hospitalization and requests authority to administer treatment without consent, the advocate discusses the tribunal hearing process with both the patient and their nearest relative.

Review Rights: The Review Board

Involuntary patients have the right to apply for a Review Board inquiry at any time to challenge the basis for their detention and to review consent and treatment decisions. The Review Board is independent of the treating psychiatrist and the health authority.

Prince Edward Island: Mental Health Act (Cap. M-6.2)

Prince Edward Island enacted a new Mental Health Act (SPEI 2023, c 28, consolidated as RSPEI 1988, Cap. M-6.2) in 2023, which introduced significant changes to the province's involuntary admission framework including the introduction of community treatment orders and an expanded criterion allowing admission on the basis of risk of substantial mental or physical deterioration (not solely imminent harm to self or

others). The new Act came into force on February 1, 2024. The authorized forms are prescribed by the Mental Health Act General Regulations, current to February 1, 2024.

Criteria for Involuntary Admission

Under section 10 of PEI's Mental Health Act (Cap. M-6.2), a psychiatrist may admit a person as an involuntary patient following an involuntary psychiatric assessment if the psychiatrist concludes that:

- The person has a mental disorder; and
- As a result of the mental disorder, the person has caused or is likely to cause harm to the person or to others, OR is likely to suffer substantial physical or mental deterioration or impairment; and
- The person requires care and treatment in a psychiatric facility; and
- The person refuses or is unable to consent to admission.

The inclusion of "substantial physical or mental deterioration or impairment" as a standalone criterion, in addition to the harm-to-self-or-others ground, is a significant feature of the 2023 Act and represents an expansion compared to PEI's former legislation.

Designated Psychiatric Facilities in PEI

Under the Mental Health Act General Regulations (current to February 1, 2024), the facilities designated for the assessment, care, and treatment of persons with mental disorders are:

- Hillsborough Hospital
- Prince County Hospital
- Queen Elizabeth Hospital

The Certification Process and Forms

The PEI Mental Health Act General Regulations prescribe the following forms:

Form 1, Order for Involuntary Psychiatric Assessment (Section 8 of the Act)

Issued by a medical practitioner or nurse practitioner who has personally examined the person and formed the opinion that the person has a mental disorder and meets the relevant criteria. This order is sufficient authority for a peace officer to apprehend the person and take them to a designated psychiatric facility. It authorizes detention

at the facility for not more than 72 hours and an involuntary psychiatric assessment. The person must refuse or be unable to consent to an assessment for Form 1 to apply.

Form 2, Order for Involuntary Psychiatric Assessment (Section 9 of the Act)
Issued by an attending psychiatrist for a voluntary patient who has requested discharge from the facility, when the psychiatrist has reasonable grounds to believe the patient meets the involuntary admission criteria. Authority for detention for not more than 72 hours for assessment.

Form 3, Certificate of Involuntary Admission (Section 10 of the Act)
Issued by a psychiatrist following completion of an involuntary psychiatric assessment, where the psychiatrist concludes the statutory criteria are met. This is the primary admission document. The certificate expires 30 days from the date of issue unless sooner cancelled by the attending psychiatrist.

Form 4, Certificate of Renewal of Involuntary Admission (Section 11 of the Act)
Issued by the attending psychiatrist to continue a patient's involuntary admission status after the Form 3 or a previous Form 4 expires. The attending psychiatrist must personally conduct a psychiatric assessment of the patient within the preceding 72 hours before signing each Form 4. The renewal periods are:

- **First certificate of renewal:** expires 30 days from date of issue.
- **Second certificate of renewal:** expires 90 days from date of issue.
- **Third certificate of renewal:** expires 90 days from date of issue.
- **Fourth or subsequent certificate of renewal:** expires 12 months from date of issue.

Forms 5 to 11
- **Form 5** - Certificate of Leave (Section 15): authorizes an involuntary patient to be absent from the psychiatric facility subject to specified conditions, for a defined period.
- **Form 6** - Certificate of Cancellation of Leave (Section 15): cancels a certificate of leave and is sufficient authority for a peace officer to apprehend the involuntary patient and return them to the facility. Grounds include the patient being likely to cause harm while on leave, or failure to comply with the terms of the leave.
- **Form 7** - Certificate of Incapacity (Section 17): documents the attending psychiatrist's opinion that the patient is not capable of consenting to treatment in accordance with PEI's Consent to Treatment and Health Care Directives Act.

- **Form 8** - Community Treatment Order (Section 18): authorizes an eligible patient to receive treatment in the community under specified conditions rather than remaining as an inpatient.
- **Form 9** - Renewal of Community Treatment Order.
- **Form 10** - Order for Psychiatric Assessment (court-ordered assessment).
- **Form 11** - Notice of Revocation of Community Treatment Order.

Holding Periods Under PEI's Mental Health Act

- **Initial detention for assessment under Form 1 or Form 2:** Not more than 72 hours.
- **Certificate of Involuntary Admission (Form 3):** 30 days from date of issue.
- **First Certificate of Renewal (Form 4):** 30 days from date of issue.
- **Second Certificate of Renewal (Form 4):** 90 days from date of issue.
- **Third Certificate of Renewal (Form 4):** 90 days from date of issue.
- **Fourth and subsequent Certificates of Renewal (Form 4):** 12 months from date of issue.

At each renewal, the attending psychiatrist must personally conduct a psychiatric assessment of the patient within the preceding 72 hours. A renewal completed without this required assessment is procedurally irregular and may support a wrongful hospitalization claim.

Court Orders for Assessment

An order for an involuntary psychiatric assessment (Form 10) may be issued by a court in appropriate circumstances. An order made under the relevant section of the Act is valid for 7 days.

Review Rights: The Mental Health Act Review Board

PEI's Mental Health Act continued the Mental Health Act Review Board established under the former Act. The Review Board is composed of seven members appointed by the Lieutenant Governor in Council. Panels operate with a quorum of three members, including legal, clinical, and lay representation. The Review Board hears applications from involuntary patients and has authority to review the basis for an involuntary admission and to order discharge where the statutory criteria are not met.

Newfoundland and Labrador: Mental Health Care and Treatment Act (MHCTA)

Newfoundland and Labrador's Mental Health Care and Treatment Act (MHCTA), SNL 2006, c M-9.1, came into force on October 1, 2007, replacing the former Mental Health Act. It governs the involuntary admission and treatment of patients in NL's designated psychiatric units. The Department of Health and Community Services publishes a Provincial Policy and Procedure Manual that provides detailed guidance on the implementation of the MHCTA.

Criteria for Involuntary Admission

Under section 17 of the MHCTA, a certificate of involuntary admission may be issued where the examining person is of the opinion that:

- The person has a mental disorder, defined as a disorder of thought, mood, perception, orientation or memory that impairs judgment or behaviour, the capacity to recognize reality, or the ability to meet the ordinary demands of life, and in respect of which psychiatric treatment is advisable;
- As a result of the mental disorder, the person is likely to cause serious physical harm to themselves or others, or is likely to suffer serious physical impairment or substantial mental or physical deterioration;
- The person is unable to fully appreciate the nature and consequences of the mental disorder or to make an informed decision regarding their need for treatment or care and supervision; and
- The person requires involuntary admission to a designated psychiatric unit for the purpose of treatment, care, and supervision.

NL's legislation is notable for its enhanced capacity criterion. The requirement that the person be “unable to fully appreciate” the nature and consequences of their mental disorder is a more demanding standard than the equivalent provisions in some other provinces, and reflects NL's statutory emphasis on capacity as a precondition for involuntary admission.

Designated Psychiatric Units in Newfoundland and Labrador

The Minister has designated six facilities as psychiatric units under the MHCTA:

- Western Memorial Regional Hospital, Corner Brook

- Central Newfoundland Regional Health Centre, Grand Falls-Windsor
- Waterford Hospital, St. John's
- Health Sciences Centre, St. John's
- St. Clare's Mercy Hospital, St. John's
- Janeway Children's Hospital, St. John's (persons under 18)

The Certification Process and Forms

The MHCTA uses a numbered "MHCTA" form designation. The forms are available from the Department of Health and Community Services and from each regional health authority.

MHCTA-01, First Certificate of Involuntary Admission (Section 17 of the MHCTA)

Completed by a physician or nurse practitioner (or, where a psychiatrist is not readily available, by a physician alone) who has personally conducted a psychiatric assessment of the person within the immediately preceding 72 hours. The certificate must contain both facts observed directly by the certifying professional and facts communicated by other persons, distinguished on the face of the form. Two MHCTA-01 certificates from two different physicians or nurse practitioners are required before a person may be admitted as an involuntary patient. This two-certificate requirement is a significant procedural safeguard unique to NL among the Atlantic provinces.

MHCTA-02 to MHCTA-12

- **MHCTA-02** - Certificate of Renewal (Section 30(2)): issued to continue the patient's involuntary status beyond the initial 30-day admission period. The attending physician must assess the patient and confirm that the MHCTA criteria continue to be met at the time of each renewal.
- **MHCTA-03** - Community Treatment Order: issued by the attending psychiatrist for eligible patients, authorizing treatment in the community under specified conditions rather than continued inpatient detention.
- **MHCTA-04** - Community Treatment Plan: documents the individualized treatment plan for a patient subject to a community treatment order.
- **MHCTA-05** - Authorized Patient Pass: authorizes an involuntary patient to be absent from the psychiatric unit for a specified period.
- **MHCTA-06** - Order for Apprehension and Conveyance of an Involuntary Patient Due to Unauthorized Leave: authorizes a peace officer to apprehend and return an involuntary patient who has left the psychiatric unit without authorization. This

order expires 30 days after the day it is issued.
- **MHCTA-12** - Involuntary Certification / Communications Checklist: used to track and document the communications and notifications required under the MHCTA during and following the certification process.

Holding Periods Under the MHCTA

The MHCTA provides the following framework of detention periods (sections 28 and 31):

- **Initial admission under two MHCTA-01 certificates:** Not more than 30 days from the date of the first certificate (section 28).
- **First Certificate of Renewal (MHCTA-02):** Not more than 30 additional days (section 31(1)(a)).
- **Second Certificate of Renewal (MHCTA-02):** Not more than 60 additional days (section 31(1)(b)).
- **Third and subsequent Certificates of Renewal (MHCTA-02):** Not more than 90 additional days each (section 31(1)(c)).
- There is no absolute limit on the number of certificates of renewal that may be issued, provided the patient continues to meet the statutory criteria at each reassessment (section 31(2)).

The initial 30-day period begins from the date of signing of the first certificate, not the date of physical admission to the facility. Patients admitted under the MHCTA must be re-examined after 72 hours to confirm continued certification.

Order for Involuntary Psychiatric Assessment

A judge may issue an Order for Involuntary Psychiatric Assessment under section 19 of the MHCTA, authorizing a peace officer to apprehend and convey the person to a facility for a psychiatric assessment. This order expires 30 days after the day it is issued.

Rights Advisor and Patient Representative

The MHCTA establishes specific mandatory roles. The Rights Advisor is responsible for informing the involuntary patient of their rights under the Act immediately following certification. The Patient Representative is a person designated by the patient to act on their behalf; where no person has been designated, the next of kin serves in this role unless the patient objects. The administrator of the facility must provide the patient

and their patient representative with copies of all notices and certificates required by the Act, and must inform the patient of their right to retain and instruct counsel without delay.

Review Rights: The Mental Health Care and Treatment Review Board

Involuntary patients may apply to the Mental Health Care and Treatment Review Board at any time for a review of the certificate of involuntary admission or any certificate of renewal. The Review Board has authority to examine the basis for the certification and to order discharge where the statutory criteria are not met.

QUICK REFERENCE, INVOLUNTARY ADMISSION FORM EQUIVALENTS ACROSS ATLANTIC CANADA. Initial 72-Hour Detention / Assessment Authority: NS, Form 2 (Certificate for Involuntary Psychiatric Assessment, Part 1); NB, Examination Certificate (prescribed ministerial form); PEI, Form 1 (Order for Involuntary Psychiatric Assessment); NL, MHCTA-01 (First Certificate of Involuntary Admission, two required). Primary Admission Document (Involuntary Inpatient Status): NS, Form 4 (Declaration of Involuntary Admission, valid 30 days); NB, Certificate of Detention (issued following tribunal order); PEI, Form 3 (Certificate of Involuntary Admission, valid 30 days); NL, two MHCTA-01 certificates (authorize up to 30 days). Renewal Document: NS, Form 5 (Declaration of Renewal); NB, Certificate of Renewal (Review Board approval required from third renewal onward); PEI, Form 4 (Certificate of Renewal); NL, MHCTA-02 (Certificate of Renewal).

Private Practitioner vs. Public Institution: Does It Matter How Your Case Proceeds?

The vast majority of psychiatric practice in Atlantic Canada occurs in publicly funded institutions, regional health authorities, hospitals, and provincial community mental health programs. This has significant legal consequences for how a claim is structured

and pursued.

Suing a Private Psychiatrist

A private psychiatrist who operates an independent practice is personally liable for their own negligence. The claim is brought directly against the individual and will be defended by the CMPA. Private psychiatric practice exists in Atlantic Canada but is less common than in larger urban centres.

Even in private practice cases, the CMPA provides legal defence for all physician members. The CMPA is one of the most experienced and well-resourced medical defence organizations in the world. Cases defended by the CMPA are typically defended thoroughly. This is not a reason not to pursue a legitimate claim, but it is a reason to ensure your legal counsel has specific experience in medical malpractice litigation.

Suing a Public Health Authority or Hospital

When a psychiatrist is employed by a regional health authority, a public psychiatric hospital, or a provincially funded community mental health program, the claim is typically brought against both the individual psychiatrist and the employing institution. Health authorities in Atlantic Canada are creatures of provincial statute. Suing them is governed not only by ordinary negligence law but also by the provincial Proceedings Against the Crown Act (or equivalent legislation), which establishes the conditions under which the Crown and Crown agencies can be sued and may impose procedural requirements that do not apply to private defendants.

- **Nova Scotia:** Proceedings Against the Crown Act (RSNS 1989, c 360)
- **New Brunswick:** Proceedings Against the Crown Act (RSNB 1973, c P-18)
- **Prince Edward Island:** Crown Proceedings Act (RSPEI 1988, c C-32)
- **Newfoundland and Labrador:** Proceedings Against the Crown Act (RSNL 1990, c P-26)

In all Atlantic provinces, the Crown has waived its common law immunity for tortious acts committed by its servants and agents in the course of their duties. A distinction applies between “core policy decisions” (generally immune from suit) and “operational decisions” (not immune). A clinical decision made by an individual psychiatrist in the course of delivering patient care is an operational decision and is not protected.

Vicarious Liability: When the Employer Is Responsible

Under the principle of vicarious liability established in Bazley v Curry, 1999 CanLII 692 (SCC), a health authority that employs a psychiatrist and places them in a position of intimate authority over vulnerable patients has materially increased the risk of the specific harms that can arise in that relationship. The institution's vicarious liability does not depend on proving that the institution itself was negligent.

The Proceedings Against the Crown

Suing a public health authority involves additional procedural requirements that do not apply to claims against private practitioners, including requirements around service of documents on specific government officers and, in some provinces, mandatory notice periods before a claim can be commenced. Your lawyer must be aware of these requirements. Failure to follow the correct procedural steps can result in a claim being dismissed on technical grounds that have nothing to do with the merits of the underlying negligence.

Practical Differences in Litigation

Records and document production

A public health authority may have extensive documentation beyond what a private psychiatrist keeps, inpatient charts, multidisciplinary team notes, nursing records, medication administration records, incident reports, and quality review records. This can be an advantage for the plaintiff in establishing what happened, but it also means a more complex discovery process.

Institutional defendants are better resourced
A regional health authority will typically be represented by experienced defence counsel with institutional resources. Cases against public health authorities may involve a more protracted litigation process and a better-funded opposition.

Multiple defendants are common in institutional psychiatric cases
An inpatient psychiatric case may name the treating psychiatrist, resident physicians, nursing staff, and the institution as co-defendants. Each may take different positions, retain separate counsel, and advance different theories. Managing this complexity requires experienced counsel.

Will a Psychiatrist or Institution Tell Me If Something Went Wrong?

The short answer is not necessarily, and not in the way you might hope for.

In the hospital and public institution context, the Canadian Disclosure Guidelines on disclosure of adverse events apply, and there is a general expectation of candour following adverse outcomes. (These guidelines, originally published by the Canadian Patient Safety Institute, are now maintained by Healthcare Excellence Canada.)

In practice, patients and families in the psychiatric context face meaningful additional challenges:

- Psychiatric outcomes are inherently difficult to attribute clearly to one practitioner's decisions. A psychiatrist or institution will rarely acknowledge that a patient suicide, third-party harm, or clinical deterioration was caused by substandard care.
- Psychiatric records are sometimes more contested in disclosure proceedings than other medical records, given the sensitivity of the information and its potential implications in multiple areas of the patient's life.
- In cases involving sexual misconduct or boundary violations, practitioners almost never self-report. The complaint and the disclosure of what happened comes from the patient.

- In wrongful commitment cases, the institution may have no obligation to acknowledge the deficiencies in the certification process unless compelled to do so through legal proceedings or a regulatory complaint.

You do not need a practitioner or institution to acknowledge fault before protecting your rights. You can:

- Request all records, notes, medication administration records, and any internal documentation related to your treatment in writing.
- File a regulatory complaint with the relevant college of physicians and surgeons (listed in Section 2 of this guide).
- Seek an independent clinical assessment.
- Consult a medical malpractice lawyer.

What Are the Statutes of Limitations for Filing a Psychiatric Malpractice Claim?

General Limitation Periods in Atlantic Canada

Nova Scotia
The Limitation of Actions Act (SNS 2014, c 35) sets a basic limitation period of 2 years from discovery and an ultimate period of 15 years from the date of the act.

New Brunswick
The Limitation of Actions Act (SNB 2009, c L-8.5) sets a 2-year period from discovery and an ultimate period of 15 years.

Prince Edward Island
The Statute of Limitations (RSPEI 1988, c S-7) sets a 2-year period for personal-injury and negligence claims (s. 2(1)(d); the residual period for other actions is 6 years), with discoverability applied by the courts.

Newfoundland and Labrador

The Limitations Act (SNL 1995, c L-16.1) provides a general 2-year period from discovery.

The Discoverability Principle

The limitation clock does not necessarily begin on the date of the harmful event. Under the discoverability principle, time begins to run when the claimant knew or reasonably ought to have known that an injury occurred, that it may have been caused by the practitioner's acts or omissions, and that a legal claim was available.

In psychiatric cases, this is particularly important where:

- The harm is psychological and may not be clearly linked to the psychiatrist's conduct until the patient has received independent clinical assessment.
- A patient who was wrongfully committed may not recognize the legal nature of what occurred until they receive independent legal advice.
- In wrongful commitment cases, the patient's psychiatric condition may itself have impaired their capacity to recognize or act on the harm during and immediately after the period of involuntary detention.

Suspension for Mental Incapacity

Limitation periods in Atlantic Canada are typically suspended during any period of mental incapacity. This is of particular relevance in wrongful commitment cases, where a patient's capacity to recognize and act on their legal rights may have been impaired during and following the period of involuntary detention. Do not assume that a limitation period has expired without consulting a lawyer about whether the discoverability principle or a statutory suspension applies to your circumstances.

Claims on Behalf of a Deceased Person

Where a patient has died as a result of inadequate psychiatric care, including a failure to hospitalize where the patient subsequently died by suicide, or a failure to warn where a third party was murdered, a claim may be brought by the deceased's estate or dependants under the applicable provincial legislation. These claims are complex, subject to their own limitation periods, and require prompt legal advice.

Damages and Compensation for Psychiatric Malpractice Claims in Canada

Psychiatric malpractice claims involve a distinctive damages framework shaped by the nature of psychiatric harm and the unique consequences of certain categories of claim, including wrongful commitment.

Types of Damages

Non-Pecuniary General Damages (Pain, Suffering, and Loss of Enjoyment of Life)

These compensate for psychological pain, emotional suffering, loss of trust, and the reduction in quality of life caused by the psychiatrist's conduct. In sexual misconduct cases, courts have recognized profound and lasting harm to a person's capacity for intimacy, trust, and psychological wellbeing. In wrongful commitment cases, courts recognize the deprivation of liberty itself as a significant and independently compensable harm.

Damages Specific to Wrongful Commitment

Where a patient was wrongfully detained under provincial mental health legislation without meeting the statutory criteria, damages include compensation for the deprivation of liberty itself, which Canadian courts recognize as independently significant. Additional damages may include psychological harm caused by the detention, reputational harm, loss of employment, and any physical consequences of the detention or of treatment administered without a lawful basis.

Cost of Future Treatment

A patient harmed by negligent psychiatric care will typically require significant additional treatment. The reasonable cost of ongoing psychiatric care, psychotherapy, and medication management is recoverable. In cases of serious harm, this can represent substantial ongoing costs over many years.

Pecuniary Special Damages

These cover actual financial losses including:

- Lost wages during periods of incapacity caused by the harm.
- Costs of treatment not covered by provincial health insurance.
- Costs of legal and regulatory proceedings.

Loss of Income and Earning Capacity

Where the harm caused by psychiatric negligence substantially impairs the patient's ability to work, loss of income and reduced future earning capacity are recoverable.

Medication Harm Damages

In negligent prescribing cases, damages include compensation for physical harm caused by the medication (such as tardive dyskinesia or severe metabolic effects), costs of treatment for those physical effects, and in serious cases, loss of earning capacity attributable to the physical harm.

The Cap on Non-Pecuniary Damages

The Supreme Court of Canada's 1978 damages trilogy (Andrews v Grand & Toy Alberta Ltd.; Thornton v Board of School Trustees; Arnold v Teno) established a cap on non-pecuniary damages for pain and suffering, currently approximately $430,000 to $450,000 in the mid-2020s.

This cap applies to pain and suffering specifically. Pecuniary losses, future care costs, and other heads of damages are not capped. In cases of serious harm from psychiatric negligence, total awards can be significant.

The Particular Challenge of Proving Psychiatric Harm

Proving psychiatric harm in a malpractice claim requires objective evidence from independent expert witnesses, typically qualified psychiatrists or psychologists, establishing: the nature and severity of the harm; that the harm was caused or materially worsened by the defendant's conduct rather than by the patient's underlying condition; and the likely trajectory of the harm and the treatment needs it creates. The causation question, separating harm caused by the psychiatrist from harm attributable to the underlying condition, is frequently the central contested issue in psychiatric malpractice litigation.

How Much Does It Cost to Pursue a Psychiatric Malpractice Claim in Canada?

Contingency Fee Arrangements

Most psychiatric malpractice claims in Canada are handled on a contingency fee basis, meaning no legal fee is charged unless the case succeeds. Contingency fees in medical malpractice cases in Atlantic Canada typically range from 25% to 33% of the final recovery. The arrangement must be set out in a written agreement.

This means that access to experienced legal representation is not dependent on a patient's ability to fund the litigation upfront.

Disbursements and Expert Costs

Psychiatric malpractice cases require expert evidence from qualified psychiatrists. Typical disbursements include:

- Independent psychiatric expert reports assessing the standard of care (individual reports commonly range from $10,000 to $30,000 or more, depending on scope and

specialty).

- Independent psychiatric assessment of the plaintiff's condition and causation of harm.
- In negligent prescribing cases, expert evidence from pharmacological or neurological specialists where physical harm is involved.
- In wrongful commitment cases, expert evidence on the statutory criteria and whether the clinical picture met the legal threshold for involuntary admission.
- Psycho-vocational expert evidence in cases involving loss of earning capacity.
- Medical record retrieval, court filing, discovery transcript, and travel costs.

Most firms working on contingency will advance these costs, to be recovered from the settlement or judgment at the end of the case. Confirm this in writing before retaining counsel.

What Happens If You Lose?

As in all civil litigation in Canada, an unsuccessful party may be ordered to pay a portion of the successful party's costs. The CMPA defends psychiatric malpractice cases thoroughly and with substantial resources. This is a genuine adverse costs risk that must be discussed openly with your lawyer at each key decision point.

Cases against the CMPA-defended psychiatrist or a well-resourced health authority carry a meaningful adverse costs risk if the case proceeds to trial and is unsuccessful. Thorough expert review before filing is the most important protection against pursuing a claim that cannot be won.

How Long Does a Psychiatric Malpractice Case Typically Take in Canada?

Psychiatric malpractice cases are among the most time-consuming medical malpractice matters, in large part because of the complexity of causation analysis and the expert evidence required.

Stages of a Claim

Stage 1: Initial Consultation and Case Evaluation (1 to 3 months)
The lawyer reviews available materials, including records, correspondence, and any notes the client can provide. Some firms engage a psychiatric consultant for a preliminary opinion before committing to full investigation.

Stage 2: Record Collection and Expert Review (6 to 18 months)
Obtaining complete psychiatric records, nursing notes, medication administration records, hospital incident reports, and any regulatory college records is the foundation. Expert review by a qualified psychiatrist is required before a claim is filed. In sexual misconduct cases, regulatory college proceedings often run parallel to or precede the civil claim.

Stage 3: Issuing the Statement of Claim
Once expert evidence supports the claim, court proceedings are commenced.

Stage 4: Pleadings and Discoveries (1 to 2 years)
Both parties exchange documents and examine witnesses under oath. The plaintiff's psychiatric history and the question of pre-existing vulnerability are central areas of examination for the defence.

Stage 5: Mediation and Negotiation (ongoing)
Suicide cases tend to be more heavily contested than sexual misconduct cases. Cases against public health authorities may be slower to resolve given the institutional structure of the defendant and the multiple parties often involved.

Stage 6: Trial (if settlement is not reached)
Trials in complex psychiatric malpractice cases typically run from two to four weeks. Expert psychiatric evidence, records analysis, and causation are all closely contested areas.

When Settlements Are Most Likely

Sexual misconduct cases with strong evidence frequently settle, as defendants and their insurers generally prefer to avoid the public record of trial findings.

Suicide cases and failure-to-warn cases tend to be more heavily contested, as causation is disputed and defendant practitioners argue that the outcome was not preventable by any reasonable clinical intervention.

Wrongful commitment cases present a distinctive settlement dynamic: the deprivation of liberty is an objective fact, and the dispute tends to centre on whether the statutory criteria were met at the time of the certification.

The Reality of Protracted Litigation

From initial consultation to resolution, a psychiatric malpractice case will typically take four to seven years. Causation disputes are inherently complex and expert-dependent. Patience, experienced counsel, and realistic expectations are essential.

Things to Consider When Choosing a Lawyer for a Psychiatric Malpractice Claim

Psychiatric malpractice is one of the most specialized areas within an already specialized field. The combination of clinical complexity, the unique statutory framework governing involuntary admission, the prescribing liability dimension, and the formidable defence resources of the CMPA means that not every medical malpractice lawyer will have the depth of experience these cases require.

Experience in psychiatric malpractice specifically
Ask directly whether the lawyer has handled cases involving psychiatrists, and specifically whether they have experience with involuntary admission decisions,

negligent prescribing, or inpatient suicide cases. The statutory frameworks, relevant case law, and expert witness relationships in psychiatric malpractice are distinctive from those in surgical or obstetric malpractice.

Understanding of the provincial certification framework

In wrongful commitment and failure to commit cases, the lawyer must understand the specific mental health legislation in your province, the statutory criteria for involuntary admission, the required forms and timelines, and the review rights that apply. This is specialized knowledge that requires familiarity with the applicable provincial statute and its implementation in practice.

Experience with institutional defendants where relevant

The vast majority of psychiatric malpractice in Atlantic Canada involves institutional defendants. The lawyer needs experience with the Proceedings Against the Crown Act, vicarious liability in the institutional context, and the particular dynamics of litigating against a CMPA-defended physician within a larger institutional defendant structure.

Access to qualified psychiatric expert witnesses

A claim against a psychiatrist requires a qualified psychiatrist as the expert witness. Ask whether the lawyer has established working relationships with credible psychiatric experts who are willing to review cases and testify.

Sensitivity to the personal dimensions of these cases

Clients bringing psychiatric malpractice claims, particularly those who were wrongfully committed or whose loved ones died due to inadequate psychiatric care, are often in a particularly vulnerable position. The right lawyer will understand this and will handle the process with care.

Written fee agreement

The contingency fee percentage, disbursement terms, and adverse cost risk should all be clearly set out in writing before you sign.

Many medical malpractice lawyers offer a free initial consultation. If you are considering bringing a psychiatric malpractice claim, this consultation is an opportunity to evaluate whether the lawyer has genuine experience in this specific area, not just willingness to learn on your case. You are not obligated to retain anyone you speak with, and consulting more than one firm before deciding is entirely reasonable.

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https://www.assembly.nl.ca/legislation/sr/statutes/l16-1.htm

Proceedings Against the Crown Legislation

Nova Scotia Proceedings Against the Crown Act (RSNS 1989, c 360)
https://www.canlii.org/en/ns/laws/stat/rsns-1989-c-360/latest/rsns-1989-c-360.html

New Brunswick Proceedings Against the Crown Act (RSNB 1973, c P-18)
https://www.canlii.org/en/nb/laws/stat/rsnb-1973-c-p-18/latest/

Prince Edward Island Crown Proceedings Act (RSPEI 1988, c C-32)
https://www.princeedwardisland.ca/en/legislation/crown-proceedings-act

Newfoundland and Labrador Proceedings Against the Crown Act (RSNL 1990, c P-26)
https://www.canlii.org/en/nl/laws/stat/rsnl-1990-c-p-26/latest/

Further Reading and Support Organizations

Regulatory Colleges, Psychiatry

College of Physicians and Surgeons of Nova Scotia (CPSNS)
https://cpsns.ns.ca/

College of Physicians and Surgeons of New Brunswick (CPSNB)
https://cpsnb.org/en/

College of Physicians and Surgeons of PEI (CPSPEI)
https://cpspei.ca/

College of Physicians and Surgeons of NL (CPSNL)
https://cpsnl.ca/

Professional Associations

Canadian Psychiatric Association
https://www.cpa-apc.org/

Canadian Medical Protective Association (CMPA)
https://www.cmpa-acpm.ca/

Mental Health Support

9-8-8 Suicide Crisis Helpline
Call or text 988 (24/7, bilingual)
https://988.ca/

Canadian Mental Health Association, Nova Scotia
https://novascotia.cmha.ca/

Canadian Mental Health Association, New Brunswick
https://cmhanb.ca/

Canadian Mental Health Association, PEI
https://pei.cmha.ca/

Canadian Mental Health Association, NL
https://cmhanl.ca/

Legal Research and Referral

CanLII
Free access to Canadian case law
https://www.canlii.org/

Law Society of Nova Scotia
Lawyer Referral Service
https://www.nsbs.org/

Law Society of New Brunswick
https://www.lawsociety-barreau.nb.ca/en/

Law Society of Prince Edward Island
https://lawsocietypei.ca/

Law Society of Newfoundland and Labrador
https://lsnl.ca/

Canadian Disclosure Guidelines (Healthcare Excellence Canada)
https://www.healthcareexcellence.ca/en/resources/canadian-disclosure-guidelines/