Office of the Information and Privacy Commissioner for Nova Scotia
Report of the Commissioner (Review Officer)
Tricia Ralph

REVIEW REPORT 21-07

June 16, 2021

Nova Scotia Health Authority

Summary: The complainant completed the Driving While Impaired Program (DWI Program), a mandatory program for drivers whose licenses have been suspended due to an impaired driving offence. The DWI Program was administered by Nova Scotia Health[1] (NSH) and was composed of a standardized education component, an optional referral to healthcare treatment services and a biopsychosocial assessment resulting in an individualized risk rating. The risk rating was then disclosed to the Registry of Motor Vehicles (RMV) for its use in its administrative decision-making about whether to reinstate the driver's license. The complainant complained that in administering the DWI Program, NSH collected, used and disclosed his personal information without authority.

The Commissioner finds that in operating the DWI Program, NSH was acting as a public body subject to the *Freedom of Information and Protection of Privacy Act* when it delivered the DWI Program to the complainant. The Commissioner finds that NSH was authorized to collect information about the complainant's behaviours, attitudes and experience with alcohol and/or substance use from the complainant. The Commissioner finds that NSH was not authorized to collect personal information about the complainant from collateral sources. The Commissioner finds that NSH was not authorized to use the complainant's existing medical record in the custody and control of NSH for the purposes of the DWI Program in the manner that it did. Finally, the Commissioner finds that while NSH is authorized to disclose the DWI Program's risk rating to the RMV generally, in this case, because of the Commissioner's finding that the DWI Program collected and used information that was not authorized, it was therefore not authorized to disclose the individualized risk rating for the complainant to the RMV.

The Commissioner makes a number of recommendations to NSH including conducting a privacy impact assessment of the DWI Program and developing fulsome procedures and guidelines to better govern its administration of the DWI Program in compliance with its statutory authorities.

[1] Note that the legal name of NSH is the Nova Scotia Health Authority.

Statutes considered: *Freedom of Information and Protection of Privacy Act*, SNS 1993, c. 5, ss. 24(1)(a)(b)(c), 26(a)(b)(c), 27(c); *Freedom of Information and Protection of Privacy Regulations*, NS Reg 105/94, s. 8; *Personal Health Information Act*, SNS 2010, c.41 ss. 3(k), 6(1)(b), 8(1)(2)(3); *Personal Health Information Act Regulations*, NS Reg 217/2012 ss. 2, 3; *Motor Vehicle Act* SNS 1989, c. 293 (as amended), s. 67(11), *Alcohol Rehabilitation Programs Regulations* N.S. Reg 99/2001 (as amended), ss. 2, 3; *Immigration and Refugee Protection Act* SC 2001, c.27, *Immigration and Refugee Protection Regulations* SOR 2002-27.

Authorities considered: Supreme Court of Canada: *R. v. Dyment*, 1988 CanLII 10 SCC; **British Columbia:** *Board of Education of School District No. 75 (Re)*, 2007 CanLII 30395 (BC IPC); *Royal City Jewellers & Loans Ltd. V. New Westminster (City)*, 2007 BCCA 398 (CanLII); *Order F14-26* 2014 BCIPC No. 29 (CanLII); **Northwest Territories:** *(Education, Culture and Employment)(re)*, 2018 NTIPC 5 (CanLII); **Nova Scotia:** *Review Report 16-06* 2016 NSOIPC 6 (CanLII); **Saskatchewan:** *R v. Bigsky*, 2016 SKPC 106 (CanLII); **Prince Edward Island:** *Worker's Compensation Board (Re)*, 2006 CanLII 39091 (PE IPC).

Other sources considered: *Black's Law Dictionary, 8th ed. sub verbo* "rehabilitation"; World Health Organization, *Rehabilitation*, 2020, https://www.who.int/news-room/fact-sheets/detail/rehabilitation; *Merriam-Webster Dictionary*, "Rehabilitation", https://www.merriam-webster.com/dictionary/rehabilitation; Harrison ER, Haaga J, Richards T. Self-reported drug use data: what do they reveal? *Am. J. Drug Alc. Abuse.* 1993;19:423–441; and O'Malley PM, Bachman TE, Johnston LD. Reliability and consistency of self-reports of drug use. *Int. J. Addict.* 1983;8:805–824.

INTRODUCTION:

[1] The complainant paid a fee to the Registry of Motor Vehicles (RMV) to enter an alcohol and/or substances rehabilitation program as required under the *Motor Vehicle Act*[2] in order to apply for his driver's license to be reinstated following a suspension for impaired driving. The program was the Driving While Impaired Program (DWI Program) delivered by Nova Scotia Health (NSH).

[2] The complainant complained to NSH that his privacy was violated when the DWI Program collected and used his personal health information to complete an assessment and then disclosed some of his personal health information when it issued a risk rating letter to the RMV. In response, NSH acknowledged the DWI Program's access and use of personal health information went beyond reasonable knowledgeable implied consent and implemented a new process to explicitly obtain consent from program participants before accessing their medical records. The complainant was not satisfied with this response and appealed to the Office of the Information and Privacy Commissioner (OIPC).

[2] RSNS 1989, c 293.

ISSUES:

[3] The issues under review are listed below.

1. Which *Act* is applicable to the collection, use and disclosure of personal information for the purposes of the DWI Program?
   (a) Does the DWI Program provide health care as defined in s. 3(k) of the *Personal Health Information Act*?
2. Was the collection, use and disclosure of the complainant's personal information authorized by the applicable legislation?

PRELIMINARY MATTERS:

Canadian Charter of Rights and Freedoms

[4] In his representations to this office, the complainant raised several concerns related to the *Canadian Charter of Rights and Freedoms* (*Charter*).[3] He argued that NSH's actions amounted to an unreasonable search or seizure in violation of the *Charter* and sought specific *Charter*-related remedies.

[5] While I did approach my analysis keeping in mind the spirit of the *Charter*, I did not consider directly the complainant's allegations of violations of the *Charter*. I will leave the constitutional questions to the court system. I have jurisdiction to consider privacy rights in the context of the *Personal Health Information Act* (*PHIA*) and the *Freedom of Information and Protection of Privacy Act* (*FOIPOP*) and to provide recommendations to public bodies and custodians under those *Acts*.

DISCUSSION:

Background

The DWI Program

[6] NSH delivers the DWI Program as part of a suite of community-based addictions services, referred to as Mental Health and Addictions. The DWI Program was created under the oversight of a provincial committee with representation from the RMV, Service Nova Scotia and Municipal Relations,[4] the Department of Health and Wellness and the Nova Scotia Health Authority. However, operational authority for the program rests with NSH.

[3] Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.
[4] As it was known previously. The Department of Service Nova Scotia and Municipal Affairs has since split into two separate departments, the Department of Service Nova Scotia and Internal Services; and the Department of Municipal Affairs.

[7] The way that the DWI Program works is multi-faceted but there are three main components, as set out in a document dated June 2012 and labelled as a draft entitled "*Driving While Impaired Program: Preferred Practices*":[5]

1. Education: NSH delivers education in a group setting to participants to provide them with information on safe driving and the effects of alcohol and other drugs on one's ability to safely drive a motor vehicle.
2. Biopsychosocial assessment: NSH does a biopsychosocial assessment of each participant using approved screening tools, one-on-one interviews, a review of the participant's existing medical record and collection of collateral information from the participant's identified close contacts and past healthcare providers.
    a. The assessment results in a one-word risk rating that is disclosed to the RMV.
3. Treatment: The treatment consists of individual or group counselling and when necessary, other elements drawn from the continuum of addiction and other services for those individuals who need to address problems related to alcohol and drug use to sustain healthy lifestyle changes.
    a. Note that whether to engage in treatment is a voluntary decision of the participant.

[8] In practice, the program is focused on the first two components. The program description on NSH's website describes the program as including only the first two components of "an educational course and an alcohol and drug assessment screening."[6] In a submission on November 4, 2019, NSH stated, "the program does not provide rehabilitation services to the participants." Participants can be referred to additional services or treatment depending on the outcome of the assessment component of the program.

[9] It is mandatory for individuals whose driver's licenses are suspended because of impaired driving to complete the DWI Program prior to requesting the reinstatement of their driver's license. Participants must pay a fee to attend the DWI Program.

[10] The RMV used the risk rating from the DWI Program as well as whether the program was completed as part of its decision about whether to reinstate the complainant's driving license and whether to impose restrictions upon reinstatement.

The statutory framework for the DWI Program

[11] The statutory foundation for the DWI Program is in the *Motor Vehicle Act* s. 67(11).[7] It states:

> The Registrar shall require that a person whose driver's license or privilege of obtaining a driver's license has been revoked for an impairment-related offense involving alcohol or suspended pursuant to Section 279A for impairment-related offence involving alcohol participate in such alcohol rehabilitation program as may be prescribed by regulation made by the Governor in Council before he is entitled to reinstatement of his license.

[5] Note this is not a public document.
[6] http://www.nshealth.ca/service-details/Driving%20While%20Impaired%20(DWI)%20Program.
[7] RSNS 1989, c. 293.

[12] Section 2 of the *Alcohol Rehabilitation Programs Regulations*[8] states that an "alcohol rehabilitation program" means "a program that is conducted, directed or promoted by a health authority established under the *Health Authorities Act* for a person whose driver's license has been revoked for an impairment-related offence involving alcohol or suspended under section 279A of the Act."

[13] Section 3(1) of the *Alcohol Rehabilitation Programs Regulations* establishes that individuals who are required to participate in an alcohol rehabilitation program under the Regulations must "provide the Registrar with evidence of participation in an alcohol rehabilitation program and of satisfactory rehabilitation before consideration will be given to the application."

[14] Section 3(2) of the *Alcohol Rehabilitation Programs Regulations* allows that the health authority that "conducted, directed or promoted the alcohol rehabilitation program" may provide the evidence of satisfactory rehabilitation required by Regulation 3(1). These Regulations do not specify how the alcohol rehabilitation program should determine rehabilitation nor what evidence satisfies the burden of proving satisfactory rehabilitation.

Privacy complaint

[15] The complainant raised privacy concerns about the DWI Program's access to his personal health information during his first assessment meeting with DWI Program staff. It was during this first assessment meeting that the complainant was informed that DWI Program staff have full access to participants' personal health information held in the medical records in the custody and control of NSH and that, in accordance with the program's policies at that time, program staff had already accessed his personal health information held by NSH.

[16] Prior to the complainant raising concerns, NSH had been working on the presumption that by signing up for the DWI Program, participants were providing implied consent for NSH to review their existing medical records.

[17] Through the course of his involvement with the DWI Program, the complainant continually raised objections about the program's access to his personal health information. In response, the complainant was continually informed by the DWI Program's staff that he must consent to the program accessing his medical records and consulting other individuals about him (called collaterals) in order to complete the DWI Program.

[18] Ultimately, the complainant did sign a consent form because he felt "he has no choice but to consent."[9]

[19] The complainant submitted a formal privacy complaint to NSH. The complainant objected to the amount and type of personal health information that the DWI Program collected and used. He also objected to NSH providing the risk rating to the RMV. The complainant's view was that it was a deterrent to seeking health care, particularly for sensitive mental health issues, if personal health information was then made available for other purposes.

[8] NS Reg 99/2001.
[9] Addictions Program Case Note, October 25, 2017.

NSH response to the privacy complaint

[20] In response to the complainant's privacy complaint, NSH conducted an investigation and concluded:

> "Based on conversations with the program leaders, a review of program materials, and discussion with the Provincial Privacy Manager, the Privacy Officer determined that the review of the complainant's medical record by their counselor prior to the complainant's first appointment with the counselor would not be covered under implied knowledgeable consent and would therefore be a breach of confidentiality. The Privacy Officer also determined that while it was a breach, it was not an intentional or malicious breach; rather an error on part of the program structure. In order to mitigate the matter a process was quickly put in place to ensure that the clients of the program sign a release of information during program orientation in order to establish express consent for the access of their records."[10]

[21] NSH modified its practices to discontinue its reliance on implied consent and replaced it with a practice of seeking express consent.

[22] The complainant was not satisfied with NSH's response because in his view, he did not consent. In his view, he did not have the opportunity to consent to the access that occurred prior to his first assessment appointment, and where he did later provide consent, his consent was not voluntarily provided. Further, in his view, the DWI Program was not authorized to have unfettered access to his medical records. He was not satisfied that the implementation of an express consent process after his assessment was completed and already sent to the RMV provided an appropriate remedy. He was seeking that the original assessment completed by the DWI Program be rescinded and expunged from his health record and from his record with the RMV.

[23] The complainant appealed to the OIPC. An investigator from this office attempted informal resolution of this matter but was not successful. As such, the file proceeded to me to conduct my review and issue a public report.

Burden of proof

[24] Both *PHIA* and *FOIPOP* are silent on burden of proof in the context of determining whether a custodian/public body[11] has the authority to collect, use and disclose personal information. In the absence of a statutory burden of proof, there is an evidentiary burden on the complainant who brings the complaint. The usual principle of "she who alleges must prove" applies. This is an evidentiary burden, not a legal burden, and it requires only that the complainant provide prima facie[12] evidence of the alleged privacy complaint. Such evidence may be satisfied without doing anything other than pointing to evidence already on the record.

[10] NSH initial submission to OIPC in response to this review, June 15, 2018.
[11] Note that *FOIPOP* applies to "public bodies", as defined s. s. 3(1)(j). while *PHIA* applies to "custodians", as defined in s. 3(f).
[12] Note that *prima facie* is a Latin term meaning at first sight.

[25] Once the evidentiary burden is satisfied, the burden shifts to the custodian/public body to establish that it acted in compliance with the requirements of the legislation.[13] The complainant has met his burden of providing the necessary prima facie case for his privacy complaint. As such, NSH bears the burden of proving that the DWI Program's information practices (collection, use and disclosure) are compliant with either *FOIPOP* or *PHIA*'s requirements.

1. Which *Act* is applicable to the collection, use and disclosure of personal information for the purposes of the DWI Program?

[26] NSH is a government authority that handles both "personal information" (as defined in s. 3(1)(i) of *FOIPOP*) and "personal health information" (as defined in s. 3(r) of *PHIA*). *FOIPOP* and *PHIA* set out different rules with respect to the collection, use and disclosure of information so it is an important first step to determine which *Act* applies to NSH in the context of the delivery of its DWI Program. If acting under *FOIPOP*, NSH is termed a "public body". If acting under *PHIA*, NSH is termed a "custodian".

1. (a) Does the DWI Program provide health care as defined in s. 3(k) of the *Personal Health Information Act*?

[27] Section 8(1) of *PHIA* explains that subject to s. 8(2) and s. 8(3), *FOIPOP* does not apply to personal health information collected by a custodian or in the custody or under the control of a custodian. Most of the information collected, used and disclosed for the DWI Program would meet the definition of "personal health information" under *PHIA*, indicating that *PHIA* is the appropriate piece of legislation. However, s. 8(3) of *PHIA* goes on to explain that *FOIPOP* applies where personal health information is contained in a record primarily created for a purpose other than for health care and the custodian is a public body within the meaning of that *Act*. In this situation, we have personal health information collected by a public body, so the question becomes whether that information is contained in a record primarily created for a purpose other than for health care.

[28] With regard to s. 8(3) of *PHIA*, NSH said that it did not think *FOIPOP* would apply as its records were created for health care purposes. It also noted that any information created for the DWI Program was maintained in the participant's medical record. NSH was of the view that the DWI Program delivered health care and so *PHIA* was the appropriate piece of legislation.

[29] On its face, the activities and the purposes of the DWI Program appear to have a health care dimension to them, particularly in the context of legislation that sets out the program as a rehabilitation program and the program being delivered by a health authority. However, descriptors can be just that – I must assess whether the personal health information at issue was contained in a record primarily created for a purpose other than health care. To assess this, NSH was asked several questions about the purpose of the DWI Program.

[30] In terms of how the process of sending over the risk rating that results from the biopsychosocial assessment came to be, I understand that when the DWI Program first originated, a risk rating was not sent by NSH to the RMV. Rather, what was sent was a letter of

[13] This approach in privacy complaint matters was adopted in Nova Scotia by the Information and Privacy Commissioner in *Review Report 16-06* [*Nova Scotia Justice (Re),* 2016 NSOIPC 14 (CanLII)]. It is consistent with, for example, *BC OIPC Order F13-04* [*BC Lottery Corporation (Re*), 2017 BCIPC 21 at para. 5].

completion of the program. However, over the years, "the RMV stated that they required more documentation than a letter of completion. The risk assessment was agreed upon as a solution that would provide a clinical determination without compromising patient confidentiality as there was a shared understanding of what each risk rating meant."[14] NSH further explained that "…the risk rating was a component requested by RMV as a means to verify that the client had completed the DWI Program and as a measure of risk of the likelihood that the client was harmfully involved in substances (low, medium, high)."[15]

[31] NSH was asked what the purpose was of sending the risk rating to the RMV. Its response was, "It is to be utilized as one component of their decision-making process. As explained in question 9(a) above, the risk rating was requested by the RMV to verify that the client had completed the DWI Program and as a measure of risk of the likelihood that the client was harmfully involved with substances (low, medium or high)." [16]

[32] NSH was asked whether risk rating assessments done under the DWI Program were used for any other purpose. It was asked what happens with the assessments after they were completed and if there were any other results, consequences, outcomes or referrals triggered by an assessment done under the DWI Program. NSH responded, "No, they are not. The assessment is placed on the health record. Follow up care may be recommended as outlined below."[17]

[33] NSH was asked whether the personal health information accessed by the DWI Program was used for any purpose other than producing the risk rating assessment. NSH responded, "Only for the biopsychosocial assessment, there would be no other reason to check the health record."[18]

[34] NSH explained its position that in administering the DWI Program, it provides health care. NSH asserted that the DWI Program provides health care as defined in s. 3(k) of *PHIA* because NSH provides a biopsychosocial assessment which it said is a clinical assessment of an individual's health status. NSH submitted, "we provide a risk rating for harmful involvement with substances which is based upon a biopsychosocial assessment which is considered healthcare as it is an assessment and covered under PHIA."[19] In this case, NSH was of the view that the information collected and used was for the biopsychosocial assessment and that without that assessment, there could not be a treatment or education component to the DWI Program.[20] The NSH said, "While sharing the risk rating may not be considered a healthcare purpose, it does not follow that the assessment itself is not healthcare." In NSH's opinion, it is impossible to separate the biopsychosocial assessment from the other portions of the program as they are part and parcel.[21] According to this position, if the biopsychosocial assessment has a healthcare purpose, the remainder of the DWI Program is also brought under the healthcare umbrella.

[14] NSH submission Dec 20, 2019 (response to question #4c).
[15] NSH submission Dec 20, 2019 (response to question #9a).
[16] NSH submission Dec 20, 2019 (response to question #9c).
[17] NSH submission Dec 20, 2019 (response to question #5).
[18] NSH submission Dec 20, 2019 (response to question #13g).
[19] NSH submission Dec 20, 2019 (response to question #10c).
[20] NSH submission June 12, 2020 (pg. 3).
[21] NSH submission June 12, 2020 (pg. 3).

[35] It is important to remember that s. 8(3) of *PHIA* states that *FOIPOP* applies where personal health information is contained in a record primarily created for a purpose other than for health care. It does not state that if a custodian is providing health care, *PHIA* applies. Rather, the purpose of the creation of the record is key.

[36] In my view, despite NSH's assertions otherwise, the primary purpose of the records created for the DWI Program (registration, program completion, biopsychosocial assessment, risk rating) are to fulfill NSH's statutory authority and responsibility under the *Motor Vehicle Act Regulations* to provide a specified program capable of supplying the RMV with evidence of satisfactory rehabilitation. In this case, the risk rating was developed specifically for the purpose of supplying the RMV with a rating of the measure of risk of the likelihood that the complainant was harmfully involved in substances so that the RMV could use that information in determining whether to reissue a license. As stated by NSH, it served no other purpose. It was not used to provide health care. But for being a DWI Program participant, participants would not undergo the biopsychosocial assessment and the risk rating would not be created.

[37] Risk assessments and health indicator assessments are often done for purposes not related to health care and those who perform them are not subject to *PHIA*. Health indicator assessments for insurance purposes are an example.[22] The biopsychosocial assessment and resulting risk rating are undertaken to complete the DWI Program and to supply the RMV with evidence of satisfactory rehabilitation for its administrative decision-making purpose. That purpose is not health care. While some activities may resemble healthcare activities, that is not determinative of their purpose.

[38] In addition to s. 8(3) of *PHIA*, I also looked at whether the specific components of the DWI Program would meet the definition of "health care" under s. 3(k) of *PHIA*. Section 3(k) of *PHIA* defines "health care" as an observation, examination, assessment, care, service or procedure in relation to an individual that is carried out, provided or undertaken for one or more of the following health-related purposes:

> (i) the diagnosis, treatment or maintenance of an individual's physical or mental condition,
> (ii) the prevention of disease or injury,
> (iii) the promotion and protection of health,
> (iv) palliative care,
> (v) the compounding, dispensing or selling of a drug, health-care aid, device, product, equipment or other item to an individual or for the use of an individual under a prescription, or
> (vi) a program or service designated as a health-care service in the regulations;

[39] I will now go through each health-related purpose to determine whether in administering the DWI Program, NSH was providing "health care" to the complainant within the meaning of s. 3(k) of *PHIA*.

[22] *PHIA* s. 6(1)(b).

[40] There are only two programs or services designated within the *PHIA Regulations* for the purposes of s. 3(k)(vi): an assessment done under the *Adult Protection Act* and the taking of a donation of blood products.[23] The DWI Program is not designated as a healthcare service in the *Regulations*.

[41] The purpose of the DWI Program is clearly not for the compounding, dispensing or selling of a drug, healthcare aid, device or product for the use of an individual under a prescription nor for palliative care, therefore ss. 3(k)(iv) and 3(k)(v) cannot apply.

[42] The most natural of enumerated purposes, and one that NSH identified, is s. 3(k)(i). Section 3(k)(i) of *PHIA* states that the purpose of the service or program is for the diagnosis, treatment or maintenance of an individual's physical or mental condition. In addition, NSH listed s. 3(k)(ii), which is the prevention of disease or injury, and s. 3(k)(iii), which is the promotion and protection of health, as other relevant purposes.

[43] The education component delivered by the DWI Program is a standard group education session. It is not tailored to the needs of each participant. NSH agreed that personal health information is not necessary to offer the education component but said that this part of the program cannot be separated from the rest of the program and in order to complete the program, the participants must attend all aspects.[24] I have not seen the education component, but the DWI Program's goals as set out in NSH's draft[25] guidance document entitled "*Driving While Impaired Program: Preferred Practices*" describe it as, "Provide education about the direct and indirect harms of driving while impaired." As such, it is clear that the DWI Program's education has health-related subject matter that is consistent with healthcare objectives such as the prevention of disease or injury or the promotion and protection of health. However, its purpose in relation to the complainant was still rooted in fulfilling the requirements of the DWI Program.

[44] The treatment component of the DWI Program is limited to offering additional health care. There is no other treatment offered through the DWI Program. Referring a participant to further health care, which is based upon the biopsychosocial assessment, does have a healthcare purpose because it is focused on connecting an individual participant with healthcare services specifically related to their needs. However, it is important to remember that this is only a voluntary aspect of the program which does not occur in every case and did not occur in the case of this complainant. In my view, the possibility to refer a participant to additional healthcare services does not import a healthcare purpose on the whole of the DWI Program. Making referrals to healthcare services is not an established purpose of the DWI Program. It may be a collateral potential benefit, but it is not enough on its own to import a healthcare purpose to the DWI Program. I will pause here and note that where the DWI Program offers a voluntary referral to further healthcare services for a participant and the participant agrees, the act of referral and any associated disclosure of information could proceed under the consent-based provisions of *PHIA*.

[23] The two designated services are: an assessment under the *Adult Protection Act* and the taking of a donation of blood or blood products from an individual. Regs, s. 4(a)(b).
[24] NSH submission Nov 4, 2019 (response to question #12).
[25] Note that the document supplied to the OIPC was marked as "June 2012 – Draft." My understanding is that this document is relied upon by NSH as the final guidance document despite it being marked as a draft.

[45] The biopsychosocial assessment and the corresponding risk rating used to share the clinician's opinion of the assessment with the RMV are trickier to consider. To meet the definition of "health care" in s. 3(k) of *PHIA*, the action taken by NSH must be an observation, examination, assessment, care, service or procedure. In addition, that action must be taken for one of the enumerated health-related purposes. While I can accept that the biopsychosocial assessment and corresponding risk rating result from an observation or assessment, I cannot accept that they have a health-related purpose such as the diagnosis, treatment or maintenance of an individual's physical or mental condition. Rather, it is clear to me that but for being a DWI Program participant, participants would not undergo the biopsychosocial assessment and the risk rating would not be created.

[46] The prevention of disease or injury or the promotion and protection of health may be beneficial corollaries, particularly if a participant is referred to and seeks further health care as a result. However, the biopsychosocial assessment was not undertaken in the complainant's case to achieve those specific outcomes. It was done to achieve the objectives of the DWI Program.

[47] NSH's statutory authority to deliver the DWI Program is separate and distinct from the authority which enables NSH to provide healthcare services, as set in other pieces of legislation such as the *Health Authorities Act*.[26] NSH's role in the DWI Program is fixed within the societal response to impaired driving convictions and the administrative decision-making related to individuals whose driver's licenses are suspended for driving while impaired offenses.

[48] After reviewing NSH's submissions and carefully considering the DWI Program and the statutes, I am of the view that the purpose of the DWI Program under its enabling legislation is to provide a mandatory program to individuals whose driver's licenses have been suspended due to impaired driving. The participants coming to the program are not seeking health care. They pay a fee to the RMV. Although some aspects of the program, primarily the biopsychosocial assessment, bear some resemblance to healthcare activities, the purposes of the DWI Program are far broader than the delivery of health care to an individual person. The purposes of the DWI Program are societal ones to provide a mandatory assessment and educational program for every person found guilty of driving while impaired and to offer an entryway to the healthcare system if it is needed and if the participant wants it.

[49] For all of the reasons stated here, on balance, I find that although one component of the DWI Program, the referral process, may offer "health care" within the meaning of s. 3(k) of *PHIA*, the personal health information at issue in this case was in a record primarily created for a purpose other than health care. NSH is also a public body within the meaning of *FOIPOP*. Therefore, s. 8(3) of *PHIA* dictates that the appropriate legislation that governs its actions with respect to the DWI Program is *FOIPOP* and not *PHIA*.

[50] I find the NSH was acting as a public body pursuant to *FOIPOP* when it delivered the DWI Program to the complainant.

[26] SNS 2014, c. 32.

2. Was the collection, use and disclosure of the complainant's personal information authorized by the applicable legislation?

[51] Prior to the complainant raising concerns, NSH relied on the concept of implied consent for its collection, use and disclosure practices relating to the DWI Program. In response to the complainant's concerns, NSH accepted that this approach was not sufficient and changed its practice to require express consent from DWI Program participants. NSH listened to the complainant's concerns and modified its practice in response. The question is whether this modification of its practice to request express consent was sufficient to bring NSH's actions into compliance with *FOIPOP*.

[52] On its face, the solution of requiring express consent rather than relying on implied consent seems to be an appropriate one. But the problem is, what is NSH to do in circumstances like the present one where the participant expresses that they do not wish to provide consent? For this case, NSH took the approach of noting the complainant's objections but continuing on with its collection, use and disclosure. While I don't doubt that this solution was a well intentioned one, the problem is that is it well established that forced consent cannot be considered as validly obtained consent.[27] Telling a participant that they must consent or not receive a service is not providing unforced choice. If the complainant had been asked for his consent and had been given the choice to say no but continue on with the DWI Program, that would have been voluntary consent. That was not the case here. In situations where a person refuses consent, a public body cannot simply note that and carry on. Rather, the public body must cease its collection, use and disclosure unless the legislation authorizes that collection, use and disclosure without consent.

[53] *FOIPOP* authorizes the collection, use and disclosure of personal information without the need for consent in certain limited circumstances. The reason for this is that government institutions need to collect significant amounts of information from citizens to provide government services. It would likely be unwieldy and inefficient to require express consent every time a public body collected, used or disclosed information needed to run a program.

[54] I will now conduct an analysis to determine whether NSH was authorized to collect, use and disclose the complainant's personal information without the complainant's consent for the purposes of the DWI Program.

Collection

[55] The DWI Program collects a wide range of personal information about participants from a number of sources. It collects information directly from participants and it collects information from others such as family and friends and other healthcare providers (called collaterals).

[27] See *R v. Bigsky*, 2016 SKPC 106 (CanLII) at para. 35 for the principle that forced consent is not consent in the criminal law context. See *Northwest Territories (Education, Culture and Employment) (Re)*, 2018 NTIPC 5 (CanLII) for the same principle in the context of access and privacy legislation.

[56] *FOIPOP* sets out the authority for public bodies to collect personal information as follows:

> 24 (1) Personal information shall not be collected by or for a public body unless
> (a) the collection of that information is expressly authorized by or pursuant to an enactment;
> (b) that information is collected for the purpose of law enforcement; or
> (c) that information relates directly to and is necessary for an operating program or activity of the public body.

[57] A public body is prohibited from collecting personal information unless it meets the criteria in at least one of the subsections of s. 24. Consent alone is not a basis on which a public body is authorized to collect personal information.

Section 24(1)(a): Express authorization in an enactment

[58] Did the *Motor Vehicle Act* and its *Regulations* expressly authorize the collection of personal information? The following are the relevant provisions of that legislation:

- Section 67(11) of the *Motor Vehicle Act* mandates that the Registrar "shall require that a person whose driver's license…has been revoked for an impairment-related offence involving alcohol…participate in such alcohol rehabilitation program as may be prescribed by regulation…".
- Section 2 of the *Alcohol Rehabilitation Program Regulations* defines "alcohol rehabilitation program" as "a program that is conducted, directed or promoted by a health authority established under the *Health Authorities Act* for a person whose driver's license has been revoked for an impairment-related offence involving alcohol…".
- Section 3(1) of the *Alcohol Rehabilitation Program Regulations* requires individuals to provide the Registrar with evidence of participation in an alcohol rehabilitation program and of satisfactory rehabilitation before consideration will be given to reinstatement of a driver's license.
- Section 3(2) of the *Alcohol Rehabilitation Program Regulations* permits the health authority to provide the evidence of satisfactory rehabilitation.

[59] Did these provisions of the legislation sufficiently provide express authorization for NSH to collect the complainant's personal health information for the purposes of the biopsychosocial assessment and risk rating? First, I note that s. 24(1)(a) of *FOIPOP* includes the qualifier "expressly". The *Black's Law Dictionary*[28] does not define "expressly" but does define "express" as, "Clearly and unmistakably communicated; directly stated." It also defines "expressed" as, "Declared in direct terms; stated in words; not left to inference or implication."

[60] Several cases in other jurisdictions have examined the threshold of the words "expressly authorized". In *Order No. PP-06-002*,[29] the Prince Edward Island (PEI) Information and Privacy Commissioner considered a case where a complainant claimed that the Workers Compensation

[28] Black's Law Dictionary, 8th ed, *sub verbo* "express" and "expressed".
[29] *Worker's Compensation Board (Re),* 2006 CanLII 39091 (PE IPC).

Board of PEI disclosed his personal information to his former employer without his consent. The PEI Commissioner rejected the Workers Compensation Board's argument that s. 56(4) of the PEI *Workers Compensation Act*[30] and the policies developed from them authorized this. The PEI Commissioner noted that s. 56(4) did not require any disclosure, nor did it authorize a disclosure of information. It simply stated that the procedure for reconsideration shall be determined by the Board. The PEI Commissioner found that this was insufficient authorization for disclosure of personal information to meet the threshold of "expressly authorized".

[61] In *Order F07-10*,[31] a school board required applicants for teaching positions to complete an online assessment whose purpose was to screen applicants for employment positions. The British Columbia (BC) Information and Privacy Commissioner rejected the public body's argument that s. 15 of the *School Act*[32] was specific enough to warrant authority to collect the personal information in the online assessment tool. The BC Commissioner acknowledged that it was implicit that the public body would have to collect personal information for the purpose of employing individuals. However, he found that did not meet the test under s. 26(a) of BC's *Freedom of Information and Protection of Privacy Act* (*FIPPA*), which authorized collection if it was expressly authorized under an Act. The BC legislation also allowed for collection of personal information pursuant to s. 26(c), which is if the information related directly to and was necessary for a program or activity of the public body. The BC Commissioner found that if, as the public body contended, broad enabling language of this nature were sufficient to provide express authority for s. 26(a) purposes, there would be no need for s. 26(c) of *FIPPA*.[33] He concluded that s. 15 of the *School Act* was not express enough to meet the threshold required by s. 26(a) of BC's *FIPPA*.

[62] In *Royal City Jewellers & Loans Ltd. v. New Westminster (City)*[34] the BC Court of Appeal canvassed whether s. 59(1)(b) of the *Community Charter*[35] was sufficiently express to mandate second-hand dealers to collect personal information from all persons from whom a second-hand article was received or bought and to disclose that information to the police. The Court of Appeal found that the public body had stretched the ordinary meaning of s. 59(1)(b) and the purpose it reflected beyond what it could reasonably bear. The Court stated, "However socially desirable such an initiative might be, the design of such a tool would ordinarily be influenced by considerations that underlie the provincial and federal privacy protection legislation and undoubtedly its authorization would be the express subject of a provision in the Community Charter".[36] The Court of Appeal concluded that the requirement to collect, record and transmit information to the police was beyond the organization's powers because it was not granted by the *Community Charter* or any other enactment.

[63] NSH asserted that there is no difference in what the DWI Program does and the immigration process which requires the collecting and sharing of applicants' medical

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[30] RSPEI 1988, c. W-7.1
[31] *Board of Education of School District No. 75 (Re)*, 2007 CanLII 30395 (BC IPC).
[32] *School Act*, RSBS 1996, c 412.
[33] *Board of Education of School District No. 75 (Re)*, 2007 CanLII 30395 (BC IPC) at paras 30-31.
[34] 2007 BCCA 398.
[35] S.B.C. 2003, c. 26.
[36] *Royal City Jewellers & Loans Ltd. V. New Westminster (City)*, 2007 BCCA 398.

information with immigration authorities.[37] With respect, there is a key and critical difference which is that the *Immigration and Refugee Protection Act*[38] and the *Immigration and Refugee Protection Regulations*[39] set out authority for the collection, use and disclosure of personal health information.[40] The RMV legislation does not contain express authority.

[64] The guidance I take from the dictionary meaning and the case law in other jurisdictions is that to meet the threshold of "expressly authorized", the wording of s. 24(1)(a) of *FOIPOP* requires very clear wording in another enactment. The *Motor Vehicle Act* and its *Regulations* imply that some form of personal information will be necessary to deliver the program to participants because the *Regulations* contemplate that NSH will be in a position to provide evidence of rehabilitation to the RMV. However, the legislation is silent on the extent of NSH's authority to collect personal information in order to develop this evidence. There is no provision in the *Motor Vehicle Act* or its *Regulations* that expressly authorizes the collection of personal information by the DWI Program.

[65] I find that NSH was not expressly authorized, within the meaning of *FOIPOP* s. 24(1)(a), to collect personal information for the DWI Program.

Section 24(1)(b): Law enforcement

[66] There was no suggestion made by any of the parties that the DWI Program or more specifically, the complainant's biopsychosocial assessment and risk rating, had any sort of law enforcement element. I am of the same view. I find that s. 24(1)(b) does not apply to this review.

Section 24(1)(c): Relates directly to and is necessary for a program or activity

[67] Section 24(1)(c) of *FOIPOP* allows NSH to collect personal information if that information relates directly to and is necessary for an operating program or activity of the public body. In order to qualify under s. 24(1)(c), NSH must show that the complainant's personal information it collected was both directly related to and necessary for the provision of the DWI Program.

Directly related to

[68] Determining whether the collection of personal information is directly related to an operating program requires a solid understanding of the program itself. For example, in *Order F14-26,*[41] a BC adjudicator found that when an employer collected reference information from a former employer of a job applicant without the job applicant's knowledge, that was found to be "directly related" to the operating program of making a hiring decision, although I note that that action was not found to be "necessary for" the program since the public body could have simply asked the applicant for further references.

[37] NSH submission, June 12, 2020.
[38] SC 2001, c. 27.
[39] SOR/2002-227.
[40] See s. 15-17 of the Act and s. 28-29 of the Regulations.
[41] 2014 BCIPC No. 29 at paras 31-32 and 48.

[69] To meet this test, NSH must establish that the collection of personal information from the complainant and from collaterals related directly to the program it was operating – the DWI Program.

[70] In the present case, I am satisfied that the collection of information about the complainant's relationship with alcohol and/or substances related directly to the activity of delivering the DWI Program. I accept that the collection of personal information about a participant's behaviours, attitudes and experiences with alcohol and/or substances is directly related to the DWI Program's activities of conducting its biopsychosocial assessment and risk rating. NSH's collection of the complainant's personal information therefore met the first part of s. 24(1)(c), as it related directly to the operating program or activity of running a DWI Program that conducts a biopsychosocial assessment and risk rating.

Necessary for

[71] Although the information collected about the complainant related to the delivery of the DWI Program, NSH was only authorized to collect that information if it was also "necessary for" the operation of the DWI Program.

[72] In Nova Scotia *Review Report 16-06*, former Commissioner Tully noted that it is appropriate to hold public bodies to a fairly rigorous standard of necessity.[42] Citing former BC Commissioner Loukidelis's *Order F07-10*, Commissioner Tully stated her agreement with the following criteria with respect to the use of the word "necessary" in *FOIPOP*:

- It is certainly not enough that personal information would be nice to have or because it could perhaps be of use some time in the future.
- Nor is it enough that it would be merely convenient to have the information.
- The information need not be indispensable.
- In assessing whether personal information is necessary one considers the sensitivity of the information, the particular purpose for the collection, and the amount of personal information collected in light of the purpose for collection.
- *FOIPOP*'s privacy protection objective is also relevant in assessing necessity, noting that this statutory objective is consistent with the internationally recognized principle of limited use.[43]

Collection from the complainant

[73] I have no doubt that the collection of personal information from the complainant himself about behaviours, attitudes and experiences with alcohol and/or substances was not only directly related to but also necessary for conducting the biopsychosocial assessment and risk rating components of the DWI Program. While the information collected was highly sensitive, my understanding is that collection was limited to information required to complete standardized assessment tools.[44]

[42] At para 44.
[43] *NS Review Report 16-06* at para 44.
[44] The tool used by NSH was called the RIASI test.

[74] The stated objectives of the DWI Program include working with participants to examine their alcohol and/or substance use, supporting them in making changes and ensuring they have a plan or strategy to avoid alcohol and/or substance use and driving. To deliver a program to the complainant that would achieve these objectives, the DWI Program needed to collect personal information from the complainant about his experience with alcohol and/or substance use. Furthermore, in order to deliver the evidence of rehabilitation contemplated by the *Regulations*, the DWI Program had to conduct its assessment based on information about the complainant. Clearly it was necessary for NSH to collect personal information from the complainant.

[75] I find that NSH was authorized under s. 24(1)(c) to collect personal information about the complainant's behaviours, attitudes and experiences with alcohol and/or substances from the complainant for the DWI Program.

Collection from collaterals

[76] Although I agree that the collection of personal information from the complainant was directly related to and necessary for the DWI Program's operation, can the same be said about the collection of personal information from other previous healthcare providers and from the complainant's social or family circle (collaterals)?

[77] In terms of assessing the sensitivity of the information, the DWI Program collected what is arguably the most sensitive personal health information about the complainant's medical history from his former healthcare providers and collected other sensitive information from his family and loved ones. The *Driving While Impaired Program: Preferred Practices* document outlines that the type of information collected from collaterals should cover the following:

- Driving record;
- Perception(s) of the client's involvement in the DWI Program by spouse/partner and family and/or others;
- Collateral sources' perception of the client's past and present drinking patterns; (including risk of impaired driving and need for additional treatment);
- Effects on the client's attitude regarding involvement in the DWI Program;
- Questionnaire (optional) – clinicians may ask a spouse/partner/family member to complete a standardized questionnaire if necessary and appropriate; and
- Opportunity to assess for other clinical concerns (e.g. gambling).

[78] The first step in assessing whether the collection of the complainant's personal information was necessary is to consider the particular purpose for the collection. The purpose of the collection is not set out in the RMV legislation and NSH is not operating under s. 24(1)(a) in any event. The *Driving While Impaired Program: Preferred Practices* document does not state the purpose for the collection but rather only sets out what is collected, as described in the paragraph above.

[79] In its representations, NSH explained that under the DWI Program, the reason for the collection of personal information and personal health information from collateral sources is to provide some information that is not provided directly by the participant who has a vested interest in not being as forthcoming in relation to their past history. NSH said that it would have

been impossible to complete an objective biopsychosocial risk assessment without having reviewed the complainant's medical history. It noted that if there were inconsistencies in the information, or in the information provided by the collaterals, that would have needed to be taken into account in any treatment recommendation.[45]

[80] I take NSH's point that objective information about the complainant's past history and behaviours with alcohol and/or substances may have been necessary to provide future treatment. But it is important to remember that treatment of a disease or health condition is not a mandatory component of the DWI Program. Healthcare treatments are provided on a voluntary referral basis. If the DWI Program refers a participant to rehabilitation or treatment services, those services are provided by another program or branch of NSH. Furthermore, the complainant in the case at hand was not referred to rehabilitation or treatment services and did not receive any healthcare treatment.

[81] In my view, the purpose of the collection of the complainant's personal information from the collaterals was not to enable the provision of further treatment but to test the veracity of what the complainant was saying and so that NSH would have an objective means against which to compare the complainant's description of his past/current relationship with alcohol and/or substances, with the overall goal being the delivery of evidence of satisfactory rehabilitation to the RMV.

[82] The question this argument raises is why can't NSH rely on the information supplied by the complainant? Much research has shown that self-reporting measures of alcohol and/or substance use are generally reliable and valid,[46] although there is a study that suggests that self-reported substance use may not be as reliable as earlier thought.[47] In other words, NSH was authorized to collect this information directly from the complainant, which was more likely than not a reliable source from which to gather the information needed to do the biopsychosocial assessment and risk rating. NSH provided no evidence for why the complainant's self-reported information might not be reliable aside from simply asserting that was the case. Absent that evidence and with the literature suggesting that self-reported information can be reliable, I am not convinced that it was necessary to also collect information from collaterals. That was particularly the case for the social or family circle collaterals of the complainant, who had no employment or professional obligations to ensure they were providing truthful, objective information about him. An assertion could equally be made that social or family circle collaterals might not provide accurate or even truthful information about the applicant. Furthermore, as discussed more in-depth under the heading "Section 26(a)" below, there are likely multiple ways that the NSH could structure the DWI Program in order to assess and provide evidence of satisfactory rehabilitation. However, the

[45] NSH submission, June 12, 2020, at pg. 4-5.
[46] See for example: Harrison ER, Haaga J, Richards T. Self-reported drug use data: what do they reveal? *Am. J. Drug Alc. Abuse.* 1993;19:423–441; O'Malley PM, Bachman TE, Johnston LD. Reliability and consistency of self-reports of drug use. *Int. J. Addict.* 1983;8:805–824; Johnson ME, Fisher DG, Montoya I, Booth R, Rhodes F, Andersen M, Zhuo Z, Williams M. AIDS and Behavior 2000: 4, 373-380; and Napper LE, Fisher DG, Johnson ME, Wood MM. The reliability and validity of drug users' self reports of amphetamine use among primarily heroin and cocaine users. *Addict Behav*. 2010: Apr 35(4): 350.
[47] Harrison L, The validity of self-reported drug use in survey research: an overview and critique of research methods. *NIDA Res Monogr*. 1997; 167: 17-36.

collection of personal information being done by the DWI Program does not appear to be directly related to assessing rehabilitation in any event.

[83] While it might have been nice to have a secondary source against which to compare the complainant's past history, it was not necessary to have this collateral information to deliver the DWI Program, particularly in light of the fact that no treatment referral was made. Thus, I find that the collection of the complainant's personal information from collateral sources was not necessary for the completion of the DWI Program's biopsychosocial assessment and risk rating.

[84] I therefore find that NSH was not authorized to collect the complainant's personal information from collateral sources for the DWI Program.

Use

[85] In addition to collecting new personal information, the DWI Program also delved into the complainant's existing medical record. By the time the complainant had arrived for his biopsychosocial assessment, the assessor had already reviewed his entire medical record held by NSH. User access logs obtained from NSH by the complainant document that the assessor accessed significant numbers of medical visits, health care encounters, and diagnostic results, containing highly sensitive and potentially embarrassing information spanning more than a decade of the complainant's life, most of which appeared unrelated to alcohol and/or substances. A viewing of the health record already in the custody and control of the public body, as was the case here, is considered to be a "use" as opposed to a "collection" because the information had already been collected and was stored in the complainant's medical record.

[86] Section 26 of *FOIPOP* sets out when public bodies may use personal information:

> 26 A public body may use personal information only
> (a) for the purpose for which that information was obtained or compiled, or for a use compatible with that purpose;
> (b) if the individual the information is about has identified the information and has consented, in the prescribed manner, to the use; or
> (c) for a purpose for which that information may be disclosed to that public body pursuant to Sections 27 to 30.

<u>*Section 26(a)*</u>

[87] Section 26(a) allows a public body to use personal information for the purpose for which it was collected or for a use compatible with that purpose. *FOIPOP* helpfully provides guidance on what should be meant by "compatible use":

> 28 A use of personal information is a use compatible with the purpose for which the information was obtained within the meaning of Section 26 or 27 if the use
> (a) has a reasonable and direct connection to that purpose; and
> (b) is necessary for performing the statutory duties of, or for operating a legally authorized program of, the public body that uses the information or to which the information is disclosed.

[88] My understanding from NSH's representations is that under the DWI Program, there are two predominant purposes to viewing or "using" the medical record: (1) as a corroborating tool to determine if the participant was being truthful with regard to alcohol and/or substance use, and (2) to complete the biopsychosocial assessment.

[89] With regard to the first purpose, in support of its use of the existing medical record, NSH said that the record was viewed to "verify veracity".[48] The NSH argued that it was impossible to complete an accurate biopsychosocial risk assessment in an objective way without reviewing relevant portions of the participant's medical history.[49] It said that the reason for the use of the complainant's information was because it provided a more objective source of data. NSH noted that participants have a vested interest in not being as forthcoming in relation to past history. NSH said that if there were inconsistencies in the information, that would have needed to be considered in any treatment recommendation.[50]

[90] NSH claimed that under the DWI Program, the second purpose of the use of the existing medical record is to support the development of the biopsychosocial assessment. NSH explained that under the DWI Program, the existing medical record is viewed to help complete the biopsychosocial assessment because it offers empirical data whereas the majority of the tools used for the DWI Program are self-reporting ones. NSH said, "This helps to build a stronger clinical impression in which the risk rating can be based and form treatment recommendation (sic) to support the client should they wish to process these (sic) after the program is complete.[51] NSH also said that under the DWI Program, the medical record is viewed to enable it to establish an accurate clinical picture of the extent of the participant's current and prior involvement with substances.[52] In addition, NSH submitted that it is impossible to complete an accurate biopsychosocial assessment regarding an individual's experience with harmful substances in an objective way without reviewing relevant portions of a participant's medical history.[53]

[91] In my view, for the reasons that follow, the use of the complainant's medical record in this fashion was not the purpose for which that information was obtained or compiled, nor was it for a compatible purpose.

[92] Medical records exist because of and for health care, with very limited other uses and disclosures permitted. When NSH originally collected the complainant's personal health information, it was done in the course of providing the complainant with healthcare services. The information that already existed in the medical record was created for the purpose of providing health care, not for the purpose of allowing NSH to later corroborate information provided by the complainant should he end up being involved in the DWI Program.

[93] NSH is tasked with delivering a rehabilitation program and is authorized to give over evidence of satisfactory rehabilitation of participants to the RMV. NSH does this in the form of a

[48] NSH submission, Dec 20, 2019 (response to question #13b).
[49] NHS submission, June 12, 2020 (at pg. 4).
[50] NSH submission, June 12, 2020 (at p. 5).
[51] NSH submission, Dec 20, 2019 (response to question #12).
[52] NSH submission, Nov 14, 2019 (response to question #13).
[53] NSH submission, June 12, 2020 (at p. 4).

risk rating. The risk rating disclaimer states that it is, "based almost exclusively on self-report information provided by the client at a specific point in time regarding his/her current and past behaviors, attitudes and experiences." NSH's representations emphasized that the biopsychosocial assessment and risk rating are "to determine if a participant has a low, medium, or high risk of harmful involvement with substances at the point in time of the Assessment. The risk rating addresses the participants (sic) current relationship with substances and their commitment to attitudinal and lifestyle changes."[54]

[94] NSH's representations that the assessment is focused on the participants' current relationship with alcohol and/or substances weighs in favour of the view that the participants' past medical records are neither directly related to nor necessary for the task.

[95] It is also important to step back and remember that the DWI Program originates out of the statutory foundation of the RMV legislation. This legislation contemplates NSH offering an alcohol rehabilitation program and supplying the RMV with evidence of satisfactory rehabilitation. Rehabilitation is not defined in the RMV legislation. Black's Law Dictionary defines rehabilitation in the criminal law context as "The process of seeking to improve a criminal's character and outlook so that he or she can function in society without committing other crimes <rehabilitation is a traditional theory of criminal punishment, along with deterrence and retribution>."[55] The World Health Organization defines rehabilitation as *"*a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment".[56] The Merriam-Webster Dictionary defines rehabilitation as "the action, process, or result of rehabilitating or of being rehabilitated: such as a: restoration especially by therapeutic means to an improved condition of physical function; b: the process of restoring someone (such as a criminal) to a useful and constructive place in society; c: the restoration of something damaged or deteriorated to a prior good condition."[57] The common theme among these definitions is the idea of there being an intervention of some sort and then a different behavioural outcome following the intervention.

[96] Surprisingly, NSH repeatedly and consistently claimed that under the DWI Program, it does not provide rehabilitation services and that the risk rating is not evidence of satisfactory rehabilitation. For example, NSH was asked what is involved in the biopsychosocial assessment and how it provides evidence of "satisfactory rehabilitation". In response NSH stated:

> The Program does not provide rehabilitation services to the participants and does not measure or assess the level of rehabilitation. As noted above, the Program consists of a one-day Group Education Session and an individual Alcohol and Drug Assessment. The purpose of the Assessment is to determine if a participant has a low, medium, or high risk of harmful involvement with substances at the point in time of the Assessment. The risk rating addresses the participants (sic) current relationship with substances and their commitment to attitudinal and lifestyle changes, but should not be interpreted as

[54] NSH submission Nov 4, 2019 (response to question #7).
[55] *Black's Law Dictionary*, 8th ed, *sub verbo* "rehabilitation".
[56] WHO, *Rehabilitation*, 2020, https://www.who.int/news-room/fact-sheets/detail/rehabilitation.
[57] Merriam-Webster, *Rehabilitation*, https://www.merriam-webster.com/dictionary/rehabilitation.

> predicting the likelihood of reoffending as an impaired driver or determining level of rehabilitation of the participant.[58]

[97] After receipt of the response, NSH was further pressed and asked by my office, given the above statements, to described how the DWI Program meets the requirements of the *Alcohol Rehabilitation Programs Regulations* to provide an alcohol rehabilitation program and how participation in the program could equip a participant with evidence of satisfactory rehabilitation. NSH's response was:

> The current process being offered by NSH is in keeping with the decisions made by the Provincial Driving While Impaired Committee and as per the responses to questions 1 and 4 above, it describes the processes to be followed by MHA (sic) under the DWI Program. According to the Manager representing the Department of Health promotion and Protection at the time, the risk rating letter was a component requested by RMV as a means to verify that the client had completed the DWI Program and as a measure of risk of the likelihood that the client was harmfully involved with substances (low, medium or high)…[59]

[98] For all participants, this is reflected in the completion letter which is sent from NSH to the RMV. The completion letter includes the following disclaimer:

> The risk rating provided is a clinical opinion only. It is based almost exclusively on self-report information provided by the client at a specific point in time regarding his/her current and past behaviors, attitudes and experiences. This rating is therefore not intended or believed, by the Addiction Services Program, to be an accurate prediction of future behavior. Any such assumption of predictive validity would be unfounded and would be a misinterpretation of this document. It is further understood that this rating does not present a decision or a recommendation regarding the issuance of a driver's license. Such decisions are the exclusive responsibility of the Registry of Motor Vehicles, Nova Scotia Department of Business and Consumer Services. Therefore, neither the undersigned clinician or Program Manager individually, nor the Addiction Services Program, nor the District Health Authority accept any responsibility for any decision made regarding the issuance of a drivers license by the Registry of Motor Vehicles to the client referred to in this document, nor is any responsibility accepted by these parties for any effect, results, or subsequent events related to such decisions.
>
> RISK SCALE
> This risk guideline addresses the commitment of the client to attitudinal and lifestyle change and should not necessarily be interpreted as predicting the likelihood of re-offending as an impaired driver.
>
> - LOW RISK to repeat alcohol/drug related problem behavior in light of attitudinal and lifestyle changes initiated by the client prior to and/or during the course of treatment.

[58] NSH submission, Nov 4, 2019 (response to question #7).
[59] NSH submission, Dec 20, 2019 (response to question #9a).

- MEDIUM RISK to have alcohol/drug related problems because some attitudinal and lifestyle changes were initiated by the client prior to and/or during the course of treatment, but more progress is advisable.
- HIGH RISK to repeat alcohol/drug related problems because attitudinal and lifestyle change initiated by the client prior to and/or during the course of treatment is very minimal or nonexistent.

[99] The Regulations under which NSH delivers the DWI Program set out that one of the roles of the program is to assess "evidence of satisfactory rehabilitation". In its own words, NSH does not use the medical record to achieve that goal. Rather, NSH used or viewed the complainant's medical record before he arrived to take the program, delivered the program, then quite quickly developed a risk rating based on all of the information collected. With the program structured that way, the information viewed in the medical record supplies only evidence of the complainant's engagement with substances *prior to* the rehabilitation services being offered. Viewing of the medical record at this point in time supplies no information on the effectiveness of the intervention. Furthermore, NSH does not appear to use the medical record to assess a change in the participant's risk following the intervention provided by the DWI program. The consultation of the medical record was not related to the provision of rehabilitation or treatment and the medical record was not used as an objective source against which to measure the complainant's rehabilitation. As such, it was not necessary for operating the DWI Program.

[100] The purpose of the DWI Program is not health care; it is part of a statutorily created administrative process. Medical records exist because of and for health care, with very limited other uses and disclosures permitted under *PHIA*. There is a wide gulf between these purposes. I cannot see a reasonable and direct connection between granting unfettered access to the complainant's medical record prior to the complainant receiving rehabilitation or treatment services. Based on the same reasoning as set out in the collection section above, I am not convinced that granting the DWI Program carte blanche access to participants' medical records to pick and choose information to import into its assessment is directly related to or necessary for the DWI Program's operation.

[101] For all of these reasons, I find that the DWI Program is not a compatible use for information originally collected in the course of providing health care.

[102] I find that NSH was not authorized under s. 26(a) of *FOIPOP* to use the complainant's personal health information contained in the medical record in the custody and control of NSH for the DWI Program.

Section 26(b)

[103] Section 26(b) would have allowed NSH to use the medical record if the complainant had consented to that use. The *FOIPOP Regulations* state that to be valid, the consent must be in writing, identify the information and specify to whom the information may be disclosed and how the information may be used.[60] As I already said above, the consent obtained from the complainant was not voluntary.

[60] Section 8, *Freedom of Information and Protection of Privacy Regulations*, S.N.S. 1993, c. 5.

[104] I find that NSH was not authorized under s. 26(b) of *FOIPOP* to use the complainant's personal health information contained in the medical record in the custody and control of NSH for the DWI Program.

Section 26(c)

[105] Lastly, NSH may use the medical record for a purpose for which that information may be disclosed to that public body pursuant to ss. 27 to 30 of *FOIPOP*. In other words, if one of these sections authorized disclosure to NSH, then NSH was entitled to use that which was disclosed to it.

[106] There are 17 subsections in s. 27. I will not go through them all here as in my view, none of them applied to this situation and therefore this section does not establish that the DWI Program had authority to use information within the complainant's medical record held by NSH.

[107] I find that the DWI Program was not authorized under s. 26(c) of *FOIPOP* to use the complainant's personal health information contained in medical record in the custody and control of NSH.

[108] Having not found authority under *FOIPOP* ss. 26 (a) (b) or (c), I find that NSH was not authorized to use the complainant's personal health information contained in the medical record in the custody and control of NSH for the DWI Program.

Disclosure

[109] The last question is whether NSH was authorized to disclose the complainant's risk rating to the RMV. Section 27 of *FOIPOP* lists 17 situations under which NSH may disclose personal information. Of those sections, s. 27(c) authorizes NSH to disclose personal information for the purpose for which it was obtained or compiled, or a use compatible with that purpose.

[110] In this case, the information the DWI Program was authorized to collect (i.e., the collection directly from the complainant only) was done so for the specific purpose of delivering the DWI Program's biopsychosocial assessment and risk rating. The assessment and risk rating were compiled for the DWI Program and the disclosure of information about the complainant's "rehabilitation" was expressly provided for in the *Alcohol Rehabilitation Programs Regulations.* On a general program level, I am satisfied that there is authority under s. 27(c) to disclose the risk rating to the RMV if doing so for the purpose that it was obtained or compiled.

[111] I find that the DWI Program in general is authorized under s. 27(c) of *FOIPOP* to disclose "evidence of satisfactory rehabilitation" in the form of its risk rating to the RMV.

[112] However, in this case, I must consider that I have now found that NSH exceeded its authority to collect and use information when it prepared the risk assessment about the complainant that it disclosed to the RMV. Therefore, in this case, because the risk rating was based on information that the DWI Program was not authorized to collect and use, it could not then be authorized to disclose that information to the RMV. I find that in the case of this

complainant, NSH was not authorized to disclose the complainant's personal information in the form of the risk rating to the RMV.

CONCLUSION:

[113] In conclusion, this review raised, in a very complex way, how difficult it can be to balance competing privacy and public safety rights. There are many times that privacy rights must necessarily be impacted in the greater public good. Preventing people from driving while under the influence of alcohol and/or substances is one of those times.

[114] The purpose and objectives of the DWI Program are societally important. That being said, *FOIPOP* is clear that personal information can only be collected, used and disclosed in accordance with its provisions.

[115] In the complainant's view, it is a deterrent to seeking health care, particularly for sensitive mental health issues, if the personal health information is then made available for other purposes. In response to this concern of the complainant, NSH noted that s. 38(1)(a-u) of *PHIA* outlines a number of circumstances under which personal health information may be used[61] without consent, many of which relate to legal proceedings which, NSH said, could be considered similar to the DWI Program. NSH wrote, "It stands to reason that an individual would be better served to not break the law rather than be concerned that their health information be used against them in a legal proceeding."[62]

[116] I find it is necessary to comment on this statement, although it is not necessary for me to reach my conclusions in this review.

[117] The Supreme Court of Canada has recognized the importance of protecting the sanctity of personal health information that is collected for the purpose of providing health care in the criminal case of *R. v. Dyment*.[63] In that case, a physician took a blood sample from a patient for the purpose of delivering health care but then handed it over to the police for its purpose in attempting to charge that patient with drinking and driving. The Court acknowledged the real possibility of a chilling effect on individuals' likelihood to trust healthcare providers and to seek health care if they fear the information they provide will be used later for other, unrelated purposes outside of the well-known and recognized procedures for obtaining such evidence, such as seeking a duly authorized search warrant.

[118] NSH's commentary is stark in demonstrating its misunderstanding of its authority. It shows that NSH has not fully considered the limited extent of its authority or the statutory purpose of the DWI Program being administered. People who have been charged or convicted of a crime do not lose the protections afforded to them under *FOIPOP* or *PHIA*. Public bodies and custodians who have custody and control of sensitive personal information must be mindful of their statutory authority and must have policies and processes in place to safeguard against

[61] Note that s. 38 of *PHIA* speaks to disclosure and not use.
[62] NSH submission, June 12, 2020.
[63] *R. v. Dyment*, [1988] 2 SCR 417.

unauthorized collection, use (access) and disclosure. Accordingly, I have set out a recommendation to conduct a privacy impact assessment for the DWI Program below.

[119] I have two final observations. The first is the fact that the documentation related to an individual's participation in the DWI Program is kept in their medical record. This does not seem appropriate given its administrative and non-health care primary purpose and as such I have included a recommendation in this regard.

[120] The second observation I have is with respect to the draft *Driving While Impaired: Preferred Practices* document, dated 2012, that NSH supplied to my office. I note that the document is labelled 'draft' and clearly is a draft as it contains typos and spots where commentary ends mid-sentence. This document is not available online for participants to view. It concerns me that a program that collects, uses and discloses personal information is based on a draft policy document that is not public and that is clearly not complete even though it is over nine years old. Furthermore, that document does not set out the statutory authority for NSH's collection, use and disclosure practices. Accordingly, I have set out a recommendation about finalizing the policy below.

FINDINGS & RECOMMENDATIONS:

[121] I set out here a summary of my findings from this complex review and my corresponding recommendations.

Findings

1. I find that the personal health information at issue was in a record primarily created for a purpose other than health care.
2. I find the NSH was acting as a public body pursuant to *FOIPOP* when it delivered the DWI Program to the complainant.
3. I find that NSH was not expressly authorized, within the meaning of *FOIPOP* s. 24(1)(a), to collect personal information for the DWI Program.
4. I find that s. 24(1)(b) does not apply to this review.
5. I find that NSH was authorized under s. 24(1)(c) to collect personal information about the complainant's behaviours, attitudes and experiences with alcohol and/or substances from the complainant for the DWI Program.
6. I find that NSH was not authorized to collect the complainant's personal information from collateral sources for the DWI Program.
7. I find that NSH was not authorized under s. 26(a) of *FOIPOP* to use the complainant's personal health information contained in the medical record in the custody and control of NSH for the DWI Program.
8. I find that NSH was not authorized under s. 26(b) of *FOIPOP* to use the complainant's personal health information contained in the medical record in the custody and control of NSH for the DWI Program.
9. I find that the DWI Program was not authorized under s. 26(c) of *FOIPOP* to use the complainant's personal health information contained in the medical record in the custody and control of NSH.

10. I find that the DWI Program in general is authorized under s. 27(c) of *FOIPOP* to disclose "evidence of satisfactory rehabilitation" in the form of its risk rating to the RMV.
11. In this case, because of my finding that the risk rating was based on information the DWI Program was not authorized to collect and use, I find that NSH was correspondingly not authorized to disclose this particular complainant's risk rating.

Recommendations

[122] I recommend that:

1. NSH request the retraction of the complainant's original risk rating it disclosed to the RMV within three months of the date of receipt of this review report.
2. NSH re-offer the complainant the opportunity to undergo a new biopsychosocial assessment that is developed based only on information the DWI Program is authorized to collect and use within three months of the date of receipt of this review report.
3. NSH conduct a privacy impact assessment of the DWI Program within six months of the date of receipt of this review report. The assessment must include consideration of the stigma and potential negative consequences of storing the records created primarily for a non-healthcare purpose about DWI Program participation combined with participants' medical records.
4. NSH publish an updated and final policy document that clearly sets fulsome procedures and guidelines for the collection, use and disclosure of personal information by the DWI Program in light of the privacy impact assessment and this review report within one year of the date of receipt of this review report.

June 16, 2021

Tricia Ralph
Information and Privacy Commissioner for Nova Scotia