Osgoode Hall Law Journal

Volume 29
Issue 4 *Volume 29, Number 4 (Winter 1991)*

Article 4

10-1-1991

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Abstract

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Keywords

Mental health laws; Involuntary treatment--Law and legislation; Forensic psychiatry; Canada

MENTAL HEALTH LAW AND THE COURTS©

BY ISABEL GRANT*

This paper presents an analysis of the early *Charter* cases dealing with civil commitment and compulsory treatment of individuals under provincial mental health legislation. The author describes two models for dealing with these issues: the paternalistic model and the social control model. She argues that Canadian courts have adopted a paternalistic approach and, as such, have failed to recognize the adversary relationship between the state and the individual which forms the basis of involuntary psychiatry. Courts have thus failed to develop the kinds of procedural protections that are available in the criminal law context. The author proposes that courts making decisions dealing with civil mental health issues should rely less on paternalism and recognize the serious deprivations of liberty at stake for individuals in the mental health system.

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* Assistant Professor, Faculty of Law, University of British Columbia. This paper was made possible through funding from the Foundation for Legal Research and the Arthur and Myrtle Lord Memorial Fund. I would like to thank Tara Campbell and Tamara Hunter for their research assistance. I would also like to thank Christine Boyle, Robin Elliot, Tom Kemsley, Bruce MacDougall, and Lynn Smith, all of whom made helpful suggestions on various drafts of this paper. Special thanks to both Masaru Kohno and Judith Mosoff.

> Of all tyrannies a tyranny sincerely exercised for the good of its victims may be the most oppressive.[1]
>
> C.S. Lewis

I. INTRODUCTION

The power to commit an individual involuntarily to a psychiatric facility is among the most intrusive of all state powers. Traditionally, there have been two rationales provided for the state's authority to involuntarily hospitalize and treat persons with mental disabilities.[2] One rationale is based on the state's obligation to protect individuals within its jurisdiction who are unable to protect themselves. This rationale is premised on the individual being incapable of caring for himself or herself or of making decisions about his or her own welfare. I will refer to this rationale as the "paternalistic" model of mental health law. The second rationale for civil commitment is premised on the state's role in maintaining public order. The state deprives one individual of liberty in order to protect the welfare and safety of other members of society. I will refer to this rationale as the "social control" model of mental health law.

This paper uses these two models as a conceptual framework for examining recent developments in mental health jurisprudence. The paper begins with an attempt to clarify the underlying

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[1] "The Humanitarian Theory of Punishment" (1953) 6 Res Judicatae 224 at 228.

[2] This paper will be limited to the consideration of individuals involuntarily detained in psychiatric facilities. My focus is on the civil commitment process, but occasional reference will be made to cases involving individuals detained in psychiatric facilities through the criminal justice system. The criticisms presented in this paper are limited to involuntary psychiatry and are not intended to extend to persons who voluntarily seek psychiatric hospitalization or treatment.

assumptions of each rationale. Because these models evolved in American jurisprudence, I will illustrate the implications of a court adopting one rationale over the other by contrasting decisions of the United States' Supreme Court in the area of civil commitment with decisions dealing with forced treatment. I then move on to consider the emerging Canadian jurisprudence on mental health law under the *Canadian Charter of Rights and Freedoms*.[3] I will argue that Canadian courts have been overly reliant on a paternalistic model of mental health law and that such reliance has led to the under-development of procedural protections for individuals facing involuntary commitment.

II. PATERNALISM AND SOCIAL CONTROL

The distinction between a paternalistic justification for civil commitment and some sort of state coercive authority to detain an individual in order to protect others is a very important one in mental health case law. How a court perceives the justification for commitment and forced treatment will often determine the result reached in a particular dispute.

A paternalistic model of civil commitment justifies involuntary hospitalization on the basis of preventing harm to the individual involved. It assumes that all parties involved share a common interest, *i.e.*, the best interest of the incompetent person. In the paternalistic model, everyone is perceived to be working towards the same end. Courts using a paternalistic model give little attention to individual rights and the consequential development of procedural protections because "rights" are considered important only when there is a perceived conflict between the state and the individual.

Once a court accepts this rationale for involuntary hospitalization or forced treatment, it must determine who should decide what is in the incompetent person's best interest. The assumption is made that, if the individual involved is "mentally ill," the psychiatrist has the expertise to make decisions about the person's best interest. The issue is thus constructed primarily as a

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[3] Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter *Charter*].

medical one. Both the legislatures and the courts delegate extensive authority to the psychiatric profession to determine what is best for the individual.[4]

A social control model, on the other hand, justifies involuntary hospitalization on the basis of a risk of harm to other members of the community. Because the state is acting to deprive one person of liberty for the benefit of others, conflicting interests are likely to be identified and more concern may be given to protecting the rights of the individual facing commitment, usually in the form of procedural protections. Further, because of the adversarial nature of the relationship between the individual and the state and thus the similarities to criminal law, the courts are more likely to recognize their own competence to develop procedural protections for the individual.

The distinction between these two models in mental health case law originated in United States jurisprudence. In the United States, each state has jurisdiction over criminal law (referred to as the police power), as well as a residual *parens patriae* power to protect those within its jurisdiction who are unable to protect themselves. Prior to the 1960s, the *parens patriae* rationale typified the approach to mental health law in the United States. It was not until the dawning of the civil rights era that American courts began

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[4] This paper takes no position on the value of particular doctors or psychiatric treatments in individual cases. However, because both the social control and the paternalistic models are based in part on claims that psychiatrists hold expertise in certain matters relevant to legal decisions about commitment and treatment, it is important to be aware that this expertise has its limits. For example, empirical studies have shown psychiatrists to be unable to detect persons feigning mental illness inside a mental hospital. See D.L. Rosenhan, "On Being Sane in Insane Places" (1973) 179 Science 250. Psychiatrists have also been shown to be highly influenced by previous diagnoses and unable to predict reliably which individuals present a danger to themselves or others. See J.J. Cocozza & H.J. Steadman, "The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence" (1976) 29 Rutgers L. Rev. 1084; A.M. Mesnikoff & C.G. Lauterbach, "The Association of Violent Dangerous Behaviour with Psychiatric Disorders: A Review of the Research Literature" (1975) 3 J. Psych. & L. 415; and B.L. Diamond, "The Psychiatric Prediction of Dangerousness" (1974) 123 U. Pa. L. Rev 439.

The primary treatment used in involuntary psychiatry is medication. While psychotropic medication may alleviate the symptoms of mental illness in some cases, the side-effects may be very unpleasant, sometimes permanent, and occasionally fatal. It is virtually impossible for psychiatrists to predict in advance who will suffer permanent long term damage from this medication.

applying the *Bill of Rights*[5] in the mental health law context. In criminal law, the courts were taking a more expansive approach to the constitutional rights of accused persons.[6] This new concern about rights in criminal law slowly spread into the mental health law field. Courts began to recognize that civil commitment entails a serious deprivation of liberty and that "treatment"-oriented paternalism could not replace due process protections.

The labels of *parens patriae* power and police power cannot be transferred directly to Canada because provincial governments, which have all legislated on mental health issues, have no power to enact criminal laws, nor do they have power beyond that given to them by section 92 of the *Constitution Act, 1867*.[7] However, the distinction between paternalistic and social control models is still a useful one in Canadian mental health law since all provinces do detain individuals on the basis of some form of risk to self and/or to others. Provinces do have the jurisdiction to make laws to protect local interests and property and civil rights within the province, and the courts have held consistently that civil commitment is within provincial jurisdiction.[8]

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[5] U.S. CONST. amend. I-X.

[6] See, for example, *Mapp* v. *Ohio*, 367 U.S. 643 (1961) and *Miranda* v. *Arizona*, 384 U.S. 436 (1966).

[7] (U.K.), 30 & 31 Vict., c. 3 (formerly *British North America Act, 1867*). The state's authority to care for individuals unable to care for themselves originated in the concept of the *parens patriae* authority of the sovereign and, by section 96 of the *Constitution Act, 1867*, has also been delegated to superior courts in Canada.

[8] See, for example, *Fawcett* v. *A.G. Ontario*, [1964] S.C.R. 625 upholding the Ontario *Mental Hospitals Act*, R.S.O. 1960, c. 236. More recently, in *Schneider* v. *R.*, [1982] 6 W.W.R. 673 at 697-98, the Supreme Court of Canada held that the province of British Columbia does have the jurisdiction to impose mandatory treatment (and sometimes hospitalization) for heroin addicts. The Court held that the *Heroin Treatment Act*, R.S.B.C. 1979, c. 166 was valid provincial law and did not intrude on the federal criminal law power. Dickson J. (as he then was) indicated that provinces have jurisdiction over issues involving public health under section 92(16) of the *Constitution Act, 1867*, which deals with power over matters of a local or private nature within the province. He stressed that hospitalization under the *Act* was for medical, not punitive purposes. He stated:

> The compulsory aspects of this intervention are incidental to the effectiveness of the treatment, narcotic addiction by its very nature being a compulsive condition over which the individual loses control. Although coercion will obviously play a significant role, it seems to me that the dominant or most important characteristic of the Heroin Treatment Act is the treatment and not the coercion ... The

III. THE TWO MODELS IN PRACTICE: AN AMERICAN EXAMPLE

The areas of civil commitment and forced treatment provide a useful contrast in illustrating the differences ensuing from the adoption of one model over the other in the context of American mental health law. In commitment cases, the Supreme Court has relied primarily on the social control model and insisted on procedural protections for an individual facing civil commitment. However, when dealing with forced treatment, an issue that is unique to the psychiatric context, the paternalistic model is more evident as the Court delegates to the psychiatric profession the power to make decisions about who will be forcibly medicated.[9]

A. *Civil Commitment*

The watershed case for the rejection of a paternalistic model was the United States Supreme Court decision in *Re Gault*.[10] While *Gault* involved the rights of a juvenile institutionalized in a detention centre, the case had important implications for future cases on civil commitment.[11] Prior to *Gault*, the law dealing with

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legislature is endeavouring to cure a medical condition, not to punish a criminal activity.

A province could not pass a law ordering the incarceration of someone it believed might be dangerous to others unless the source of that danger was medical, such as the power to quarantine or the power to civilly commit those with an alleged "mental illness."

[9] I will not be reviewing the extensive literature on the dangers (or the potential benefits) of anti-psychotic medications. This paper does not assume that anti-psychotic medication is always good nor always bad. Rather, the assumption is that some persons may prefer the effects of medication to their "mental illness," while others may reasonably prefer the non-medicated state. The important point is that there is a choice to be made and that the choice will not always be obvious. See S.J. Morse, "A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered" (1982) 70 Calif. L. Rev. 54 and S.J. Morse, "Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law" (1978) 51 S.C.L. Rev. 527.

[10] 387 U.S. 1, 18 L. Ed. 2d 527 (1967) [hereinafter *Gault* cited to L. Ed.].

[11] *Gault, ibid.* has been cited by the Supreme Court in several mental health cases. See, for example, *O'Connor* v. *Donaldson*, 422 U.S. 563, 45 L. Ed. 2d 396 at 410 (1975) [hereinafter *O'Connor* cited to L. Ed.]; *Addington* v. *Texas*, 441 U.S. 418, 60 L. Ed. 323 at 331

juvenile offenders had been based on a paternalistic model, focusing on the rehabilitation of the child rather than on punishment.[12] The premise that any limits on the liberty of the child were for his or her own interest led the legislatures and courts to disregard due process requirements. In *Gault*, the Court described the paternalistic attitude historically taken towards children and explained how such paternalism has served to disadvantage its supposed beneficiaries in the legal system:

> The child – essentially good, as they saw it – was to be made "to feel that he is the object of [the state's] care and solicitude," not that he was under arrest or on trial. The rules of criminal procedure were therefore altogether inapplicable. The apparent rigidities, technicalities, and harshness which they observed in both substantive and procedural criminal law were therefore to be discarded. The idea of crime and punishment was to be abandoned. The child was to be "treated" and "rehabilitated" and the procedures, from apprehension through institutionalization, were to be "clinical" rather than punitive.[13]

In the same vein, the Court stated:

> Accordingly, the highest motives and most enlightened impulses led to a peculiar system for juveniles unknown to our law in any comparable context. The constitutional and theoretical basis for the peculiar system is – to say the least – debatable. And in practice as we remarked in the *Kent* case, *supra*, the results have not been entirely satisfactory. Juvenile Court history has again demonstrated that *unbridled discretion, however benevolently motivated, is frequently a poor substitute for principle and procedure.*[14]

In rejecting a paternalistic approach, the Court held that, because delinquency proceedings could result in commitment to a state institution, a liberty interest was at stake and thus that the juvenile was entitled to due process protections under the Fourteenth Amendment.

The express recognition in *Gault* that "the essentials of due process may be a more impressive and more therapeutic attitude

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(1979) [hereinafter *Addington* cited to L. Ed.]; and *Parham* v. *J.R.*, 442 U.S. 584, 61 L. Ed. 2d 101 at 117 (1979).

[12] This same pattern took place in Canada with the repeal of the paternalistic *Juvenile Delinquents Act*, R.S.C. 1970, c. J-3 and the enactment of the *Young Offenders Act*, R.S.C. 1985, c. Y-1 which focused more on the rights and responsibilities of the young person.

[13] *Supra*, note 10 at 539 (citations omitted).

[14] *Ibid.* at 540-41 (citations omitted, emphasis added).

[than discretion] so far as the juvenile is concerned" had important implications for mental health law.[15] *Gault* signified a recognition on the part of the Court that good intentions cannot overcome the need for procedural protections.[16]

Lower courts soon picked up on *Gault* and applied it to the mental health context. In *Lessard* v. *Schmidt*,[17] for example, the U.S. District Court expanded on *Gault* and set out further procedural requirements for involuntary commitment. The Court held that a person facing commitment has a constitutional right to some kind of hearing within forty-eight hours of being detained and a right to a full hearing within ten to fourteen days of being detained. The Court did not set out the precise nature of the required hearing, but stated that "due process is not accorded by an ex parte hearing in which the individual has no meaningful opportunity to be heard either because of incapacity caused by medication or lack of counsel."[18] The Court cited *Gault* in support of the proposition that due process requires that notice be given sufficiently in advance of the hearing so that the individual will have a reasonable time to prepare.[19]

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[15] *Ibid.* at 545.

[16] For a discussion of the impact on mental health law, see L. Newell "America's Homeless Mentally Ill: Falling Through a Dangerous Crack" (1989) 15 New Eng. J. Crim. & Civ. Confin. 277 at 281.

[17] 349 F. Supp. 1078 (E.D. Wis., 1972), vacated and rem'd on other grounds, 414 U.S. 473 (1974), judgment reinstated, 379 F. Supp. 1376 (E.D. Wis. 1974), vacated and rem'd on other grounds, 421 U.S. 957 (1975), judgment reinstated, 413 F. Supp. 1318 (E.D. Wis. 1976) [hereinafter *Lessard*]. The other grounds were procedural and did not affect the substantive decision.

[18] 349 F. Supp. 1078 at 1092, *ibid.*

[19] The Court also held in *Lessard*, *ibid.* that an individual in the commitment process has the right to counsel, including appointed counsel.

In *O'Connor* v. *Donaldson*,[20] the Supreme Court of the United States applied *Gault* to the mental health context and again expressed the view that paternalism could not replace due process in civil commitment. The Court held that involuntary commitment to a mental hospital involves a deprivation of liberty and thus that such commitment cannot take place without due process of law. A finding of mental illness is not a sufficient basis for commitment if the individual is not dangerous and could live safely in freedom. Stevens J., for the Court, stated:

> [T]he mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends.[21]

While the Supreme Court did not spell out exactly what procedures were required by the due process guarantee, one can imply from *O'Connor* that a detained individual has a right to a regular review of his or her detention in order to determine whether continued confinement is justified.[22]

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[20] *Supra*, note 11. Donaldson had been detained in a state mental hospital for 15 years despite repeated efforts to obtain his release. On various occasions, friends and outside agencies had applied for his release and offered to help him adjust to life outside the hospital. The Superintendent of the hospital, O'Connor, had refused to release him and had refused him grounds privileges, occupational therapy, and the opportunity to discuss his case. Evidence at trial showed that Donaldson was not dangerous to others or himself and was only receiving custodial care. A jury awarded Donaldson both compensatory damages and $10,000 in punitive damages against O'Connor. O'Connor appealed to the United States Court of Appeals and then to the United States Supreme Court. The Supreme Court remanded the case to the District Court so that an intervening case on qualified immunity could be considered.

[21] *Ibid.* at 407.

[22] *Lessard*, *supra*, note 17 is noticeable by its absence in *O'Connor*. In *O'Connor*, the Fifth Circuit Court of Appeals had held that Donaldson had a right to such individual treatment as would give him a realistic opportunity to be cured or to improve his mental condition. See *O'Connor* v. *Donaldson*, 493 F. 2d. 507 (1974). The Supreme Court expressly declined to decide this issue. The Court transformed this case from a right to treatment case to a civil commitment case and, only in the latter context, was it prepared to grant relief. For an interesting account of how the case was *almost* decided, see B. Schwartz, *The Unpublished Opinions of the Burger Court* (New York: Oxford University Press) at 284-323.

In *Addington* v. *Texas*,[23] the Supreme Court of the United States stressed the invasive nature of civil commitment in holding that the civil standard of proof (a preponderance of the evidence) was insufficient for commitment cases. The Court instead applied a standard of "clear and convincing evidence." The Court held that "the individual should not be asked to share equally with society the risk of error when the possible injury to the individual is significantly greater than any possible harm to the state."[24] This is referred to as "heightened scrutiny" and is justified by the seriousness of the consequences facing the individual.

B. *Right to Refuse Treatment*

In contrast to the commitment cases, the Supreme Court has declined to adopt a social control model in the context of forced treatment.[25] While the Supreme Court of the United States has

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[23] *Supra*, note 11. For a discussion of *Addington*, see *infra*, note 34.

[24] *Ibid.* at 331-32.

[25] Lower federal courts and state courts have consistently held that a mentally ill person has a qualified right to refuse treatment. The high water mark of a right to refuse treatment occurred in two federal cases: *Rennie* v. *Klein*, 462 F. Supp. 1131 (1978), 476 F. Supp. 1294 (1979), (expanded to class action) mod, 653 F. 2d 836 (3rd Cir. 1981), (*en banc*) vacated and rem'd, 458 U.S. 1119 (1982), mod, 720 F. 2d 266 (3rd. Cir. 1983) and *Rogers* v. *Okin*, 634 F. 2d 650 (1980). Both these cases found a constitutional right, limited only in emergency conditions, to refuse psychotropic medication for patients who had not been assessed as incompetent to make treatment decisions.

State courts have generally held that a patient must be proved incompetent by the state at a judicial hearing in order to override the right to refuse treatment. See, for example, *Re K.K.B.*, 609 P.2d 747 (1980); *Jarvis* v. *Levine*, 418 N.W. 2d 139 (1988); *People* v. *Medina*, 705 P.2d 961 (1985); and *Rivers* v. *Katz*, 67 N.Y. 2d 485, 495 N.E. 2d 337, 504 N.Y. Supp. 2d 74 (1986). The more intrusive the treatment, the greater the protection afforded. See *Kaimowitz* v. *Deptartment of Mental Health for the State of Michigan* (Circuit Court for Wayne County, 1973: Civil Action No. 73-19434-AW) (psychosurgery); *Knecht* v. *Gillman*, 488 F. 2d 1136 (8th Cir. 1973) (behaviour aversion therapy); and *Wyatt* v. *Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), hearing on standards, 334 F. Supp. 1341, enf'd, 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387, aff'd in part, rem'd in part, res'd in part, *sub nom Wyatt* v. *Aderholt*, 503 F. 2d 1305 (5th Cir. 1974). Also see *New York City Health & Hospital Corp.* v. *Stein*, 335 N.Y. Supp. 2d 461 (1972) (electroconvulsive therapy). Admittedly, treatment is different than civil commitment. With forced treatment, we are usually dealing with an individual already detained and thus presumably of less danger to other persons. This should enable us to focus more on the individual, since he or she is no longer a threat to the public.

held that there is a liberty interest in denying consent for life-saving medical treatment,[26] another recent judgment from that Court has brought into doubt the existence and scope of the right of psychiatric patients to refuse treatment.

In *Washington* v. *Harper*,[27] the issue was whether a prison inmate, who had been transferred to a special centre for prisoners with mental illness, could be forcibly treated with neuroleptic drugs and, if so, what procedures were constitutionally required before such treatment could be carried out. The particular scheme in *Harper* allowed treatment without the patient's consent if he or she suffered from a mental disorder and was gravely disabled or posed a likelihood of serious harm to himself or herself or others. A panel consisting of a psychiatrist, a psychologist, and a hospital official could, on hearing the evidence, order involuntary treatment only if the psychiatrist was in the majority of the panel. The patient/inmate had a right to attend, cross examine witnesses, present evidence, and be represented by an advisor. The patient/inmate also had a right to seek review of the panel's decision in state court.

While the Court was unanimous in holding that there is a liberty interest in avoiding unwanted administration of neuroleptic drugs, the majority held that the *Constitution* did not require any further procedural protections than were provided in the state statute.[28] The majority held that the extent of the right to refuse

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In the commitment context, on the other hand, we may have both the interest of the individual and of public safety as important factors.

[26] In a recent case involving the right to refuse medical treatment, the United States Supreme Court assumed that a competent person has a constitutionally protected right to refuse even life-saving treatment. *Cruzan* v. *Director, Missouri Department of Health*, 111 L. Ed. 2d 224 at 242 (1990) held that "for the purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse life-saving hydration and nutrition." Madam Justice O'Connor made this point more explicitly in a concurring judgment. Citing *Snyder* v. *Massachusetts*, 291 U.S. 97 at 105 (1934), the dissent, penned by Mr. Justice Brennan (Marshall and Blackmun JJ. concurring), agreed at 259: "[F]reedom from unwanted medical attention is unquestionably among those principles so rooted in the traditions and conscience of our people as to be ranked as fundamental."

[27] 108 L. Ed. 2d 178 (1990) [hereinafter *Harper*].

[28] *Ibid.* Mr. Justice Kennedy wrote the majority reasons with Rehnquist, White, Blackmun, O'Connor, and Scalia JJ. concurring. Mr. Justice Stevens, with Brennan and

treatment had to be viewed in the context of the patient/inmate's confinement. While the majority repeatedly stated that the medication must be for treatment purposes and "in the inmate's medical interest,"[29] there was also a clear indication in the judgment that, at least in the prison context, there might be institutional justifications for forcibly medicating the inmate/prisoner. The Court first stated that drugs could only be given for treatment purposes, but then continued:

> We hold that, *given the requirements of the prison environment*, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.[30]

Having held that there are circumstances in which the state may forcibly medicate a patient/inmate, if treatment is in his or her medical interest, the next question was what procedural protections are necessary to ensure that the decision to medicate is "neither arbitrary nor erroneous."[31] Harper argued (and the court below had agreed) that a full judicial hearing was required with an independent decision-maker and a right to counsel. While acknowledging the serious interest any individual would have in avoiding unwanted administration of drugs and the often serious side-effects and dangers of neuroleptic medication,[32] the Court nonetheless held that no judicial decision-maker was necessary. The Court suggested that the patient/inmate might be better served by having a purely medical decision-maker. The closest the Court came to recognizing the political nature of a decision to forcibly medicate an individual was in the following passage:

Marshall JJ. concurring, wrote a strong dissenting opinion.

[29] *Ibid.* at 202.

[30] *Ibid.* at 201-2 (emphasis added).

[31] *Ibid.* at 202.

[32] The majority stated: "The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty ... While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects." *Ibid.* at 203.

> Though it cannot be doubted that the decision to medicate has societal and legal implications, the Constitution does not prohibit the State from permitting medical personnel to make the decision under fair procedural mechanisms.[33]

It is not yet clear whether *Harper* will be extended without qualification to the civil psychiatric context, thus denying civilly committed individuals the right to a judicial hearing before they are forcibly medicated. One could argue that the institutional concerns for safety are more pressing in the prison context, since the individuals involved have committed a criminal offence, and thus that prisoners have a narrower right to refuse treatment than do individuals civilly committed. However, in a large civil psychiatric facility, disciplinary concerns often play a significant role. Whatever the impact of *Harper*, the case signals the Court's willingness to allow a substantial delegation of coercive power from the state to the psychiatric profession.

C. *Discussion*

In the previous section, I contrasted the approach of the United States Supreme Court in commitment and treatment cases in an attempt to illustrate that the Court has applied a different model depending upon the nature of the issue.[34] Where the issues at stake are analogous to issues arising in the criminal justice system, such as the procedures necessary to justify an initial deprivation of liberty, the Supreme Court seems willing to impose standards on the

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[33] *Ibid.* at 204. The Court was very aware that requiring a judicial hearing would cost money, or in its words at 205, it would "divert scarce prison resources, both money and the staff's time, from the care and treatment of mentally ill inmates."

[34] Of course, there are cases that reflect a combination of both justifications. The Supreme Court's position on burden of proof in the civil commitment context in *Addington*, *supra*, note 11, for example, reflects the pull to the paternalistic model despite the Court's efforts to maintain a social control model. While most commentators stress the importance of the heightened level of scrutiny applied by the Court in this case, one must also recognize that the Court made a deliberate choice to put a lower standard of justification on the state than in the criminal process. The Court justified its rejection of the criminal standard by stressing several aspects of the perceived differences between civil commitment and criminal punishment. The importance of the criminal model in *Addington* is clear: what the Court added to the civil standard, it justified on the basis of similarities to criminal law; what the Court took away from the criminal standard, it justified on the basis of differences to criminal law.

state. In other words, the Court has acknowledged that civil commitment is an exercise of social control by the state and thus it has been willing to impose limits by way of the kinds of procedural protections that are essential to the criminal law process, such as the right to counsel and notice of hearings.

In contrast to the commitment cases, the Supreme Court has been particularly deferential when dealing with issues that are unique to mental health law, such as forced treatment with psychotropic medication. Just as *Gault* involved the criminalization of juvenile justice, *Harper* involved the medicalization of forced psychiatric treatment. The rationale seems to be that treatment decisions involve an exercise of the state's *parens patriae* power made for the good of the individual and thus that procedural protections are not required.

The dissenting judgment in *Harper* highlights the importance of separating a paternalistic model and a social control model. The majority attempted to stress the beneficial aspects of treatment for the inmate and thus to minimize the procedural protections that might have been required had it acknowledged that the issue was essentially an exercise of social control over a prisoner through the police power. The dissent accused the majority of understating the liberty interest involved, of misreading the medication policy at issue, and of misinterpreting the Court's previous decisions dealing with the rights of prisoners.[35] The dissent was also very critical of the majority's suggestion that institutional factors, such as security and the protection of property, could be used to justify forced treatment.[36]

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[35] On the liberty interest, Stevens J. stated:

> Every violation of a person's bodily integrity is an invasion of his or her liberty. The invasion is particularly intrusive if it creates a substantial risk of permanent injury and premature death. Moreover, any such action is degrading if it overrides a competent person's choice to reject a specific form of medical treatment. And when the purpose or effect of forced drugging is to alter the will and the mind of the subject, it constitutes a deprivation of liberty in the most literal and fundamental sense.

Supra, note 27 at 208.

[36] In the words of the dissent,

> [B]y focussing on the risk that the inmate's mental condition poses to other people and property, the Policy allows the State to exercise either parens patriae authority or police authority to override a prisoner's liberty interest in refusing psychotropic

Once it is decided that medication is "for the patient's own good," the same kinds of procedural safeguards found in the criminal justice system become less important. For example, the Court in *Harper* held that "it is less than crystal clear why lawyers must be available to identify possible errors in medical judgment."[37]

The decision to delegate extensive power to psychiatrists to make judgments about whom the state can forcibly medicate follows logically from the paternalistic model. If the state is acting benevolently to cure the sick, who better to make decisions about the sick than the medical profession. The majority in *Harper* displayed great deference to psychiatric expertise. The starting point was that psychiatric judgments on medication reflect the "truth" in terms of the patient's best interest. This shifts the issue to when we will allow the patient/inmate to depart from his or her own interests, rather than when we will let the patient/inmate make his or her own decisions about what those interests are. The majority assumed that psychiatrists know when to order medication, would never do so contrary to the interests of the patient, and are rarely wrong.[38]

Individuals confined in psychiatric facilities in the United States have had the most success in court when they have been able to frame their cases in a liberal rights oriented paradigm, focusing on the invasiveness of coercive state involvement in mental health decisions and on the similarities to criminal law. This has been most successful in the commitment context. In issues unique to psychiatry, like forced treatment, there is a greater reliance on the *parens patriae* justifications for commitment and a corresponding delegation to psychiatrists of the authority to forcibly medicate individuals apparently suffering from a mental illness.

Keeping these developments in mind, I will now turn to consider the Canadian experience and the emerging jurisprudence

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drugs. Thus, most unfortunately, there is simply no basis for the Court's assertion that medication under the Policy must be to advance the prisoner's medical interest. *Ibid.* at 213.

[37] *Ibid.* at 207, citing *Walters* v. *National Association of Radiation Survivors*, 473 U.S. 305 at 330, 87 L. Ed. 2d 220 (1985) (emphasis in original).

[38] Kennedy J. stated: "Unlike the dissent, we will not assume that physicians will prescribe these drugs for reasons unrelated to the medical needs of the patients; indeed the ethics of the medical profession are to the contrary." *Ibid.* at 199 n. 2.

under the *Canadian Charter of Rights and Freedoms*. Early *Charter* decisions from our Supreme Court indicate that, at least in criminal law, we may be going through a period of concern about individual rights and enhanced protections for accused persons analogous to that of the United States in the 1960s.[39] The American experience might lead one to expect that this development would spill over into the mental health law context, with the courts paying more attention to the rights of persons with mental disabilities. As we shall see, no such trend has yet emerged.

IV. CANADIAN EXPERIENCE

The scope of judicial involvement in mental health law has changed since the *Charter* came into force. Prior to 1982, most cases arose out of judicial review of either the commitment decision or of an administrative tribunal's review of the detention. The substance of a provincial statutory scheme for involuntary commitment and treatment was largely immune from judicial scrutiny. Since the proclamation of the *Charter*, however, the courts have had the jurisdiction to review the substance of provincial legislation regarding mental health as well as the behaviour of officials and professionals providing mental health services. Despite the early optimism that a constitutional bill of rights would be a powerful tool with which to fight for legal reforms,[40] individuals with mental disabilities have not made much progress using the *Charter*.

While there have not been a large number of *Charter* cases dealing with persons with mental disabilities,[41] a review of the case

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[39] See, for example, *R.* v. *Therens*, [1985] 1 S.C.R. 613; *Collins* v. *R.*, [1987] 1 S.C.R. 265; *R.* v. *Vaillancourt*, [1987] 2 S.C.R. 636; *R.* v. *Hebert*, [1990] 2 S.C.R. 151; *R.* v. *Martineau*, [1990] 2 S.C.R. 633; and *R.* v. *Hess; R.* v. *Ngygen*, [1990] 2 S.C.R. 906.

[40] See, for example, D. Vickers & O. Endicott, "Mental Disability and Equality Rights" in A.F. Bayefsky & M. Eberts, eds, *Equality Rights and the Canadian Charter of Rights and Freedoms* (Toronto: Carswell, 1985) 381.

[41] Robert Gordon and Simon Verdun-Jones suggest that the dearth of scholarship and jurisprudence in this area may reflect "the absence of a tradition of an adequately funded and aggressive system of delivering advocacy services on behalf of mental health patients in Canada as a whole." See "The Trials of Mental Health Law: Recent Trends and Developments in Canadian Mental Health Jurisprudence" (1988) 11 Dal. L.J. 833 at 847. Another difficulty

law reveals that Canadian courts are heavily reliant on the paternalistic model for state involvement in mental health decisions. The state is seen quite literally as a parent, protecting those who cannot protect themselves and making decisions for those who the state believes cannot make decisions for themselves. One can also detect great deference towards psychiatric expertise. While courts have taken for granted their own competence to make decisions on the rights of other disadvantaged groups,[42] they have repeatedly deferred to alleged psychiatric expertise in cases dealing with persons with a mental disability.

In the following section of this paper, I will examine recent judicial developments in Canadian mental health law in the areas of civil commitment and treatment. The fact that so few cases have reached the appellate level in Canada is an indication of the low priority given to such issues and of the difficulties associated with seeking judicial remedies.[43] Nonetheless, one can still learn about judicial attitudes towards psychiatry by looking at the few appellate and lower court decisions that are available.

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in developing a litigation strategy in mental health law relates to the problem of mootness. There appears to be a practice in some provinces of releasing patients who are plaintiffs in *Charter* challenges so that the case becomes moot and the litigation is abandoned. This is in addition to patients being released in good faith before the challenge progresses to the courts and especially to the appellate level. Given the likelihood of readmission to a psychiatric facility for many of these individuals, an exception to the mootness bar should be developed.

[42] For example, the Supreme Court of Canada has handed down several decisions dealing with the rights of women. See, for example, *R.* v. *Morgentaler*, [1988] 1 S.C.R. 30; *Brooks* v. *Canada Safeway Ltd*, [1989] 1 S.C.R. 1219; and *Tremblay* v. *Daigle*, [1989] 2 S.C.R. 530.

[43] In fact, there are no cases on civil commitment and the *Charter* that have made it to the Supreme Court of Canada. The only cases heard by the Supreme Court are *R.* v. *Swain*, [1991] 1 S.C.R. 933, 63 C.C.C. (3d) 481, rev'g. (1986) 24 C.C.C. (3d) 385, 53 O.R. (2d) 609 (C.A.) [hereinafter *Swain* cited to C.C.C.], an Ontario case dealing with the insanity defence and the constitutionality of the Lieutenant Governor's warrant process, and *R.* v. *Chaulk and Morrissette*, [1990] 3 S.C.R. 1303, 119 N.R. 161 [hereinafter *Chaulk and Morrissette*] dealing with the constitutionality of the presumption of sanity. See also *infra*, note 74. It is notable that cases dealing with mental illness in the criminal context are much more likely to reach the appellate courts than civil commitment or forced treatment cases. See *R.* v. *Godfrey* (1984), 11 C.C.C. (3d) 233 (Man. C.A.); *Swain*; *Chaulk and Morrissette*; and *Rebic* v. *Collver Prov. J. and A.G. British Columbia* (1986), 2 B.C.L.R. (2d) 364 (B.C.C.A.) [hereinafter *Rebic*].

While most of the early *Charter* challenges were procedural in nature and brought under sections 7, 9, and 10 of the *Charter*,[44] section 15 is increasingly being used as the basis of *Charter* challenges.[45] Section 15 has been addressed in six non-criminal cases in the mental health law context.[46] In only one of the cases was the section 15 argument successful.[47]

A. *Commitment Procedures*

In Canada, unlike the United States, the decision to civilly commit an individual is usually made by physicians and not by courts. Most provinces provide for review of this decision, usually by an administrative tribunal (a review board or panel). Most provincial statutes provide for judicial review of detention and/or of the review panel's decision regarding detention.

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[44] Section 7 provides: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." Section 9 provides: "Everyone has the right not to be arbitrarily detained or imprisoned." Section 10 provides: "Everyone has the right, on arrest or detention (a) to be informed promptly of the reasons therefor; (b) to retain and instruct counsel without delay and to be informed of that right; and (c) the right to have the validity of the detention determined by way of habeas corpus and to be released if the detention is not lawful."

[45] Section 15(1) provides: "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability." Section 15(2) provides: "Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."

[46] Section 15 has been raised in *Swain*, *supra*, note 43 and in *Rebic*, *supra*, note 43. In *Swain*, the Supreme Court of Canada limited the Crown's right to raise insanity and invalidated the automatic confinement resulting from an insanity acquittal. *Rebic* also involved a challenge to the insanity defence in section 16 of the *Criminal Code of Canada*, R.S.C. 1985, c. C-46 [hereinafter *Criminal Code*]. The six non-criminal cases raising mental disability under section 15 are *Reference Re Procedures and the Mental Health Act* (1984), 5 D.L.R. (4th) 577 (P.E.I. S.C.) [hereinafter *Re Mental Health Act*]; *Firth* v. *Sault Ste. Marie* (1988), 7 A.C.W.S. (3d) 377 (Ont. Dist. Ct); *Dayday* v. *MacEwan* (1987), 62 O.R. (2d) 588 (Ont. Dist. Ct) [hereinafter *Dayday*]; *Re Howlett* v. *Karunaratne* (1988), 64 O.R. (2d) 418 (Ont. Dist. Ct); *Nova Scotia (Minister of Community Services)* v. *Carter* (1988), 89 N.S.R. (2d) 275 (Fam. Ct); and *Fenton* v. *Forensic Psychiatric Services Association* (7 December 1989), C 85 4338 (B.C.S.C.), rev'd. (31 May 1991), V 01130 (B.C.C.A.) [hereinafter *Fenton*].

[47] *Fenton*, *ibid.*

1. Admission procedures

Only two challenges to commitment procedures have been successful and, in each case, the surrounding circumstances mitigated the importance of the remedy granted. In *Lussa* v. *Health Science Centre*,[48] Ms. Lussa sought review of her involuntary detention. Kroft J. held that, although the plaintiff probably had a mental disorder and had illustrated irrational and difficult behaviour, there was no evidence that she presented a danger or a risk of harm to others or to herself. Further, prior to her court action, she had not had a meaningful opportunity to challenge her detention. The Court held that, if Ms. Lussa's detention were to continue, her constitutional right not to be arbitrarily detained (section 9 of the *Charter*) would have been violated.[49]

The only other successful challenge to commitment procedures occurred in *Thwaites* v. *Health Sciences Centre Psychiatric Facility*.[50] The Manitoba *Mental Health Act*,[51] at issue in *Thwaites*, contained very broad committal criteria. Section 9(1) provided for commitment where the physician believed "that the person should be confined as a patient at a psychiatric facility." The plaintiff's argument was that the criteria for detention under the *Act* were not sufficiently specified. The Court phrased the crucial question as follows: "Does the legislation that authorizes detention sufficiently define the persons who may be subject to the legislation and the circumstances under which they may be compulsorily detained?"[52]

The Court answered this question in the negative and concluded that the compulsory admission provisions in the *Act* were arbitrary and in violation of section 9 of the *Charter*. In addressing

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[48] (1983), 9 C.R.R. 350 (Man. Q.B.) [hereinafter *Lussa*].

[49] Kroft J. also found that Ms. Lussa's right to counsel had been denied. While noting that there may have been a sign posted on the hospital wall informing her of this right, he stressed that the hospital had an obligation to ensure either that patients understood their rights or that they were incapable of so understanding.

[50] [1988] 3 W.W.R. 217 (Man. C.A.) [hereinafter *Thwaites*].

[51] R.S.M. 1987, c. M-110.

[52] *Thwaites*, *supra*, note 50 at 224.

section 1 of the *Charter*, the Court assumed, without any evidence, that providing compulsory treatment and hospitalization for a person with a mental disability is a compelling objective which could override constitutionally protected rights. However, the Court held that, because the procedures lacked any clear objective standards, they were not rationally connected to the governmental objective.

Despite the apparent success for the plaintiffs in *Lussa* and *Thwaites*, both Courts seemed to be fearful of granting remedies that would have the potential to release large numbers of persons from psychiatric facilities and fearful of what such persons would do on release. In *Lussa*, the Court was comfortable in releasing Ms. Lussa, but refused to say anything about the constitutionality of the *Act* which might be relevant to other persons involuntarily detained. The judgment was deliberately worded narrowly so as to have an effect on the detention of Ms. Lussa only.[53] Kroft J. stressed that he was not striking down any part of the *Act* and that, if a "serious concern" continued to exist about Ms. Lussa, the hospital could reinstitute commitment proceedings.

In *Thwaites*, the only successful appellate level challenge to commitment procedures, the peculiar political circumstances mitigated the importance of the remedy granted. At the time of *Thwaites*, amendments to the Manitoba *Mental Health Act* had been passed by the provincial government but not proclaimed. *Thwaites* was thus used to pressure the government to proclaim the new provisions. It was safe for the Court to invalidate the legislation because it knew the legislature was prepared to step in with new legislative provisions:

> In this case, declaring the compulsory admission provisions of the Act of no force or effect need not result in grave or far-reaching consequences. We are not told why the Lieutenant Governor in Council has not proclaimed into force the amendments to the Act passed at the last session of the Manitoba legislature to which I have referred above. Those amendments can be proclaimed into force at

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[53] Although other patients might have been able to assert a denial of the right to counsel.

> an early date. They will ensure that those persons suffering from a mental disorder and likely to cause serious harm to themselves or others or to suffer substantial mental or physical deterioration will have available to them the treatment they require, even as involuntary patients.[54]

An examination of some of the commitment cases where *Charter* arguments have failed is also instructive about judicial attitudes towards persons with mental disabilities. In *Re Mental Health Act*,[55] for example, the Prince Edward Island Supreme Court *in banco* considered the constitutionality of the Prince Edward Island *Mental Health Act*.[56] In rejecting an argument that the *Act* discriminated against persons with mental disabilities, the Court adopted a very paternalistic attitude, suggesting that the state imposes forced confinement and treatment to protect, not only the safety of the individual, but also his or her dignity. McQuaid J.'s interpretation of the historical view of persons with mental disabilities is revealing: "Historically, the law in the English tradition has had a special care and regard for all subjects who suffered from mental disturbance. Although one might question some of the earlier methods countenanced by the law of an earlier day, none the less, the intent was benign."[57] The Court described the purpose of the *Act* as follows:

> The thrust of the *Mental Health Act*, including its predecessors, has been the safety, support and succor of those who suffer from, or appear to suffer from, a debilitating mental disability or disorder and who, as a consequence, require hospitalization whether voluntary or otherwise, for their own safety or the safety of others. In this context the word "safety" goes beyond mere protection from the

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[54] *Supra*, note 50 at 231. Shortly after *Thwaites* and after the proclamation of the new legislation, the constitutionality of Manitoba's *Mental Health Act*, *supra*, note 51 was before the Court of Queen's Bench. In *Bobbie* v. *Health Sciences Centre*, [1989] 2 W.W.R. 153, Scott A.C.J.Q.B. held that the new *Act* met the concerns expressed in *Thwaites* by including within it "objective criteria" for involuntary detention. The new *Act* adopted a "dangerousness" test for admission and included within it revised definitions of "mental disorder" and "mental retardation."

[55] *Supra*, note 46.

[56] R.S.P.E.I. 1974, c. M-9.

[57] *Re Mental Health Act*, *supra*, note 46 at 589. This reflects a commonly held view that, while psychiatry may have been lacking in expertise and understanding of mental illness in the past and while some of its treatments may have been inhumane, we have now reached a state where psychiatry is so scientific and its methods so well developed that comparisons to an earlier era are inappropriate.

> infliction of physical injury but includes such things as the alleviation of distressing physical, mental or psychiatric symptoms as well as the provision of creature comfort in appropriately congenial physical surroundings.[58]

The conclusion on section 15 was terse: "If this be discrimination, as contemplated by section 15(1) of the Charter, based on mental disability, then so be it."[59] The Court went on to hold that even if the *Act* violated section 15 (a possibility that never received serious attention), it could be upheld as a reasonable limit under section 1 of the *Charter*.

The Court's view seems to be that "special" treatment (justified under a paternalistic rationale) could never violate rights. The Court also generalized about the competence of individuals psychiatrically detained and the usefulness of legal mechanisms to assert patient rights. It even went so far as to set out a *de facto* presumption of incompetence for individuals seeking judicial relief:

> As a class (although there may well be individual exceptions within that class), persons who suffer from a mental disorder of such a nature or degree as to require hospitalization for their own safety or the safety of others, are, in general, not competent to instruct counsel, nor would counsel accept and act upon instructions of one who was, at the time, suffering from such a disability.[60]

While the P.E.I. Court acknowledged the uncertainties and fallibility of psychiatry, it concluded by advising the greatest of caution in disagreeing with a psychiatric judgment:

> [T]he law, as I perceive it to be, leans in favour of the care and treatment of those who do so suffer, even by involuntary detention if need be, when that illness has been demonstrably diagnosed by those practitioners skilled in the discipline, and *only for the gravest reasons should the court, or a board, an inquiry or review, substitute its lay opinion for the professional opinion.*[61]

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[58] *Ibid.*

[59] *Ibid.*

[60] *Ibid.* at 590.

[61] *Ibid.* at 591 (emphasis added). Mr. Jenkins, whose action for *habeas corpus* triggered *Re Mental Health Act*, was back before McQuaid J. in *Re Jenkins* (1986), 178 A.P.R. 62 (P.E.I. S.C.), arguing that the earlier case had been implicitly overruled by *Reference Re Section 94(2) of the Motor Vehicle Act*, [1985] 2 S.C.R. 486. Mr. Jenkins was representing himself and the Court did not bother to spell out the nature of his argument. Given that the *Charter* issue in *Re Mental Health Act* revolved around section 15, it is difficult to speculate on the nature of Mr. Jenkins's argument. In any event, McQuaid J. held that the *Act* did not violate sections 7 or 9 of the *Charter*.

This view seems to suggest that the Court is willing to have professionals decide the very issues before it. If this view is followed, the psychiatrist takes on the role of the trier of fact and judicial responsibility is minimized.

2. Review of detention

Most provincial mental health statutes in Canada provide for some form of administrative review during the first month of commitment.[62] For most committed individuals, this review may be

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[62] In Alberta, a hearing must be held by the review panel as soon as is possible or within 21 days of the receipt of the application by the chairman. See *Mental Health Act*, S.A. 1988, c. M-13.1, s. 40(4).

In British Columbia, a patient is entitled to a review panel within one month of his or her involuntary detention. The task of the review panel is to decide whether that individual should be detained or released. See *Mental Health Act*, R.S.B.C. 1979, c. 256, s. 21(4), as am. S.B.C. 1987, c. 42, s. 72(a).

In Ontario, a patient is entitled to a review hearing within seven days after the day that the review board receives notice requiring a hearing. See *Mental Health Act*, R.S.O. 1980, c. 262, s. 33(b)(2).

In Manitoba, the patient's status must be reviewed "promptly" upon the receipt of an application for review. See *The Mental Health Act*, *supra*, note 51, s. 26.2.

The New Brunswick *Mental Health Act*, R.S.N.B. 1973, c. M-10, as am. S.N.B. 1985, c. 59, ss 29, 31 includes a provision which allows any involuntary patient to apply to a review board for a review of his or her detention when any certificate of detention comes into force. The board must conduct an inquiry within five days of receiving such an application and may hold a hearing for the purpose of receiving oral testimony.

In Newfoundland, *The Mental Health Act*, S.N. 1971, No. 80 provides for review of an involuntary patient's detention upon the receipt of an application for review by the board. Section 17 provides that any person "aggrieved and affected by the detention of a patient" may make such an application. There seems to be no specified time within which the review must be held, although section 18(1) permits the review board to summarily dismiss an application in certain circumstances.

In the Northwest Territories, an involuntary patient, or someone on his or her behalf, may make an application to the Supreme Court for a review of the patient's detention. Such review and the decision of the judge must be made within 14 days of the application for review. See *Mental Health Act*, S.N.W.T. 1985 (2d Sess.), c. 6, ss 27(1), 29(2).

In Nova Scotia, a review board must review the file of a patient within one month of receiving a request for review. See the *Hospitals Act*, R.S.N.S. 1989, c. 208, s. 65(1).

The Prince Edward Island *Mental Health Act*, R.S.P.E.I. 1988, c. M-6, ss 25-26 permits an involuntary patient, or another person on his or her behalf, to apply to a review board for a review of his or her detention. Within 14 days of the receipt of such application by the chairman of the review board, the board must conduct an inquiry as to the validity of the detention and may hold a hearing to hear testimony in that regard.

In Quebec, a close treatment patient, or specified others on his or her behalf, may apply to the *Commission des affaires sociales* for a review of the detention. See *Mental*

the only meaningful opportunity to challenge the detention. Thus, this process raises many important questions about how best to protect the interests of the person who has been detained. Review panels or boards make important decisions about the liberty of the individual before them. In some provinces, the procedures and rules of evidence for a review panel are left almost entirely to the discretion of the chair of the panel.[63] This is justified by the alleged need for flexibility in order to deal with the vast array of fact situations that come before the panel.[64]

One important question in the review context is what evidence should be considered by the review board or panel. Review boards almost always rely heavily on hearsay evidence: medical reports, nursing reports, notes from social workers, and statements from people the social worker may have interviewed. Allegations of past violence or police contact, even if not substantiated, often form part of the record. Given the dynamics of the review process, once this evidence is seen, it is almost impossible

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Patients Protection Act, R.S.Q. 1974, c. P-41, s. 30.

In Saskatchewan, upon receipt of an involuntary patient's notice of appeal, the review panel shall "immediately carry out any investigation that it considers necessary to speedily determine the validity of the appeal," and it shall then invite the persons affected by the appeal to testify or present evidence relating to the appeal. See *The Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 34(6).

The Yukon *Mental Health Act*, R.S.Y.T. 1986, c. 115, ss 8(2), 9 provides for the review of an involuntary patient's detention by the Mental Health Review Board "as soon as is practical after the committal."

[63] In British Columbia, for example, there is no statutory guidance on the standard of review the panel is to apply. There are informal meetings of the members of the panel, the patient, and occasionally the patient's counsel. While a detained individual has a statutory right to counsel, the Legal Services Society does not provide funding for patients to have counsel before the review panel. Instead, a patient advocate office, staffed with two lawyers, is supposed to provide legal services for all psychiatric patients in the lower mainland.

[64] There have been a number of cases dealing with the procedures of the various review boards set up under the *Criminal Code*, *supra*, note 46 for the review of patients on Lieutenant Governor's Warrants (LGW). Although this review process is entirely separate from the function of a civil review panel, some of the fairness issues in the LGW cases are relevant to the standards of fairness a review panel must provide, since both bodies are making decisions about the liberty of the individual. See, for example, *Re Abel and Advisory Review Board* (1980), 56 C.C.C. (2d) 153 (Ont. C.A.); *Re McCann and the Queen* (1982), 136 D.L.R. (3d) 629 (B.C.C.A.); *Re Egglestone and Mousseau and Advisory Review Board* (1983), 42 O.R. (2d) 268 (Div. Ct.); *Re Jollimore and the Queen* (1986), 27 C.C.C. (3d) 166 (N.S. S.C. T.D.); and *A.G. Ontario* v. *Grady* (1988), 34 C.R.R. 289 (Ont. H.C.).

for the patient to negate it effectively. By its very presence in the medical chart, the evidence takes on an air of credibility that few patients are able to rebut. Attempts to deny information in the record are often characterized as further proof of mental illness.

In *Dayday* v. *MacEwan*,[65] Ms. Dayday challenged the constitutionality of the admission of hearsay evidence before the review board in its hearing to review her involuntary detention. Her section 15 *Charter* argument was that detaining a person based on hearsay evidence constitutes discrimination on the basis of mental disability. Since the state does not detain non-mentally disabled persons on the basis of hearsay evidence, it should not detain mentally disabled persons on this basis.

While the Court was somewhat troubled by the use of hearsay evidence, it allowed its admission relying on a very paternalistic view of the review process. Hence, Ms. Dayday's section 15 challenge failed:

> Although one might have serious reservations about the wisdom of allowing hearsay evidence to be used in such cases, the ultimate decision to do so must be left to the legislature so long as it legislates within the confines of the *Charter* ... In my view, mentally disordered persons fall into a *special class of persons who require special legislative treatment for their own protection and that of society.* To give them such special treatment does not violate section 15 of the *Charter*.[66]

The Court did find for Ms. Dayday on narrower grounds. Her certificate of renewal was rescinded because the same psychiatrist sat on both review boards.[67] While Ms. Dayday lost her *Charter* challenge to the admission of hearsay evidence on the basis of the "specialness" of mental disability, she won her case on the issue of bias, a familiar doctrine in administrative law. This suggests that, when dealing with the "specialness" of mental illness, the Court was unwilling to draw analogies to other areas of law and reduced procedural protections were justified. When the Court was able to draw an analogy to another area of law, where fairness (and the perception thereof) to the individual is a guiding principle, it was

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[65] *Supra*, note 46.

[66] *Ibid.* at 596-97 (emphasis added).

[67] This was prohibited by statute.

able to grant the plaintiff relief. As with *Lussa*[68] and *Thwaites*,[69] the Court was concerned about limiting the scope of the relief to the party before it.[70]

3. Burden of proof

Another important issue which arises at commitment and review of commitment is the issue of burden of proof: who must prove, and on what standard, whether an individual should be committed or released. Decisions about burden of proof are decisions about certainty and risk allocation. The question of certainty focuses on whether some kinds of judgments, such as psychiatric evaluations, can ever be "proven" on a sufficiently stringent legal standard. This is related to the risk allocation function. If there is some chance that the decision in issue could be mistaken, the burden of proof determines who should bear the risk of such a mistake. Normally, the risk of mistake is allocated to the party who would suffer the least negative consequences from that mistake.

The burden of proof to justify commitment has been addressed in several Canadian cases, usually as a question of statutory interpretation rather than of constitutional requirement.[71] Most Canadian courts have taken the view that, when an involuntary

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[68] *Supra*, note 48.

[69] *Supra*, note 50.

[70] The Court in *Dayday*, *supra*, note 46 at 600 recognized that the role of civil commitment was limited and that nuisance to families, neighbours, and possibly even the individual himself or herself is not a sufficient cause for detention. Matlow J. stated:

> There are, unfortunately, many people in our community who suffer from mental disorders of a nature or quality that likely will result in minor assaults and nuisances to other persons. I am persuaded that the applicant satisfies this general description. The Mental Health Act, however, does not authorize their detention even though their being free may occasionally result in injury to others.

[71] See, for example, *Re Robinson and Hislop* (1980), 114 D.L.R. (3d) 621 (B.C.S.C.) [hereinafter *Robinson*]; *Re Mental Health Act*, *supra*, note 46; and *Re Azhar and Anderson* (25 June 1985), (Ont. Dist. Ct) [unreported]. In *Robinson*, a pre-*Charter* decision, Locke J. of the B.C. Supreme Court held that, in a judicial review of a civil commitment, the patient must show there is a *prima facie* case for release and the burden then shifts to the hospital to show, on a balance of probabilities, that the commitment and continued detention were justified.

commitment is being challenged in court, the hospital must justify the detention on a simple civil standard: a balance of probabilities.[72] The courts have consistently rejected the more stringent criminal burden of proof and even the heightened civil standard of proof that the American Supreme Court has said is constitutionally required.[73]

In contrast to criminal law, Canadian courts have not given much consideration to the constitutional aspects of burden of proof in the mental health law context.[74] For example, in *Re Azhar and Anderson*,[75] Judge Locke described the issue as follows:

> In my respectful view, the required standard of proof while important is not pivotal in the process of protecting and balancing the rights of individuals as against the responsibility that the state owes to society in general in the field of mental health. If the standard is made too onerous, it seems obvious that society may become endangered by the failure of sincere physicians to adequately detain and treat dangerous or potentially dangerous people who unfortunately suffer from mental disorders.[76]

Locke J. minimized the role of the criminal standard of proof in allocating the risk of mistaken deprivations of liberty to the state:

> On the other hand, even with the imposition of the high criminal standard of proof being beyond a reasonable doubt, individuals in society will not always necessarily automatically be protected from the abuse of improper committals. The standard

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[72] The Supreme Court of Canada recently held that the presumption of sanity in section 16(4) of the *Criminal Code*, which puts the burden of proof on the accused when alleging insanity, is a reasonable limit on the presumption of innocence. See *Chaulk and Morrissette*, *supra*, note 43. The majority decision of Lamer C.J.C. in *Chaulk and Morrissette* marked the first major retreat from the stringent section 1 *Oakes* test in the criminal law context. It is significant that Lamer C.J.C. would make his first retreat from *Oakes*, in the criminal law context in a case involving mental illness. See *infra*, note 74.

[73] See *Addington*, supra, note 11.

[74] Contrast this with the number of Supreme Court of Canada cases on the *Charter* implications for burden of proof in the criminal context. See, for example, *R.* v. *Oakes*, [1986] 1 S.C.R. 103; *R.* v. *Holmes*, [1988] 1 S.C.R. 914; *R.* v. *Whyte*, [1988] 2 S.C.R. 3; and *R.* v. *Schwartz*, [1988] 2 S.C.R. 443. The first Supreme Court of Canada *Charter* decision dealing with mental illness also arose in the criminal law context. See *Chaulk and Morrissette*, *supra*, note 43.

[75] *Supra*, note 71.

[76] *Ibid.* at 13.

> of proof is but one important factor among several that should achieve the desirable balance.[77]

The Court failed even to acknowledge that the potential danger to the public from persons who commit criminal offenses has not led us to adopt a lower standard of proof in criminal law. The potential presence of mental illness, as opposed to just criminality, is used to justify reduced concern about the mistakes made by the system.[78] Nor does the Court consider the other issue involved in burden of proof, namely, that of certainty. The empirical evidence suggests that psychiatrists are not very good predictors of who will be dangerous to themselves or to others.[79] Nonetheless, civil commitment is often based on such predictions.

B. *Right to Refuse Treatment*

The common law recognizes a competent person's right to refuse medical treatment. In a recent decision, the Ontario Court of Appeal held that an individual has a common law right to refuse even life sustaining treatment and that the right is not premised on

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[77] *Ibid.*

[78] In contrast to civil commitment are the dangerous offender provisions, sections 752-761 of the *Criminal Code*, *supra*, note 46. A judge must decide whether an accused person should be subjected to indeterminate incarceration as a dangerous offender. Canadian courts have consistently required that the Crown prove the likelihood of dangerousness beyond a reasonable doubt. Admittedly, I have elsewhere challenged whether the reasonable doubt standard can have any meaning in the predictive context because all the empirical evidence suggests psychiatrists do not have the ability to predict dangerousness with sufficient precision. See I. Grant, "Dangerous Offenders" (1985) 9 Dal. L.J. 347 at 360-61. See also *R.* v. *Lyons*, [1987] 2 S.C.R. 309, where La Forest J. holds that indeterminate detention in the criminal context, based on past crimes and predictions of future dangerousness, does not violate the *Charter*. Nonetheless, the burden of proof also serves a symbolic function. In criminal law, the "beyond a reasonable doubt" standard is a recognition of the gravity of the consequences facing an accused person. The lack of attention given to this issue in mental health law reflects a failure to acknowledge the gravity of the consequences of mistaken or unnecessary commitments.

[79] See Cocozza & Steadman, *supra*, note 4, where the authors describe the literature on the dangerousness of psychiatric patients. See also Mesnikoff & Lauterbach, *supra*, note 4 and Diamond, *supra*, note 4.

understanding the risks of refusal.[80] The Court explained the right to refuse treatment as follows:

> The right of self-determination which underlies the doctrine of informed consent also obviously encompasses the right to refuse medical treatment. A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor's opinion, it is the patient who has the final say on whether to undergo the treatment ... [P]eople must have the right to make choices that accord with their own values regardless of how unwise or foolish these choices may appear to others.[81]

Since the common law is clear that all competent individuals have a right to refuse medical treatment, one would expect that competent psychiatric patients would have the right to refuse treatment "however unwise or foolish these choices may appear to others."[82] However, legislatures and courts have treated civilly committed persons differently than other hospitalized patients. Several provinces have legislatively overridden the common law and provided for forced treatment of competent civilly committed persons.[83] In addition, virtually every province has statutory

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[80] *Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 (Ont. C.A.) [hereinafter *Malette*]. In *Malette*, the plaintiff was brought to the hospital unconscious after a car accident. A card was discovered in her purse indicating that, on the basis of her religion, she did not consent to the administration of blood products. Dr. Shulman, believing her life to be at risk, gave her blood transfusions nonetheless. Ms. Malette successfully sued the doctor and received damages of $20,000.

[81] *Ibid.* at 328. It is important to note that, in *Malette*, the plaintiff was clearly incompetent to make a decision about the proposed treatment at the time it was to be administered; she was unconscious. Nonetheless, the Court looked at the wishes of the plaintiff at an earlier time when she was competent to make the decision. Thus, the situation was analogous to the case of a person in a psychiatric facility who, while presently incompetent, has previously expressed his or her wishes not to receive treatment.

[82] *Ibid.*

[83] Competent patients can be treated without their consent in Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland, the Northwest Territories, and the Yukon. See the Alberta *Mental Health Act*, *supra*, note 62, s. 29; British Columbia *Mental Health Act*, *supra*, note 62, as am. S.B.C. 1981, c. 21, s. 47; Manitoba, *The Mental Health Act*, *supra*, note 51, s. 25; New Brunswick *Mental Health Act*, *supra*, note 62, s. 13.1; Newfoundland *The Mental Health Act*, *supra*, note 62, s. 6(1); Northwest Territories *Mental Health Act*, *supra*, note 62, s. 22; and Yukon Territories *Mental Health Act*, *supra*, note 62, s. 7.

In Quebec, patients who have been found unfit to manage their affairs can also be subject to involuntary treatment. See *Public Curatorship Act*, R.S.Q. 1977, c. C-80, s. 8. The Prince Edward Island *Mental Health Act*, *supra*, note 62 makes no reference to treatment

provisions providing for the forced treatment of *incompetent* persons detained in a psychiatric facility.[84]

Prior to the *Charter*, challenges to legislated compulsory treatment were limited in scope to questions of statutory interpretation and fair procedures. For example, in *Re T and Board of Review for the Western Region*,[85] the hospital involved was seeking authorization of electroconvulsive therapy (ECT) for a patient who had denied her consent and for whom family members had denied substitute consent. Under the legislation existing at the time, the board of review could compel the patient to have the treatment as long as it was not "psychosurgery." Thus, the whole case focussed on whether ECT was a form of psychosurgery. The question of how the state could possibly justify imposing ECT on a patient, when both the patient and her family objected, was not considered.[86]

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decisions and thus presumably the common law applies. In Saskatchewan, only patients who are incompetent to make treatment decisions are subject to committal and therefore, once a patient is admitted involuntarily, that patient may be forced to undergo any treatment which the physician considers necessary to treat the mental disorder, with the exception of psychosurgery and experimental treatment. See *The Mental Health Services Act*, *supra*, note 62, ss 24(2) and 25(2).

Nova Scotia and Ontario are the only provinces with a clear right to refuse treatment for competent patients. See the Nova Scotia *Hospitals Act*, *supra*, note 62, ss 51, 54 and 56 and the Ontario *Mental Health Act*, *supra*, note 62, s. 35(2)(a). Some provinces distinguish the types of treatment that can be authorized without consent. In Alberta, for example, treatment refusal can be overridden for competent and incompetent patients, although psychosurgery cannot be performed without consent. See *Mental Health Act*, *supra*, note 62, s. 29. In the Northwest Territories, a *competent* patient may be treated, notwithstanding his or her refusal to consent to treatment, if the patient's nearest relative consents to the treatment. Psychosurgery may not be performed on a patient unless that patient is competent and consents to the procedure, and ECT may not be performed on a patient unless the patient is competent and consents, or in the case of an incompetent patient, the patient's nearest relative gives consent to the treatment. See *Mental Health Act*, *supra*, note 62, ss 22 and 23.

[84] The Prince Edward Island statute does not provide for compulsory treatment, but the common law would probably allow for involuntary treatment of incompetent patients. Some provinces employ a system of substitute decision-makers for incompetent persons. In Ontario, for example, the legislation lists, in order of priority, persons who might make substituted decisions for the incompetent person. Substitute decision-makers may decide the treatment question on the basis of what the incompetent individual wanted at a time when he or she was competent or by some formulation of a best interests test.

[85] (1983) 3 D.L.R. (4th) 442 (Ont. H.C.).

[86] The Court held that ECT was not a form of psychosurgery and thus that the board could authorize the procedure without consent.

The *Charter* has provided a mechanism to challenge both the procedural requirements of overriding a patient's refusal and the substance of the override itself. To date, however, such challenges have met with little success.[87] In *Re Howlett* v. *Karunaratne*,[88] for example, the plaintiff challenged the constitutionality of compulsory treatment for a person found to be incompetent. She alleged that forcible treatment constituted a violation of her security of the person under section 7 and that the violation was not in accordance with the principles of fundamental justice. McDermid D.C.J. concluded that any deprivation of security of the person was in accordance with the principles of fundamental justice:

> [I]t is generally accepted as a fundamental principle of our society that the state has an obligation to care for disabled persons who are through no fault of their own, unable to care for themselves. While there is debate as to the type of care that should be provided and the persons to whom it should be extended, the principle itself is generally accepted.[89]

McDermid D.C.J. held that the distinction made by the Ontario *Mental Health Act* was not a distinction between persons suffering from a mental disability and persons not so suffering, but rather between persons who are competent to make decisions regarding treatment and those who are not. He indicated that since

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[87] For a summary of the developments in Canadian jurisprudence in this area, see S.N. Verdun-Jones, "The Right to Refuse Treatment: Recent Developments in Canadian Jurisprudence" (1988) 11 Int'l J. L. & Psych. 51. Most of the challenges to forced treatment have taken place in Ontario and have involved individuals found to be *incompetent*. The recent challenge to the British Columbia legislation, which permits compulsory treatment of *competent* patients, may have a better chance of success. In British Columbia, an involuntary patient can be treated without consent by the authorization of the director of the facility. There is no statutory requirement that the patient be found incompetent before such authorization takes place. Rather, treatment authorized by the director of the facility is deemed to be given with the patient's consent. The first *Charter* challenge to the forced treatment of *competent* patients was initiated in *Phillip Clapci* v. *A.G. British Columbia* (Supreme Court of British Columbia, statement of claim filed 3 May 1990, Vancouver Registry). As in many cases involving psychiatrically detained individuals, Mr. Clapci has been in and out of the hospital since the writ was filed and it is unclear whether the case will proceed.

[88] *Supra*, note 46.

[89] *Ibid.* at 430.

mentally competent persons are not similarly situated to mentally incompetent persons, there was no section 15 violation.[90]

In another unsuccessful *Charter* challenge to the forced treatment provisions for incompetent persons in Ontario's *Mental Health* Act, Tobias D.C.J. rejected the argument that the provisions violated section 7 or section 15 of the *Charter*.[91] In so doing, he relied entirely on a paternalistic model of forced treatment and assumed that the psychiatric staff was best placed to ensure that the system operated fairly. He went so far as to suggest that if section 15 were violated, the legislative provisions for compulsory treatment could be saved under section 15(2) of the *Charter* which provides for affirmative action programs for disadvantaged groups or individuals. Paternalism was prevalent throughout the judgment:

> There is nothing oppressive or unconscionable, nothing contrary to public policy to authorize the state to care for those hapless individuals who, by reason of mental infirmity and disease, having lost the thread of reality, must be nurtured in a special way to give their lives some dignity and tranquil times.[92]

Forced treatment was seen as part of the state's duty to protect the individual under its care. The exercise of this duty was delegated to the psychiatric staff:

> [T]he helpless, the incompetent involuntary patient depends entirely upon a concerned society exemplified by the staff of the psychiatric facility for his care, treatment and protection. The duty of care owed to the incompetent involuntary patient is total: as with a child of tender years he demands the ultimate in social concern.[93]

Tobias D.C.J. did acknowledge that substitute consent providers could make errors in authorizing treatment and even indicated that the patient may need protection from such mistakes.

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[90] It should be noted that this decision was handed down before the Supreme Court of Canada's judgment in *Andrews* v. *The Law Society of British Columbia*, [1989] 1 S.C.R. 143 which rejected the similarly situated analysis that had been applied by lower courts. The Court also rejected the argument that forced treatment was cruel and unusual treatment under section 12 of the *Charter*. It held that administering treatment to a non-consenting patient under the provisions for substitute consent in the *Act* was not so excessive as to outrage standards of decency. *Ibid.* at 435.

[91] *Fleming* v. *Reid* (1990), 73 O.R. (2d) 169 (Dist. Ct) [hereinafter *Fleming*].

[92] *Ibid.* at 176.

[93] *Ibid.* at 180.

That protection, however, was seen as emanating from the psychiatric staff, not from legal safeguards:

> [W]here is the protection for the incompetent involuntary patient if the substitute consent-giver wrongly gives his consent to unwarranted or improper specified psychiatric treatment? The answer clearly rests in the reliance placed by the *Act* upon the professionalism of the physicians making the treatment proposals. If every treatment decision involving incompetent patients in psychiatric facilities were challenged and reviewed their treatment would grind to a halt and the patients would suffer. The efficacy of the decisions of the attending physician with respect to those specified psychiatric treatments which receive the consent of the substituted consent giver are wisely left untouched by the provisions of the *Act*.[94]

Thus, the same professionals who prescribe the proposed treatment and seek substitute consent are relied upon to protect the patient from unwise decisions in favour of treatment.[95]

C. *Other Cases*

The one successful trial level section 15 challenge in the mental health context involved neither commitment nor treatment, but rather the rights of persons involved in work projects during their psychiatric hospitalizations. This case is important because it illustrates the court's willingness to grant relief where it could analogize to another, less contentious, area of the law.

In *Fenton* v. *Forensic Psychiatric Services Commission*,[96] the plaintiff had been a patient at the Forensic Psychiatric Institute (FPI) in Port Coquitlam, British Columbia since having been found not guilty by reason of insanity of obstructing a police officer. Mr. Fenton claimed that he should be entitled to minimum wage for the work he performed at FPI and that section 8(2)(d) of the

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[94] *Ibid.* at 191.

[95] With respect to provinces that permit forced treatment of competent patients, it is interesting to note that, in *Fleming*, *ibid.* at 180, Tobias D.C.J. was of the view that forced treatment of *competent* patients could not be justified:

> [T]here can be no challenge to the right of a competent person to decide how his or her body is to be touched and treated except in the most extreme cases of virulent diseases where the universal well-being of the population justifies the restraints placed on personal liberty of an infected person.

[96] *Supra*, note 46.

Employment Standards Act Regulations[97] violated section 15 of *Charter* because the provision enabled an employer to avoid minimum wage legislation "in a therapeutic work program designed primarily to facilitate the development of occupational skills for that disabled person."

The trial judge held that section 8(2)(d) of the *Employment Standards Act Regulations* discriminated on the basis of mental disability and that Mr. Fenton should have received the minimum wage for his work at FPI. The Court did stress that the discrimination might be justified under section 1 of the *Charter*, but that the Crown had not laid a sufficient evidentiary basis to meet its burden on this issue. Hence, the regulation was struck down as unconstitutional. This case has recently been overturned by the British Columbia Court of Appeal on the basis that inmates at the Forensic Institute are not employees and therefore are not entitled to protection under labour standards legislation.[98] Counsel for Mr. Fenton has indicated that leave to appeal to the Supreme Court of Canada will be sought.[99]

D. *Discussion*

Unlike the American case law, Canadian jurisprudence on mental health law does not appear to be taking a different approach to commitment and treatment refusal cases. With a few limited exceptions, Canadian courts are adopting a paternalistic model for most aspects of mental health law. The individual before the court is seen as a patient who needs the psychiatric profession to determine his or her own best interest. The uniqueness of mental disability is often used to justify the denial of procedural protections that we would insist upon in other contexts.

Many Canadian courts are adopting what might be referred to as a presumption of incompetence. The suggestion is that anyone

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[97] B.C. Reg 37/81, s. 2(d)ii, passed pursuant to the *Employment Standards Act*, S.B.C. 1980, c. 10.

[98] *Fenton*, *supra*, note 46.

[99] See the Community Legal Assistance Society, Press Release (31 May 1991).

in a psychiatric facility loses the ability to say whether they belong there or whether their rights have been violated in the commitment process. The presumption also has implications for treatment. Judges often make the assumption that, if a person has been committed involuntarily, he or she must be incompetent to make decisions about treatment. If a patient refuses treatment, that is seen as merely more evidence in support of the patient's illness. Treatment refusal is seen as a function of incompetence, rather than as an individual choice. Almost no attention is paid to possible legitimate reasons for refusing treatment or to the possibility that the proposed treatment is not in the individual's best interest. The starting point is that the patient will be better off if on medication than if left to suffer the ravages of "mental illness." There is a recognition that treatment cannot cure most "mental illnesses," but the assumption is nonetheless made that pharmacological control of some symptoms is always preferable to a non-medicated life.[100] This presumption of incompetence, evident in *Re Mental Health Act*,[101] in combination with the assumption that psychiatrists are best equipped to assess the interests of the incompetent person, leaves very little role for judicial intervention.

The presumption of incompetence obscures the important distinction between the criteria for civil commitment and the criteria for forced treatment. An individual who has been civilly committed is not necessarily incompetent to make treatment decisions.[102] The test for commitment in all Canadian provinces involves some formulation of whether a person is dangerous to self or to others. Competence to make treatment decisions relates to the person's ability to understand the nature of the treatment and to assess its potential benefits and harms. Suppose, for example, a person believes that monsters from outer space have ordered him to kill his children and the person starts to make plans to carry out this

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[100] Many patients who are treated with these drugs for years still stop taking them when they have the choice. Surely, this indicates either that the drugs are not really doing what doctors claim they do (help the patient realize his or her need for medication) or that the side-effects of drugs for some patients outweigh the benefits.

[101] *Supra*, note 46.

[102] The one exception to this is Saskatchewan, where the criteria for commitment include a finding of incompetence with respect to treatment. See *supra*, note 83.

instruction. This person will probably meet a "dangerous to others" test and thus be committable. Let us suppose further that, once the person is hospitalized, he refuses psychotropic medication. If the refusal is based on instructions from the monsters from outer space, it is likely that the person is not competent to make treatment decisions. However, if the refusal is based on rational grounds, such as the unpleasant side-effects that accompanied the same medication in the past (*e.g.*, shakiness, blurred vision, or memory loss), the refusal may be unrelated to the reason for involuntary commitment and may be a competent refusal. The individual could still feel compelled to carry out the instruction of the monsters, while holding a reasonable view on the treatment issue. Competence is not an all or nothing phenomenon. Even persons suffering from mental illness may be competent to make many decisions about their own lives.

In the criminal law context, the starting point is that an individual is competent and that his or her alleged criminal actions were a result of an exercise of free will.[103] The presumption of innocence requires that we presume innocence until guilt has been proven beyond a reasonable doubt. When an individual has not even been charged with a criminal offence, and yet is facing a deprivation of liberty as serious as that faced by a criminal accused, why would incompetence be the starting point? If a court assumes that any psychiatric patient brought before it is by definition mentally ill and probably unable to instruct counsel, then the court is pre-judging the very issues before it.[104]

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[103] See, for example, the presumption of sanity in section 16(4) of the *Criminal Code*, *supra*, note 46.

[104] In criminal law, every deprivation of liberty must be reviewed by a court before it will be allowed to continue over 24 hours. Invasions of privacy through a search, except in emergency circumstances, must be authorized judicially before they are undertaken. Consider the following words spoken by then Chief Justice Dickson in *Hunter* v. *Southam Inc.*, [1984] 2 S.C.R. 145 at 161-62:

> The purpose of a requirement of prior authorization is to provide an opportunity, before the event, for the conflicting interests of the State and the individual to be assessed, so that the individual's right to privacy will be breached only where the appropriate standard has been met, and the interests of the State are thus demonstrably superior. For such an authorization procedure to be meaningful it is necessary for the person authorizing the search to be able to assess the evidence as to whether that standard has been met in an entirely neutral and impartial manner.

The standard of beyond a reasonable doubt in criminal law is a reflection of the seriousness of the deprivation of liberty for the accused and a recognition of society's decision to prefer to risk that guilty persons go free than that innocent persons be convicted.[105] In the mental health context, however, courts seem more willing to apply a less rigorous standard of proof because the state is allegedly acting to protect rather than to punish. If the function of a burden of proof is to allocate the risk of error, it must be realized that mistakes in the mental health law system are often very difficult to correct. Once someone has been stigmatized as mentally ill and involuntary commitment has been authorized, it is very difficult for the patient to assert wrongful commitment. Protests against commitment are often characterized as "a lack of insight" which is itself seen as symptomatic of mental illness.[106]

The presumption of incompetence seems related to a second presumption made by courts: the benevolence of involuntary psychiatric hospitalization and treatment. One Ontario court has taken this second presumption so far as to say that civil commitment and forced treatment are forms of affirmative action for the mentally disabled and thus can be upheld under section 15(2) of the *Charter*.[107] It is difficult to imagine any other circumstances in which we would force members of a disadvantaged group (who may not even think they belong to the group) to accept unwanted affirmative action. Affirmative action regimes are usually something that people outside the identified group might want to challenge as being an unfair benefit to the members of the class in question. It is absurd to suggest that people without mental disabilities might be

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The above passage describes the right to privacy held by a corporation in Canada. It is in stark contrast to the absence of prior authorization in most provincial mental health statutes.

[105] Judges seem to be less afraid of potentially guilty persons going free in the criminal justice system than of "mentally ill" persons not being detained in the mental health system. Criminals seem to frighten courts less than persons with mental disabilities. This is so even in the absence of empirical support for the belief that mentally disabled persons commit more dangerous or violent acts than the general public. See Cocozza & Steadman, *supra*, note 4 and Mesnikoff & Lauterbach, *supra*, note 4.

[106] See Rosenhan, *supra*, note 4 at 254: "Once a person is designated abnormal, all of his other behaviors and characteristics are colored by that label."

[107] See *Fleming*, *supra*, note 91.

able to challenge civil commitment because they too are not entitled to it. More importantly, section 15(2) deals with affirmative action that ameliorates the social and political disadvantage experienced by members of the disadvantaged group. Civil commitment and forced treatment of persons with mental disabilities (with few procedural protections) are examples of historical disadvantage, not a means by which to remedy it.

Why have Canadian courts held so tenaciously to the paternalistic model of mental health law? Strong communitarian values, which have historically formed an important part of the Canadian political tradition, encourage the community to take care of its members, particularly those who are seen to be needy or to have diminished capacity. This communitarian ethic is in contrast to the liberal individualistic ideology that has characterized the American political tradition.[108]

The Canadian communitarian tradition is reflected in the nature of health care in Canada. The state and the practice of medicine are connected in Canada by the establishment and the acceptance of socialized medicine. The right to medical care is considered more fundamental than in a country, such as the United States, where the practice of medicine is organized as a matter of private enterprise. Thus, the communitarian ethic and the adoption

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[108] In *Politics and the Constitution: The Charter, Federalism and the Supreme Court of Canada* (Agincourt, Ont.: Carswell, 1987) at 105, Patrick Monahan describes the strong communitarian tradition in Canada:

> Canadian politics has always placed particular emphasis on communitarian values. Moreover, Canadians traditionally have regarded the state as a vehicle for creating individual freedom, rather than as the antithesis of such freedom. Claims for social justice have been advanced and have succeeded in the political, rather than the judicial, arena.

Also, in *Continental Divide: The Values and Institutions of the United States and Canada* (New York: Routledge, 1990) at 93, Professor Seymour Martin Lipset describes the contrast between the constitutions of the two countries:

> [T]he concern of Canada's fathers of Confederation with "peace, order, and good government" implies control of and protection for the society. The parallel stress by America's founding fathers on "life, liberty, and the pursuit of happiness" suggests upholding the rights of the individual.

of socialized medicine may have led Canadian judges to view "mentally ill" individuals as persons deserving the state's care even if the individual involved is too "sick" to recognize the need for hospitalization and/or treatment.[109]

At the same time as the communitarian ethic is flourishing in Canadian mental health law, our courts have moved increasingly toward a liberal analysis in the criminal context, focusing on the protection of the rights of accused persons. Why has this not spilled over into mental health law? I would suggest that part of the reason is that we have socially constructed the criminal trial in a manner very different from our construction of mental health proceedings. The adversarial nature of the criminal trial is evident throughout the process as is the uneven distribution of resources between the state and the accused person. In stark contrast, legal action initiated by a person detained in a psychiatric facility is brought against the hospital or the doctor who is involved in the detention. The dispute is depicted as being, not between the individual and the state, but rather between the individual and his or her doctor. Moreover, the complaint is brought against psychiatry by someone whose competence is already suspect because he or she has already been deemed mentally ill by the very psychiatrists being challenged. If the "patient" loses the case, he or she will not face imprisonment, but rather hospitalization and/or treatment. The fact that the physician is an agent of the state and exercising power expressly delegated from the state is obscured. The power of the state is masked by the medical model of involuntary psychiatry.

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[109] A "right to treatment" (a communitarian based right) might receive more sympathetic treatment from Canadian courts than a "right to refuse treatment" which is based on a more individualist tradition.

V. CONCLUSION

Throughout this paper, I have been stressing the power given to doctors in the context of involuntary psychiatry. Such power results from a combination of political, legal, and social influences that shape the way we see persons with mental disabilities.

This power may be enhanced by the nature of mental disability. Mental disability is a unique form of disadvantage. Individuals who the state might purport to bring within the category of mental disability may deny that they belong in the relevant class. Mental disability is one of the few forms of disadvantage in our society for which membership in the group is defined largely from the outside. Decisions as to who is properly within the class are made by people who are not members of the class.[110] In addition to this external definition of membership, what is in the interests of persons with mental disabilities is usually defined by persons other than the individuals themselves. Be it psychiatrists or rights advocates, many of us are telling individuals with mental disabilities just what is in their best interests.[111] Psychiatrists both define the

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[110] Of all the enumerated groups in section 15, that of mental disability is probably the most elusive and difficult to define. Many individuals with mental disabilities also fall within other disadvantaged groups protected by section 15 and thus may be doubly disadvantaged. For example, there have been studies conducted in the United States which have found that women are treated in a discriminatory manner in psychiatric facilities. In "Sex-Based Discrimination in the Mental Institutionalization of Women" (1974) 62 Calif. L. Rev. 789 at 806, Robert T. Roth and Judith Lerner suggest that it is easier for women to get into a psychiatric hospital and harder for them to get out. The authors suggest that women, who do not conform to the stereotyped view of what women are supposed to do, are more likely to face detention and forced treatment. It is also suggested that a woman's chance of being released from a psychiatric facility is related to "limited education, possession of domestic skills *only*, having a spouse or immediate family, and length of stay ... medical diagnosis, and treatment had no significant effect on the rate of release." See also R. Anand, "Involuntary Civil Commitment in Ontario: The Need to Curtail the Abuses of Psychiatry" (1979) 57 Can. Bar Rev. 250 at 259.

[111] I realize that I am doing just that in this paper. I am making the assumption that increased "legal" protections are in themselves a "good" that should be sought by and on behalf of individuals with mental disabilities. Psychiatrists make different assumptions about the benefits of compulsory treatment and hospitalization.

class of persons seen as "mentally disabled" and prescribe how the class should be treated once defined.[112]

Rather than provide an effective check on the exercise of state power by psychiatrists, Canadian courts have enhanced the power of psychiatrists in their unwillingness to scrutinize the decisions of the "experts." Courts reason by analogy and thus, when faced with a new legal issue, they look to old cases and to other areas of law in an attempt to incorporate any new issue into an existing legal framework. Where they can draw such analogies, they are comfortable in asserting their own expertise in deciding disputes brought before them.[113] However, when courts face an issue for which there are no obvious analogies, like the forced treatment of individuals in psychiatric facilities, they have chosen either to apply analogies that do not quite work or to renounce their own ability to resolve the dispute.

In the mental health context, both of these options have resulted in an extensive delegation of power to psychiatrists. Where the court is without analogy, it turns to someone it feels is more equipped to make the decision and delegates extensive power over commitment and treatment decisions to psychiatrists. When the courts do find an analogy, the one most often utilized is that of a helpless child, incapable of making any decisions about his or her best interests. Adopting this model also leads to a delegation of decision-making authority to the psychiatrist because he or she is seen as the person best equipped to care for the ailing individual.

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[112] Ivan Illich explains in *Limits to Medicine: Medical Nemesis: The Expropriation of Health* (Toronto: McClelland & Stewart, 1976) at 6: "Society has transferred to physicians the exclusive right to determine what constitutes sickness, who is or might become sick, and what shall be done to such people."

[113] *Fenton, supra*, note 46 is one mental health case where the Court was able to draw an analogy to a "safer" area of law. While the decision was an important victory in terms of structuring work programs in institutions (and for disabled persons in general) and in terms of provincial funding obligations, it is not a typical mental health case. There was no issue on which the Court had to second guess psychiatric judgments; there was no question of releasing, or even not treating, any patient as a result of the decision. In other words, the Court was treading in an area in which courts are commonly known to tread – labour standards and their equal application. *Fenton* may be of limited use in helping courts to determine issues that really are unique to involuntary psychiatry, like commitment or forced treatment.

If courts do have to make analogies to deal effectively with forced commitment and treatment, then the most appropriate analogy is that of the criminal law. Only this model recognizes the massive deprivations of liberty involved in forced commitment and treatment and the coercive nature of involuntary psychiatry in general. When an individual is "hospitalized" or "treated" without his or her consent under the auspices of mental health legislation, the state is exercising one of the most invasive powers known in our law. State compelled psychiatric treatment is not just a medical issue, it is also a political and social one.[114] The state delegates extensive power to psychiatrists to decide whom we as a society will deprive of their liberty and of their freedom of thought. The mere fact that we are depriving a person of liberty purportedly in his or her own best interest should not allow us to rob the individual involved of all rights to which he or she would otherwise be entitled.

A person accused of a crime in Canada has far more protections built into the law than does a person facing civil commitment. While our system of criminal justice is far from perfect, we have accepted a system weighted heavily in favour of the rights of accused persons. We have chosen a rights model in criminal law because we recognize the seriousness of the deprivation of liberty facing an accused person. The cost to any accused person of the system making a mistake is so serious that we need to erect hurdles over which the state must jump in order to justify imprisonment. There is a recognition in the criminal context that the difference in power between the state and the accused person requires significant legal protections for the accused. Proof beyond a reasonable doubt and the presumption of innocence serve this function.

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[114] History is replete with examples of political abuse being perpetrated through manipulations of the concept of "mental illness." One glaring example in North American history occurred as recently as the 1970s. Prior to 1973, the American Psychiatric Association viewed homosexuality as a mental disorder. After holding a referendum of its members in 1973, homosexuality was removed from the diagnostic manual of the Association. Had the Association voted differently, presumably homosexuality would still be seen as a form of mental illness. See the American Psychiatric Association, "Position Statement on Homosexuality and Civil Rights" (1974) 131 Am. J. Psych. 497. For a disturbing account of the misuse of psychiatry for political purposes in the Soviet Union, see R. J. Bonnie, "Coercive Psychiatry and Human Rights: An Assessment of Recent Changes in the Soviet Union" (1990) 1 Crim. L. Forum 319.

Given the serious consequences ensuing from civil commitment and involuntary treatment, we must insist on similar hurdles in the context of involuntary psychiatry. Mistakes in the commitment context can have serious and potentially irreversible consequences for the individual. Doctors, like any other persons exercising force under state authority, must be required to justify their decisions and to subject those decisions to careful scrutiny by an independent body. Putting hurdles in front of doctors making commitment and treatment decisions could well improve the quality of their decision-making and force them to resort to involuntary commitment and treatment only when absolutely necessary.[115]

Increased procedural protections might slow down and on occasion interfere with the smooth running of psychiatric facilities. Involuntary treatment might be delayed and some patients could suffer as a result. However, no system that exercises as much power as is involved in decisions to commit and to treat forcibly should be allowed to function unimpeded without any accountability to outsiders or any examination of the fairness of its decision-making.

I am not suggesting that courts are the best institution to be making detailed decisions about what kinds of treatment detained individuals should undergo. Rather, I am suggesting that courts are competent to scrutinize the judgments of experts to ensure that they are being applied in a manner consistent with the constitutional rights to which all Canadians are entitled. Judges are often called upon to evaluate expert evidence; the mental health context should be no different. In the words of one American judge:

> Very few judges are psychiatrists. But equally few are economists, aeronautical engineers, atomic scientists, or marine biologists. For some reason, however, many people seem to accept judicial scrutiny of, say, the effect of a proposed dam on fish life, while they reject similar scrutiny of the effect of psychiatric treatment on human lives. Since it can hardly be said that we are more concerned for the salmon than the schizophrenic, I suspect the explanation must lie in our familiarity

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[115] Procedural protections are not only a means to a fairer decision making process, they also reflect the degree of respect and concern given by the state to the individual facing a deprivation of liberty. In *Constitutional Choices* (Cambridge, Mass.: Harvard University Press, 1985) at 13, Professor L.H. Tribe comments: "If process is constitutionally valued, therefore, it must be valued not only as a means to some independent end, but for its intrinsic characteristics: being heard is part of what it means to be a person."

with judicial supervision of such matters as railroad rates, airplane design, power plant construction and dam-building. While the importance of this factor can be overestimated, in the law as in all other areas we tend to accept the accustomed and fear the new.[116]

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[116] D. Bazelon, "Implementing the Right to Treatment" (1969) 36 U. Chi. L. Rev. 742 at 743.

After this paper went to press, the Ontario Court of Appeal handed down a landmark ruling on the right to refuse treatment. In *Fleming* v. *Reid*; *Fleming* v. *Gallagher*, (28 June 1991), 357/90, 356/90 (Ont. C.A.), a unanimous Court struck down the provisions of the Ontario *Mental Health Act* which empowered the review board to override treatment refusals of a substitute decision-maker. In both cases before the Court, the individuals involved were detained by way of a Lieutenant Governor's Warrant, rather than through the civil commitment process. Both were deemed presently incompetent to make treatment decisions, but had previously, while competent, indicated a desire to refuse anti-psychotic medication. It was on this basis that their substitute decision-maker denied consent on behalf of both men. The Court held that it was unconstitutional for the review board to make its decision on the basis of the "best interests of the patient," rather than on the expressed wishes of the men when competent.

The case specifically limits the ability to forcibly treat an incompetent person, when that person has previously expressed a competent wish to refuse treatment. The case will also have major implications for all provinces that allow forced treatment of individuals who are competent to make treatment decisions and, if followed, could result in striking down legislation in Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland, the Northwest Territories, and the Yukon. The decision is consistent with the analysis in this paper because the Court recognized the intrusiveness of forced treatment as well as the right of all individuals to make choices for themselves, even if those choices may not be in the best interests of the individual involved.