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Isabel Grant

Peter J. Carver

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Abstract
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Keywords
Mentally ill--Commitment and detention; Capacity and disability; Mentally ill--Civil rights; Mental health laws; Ontario

PS v Ontario: Rethinking The Role of the Charter in Civil Commitment†

ISABEL GRANT* AND PETER J. CARVER**

In *PS v Ontario*, the Ontario Court of Appeal held that section 7 of the *Charter* requires that persons who are civilly committed for six months or more must have access to meaningful review over the conditions of their detention. In this paper, the authors argue that the decision has broad implications for provincial civil commitment regimes across the country. In particular, the Court's analogy to the *Criminal Code* Review Board jurisprudence opens the door to a fuller recognition of the profound deprivation of liberty involved in civil commitments. An expanded role for civil review tribunals may be required, including *Charter* jurisdiction. The decision, and Ontario's legislative response, also leave open the pressing question of the scope of liberty interests guaranteed by section 7 for those who are civilly committed for shorter periods of time. The authors conclude that this decision should trigger a reconsideration of civil commitment review processes across the country for all persons detained in psychiatric facilities.

Dans l'affaire *PS c. Ontario*, la Cour d'appel de l'Ontario a conclu que l'article 7 de la *Charte* exige que les personnes internées pour six mois ou davantage dans un hôpital psychiatrique aient droit à une révision probante de leurs conditions d'incarcération. Dans cet article, les auteurs prétendent que ce jugement affecte largement partout au pays les programmes

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* Professor, Peter A. Allard School of Law, University of British Columbia.

** Professor, Faculty of Law, University of Alberta.

provinciaux d'internement dans des hôpitaux psychiatriques. En particulier, l'analogie entre la Cour et la jurisprudence relative aux commissions d'examen en matière criminelle ouvre la porte à une meilleure reconnaissance de la profonde privation de liberté qu'entraîne l'internement dans un hôpital psychiatrique. Cela pourrait donner aux tribunaux responsables de la révision des cas d'internement dans des hôpitaux psychiatriques un rôle plus étendu, comprenant une compétence sur la *Charte*. Le jugement et la réponse législative de l'Ontario ouvrent également la porte à la question contraignante de la portée des libertés que garantit l'article 7 aux personnes internées pour de plus courtes périodes de temps. Les auteurs sont d'avis que ce jugement devrait entraîner dans l'ensemble du pays une reconsidération du processus de révision de l'internement dans des hôpitaux psychiatriques.

CIVIL COMMITMENT REGIMES in every province and territory in Canada allow the state to detain individuals with a mental illness without their consent, usually on the basis that they present a threat to themselves or to others, or are at risk of serious physical or mental deterioration.[1] Such detentions must be renewed

1. See *Mental Health Act*, RSBC 1996, c 288, s 22(3)(c)(ii) [BC *Mental Health Act*]; *Mental Health Act*, RSA 2000, c M-13, s 2 [Alberta *Mental Health Act*]; *Mental Health Services Act*, SS 1984-85-86, c M-13.1, s 24(2)(a)(iii) [Saskatchewan *Mental Health Services Act*]; *Mental Health Act*, CCSM, c M110, s 17(1)(b)(i) [Manitoba *Mental Health Act*]; *Mental Health Act*, RSO 1990, c M.7, s 20(1.1) [Ontario *Mental Health Act*]; *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, s 17 [Nova Scotia *Involuntary Psychiatric Treatment Act*]; *Mental Health Act*, RSNB 1973, c M-10, s 8.1(1) [New Brunswick *Mental Health Act*]; *Mental Health Care and Treatment Act*, SNL 2006, c M-9.1, s 17(1)(b)(ii)(A) [Newfoundland *Mental Health Care and Treatment Act*]; *Mental Health Act*, SPEI 1994, c 39, s 13(1) [PEI *Mental Health Act*]; *Mental Health Act*, RSY 2002, c 150, s 13(1) [Yukon *Mental Health Act*]; *Mental Health Act*, RSNWT 1988, c M-10, s 13 [NWT *Mental Health Act*]; *Mental Health Act (Nunavut)*,

periodically. While there are limits on each renewable period of detention, no jurisdiction has imposed a limit on the overall length of time an individual may be detained. Every province and the Yukon have a tribunal to which a civilly committed individual may apply to have his or her detention reviewed.[2]

Civil commitment has been described as "the most significant deprivation of liberty without judicial process that is sanctioned by our society."[3] Some advocates hoped that the *Canadian Charter of Rights and Freedoms*[4] would serve as the catalyst for the reform of civil commitment laws and for a greater recognition of the liberty interests involved but, with a few exceptions, the *Charter* has not lived up to its billing.[5] H Archibald Kaiser has called for a reassessment of coercive hospitalization and treatment as the centrepiece of mental health law given

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RSNWT 1988, c M-10, s 13 [Nunavut *Mental Health Act*]. In Québec a physician may place a person under preventive confinement for up to 72 hours without authorization of the court and prior to psychiatric examination if he or she is of the opinion that the person presents a grave and immediate danger to himself and others: *An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others*, CQLR c P-38.001, s 7 [*Protection Act*]. With respect to deterioration, Ontario requires "serious physical impairment" to the individual (*ibid,* s 20 (5)(a)(iii)), whereas British Columbia requires "substantial physical or mental deterioration" (*ibid,* s 22(3)(c)(ii)).

2. BC *Mental Health Act*, *supra* note 1, s 25; Alberta *Mental Health Act*, *supra* note 1, s 41; Saskatchewan *Mental Health Services Act*, *supra* note 1, s 34(8); Manitoba *Mental Health Act*, *supra* note 1, s 56(1); Ontario *Mental Health Act*, *supra* note 1, s 39(1); Nova Scotia *Involuntary Psychiatric Treatment Act*, *supra* note 1, s 68; Newfoundland *Mental Health Care and Treatment Act*, *supra* note 1, s 64(1)(a); PEI *Mental Health Act*, *supra* note 1, s 28(1); Yukon *Mental Health Act*, *supra* note 1, s 30(1). North West Territories and Nunavut do not have a review tribunal and instead decisions on detention are made by a territorial judge. In Québec, appeals are heard before the Administrative Tribunal of Québec: *Protection Act*, *supra* note 1, s 21. In New Brunswick the tribunal reviews applications submitted by reviewing physicians for involuntary admission and then determines whether to confirm in writing an order for that person to be admitted involuntarily: New Brunswick *Mental Health Act*, *supra* note 1, s 8.1(1).
3. Raj Anand, "Involuntary Civil Commitment in Ontario: The Need to Curtail the Abuses of Psychiatry" (1979) 57 Can Bar Rev 250 at 251.
4. *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.
5. H Archibald Kaiser, "Canadian Mental Health Law: the Slow Process of Redirecting the Ship of State" (2009) 17 Health LJ 139 at 148-49. One notable exception is the decision in *Fleming v Reid*, [1991] 4 OR (3d) 74, 82 DLR (4th) 298, where the Ontario Court of Appeal found that the existing treatment regime for persons deemed incompetent to consent to treatment violated section 7 of the *Charter* because it failed to consider previously expressed wishes made by the individual when competent.

Canada's ratification of the *Convention on the Rights of Persons with Disabilities*.[6] To date, neither courts nor legislatures have picked up on this call to action.

Three aspects of the civil commitment process have attracted *Charter* scrutiny. First, the *Charter* has been used to challenge the criteria by which the commitment decision is made, usually by physicians. With one notable exception, judges have shown deference to legislators and to physicians in assessing the criteria for civil commitment.[7] Second, the *Charter* can be used to challenge the statutory regime for nonconsensual treatment that may accompany

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6. *Convention on the Rights of Persons with Disabilities*, 13 December 2006, 189 UNTS 137 [*CRPD*]. While the *CRPD* does not explicitly address involuntary hospitalization and treatment, Kaiser argues that some provisions bring the coercive nature of provincial Mental Health Acts into question. For example, he refers to article 17: "Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others." Kaiser concludes that "[t]he CRPD demands no less than a *tabula rasa* study of the entire current system of Canadian involuntary measures, which are so firmly anchored in the now displaced or at least repositioned medical model." H Archibald Kaiser, "Law and Psychiatry in the Age of the *Convention on the Rights of Persons with Disabilities* (*CRPD*)" in Richard D Schneider & Hy Bloom, eds, *Law and mental disorder: a comprehensive and practical approach* (Toronto: Irwin Law, 2013) 1333 at 1345 [Kaiser, "Law and Psychiatry"]. See also H Archibald Kaiser, "The *Convention on the Rights of Persons with Disabilities*: Beginning to Examine the Implications for Canadian Lawyers' Professional Responsibilities" (2012) 20:2 Health L Rev 26. The *PS* Court does not refer to the *CRPD*, which in general has not garnered the attention of courts in Canada.

7. *McCorkell v Riverview Hospital (Director)*, [1993] BCJ No 1518, 104 DLR (4th) 391 [*McCorkell*]. In *McCorkell,* Justice Donald rejected a *Charter* challenge to the BC civil commitment criteria. For a more detailed discussion, see the text accompanying note 69. See also *Thompson and Empowerment Council v Ontario*, 2013 ONSC 5392, [2013] OJ No 4106; *Reference re Procedures and Mental Health Act* (1984), 5 DLR (4th) 577, 8 CRR 142, (sub nom *Re Jenkins)* 45 Nfld & PEIR 131, 132 APR 131 (PEICA) where the PEI Court of Appeal upheld the impugned legislation, finding that the provision on involuntary commitment did not constitute prohibited discrimination on the basis of mental disability under s 15(1) and that restrictions owing to the infirmity of people with mental disabilities were reasonable limits within s 1. Further, since involuntary persons detained under the Act may have the validity of their detention determined by *habeus corpus*, there was no violation of s 10.

   Thwaites v Health Sciences Centre Psychiatric Facility, [1988] 3 WWR 217 [*Thwaites*], was an early exception to this where the Manitoba Court of Appeal held that committal criteria failed to sufficiently define the persons who could be subject to committal and the circumstances under which they could be compulsorily detained. The standard at issue in *Thwaites* was extremely all-encompassing as the legislation provided that a person could be admitted involuntary if a qualified medical practitioner thought the person "should be admitted as a patient at a psychiatric facility." After the *Thwaites* decision, the government responded by amending the legislation to provide for a "dangerousness" test to be met prior to certifying involuntary admission. The legislation also provided a more specific definition of "mental disorder" and "mental retardation."

civil commitment, depending on the particular legislative regime in force in the province.[8] Finally, the procedures and powers of the review tribunals that exist in almost every jurisdiction to review civil commitment may be subject to a *Charter* challenge. It is this last stage that is the focus of this article.

This article addresses a groundbreaking decision of the Ontario Court of Appeal that required the Ontario government to revise significantly the legislation governing its civil commitment review tribunal and has the potential to prompt changes to the role of such tribunals across Canada. In *PS v Ontario*,[9] a panel of five judges of the Court of Appeal unanimously concluded that the civil commitment legislation in Ontario violated section 7 of the *Charter* because it provided for long-term commitment without adequate procedures to protect the liberty interest of the person committed. The Court held that an individual could not be civilly committed beyond six months, because the Consent and Capacity Review Board ("CCB"), the tribunal that reviews commitment decisions in Ontario, did not have jurisdiction to monitor and ensure that the committed individual was receiving appropriate treatment and being held in conditions that were minimally restrictive of his or her liberty. In this article, we argue that the Court's decision is broad enough to apply to all Canadian jurisdictions that have civil mental health tribunals and has the potential to change radically the landscape of civil commitment review tribunals in Canada. We also examine the Ontario government's response to the *PS* decision and argue that, while the response will improve the plight of persons detained for more than six months, its narrow scope is likely to lead to further litigation around the protections given to those detained for shorter periods of time.[10]

This amended legislation was upheld in *Bobbie v Health Sciences Centre*, [1988] MJ No 485, [1989] 56 Man R (2d) 208 (MBQB).

8. In a landmark Ontario Court of Appeal decision, the Court struck down the provisions of Ontario's *Mental Health Act* that allowed the best interests of an incompetent individual to override his or her previously expressed competent wishes about treatment. See *Fleming v Reid*, *supra* note 5. Recently, a *Charter* challenge was launched to the provisions of the BC *Mental Health Act* which provide that any treatment given to someone detained involuntarily is "deemed" to be given with the consent of that person. The Council of Canadians with Disabilities and two individual plaintiffs are challenging this law under s.7 of the *Charter*. See Andrew Woo, "B.C. patients launch court challenge over psychiatric treatments" *The Globe and Mail* (13 September 2016), online: <www.theglobeandmail.com/news/british-columbia/bc-patients-launch-court-challenge-over-forced-psychiatric-treatments/article31846031/>; *BC Mental Health Act*, *supra* note 1, s 31(1).
9. 2014 ONCA 900, [2014] 379 DLR (4th) 191 [*PS*].
10. When we refer to commitment of greater than six months in *PS*, we are actually referring to commitments that are longer than six months and two weeks, which is the actual time allowed for by the Ontario Court of Appeal's remedy. See *infra* note 53.

I. PS V ONTARIO AND ITS NATIONAL SCOPE

A. THE FACTS

After serving a sentence of forty-five months in Kingston Penitentiary for sexual assault against a twelve year-old boy, during which time he received no treatment or therapy,[11] PS was civilly committed under Ontario's *Mental Health Act*. He remained committed at the Oak Ridge division of Penetanguishene Mental Health Centre (now called the Waypoint Centre for Mental Health Care) for nineteen years in circumstances that even his doctors conceded constituted mere warehousing.[12] The appellant was deaf and had very limited ability to speak or understand spoken language. He communicated using a version of Signed English and some American Sign Language (ASL).[13] PS spent his entire time in a maximum security wing at Waypoint Centre even after a hearing by the CCB concluded that, while he met the conditions of civil commitment, he did not require placement in maximum security. The CCB also found repeatedly that Waypoint did not have treatment programs suitable for someone with his limited communication skills. Year after year, medium security facilities declined to accept the appellant as an inpatient.[14] PS was fifty-six years old at the time of the hearing.

B. THE PRACTICE OF PSYCHIATRIC "GATING"

Why had PS been detained for such a long period of time? He was subject to a practice that is commonly referred to as psychiatric "gating."[15] Gating is a colloquial term used to describe the practice of civilly committing a person, who is identified as dangerous, at or near the end of a sentence of imprisonment.[16]

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11. *PS*, *supra* note 9 at para 7.
12. *Ibid* at para 61. Generally, warehousing refers to the detention of a person indefinitely in a therapeutic hospital setting without providing him or her with medical treatment *i.e.*, a non-therapeutic detention.
13. *Ibid* at para 6.
14. *Ibid* at para 9.
15. See Yukimi Henry, "Psychiatric Gating: Questioning the Civil Committal of Convicted Sex Offenders" (2001) 59:2 UT Fac L Rev 229; Andres Hannah-Suarez, "Psychiatric Gating of Sexual Offenders under Ontario's Mental Health Act: Illegality, Charter Conflicts and Abuse of Process" (2005-2006) 37:1 Ottawa L Rev 71.
16. In several US states, "gating" has been accomplished by the passage of statutes authorizing the civil commitment of sexual offenders to psychiatric treatment facilities. In June 2015, a Federal District Court Judge in Minnesota ruled the civil commitment of sexual offenders at the end of their criminal sentences to be unconstitutional. *Karsjens et al v Jenson et al*, Civ No 11-3659 (D Minn 2015).

In effect, gating represents the use of civil commitment to continue to detain someone who can no longer be held by the criminal justice system but is thought to present a danger to the public. It is used almost exclusively for sex offenders, whose sexual deviance can be labelled as a form of mental illness in order to satisfy the legal requirements of civil commitment. The Ontario Court of Appeal upheld this practice in 1995 in *Starnaman v Penetanguishene Mental Health Centre*,[17] as long as the individual meets the requirements for commitment prescribed by the *Mental Health Act*. The Court of Appeal in *Starnaman* rejected arguments that gating is an inappropriate use of the civil commitment system to augment the dangerous offender regime set out in the *Criminal Code*,[18] and held that it was not contrary to section 7 of the *Charter*. Gating is controversial in part because serious doubts are available with respect to whether effective treatment regimes exist for personality disorders and disorders such as pedophilia. In other words, persons committed to hospital for personality and sexual disorders have little realistic opportunity of having a diagnosed condition remediated to the point of no longer meeting the civil commitment requirements.[19] Thus, individuals who are gated are likely to become long-term detainees of psychiatric facilities. While the decision in *PS* is not limited to those who have been gated and applies to anyone detained involuntarily for more than six months, gated individuals are likely to become long-term detainees.

We have not been able to find any gating cases outside Ontario. While this may be explained by different protocols and policies adopted by health systems and practitioners in the other provinces, it would also seem to result from the variation in commitment criteria. Criteria in several jurisdictions incorporate the requirement that the mental disorder require treatment in a psychiatric facility.[20]

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17. *Starnaman v Penetanguishene Mental Health Centre,* [1995] 24 OR (3d) 701,100 CCC (3d) 190 [*Starnaman*]. The Ontario Divisional Court reached a similar result in *Penetanguishene Mental Health Centre v Stock*, [1994] OJ No 1545 [1994] 116 DLR (4th) 550.
18. *Criminal Code*, RSC 1985, c C-46.
19. Kaiser describes the intractable problem created by those who present a danger based on a personality disorder yet who are found to be criminally responsible: "The very nature of a personality disorder compared to psychosis virtually guarantees that there will be conflict and uncertainty at every level of the accused's experience with the criminal justice and mental health care systems." H Archibald Kaiser, "*R v Knoblauch*: A Mishap at the often ambiguous crossroads between the criminal justice and the mental healthcare systems" (2001) 37 CR (5th) 401 at 404.
20. See *e.g.* BC *Mental Health Act*, *supra* note 1, s 22(3)(c)(i); Saskatchewan *Mental Health Services Act*, *supra* note 1, s 24(2)(a)(i); and Manitoba *Mental Health Act*, *supra* note 1, s 17(1)(b)(ii).

Ontario has no such requirement.[21] *PS* was heard by a panel of five justices because the Court of Appeal thought that the constitutionality of psychiatric gating, upheld in *Starnaman,* might need to be reconsidered. In the end, however, the Court focused on all long-term detainees and did not address the constitutionality of gating.

C. JURISDICTION OF THE CONSENT AND CAPACITY BOARD

The *PS* case deals with the decision-making authority of Ontario's CCB, an administrative tribunal whose extensive jurisdiction in health care matters is unique among Canadian provinces. The CCB serves as a review tribunal for those who have been civilly committed to psychiatric facilities in Ontario, but it has several other functions as well. The CCB has decision-making authority with respect to review of medical determinations of incapacity to consent to treatment,[22] the appointment of a representative to consent to treatment,[23] review of appointments of substitute decision-makers for incapable individuals, applications by substitute decision-makers to depart from the prior wishes of a person made during a period of capability,[24] and review of consent given to the admission of incapable individuals to hospital facilities.[25] These functions are all in addition to its review of civil commitment to psychiatric facilities and commitment to community treatment orders (CTOs) under the Ontario *Mental Health Act*. The CCB has no counterpart in the rest of Canada[26] where, generally speaking, civil mental health review tribunals have jurisdiction only to review civil commitment and, in some provinces, to review CTOs and applications by hospitals to override treatment refusals.[27] Given its various roles, the CCB is a

21. Ontario *Mental Health Act*, *supra* note 1, s 20(5).
22. *Health Care Consent Act, 1996*, SO 1996, c 2, Sched A, s 32.
23. *Ibid*, s 33.
24. *Ibid*, s 36.
25. *Ibid*, s 34.
26. With the exception of the Yukon's Capability and Consent Board, empowered under the Territory's *Care Consent Act*, SY 2003, c 21, Sched B for purposes similar to the CCB in Ontario.
27. In the Northwest Territories and Nunavut, reviews of involuntary admission are conducted by the Supreme Court of the Northwest Territories, and the Nunavut Court of Justice, respectively: See NWT *Mental Health Act*, *supra* note 1, s 26. Both Courts have the authority to "make any other order the judge considers appropriate" in addition to confirming or canceling the certificates of admission, under s 28(2)(c).

large tribunal with an extensive jurisprudence.[28] Prior to the changes prompted by the *PS* decision, the CCB's jurisdiction to review civil commitment was narrowly defined, much as is the case with other provinces' review tribunals. It could order that involuntary detention continue or that involuntary status be rescinded and the individual released. In 2010, the Ontario legislature gave the CCB the jurisdiction to order that an individual detained involuntarily be transferred to another facility at certain points after at least nine months of civil commitment.[29]

D. THE DECISION

1. SUPERIOR COURT OF JUSTICE

PS brought a *habeas corpus* application to the Ontario Superior Court of Justice seeking, among other things, a declaration that his rights had been violated under sections 7 and 15 of the *Charter*. Justice McCarthy held that the decision in *Starnaman* had "conclusively" determined that the *Mental Health Act* does not offend against the procedural component of the principles of fundamental justice.[30] He found that PS had been properly admitted and that the CCB had regularly reviewed his involuntary status.[31] Justice McCarthy found that, although PS was detained in a maximum security facility that was excessive for his needs, he enjoyed "uncommon" freedoms and privileges that were often tailored to his individual needs.[32] In rejecting the argument that PS's security interests were infringed, he found that PS had not suffered "any serious state imposed psychological harm or stress."[33] He also went on to reject PS's argument that Waypoint's failure to retain deafness experts to assist in his assessments and treatment left him unable to participate meaningfully in his rehabilitation, thereby lengthening his detention. Instead, Justice McCarthy found that the record was "replete with treatments and opportunities afforded to the Appellant."[34] He

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28. In the 2014-2015 year, the CCB had 123 members, divided roughly equally between lawyers, psychiatrists and members of the public. The Board convened 3,586 hearings. See Consent and Capacity Board, *Annual Report of the CCB for 2014-2015*, (Ottawa: Consent and Capacity Board 2015), online: CCB <http://www.ccboard.on.ca/>.
29. Ontario *Mental Health Act*, *supra* note 1, s 39.2. This provision was repealed as part of the amendments made following the Court of Appeal's decision in *PS*, amendments that included giving the CCB the power to order transfers for those subject to a "certificate of continuation." See discussion in Part II below.
30. *Scott v Her Majesty the Queen*, 2013 ONSC 2970 at para 43, 229 ACWS (3d) 259.
31. *Ibid* at para 45.
32. *Ibid* at para 69.
33. *Ibid* at para 72.
34. *Ibid* at para 76.

concluded his section 7 analysis by rejecting the argument that PS had merely been warehoused, and found that the evidence indicated that he had enjoyed a variety of opportunities and freedoms, transfer options had been explored, and that PS's own failure to take action to initiate a transfer had contributed to his remaining at Waypoint.[35] Accordingly, he held that the impugned provisions of the *Mental Health Act* and the actions of Waypoint had not infringed section 7 of the *Charter*.[36]

PS based his challenge under section 15(1) of the *Charter* on an allegation of discrimination on the ground of physical disability, specifically deafness. He presented evidence demonstrating that, throughout his nineteen years of involuntary committal, therapeutic interactions with him had generally been carried out without the provision of ASL interpreters. Justice McCarthy concluded that the Supreme Court of Canada's seminal ruling in *Eldridge v British Columbia (Attorney General)*,[37] in which the Court held that equality required public hospitals to provide interpreters for deaf patients as part of delivering medical services, applied to PS's circumstances. However, he interpreted the *Eldridge* principle as requiring interpretation only for "*significant* therapeutic interventions,"[38] which he believed had occurred on four specified occasions, all prior to 2006. On none of those occasions, he noted, were the breaches "intentional."[39] At worst, PS was simply in an inappropriate facility for his needs. Justice McCarthy found no violations of section 15(1) since that time, and made no declaration with respect to section 15(1).

2. THE ONTARIO COURT OF APPEAL

PS appealed the decision to the Ontario Court of Appeal. With respect to section 7, the Court of Appeal began by making a distinction between those individuals who are civilly committed for less than six months (roughly 98%), and those who are civilly committed for more than six months (roughly 2%).[40] Relying on these statistics, the Court held that the focus of the CCB is on short-term committal and whether the patient meets the criteria for commitment.[41] However, when

35. *Ibid* at para 86.
36. *Ibid* at para 103.
37. [1997] 3 SCR 624, 151 DLR (4th) 577.
38. *Supra* note 30 at para 103 [emphasis added].
39. *Scott v Her Majesty the Queen*, *supra* note 30 at para 100.
40. *PS*, *supra* note 9 at para 26.
41. *Ibid* at para 193.

commitments extend beyond six months, the *Charter* requires that the CCB have additional powers to deal with those commitments.[42]

The Court acknowledged the significant deprivation of liberty involved in civil commitment. Even where protection of the public requires detention, "the state cannot detain people for significant periods of time without providing them with a fair procedural process."[43] The Court acknowledged that the greater the impact on the liberty of the individual the greater the need for procedural protections and that "factual situations which are closer or analogous to criminal proceedings will merit greater vigilance by the courts."[44] This finding was particularly significant because it enabled the Court to rely heavily on jurisprudence involving various provincial *Criminal Code* Review Boards in which concerns around the liberty interests of the accused have been much more front and centre than in the civil commitment context. *Criminal Code* Review Boards have the power to impose conditions that relate to the provision of medical services and treatment and, by analogy, so must tribunals that review civil commitment:

> In sum, the case law suggests that in the non-punitive detention context, s. 7 requires the body reviewing detention to have the procedures and powers necessary to render a decision that is minimally restrictive on liberty in light of the circumstances necessitating the detention.[45]

By failing to give the CCB the necessary tools to protect the liberty interests of long-term involuntary detainees, the *Mental Health Act* failed to ensure that "the liberty interest of the [detained individual is] built into the statutory framework."[46] Specifically, the Court held that the CCB lacked the jurisdiction "to supervise security level, privileges, therapy and treatment of long-term detainees and to craft orders that would ensure an appropriate balance between public protection and the protection of detainees' liberty interests."[47]

The Court rejected the argument that the CCB's new jurisdiction to transfer those held involuntarily, conferred by the 2010 amendments, was sufficient to uphold the legislation under section 7. The CCB had no authority to order that the individual be transferred to a different level of security within a detaining

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42. *Ibid* at paras 128-29, 197.
43. *Ibid* at para 78 citing *R v Kobzar*, 2012 ONCA 326 at para 57, 110 OR (3d) 671.
44. *Ibid* at para 79 citing *Dehghani v Canada (Minister of Employment & Immigration)*, [1993] 1 SCR 1053 at 1077, 101 DLR (4th) 654.
45. *Ibid* at para 92.
46. *Ibid* at para 115 citing *Penetanguishene Mental Health Centre v Ontario (Attorney General)*, 2004 SCC 20 at para 53, [2004] 1 SCR 498.
47. *Ibid* at para 115.

institution, to transfer the individual to another hospital with conditions, or to increase access to the community or order conditions to prepare for gradual release.[48] One example of the inadequacy of the CCB's powers was the fact that the *Mental Health Act* did not give it "the power to issue a community treatment order as an alternative to detention for an individual certified as an involuntary patient."[49] The Court held that the *Mental Health Act* must provide the CCB with sufficient flexibility to ensure that individuals are not subjected to overly restrictive or prolonged detentions and to make sure that the individual's treatment is moving them towards reintegration into society. The Court envisaged a review mechanism that would allow the CCB to examine basic questions as to "where and how a person is detained and how they are discharged into the community."[50]

The Court crafted a simple but elegant remedy in this case, pursuant to section 52(1) of the *Constitution Act, 1982*.[51] Rather than invalidating the whole civil commitment regime, it focused on the provisions that provided for renewals beyond six months. It struck out the words "or subsequent," thus disallowing renewals beyond six months.[52] Section 20(4), as modified by the Court's order provided as follows:

> An involuntary patient may be detained, restrained, observed and examined in a psychiatric facility,
>
> a. for not more than two weeks under a certificate of involuntary admission; and
>
> b. for not more than,
>
> i. one additional month under a first certificate of renewal,
>
> ii. two additional months under a second certificate of renewal, and
>
> iii. ~~three additional months~~[53]

Because the Board only had jurisdiction to order a transfer after approximately nine months, the Court held that the transfer provision would no longer be applicable because individuals could not be committed for nine

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48. *Ibid* at para 126.
49. *Ibid*. As will be discussed in Part III B, this is one deficiency identified by the Court of Appeal that was not addressed in the Ontario government's amendments.
50. *Ibid* at para 127.
51. *Constitution Act, 1982*, being Schedule B to the Canada Act 1982 (UK), 1982, c 11.
52. *Ibid* at para 202.
53. Ontario *Mental Health Act*, *supra* note 1, s 20(4) [strike-out added to reflect the Court's order]. The Court apparently overlooked the fact that the remedy ordered here actually allows for commitment beyond six months since there is the initial two weeks, followed by one month, an additional two months, and finally three more months add up to a total of six months and two weeks.

months. The Court left for another day the question of whether problems of the kind encountered in this case could arise in short-term civil commitment.[54] It suspended the operation of its remedy for a period of twelve months so that the Ontario government could consider how to revise its legislative regime.[55]

With respect to the equality rights claim, again the Court of Appeal unanimously found in PS's favour. The Court rejected the "significant intervention" test as being too narrow for this form of discrimination. It stated that properly interpreted, *Eldridge* had established a threshold of "effective communication," and that in the context of civil commitment, this had a particularly strong content. Justice Sharpe described the implications as follows:

> I note here that s. 15(1) does not require "24/7" interpretation services for all aspects of daily living, but in the context of involuntary detention, it certainly does require a degree of accommodation beyond the context of significant therapeutic services and interactions. In *Eldridge*, the court held, at para. 82, that the "'effective communication' standard is a flexible one, and will take into consideration such factors as the complexity and importance of the information to be communicated, the context in which the communications will take place and the number of people involved." The means for effective communication does not have to be provided at all times and in every situation.
>
> However, statutorily-mandated detention renders detainees entirely dependent upon the hospital, whether privately or publicly operated, for essential services and treatment. In my view, in the context of detention, the flexible *Eldridge* standard of "effective communication" mandates the regular provision of communication through deaf appropriate services in order to ensure that the detainees' basic and fundamental personal needs are being fully understood and consistently addressed.[56]

The Court went on to say that the applications judge had erred by finding violations of PS's section 15 rights only on isolated occasions, in the face of evidence that hospital authorities had relied for years on written communication with PS despite being aware that he was functionally illiterate and required ASL interpretation for comprehension. The Court made a particular point of noting the importance of using interpreters for effective communication of requests for consent to treatment, something the facility had consistently failed to do.

With respect to its ruling that PS's equality rights had been consistently and unjustifiably violated over a period of years, the Court awarded declaratory relief as follows, pursuant to the remedial power in section 24(1) of the *Charter*:

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54. *PS*, *supra* note 9 at para 204.
55. *Ibid* at para 206.
56. *Ibid* at paras 147-148.

1. that the appellant's s. 15(1) rights have been violated, and

2. setting out in general terms the nature and extent of his entitlement under s. 15(1), namely, that Ontario and Waypoint are required to provide the necessary and appropriate communication services that will ensure: (i) that the appellant's basic and fundamental personal needs as a detainee are fully understood and addressed, and (ii) that the appellant is able to communicate effectively to access the therapeutic, treatment and other programs offered to hearing detainees.[57]

PS represents the most fulsome elaboration by a Canadian appellate court of the *Eldridge* principles with respect to access to equal public services by deaf persons, and indeed by persons with disabilities generally.

E. NATIONAL SIGNIFICANCE OF PS V ONTARIO

Since *PS* has binding force only in Ontario, why should academics and lawyers outside the province still take heed of this decision? While the mental health regime in Ontario is unique, features of Ontario's legislation germane to the reasoning in *PS* are common to most provincial and territorial mental health statutes.[58] In other words, the shortcomings identified by the Ontario Court of Appeal in *PS* exist across the country. Every province and territory provides for civil commitment that can last longer than six months.[59] For example, in British Columbia, an individual can be detained for one month, renewed for a second month, then three months followed by an unlimited number of six-month

57. *Ibid* at para 207.

58. We confine our general remarks to Canada's common law jurisdictions. Mental health law in Québec has distinct features owing both to its civil law system and the role of an omnibus administrative tribunal, the Administrative Tribunal of Québec (ATQ). Civil mental health law in Québec is governed By provisions of that province's *Civil Code of Québec*, CQLR c CCQ-1991, the *Code of Civil Procedure, CQ*LR c C-25, and the *Protection Act*, *supra* note 1. Beyond an initial 72 hour period of hospital confinement, a person is subject to involuntary admission only by virtue of a court order, and for a period specified by the court (subject to renewal). The individual may seek a review of the order of confinement before the ATQ, the tribunal that conducts administrative reviews across many areas of public governance in Québec. The ATQ also acts as the forensic review board in Québec for purposes of Part XX.1 ("Mental Disorder") of the *Criminal Code*, *supra* note 18.

59. BC *Mental Health Act*, *supra* note 1, s 24(1)(c); Alberta *Mental Health Act*, *supra* note 1, s 8(3)(c); Saskatchewan *Mental Health Services Act*, *supra* note 1, ss 24.5(1); Manitoba *Mental Health Act*, *supra* note 1, s 21(4); Ontario *Mental Health Act*, *supra* note 1, s 20(4)(b); *Civil Code of Québec*, *supra* note 58; Nova Scotia *Involuntary Psychiatric Treatment Act*, *supra* note 1, s 22; New Brunswick *Mental Health Act*, *supra* note 1, s 13(1)(c); Newfoundland, *Mental Health Care and Treatment Act*, *supra* note 1, s 31(1)(c); PEI *Mental Health Act*, *supra* note 1, ss 16(3), 16(3)(c); Yukon *Mental Health Act*, *supra* note 1, s 16(1); NWT *Mental Health Act*, *supra* note 1, s 23.2(1); Nunavut *Mental Health Act (Nunavut)*, *supra* note 1, s 23.2(1).

renewals.[60] Nova Scotia is similar except no single renewal is for more than three months.[61] None of these jurisdictions puts a limit on how long a person can be detained. Some provinces provide a role for the tribunal in reviewing treatment decisions[62] while others limit their tribunals to reviewing the status of civil commitment and release.[63] In British Columbia, for example, the civil review tribunal only has the jurisdiction to review detention, although this extends to those on extended leave.[64] Unlike in Ontario, the BC statute gives the review panel no jurisdiction whatsoever regarding treatment which, for those with involuntary status, can be imposed without consent.[65] Further, no provincial mental health legislation in Canada provides the kind of jurisdiction envisaged by the Ontario Court of Appeal in *PS* to supervise the conditions of long-term commitment. Nor does any provincial review tribunal, outside of Ontario, have the authority to transfer the individual to another facility, although Prince Edward Island and the Yukon provide for review of a physician's transfer decision,[66] and New Brunswick requires the review tribunal to approve transfers to another jurisdiction.[67] The legislative amendments made in Ontario following the judgement in *PS*—discussed below in Part II—mean that Ontario is now the only province in Canada that provides significant procedural protections to long-term civilly committed individuals.

We have seen small steps towards expanding the jurisdiction of review tribunals in some provinces. Nova Scotia, for example, allows the Review Board

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60. BC *Mental Health Act*, *supra* note 1, s 24(1).
61. Nova Scotia *Involuntary Psychiatric Treatment Act*, *supra* note 1, s 22.
62. Manitoba *Mental Health Act*, *supra* note 1, s 30(5); PEI *Mental Health Act*, *supra* note 1, s 24(4).
63. See, for example, BC (*Mental Health Act*, *supra* note 1, s 25(2)) and Saskatchewan (*Mental Health Services Act*, *supra* note 1, s 34(8)).
64. BC *Mental Health Act*, *supra* note 1, ss 25(2), 39(1). Extended leave refers to the practice in British Columbia of releasing people from a psychiatric facility where they retain the status of being detained involuntarily. Such individuals may be brought back into the hospital at any time without any procedural protections and continue to be subject to treatment without consent, which is allowed for all those who are civilly committed in British Columbia. Individuals on extended leave continue to have access to the Review Panel but the *Mental Health Act* puts no limit on the length of time an individual can be on extended leave.
65. *Ibid* s 31.
66. PEI *Mental Health Act*, *supra* note 1, 28(1)(g); Yukon *Mental Health Act*, *supra* note 1, s 24(2).
67. New Brunswick *Mental Health Act*, *supra* note 1, s 27. New Brunswick has a somewhat unique regime in which a physician must apply to the Review Board in order to have a person admitted to a psychiatric facility, although the person may be detained and treated pending the tribunal's decision.

to assess community treatment orders.[68] In general, when the Review Board is considering an application to review detention or a community treatment order, it may make "such recommendations to the chief executive officer as it sees fit respecting the treatment or care of a patient."[69] However, the statute stops short of giving the Board the jurisdiction to make orders regarding treatment or other conditions of detention as the chief executive officer is not required to implement any of the recommendations made by the tribunal.[70] Prince Edward Island has a unique provision guaranteeing certain communication rights on the part of the detained individual, and the tribunal can review denial of those rights.[71] Despite these exceptions, no province outside Ontario has enacted the kinds of powers required as a matter of constitutional law by *PS*. No provincial tribunal has, for example, the power to order transfers to lower levels of custody, the power to release an individual on conditions or on a community treatment order rather than prolonging detention, the power to scrutinize an individual's freedom of movement within the facility and its surrounding community, or the power to scrutinize treatment plans to ensure that the individual is making progress towards reintegration into the community. *PS* provides important ammunition for challenging all these shortcomings in provincial and territorial regimes.

II. A NEW ROLE FOR ONTARIO'S CONSENT AND CAPACITY BOARD

Having outlined the *PS* decision and its national significance, we wish to explore the significance of the ruling in *PS* for enhanced administrative supervision of the civil mental health systems in Ontario and all common law provinces. We focus on the systemic section 7 issue, rather than on the individualized section 15 claim that was unique to PS's case.

We begin by demonstrating that the most significant aspect of the Court's decision was its reliance on the *Criminal Code* Review Board jurisprudence. We then move on to examine the response to *PS* recently enacted by the Ontario government and demonstrate that, while progressive and important for long-term detainees, it stops short of fully vindicating section 7 liberty interests and may even raise its own section 15 concerns for persons civilly committed for shorter periods of time. Finally, we suggest that the Court's reasoning might imply a

68. Nova Scotia *Involuntary Psychiatric Treatment Act*, *supra* note 1, ss 58, 76(2)(f).
69. *Ibid*, s 68(2).
70. *Ibid*.
71. PEI *Mental Health Act*, *supra* note 1, ss 33(2), 28(1)(h).

broader role for administrative tribunals in the mental health field. Specifically, we raise the possibility of according review responsibility to tribunals with respect to important liberty interests of civilly committed individuals that are put in jeopardy by ongoing use of measures such as physical restraint and seclusion. In turn, this leads us to a brief consideration of an issue raised but not resolved in *PS*—the jurisdiction of mental health review tribunals to address and remedy breaches of a civilly committed individual's *Charter* rights. In our view, a move in the direction of increased independent review of security measures and discharge planning is overdue. Such broad jurisdiction would respond more appropriately to the constitutional interests of liberty and security of person of individuals involuntarily detained in psychiatric facilities across Canada.

A. RELIANCE ON THE *CRIMINAL CODE* REVIEW BOARD MODEL

In 1991, Isabel Grant argued that the coercive nature of civil commitment becomes clearer when analogies are made to the deprivations of liberty involved in the criminal justice system.[72] In *PS*, the Ontario Court of Appeal took a step in that direction by relying heavily on *Criminal Code* Review Board jurisprudence, thus revitalizing the judicial understanding of civil commitment. In our view this is the most significant implication of the decision. The Court's reliance on case law dealing with the *Criminal Code* Review Boards, tribunals established in each province under the *Criminal Code* to make decisions regarding persons found not criminally responsible by reason of mental disorder (NCR) or unfit to stand trial, enables the Court to recognize the serious deprivation of liberty involved in civil commitment. This is in sharp contrast to the approach taken by Justice Donald of the British Columbia Supreme Court in *McCorkell*, an earlier *Charter* challenge to the criteria justifying civil commitment.[73] In *McCorkell*, Justice Donald applied a much more paternalistic approach to civil commitment, justifying the lack of procedural protections on the basis that the system is aimed at helping people who are sick. The analogy to criminal law procedural protections was not relevant to the civil commitment context because of these different rationales:

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72. Isabel Grant, "Mental Health Law and the Courts" (1991) 29 Osgoode Hall LJ 747. Grant's paper was written before the creation of the *Criminal Code* Review Board and thus the author focused on criminal law more broadly. Since that time, the Supreme Court of Canada has differentiated the *Criminal Code* Review Board from the criminal trial process more broadly because of its inquisitorial nature. See *Winko v Forensic Psychiatric Institute*, [1999] 2 SCR 625, 175 DLR (4th) 193 [*Winko*]. However, the *PS* court focuses its analysis on the connection between the *Criminal Code* Review Board and mental health tribunals.
73. *McCorkell*, *supra* note 7.

> It is necessary at this point to repeat what I said earlier concerning the use of criminal cases to decide a mental health matter: the objects and purposes of criminal law and mental health legislation are so different that cases in one area will be of little guidance in the other. A protective statute and a penal statute operate in dramatically dissimilar contexts. Strict and narrow criteria for the detention of persons in a criminal law context reflect our society's notions of fundamental justice for an accused person and protection of the public is a foremost consideration. But in the field of mental health, the same criteria would defeat the purpose of the legislation which is to help seriously mentally ill people in need of protection.[74]

The *McCorkell* Court failed to recognize that even a statute with a protective *purpose* can have the same *effect* on the individual as a punitive statute and thus should trigger the same liberty interests.[75]

Two years prior to *McCorkell*, the law concerning the criminal or forensic psychiatric system had been sent on a new trajectory. In *R v Swain*,[76] the Supreme Court of Canada ruled that the *Criminal Code* provisions that provided for immediate and indefinite detention of a person found to have been NCR at the time of an offence, without assessment of their mental condition at the time of disposition, unjustifiably infringed both sections 7 and 9 of the *Charter*. The Court's decision in *Swain* effectively endorsed a package of reform measures enacted shortly thereafter as Section XX.1 of the *Criminal Code*, the "Mental Disorder" provisions. Central to the reform package was the constitution of Review Boards at the provincial level to supervise the progress of NCR detainees in the forensic psychiatric hospital system. These Boards have authority to rule on issues of discharge, conditions of discharge, security levels within hospital custody, and treatment planning.

In *PS*, the Ontario Court of Appeal revisited and relied on the reasoning in *Swain*. In particular, the Court found that the Supreme Court's understanding of the procedural aspects of fundamental justice in circumstances where the state detains individuals were applicable to civil commitment, at least so far as it relates to those detained involuntarily. The Court of Appeal cited the Supreme Court of Canada's 2007 decision in *Charkaoui et al v Canada (Citizenship and Immigration)*[77] concerning the statutory scheme for detaining and deporting non-citizens believed to pose national security threats to Canada, quoting in

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74. *Ibid* at 48.
75. See *e.g. Andrews v Law Society of British Columbia*, [1989] 1 SCR 143, 56 DLR (4th) 1; *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 44, [2011] 3 SCR 134.
76. [1991] 1 SCR 933, 5 CR (4th) 253 [*Swain*].
77. 2007 SCC 9, [2007] 1 SCR 350.

particular the Court's statement that section 7 requires that detention for an extended period "must be accompanied by a meaningful process of review that takes into account the context and circumstances of the individual case."[78]

In the twenty-five years following *Swain*, Canadian courts have recognized that forensic review boards play an important role in protecting the liberty interests of NCR accused and those found unfit to stand trial. In fact, the *Charter* jurisdiction of Canadian administrative tribunals in general was confirmed in a decision involving the Ontario *Criminal Code* Review Board (the Review Board). In *R v Conway*,[79] the Supreme Court of Canada ruled that the Review Board had jurisdiction to decide issues of law and thus had *Charter* jurisdiction. The Court described the broad role of the Review Board in these terms:

> The Board is a quasi-judicial body with significant authority over a vulnerable population. It is unquestionably authorized to decide questions of law. It was established by, and operates under, Part XX.I of the *Criminal Code* as a specialized statutory tribunal with ongoing supervisory jurisdiction over the treatment, assessment, detention and discharge of those accused who have been found not criminally responsible by reason of mental disorder ("NCR patient").[80]

Criminal Code Review Boards regularly assess the levels of custody in which an individual is detained and the level of privileges an individual is afforded. By contrast, civil tribunals rarely have any jurisdiction to assess whether the hospitalization is doing anything positive for the individual or moving him or her closer to discharge. *PS* provided a stark demonstration of the impact that the lack of a similar jurisdiction has on the civil side of the mental health system in Ontario. Year after year the CCB reported that PS did not require placement in maximum security and yet he continued to be detained, untreated, in maximum security: an unconstitutional deprivation of liberty that the CCB was powerless to address. It took a case about psychiatric gating, arising out of the criminal justice system, to get the Court to explicitly acknowledge the connection between coercive deprivations of liberty in the criminal system and coercive deprivations of liberty through civil commitment.

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78. *Ibid* at para 107.
79. 2010 SCC 22, [2010] 1 SCR 765 [*Conway*].
80. *Ibid* at para 84 (*per* Abella J). Note that in *Conway*, the Supreme Court ruled that even though the Review Board had *Charter* jurisdiction and was a "court of competent jurisdiction" for the purposes of section 24(1), its remedial authority under that provision was limited to the orders it was authorized to make by its parent statute *i.e.*, the *Criminal Code*. This is a further limitation on the scope of tribunal jurisdiction in *Charter* matters that complicates the field.

The Review Board's powers with respect to scrutinizing treatment decisions are not explicitly set-out in the *Criminal Code*, but rather are inferred from the Review Board's broad jurisdiction to make decisions about the risk the accused presents to the community and about reintegrating the accused into the community.[81] This supervisory power given to the Review Board was not inevitable but rather the result of deliberate choices by the courts. For example, in *Mazzei v British Columbia (Director of Adult Forensic Psychiatric Services)*,[82] the Supreme Court upheld the BC Review Board's order that the treating hospital develop a comprehensive treatment plan for the detained individual and "undertake assertive efforts to enroll the accused in a culturally appropriate treatment program."[83] While *Mazzei* made clear that it was not the job of the BC Review Board to prescribe specific treatments, the Court held that "Review Boards have the power to bind hospital authorities and to impose binding conditions regarding or supervising (but not prescribing or imposing) medical treatment for an NCR accused."[84] The role of the Review Board is to make sure that there is an appropriate treatment plan in place that is moving the individual towards reintegration in the community.[85]

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81. It is important to acknowledge that Parliament has made significant revisions to the disposition provisions that are applied by the Review Board, most significantly removing the requirement that the Review Board impose the least restrictive option when imposing a disposition. Now the Review Board is instructed to give priority to the safety of the public and the accused's liberty interest has been given less weight. This is particularly problematic given the Supreme Court of Canada's reliance on the least restrictive requirement to uphold the disposition provisions under the *Charter* in *Winko*, *supra* note 72. It remains to be seen how this change will affect the scope of the Board's jurisdiction. For further discussion, see Lisa Grantham, "Bill C-14: A Step Backwards for the Rights of Mentally Disordered Offenders in the Canadian Criminal Justice System" (2014) 19 Appeal 63.
82. 2006 SCC 7, [2006] 1 SCR 326 [*Mazzei*].
83. *Ibid* at para 4.
84. *Ibid* at para 7.
85. We are not suggesting that the plight of individuals detained in the forensic system is ideal by any means nor that an expansive approach to Review Board jurisdiction has been a panacea for all the problems of the forensic system. Kaiser laments the long periods of detention that the courts appear to be willing to tolerate in the forensic context and the refusal to consider proportionality as a limiting factor, stating that "some accused face huge obstacles in obtaining the kind of treatment they desire, and the promise of eventual liberty and reintegration remains unfulfilled for them." Conway himself had spent 26 years in custody. H Archibald Kaiser, "*Conway*: A Bittersweet Victory for Not Criminally Responsible Accused" (2010) 75 CR (6th) 241 at 241 [Kaiser, "*Conway*: A Bittersweet Victory"]. See also H Archibald Kaiser, "Mazzei: Constrained Progress in Construing Review Board Powers" (2006) 36 CR (6th) 37.

The fact that the Court of Appeal in *PS* was willing to consider the *Criminal Code* Review Board jurisprudence opens the door to a much higher level of scrutiny of the individual's liberty interests in the civil commitment context. We argue that the forensic model is the most appropriate model for common law jurisdictions to ensure adequate protection of those interests. The power of the Review Board to, for example, ensure that the individual has an appropriate treatment plan would not appear to have impeded physicians in treating individuals found not criminally responsible or unfit to stand trial. Rather, this jurisdiction has served as a check on the unfettered powers of the treating psychiatrists and hospital administrators. Counsel for Ontario in *PS* had argued that the Supreme Court's decision in *R v Conception*[86]—which recognized a forensic hospital's limited right to refuse to accept an individual referred to in under the *Criminal Code*—supported the idea that hospital personnel have plenary authority over treatment decision-making. Justice Sharpe rejected this argument:

> *Conception* certainly does not detract from the long line of authority discussed above as to the need for ongoing supervisory review of the treatment of NCR accused and those found unfit to stand trial: see *Mazzei*, at paras. 40-41, and *Penetanguishene*, at para. 67. Nor does it stand for the proposition advanced by Ontario that by conferring discretion on health care professionals, a statute such as the MHA can somehow avoid the need for an effective review mechanism.[87]

In our view, the decision in *PS* was made possible by the recognition that significant deprivations of liberty by the state in the civil commitment context are analogous to those in the forensic context where someone is being detained in the absence of a criminal conviction. In other words, the Court recognized the coercive nature of civil commitment regardless of whether it is used for the purported benefit of the individual or the state. The notion that someone who has been civilly committed has fewer liberty interests at stake than does someone in the forensic system simply because the former has not been charged with a crime cannot be justified.

B. THE ONTARIO GOVERNMENT'S RESPONSE TO PS

1. THE AMENDMENTS

Ontario had a number of options open to it in response to the decision in *PS*. It could have simply done nothing and allowed the suspended declaration of invalidity to take effect thus prohibiting civil commitment beyond six months.

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86. 2014 SCC 60, [2014] 3 SCR No 82 [*Conception*].
87. *PS*, *supra* note 9 at para 121.

Doing nothing was likely an unpopular option with the government because it would raise the possibility that individuals who were identified as dangerous, but who had been detained longer than six months, would have to be decertified as soon as the declaration of invalidity took effect. Ontario could also have given the CCB more powers in relation to all civilly committed individuals regardless of how long they are detained, or in relation to all individuals who are hospitalized in a psychiatric facility for more than six months, whether voluntarily or involuntarily. Extending the CCB's powers in either of these ways would have gone beyond the strict requirements of *PS*, but would have been preferable solutions.

Instead, the Ontario government designed a solution that was limited to individuals civilly committed for periods longer than the six months allowed by *PS*. The solution took the form of section 20(1.1) of the *Mental Health Act*, which created a new mechanism, a "certificate of continuation," to authorize the continued detention of those who have reached the maximum of three "certificates of renewal" of civil commitment under section 20(4), adding up to six months' detention following an initial period of two weeks.[88] The criteria for a certificate of continuation are the same as for civil commitment. Certificates of continuation authorize detention for a further three months and can be renewed an indefinite number of times. With respect to each certificate of continuation or renewal, the committed individual or his or her representative may apply to the CCB to determine whether the committal criteria continue to be met. As with certificates of renewal, the Board may rescind a certificate of continuation should it find that committal criteria are not met.[89] The statute also provides that an application for review shall be deemed to be made by a detained individual on the completion of a first certificate of continuation and every fourth such certificate thereafter.[90]

The centerpiece of the amendments is found in the new section 41.1(2) of the *Mental Health Act*. It states that, should the Board confirm a certificate of continuation, the detained individual or someone on his or her behalf may request the Board to make one or more of the following orders:

> 1. Transfer the patient to another psychiatric facility … but only if the patient does not object.
> 2. Place the patient on a leave of absence for a designated period on the advice of a physician […]

88. Ontario *Mental Health Act*, *supra* note 1, ss. 20(1.1) and (4).
89. *Ibid*, ss 41(3) and (4).
90. *Ibid*, s 39(4). Section 39(5) provides that a patient cannot waive deemed applications.

3. Direct the officer in charge of the psychiatric facility to provide the patient with a different security level or different privileges within or outside the psychiatric facility.
4. Direct the officer in charge of the psychiatric facility to allow the patient to be provided with supervised or unsupervised access to the community.
5. Direct the officer in charge of the psychiatric facility to provide the patient with vocational, interpretation or rehabilitative services.[91]

The Board may make any or all of these orders on its own motion, but is expressly barred from making any other order.[92] Section 42(2) lists the parties to a hearing on a certificate of continuation, including the Minister should he or she wish to appear, and provides that parties may seek a variance of the Board's orders during a continuation period on the basis of a change "in material circumstances." Barring such a change, an individual can make only one application under section 41.1(2) every 12 months.[93]

The CCB is required to impose the order that is the least restrictive given the circumstances justifying detention.[94] It must consider public safety, the facility's ability to manage and care for the individual, the individual's mental condition, his or her reintegration into society, and any other needs of the individual. The Board has no jurisdiction to require a physician to provide treatment,[95] although it may order an independent assessment of the individual's "mental condition or his or her vocational, interpretation or rehabilitative needs."[96] As an extraordinary precaution, the amendments provide that the officer in charge of the facility may take an action contrary to an order of the CCB for a period of up to seven days.[97] To extend the action any further, the officer in charge must apply "promptly" to the CCB to cancel or vary the Board's order.[98] Ontario has not given its tribunal the power to issue a community treatment order as an alternative to detention, a power the *PS* Court specifically found to be lacking.[99]

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91. *Ibid*, s 41.1(2).
92. *Ibid* at s 41.1(2).
93. *Ibid*, s 39(7).
94. *Ibid*, s 41.1(3). This is particularly striking given that the Harper government amended the *Criminal Code* provisions dealing with the Review Board such that the Review Board no longer is required to grant the least restrictive disposition. *Criminal Code*, *supra* note 18, s 672.54, as amended by SC 2014, c 6, s 9.
95. *Ibid*, s 41.1(4).
96. *Ibid*, s 41.1(8).
97. *Ibid*, s 41.2(1).
98. *Ibid*, s 41.2(2).
99. *PS*, *supra* note 9 at para 127.

2. ASSESSING ONTARIO'S RESPONSE

In our view, the amendments offer a narrow resolution of the constitutional problems identified by the Court with respect to section 7 of the *Charter*. The legislature has granted the CCB a form of supervisory authority in treatment planning for long-term detainees. In so doing, Ontario has further distinguished its mental health legislation from that of other provinces in the area of protection of a detained individual's rights. Ontario stands out as a leader when it comes to protecting the liberty interests of long-term detainees. However, the amendments are couched in terms that limit the positive impact they might otherwise have. We have two primary concerns. First, the government has failed to address the fact that the line between involuntary and voluntary detention is not always clear and that manipulation of this distinction can undermine the new protections granted. Second, we have serious concerns about limiting the scope of procedural protections to those who are detained for periods longer than six months.

There is considerable potential to manipulate a detained individual's status as voluntary or involuntary.[100] Decertifying an individual may be a technique used to render a legal dispute moot and, in the context of these new provisions, could be used to deny access to the enhanced powers of the CCB that accompany a certificate of continuation. In *PS* specifically, the applicant lost his access to the CCB because he was decertified and made "voluntary" even though he was told he would be certified as involuntary if he tried to leave the facility.[101] This problem can arise even in the absence of deliberate manipulation of the system. An individual's mental state may vary over time justifying periods of decertification to voluntary status. Many individuals, like PS, may have their status changed more than once during a hospitalization; others may have brief periods in the community over the course of what is otherwise a long-term hospitalization. This potential for movement between statuses raises important concerns. Will even a brief period of decertification after civil commitment trigger the civil commitment process again, thus allowing the certificate of continuation mechanism to be avoided? The Ontario Court of Appeal explicitly ruled out the possibility that an individual could be decertified before six months and then immediately recertified to start the clock running again:

> Needless to say, it would not be acceptable to circumvent the time-limited duration of a committal by simply restarting the process with a new certificate of

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100. Ontario Legislative Assembly, Standing Committee on General Government, *Official Report of Debates (Hansard)*, No G-37 (30 November 2015) at 786, 787-788.
101. *Ibid* at para 40.

> involuntary admission upon the expiry of the three-month period contemplated by s. 20(4)(b)(iii).[102]

While the Court indicated that such a practice would not be an appropriate response to its ruling, there is nothing in the statute that prevents such status changes. Given that any one individual may go back and forth between the two statuses, it would be desirable to have some mechanism to review the circumstances of anyone who has been hospitalized for more than six months, regardless of their status.[103] Given that the incidence of long-term psychiatric hospitalizations has decreased significantly in recent decades, the safeguard should not be prohibitively expensive.[104]

While Ontario has improved the plight of long-term detainees, it has not closed the door to further litigation over the procedures for review of civil commitments of less than six months. In our view, limiting the amendments to long-term involuntary commitment has only created uncertainty and puts an undue onus on persons who are civilly committed for shorter periods of time to litigate the scope of their liberty and security interests. The Court's use of a six-month cutoff period (or to put it another way, its restricting the ruling to "long-term committals" defined as six months) is open to criticism as arbitrary. The Court arrived at this time period by analyzing statistics that demonstrated that 98% of individuals are released before six months and only 2% are detained beyond six months.[105] The Ontario government's response draws a clear line at the six-month cutoff. However, it is not entirely clear why these percentages are relevant to the cut-off point for protecting the liberty interests of an individual. The fact that only a small number of people are detained beyond six months has no coherent connection to the liberty interests of the majority released before six months. If an individual does not require maximum security, would it be appropriate to detain him or her in that level of custody for five months or even one month? If it is unacceptable to deny civilly committed persons appropriate treatment tailored to their disability for more than six months, is it acceptable to do so for three months? When one considers the revolving door syndrome and the fact that people who are detained for short periods may well be readmitted

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102. *Ibid* at para 203.
103. In the committee hearings about Bill 122, advocacy groups expressed concern about individuals who are being held "voluntarily" yet who face the threat of civil commitment. *Supra* note 100.
104. Patricia Sealy & Paul C Whitehead, "Forty Years of Deinstitutionalization of Psychiatric Services in Canada: An Empirical Assessment" (2004) 49 Can J Psychiatry 249.
105. *PS*, *supra* note 9 at para 26.

subsequently, many individuals may spend long periods of time civilly committed without any effective mechanism of review of the conditions of that detention.[106] The Court left these questions for another day given that PS had been detained for nineteen years. However, the Court's rationale applies just as persuasively to review tribunals that are considering shorter-term commitments and reviewing individuals who are on extended leave or released on CTOs. We can think of no other context in which deprivations of liberty are allowed to continue unchecked for up to six months before the full panoply of section 7 rights takes effect.[107] The *PS* Court recognized that by limiting its analysis to long-term detention, it opened the door to future challenges to the constitutionality of the failure to have an administrative tribunal with a broad-based supervisory role for shorter periods of commitment.

There are two arguments against extending the CCB jurisdiction to all civil commitments. The first is that because the number of short-term commitments is much larger, the cost would correspondingly increase. We do not feel this is an acceptable reason to deny the vindication of section 7 rights. The second argument against extending jurisdiction to this group of individuals is that it might unduly interfere with the treatment goals of the treating physician for shorter-term commitments. We believe this problem can be minimized by, for example, limiting the number of times an individual can access the extended powers of the CCB, just as Ontario has already done for long-term commitments.

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106. We note here the more robust view of the Supreme Court of Canada when describing the appropriate supervisory role of a Nova Scotia Provincial Court judge in the context of the continuing supervision of a "protection order" for a vulnerable adult, authorized by that province's *Adult Protection Act* RSNS 1989, c 2:

> The significance of independent judicial review of state action when a vulnerable adult has been deprived, at the instigation of the state, of the right to function autonomously, cannot be overstated. The court's statutorily assigned supervisory role emerges from the adult's vulnerability. The corollary of a judicial determination that an adult is in need of protection is a corresponding limitation on that adult's autonomous decision making and liberty. It is the function` of the court to monitor the scope of that limitation. The legislation must, therefore, be interpreted in a way which acknowledges the intrusiveness of the determination and offers muscular protection from state intervention incompatible with the adult's welfare.

Nova Scotia (Minister of Health) v JJ, 2005 SCC 12 at para 23, [2005] 1 SCR 177 (*per* Abella J).

107. In the very different context of security certificates under the *Immigration and Refugee Protection Act*, SC 2001, c 27, the Supreme Court of Canada rejected an argument by the federal government that sought to justify the denial of detention review for foreign nationals for a period of six months, finding such a delay to violate fundamental justice under section 7. *Charkaoui et al v Canada, (Citizenship and Immigration)*, *supra* note 77, at paras 91-92.

Given that the distinction between those detained longer than six months and those detained for shorter periods is somewhat arbitrary, we are also concerned that in limiting its solution to long-term detainees, Ontario may have exposed its statute to challenge under section 15 of the *Charter*, the equality rights provision. Ontario's decision to establish a new set of powers for the CCB with respect to individuals subject to continuation certificates creates a "benefit" or, perhaps more aptly, a "protection of the law" that is denied to those on shorter periods of commitment. This statutory distinction might discriminate on grounds of disability in violation of section 15(1) of the *Charter*. This is ironic given the strong equality rights thrust that underpinned PS's arguments and that was vindicated in the Court of Appeal's striking judgment on the section 15(1) issue. The equality rights issue as it concerns long-term and short-term commitments is of a different nature. Whereas the issue in an *Eldridge*-type case is the failure of public authorities to accommodate the needs of a disadvantaged group in order for them to participate in and enjoy equal benefit and protection of the law—what is often referred to as "adverse effect discrimination"[108]—limiting the CCB's new powers to long-term commitments is more an instance of direct discrimination. The distinction is clear on the face of the statute and is drawn between different groups of persons with mental disabilities, based on their legal status while hospitalized and the length of their stay in a psychiatric facility. Jurisprudence on section 15(1) is clear that discrimination claims can be based on differential treatment in law between sub-groups sharing the same overall enumerated or analogous characteristic.[109] The more difficult question in a section 15(1) challenge to the denial of access to the protections afforded by section 41.1(2) of the *Mental Health Act* would be whether the distinction is discriminatory in the sense of compounding disadvantages experienced by that person, through prejudice, stereotyping, or otherwise.[110] While the government would presumably argue that the additional protections afforded to those subject to continuation certificates correspond to a need for enhanced supervision of treatment planning past the point of diagnosis and early application of therapeutic interventions, this position might be less persuasive with respect to individuals

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108. For discussion of two types of discrimination, see *British Columbia (Public Service Employee Relations Commission) v BCGSEU*, [1999] 3 SCR 3, 176 DLR (4th) 1 at paras 19-24.
109. *Nova Scotia (Workers' Compensation Board) v Martin; Nova Scotia (Workers' Compensation Board) v Laseur*, 2003 SCC 54, [2003] 2 SCR 504 [*Martin*]; *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004 SCC 78, [2004] 3 SCR 657; *Corbiere v Canada (Minister of Indian and Northern Affairs)*, [1999] 2 SCR 203, 173 DLR (4th) 1.
110. *Quebec (Attorney General) v A*, 2013 SCC 5, [2013] 1 SCR 61, *per* Abella J writing for a majority on this point.

with a history of frequent or multiple recent involuntary committals. This is especially true when considering the newly added power of the CCB to order the director of a facility to provide a person with "vocational, interpretation or rehabilitative services."[111] It should be noted that this power speaks most directly to the equality rights interest raised by the *PS* case, and can be seen as a means of ensuring that those interests are not neglected. The fact that these protections are needed for long-term commitments does not inevitably lead to the conclusion that they are unnecessary for commitments of less than six months.

This discussion of the equality problem in the amended Ontario legislation is not intended to suggest that a section 15 challenge to this otherwise important reform legislation is imminent or would be straightforward. But nor can the government rely on the *PS* decision to insulate its distinction between short and long-term commitments. The Ontario Court of Appeal's decision does not mandate such a distinction. The Court was confronted by a man who had been civilly committed for nineteen years. It did not need to address short-term commitments. It thus limited its judgment based on the six-month cutoff period. It explicitly left open the possibility that further protections are necessary for short-term commitments. It held that longer-term commitments require more protections, but it did not hold that short-term commitments do not.

III. CIVIL REVIEW TRIBUNALS MOVING FORWARD

A. RESTRAINT AND SECLUSION WITHIN PSYCHIATRIC FACILITIES

The conclusion in *PS* that long-term civil commitment requires tribunal review of treatment and discharge planning implicitly raises the question of whether there are other section 7 liberty interests in civil commitment that call for enhanced administrative oversight and review. At least one other area comes distinctly within section 7's ambit: The use of disciplinary or behavioural control measures within a hospital setting, particularly the use of physical restraint and seclusion. These practices have come under increasing scrutiny in Canada and elsewhere, in both prison and hospital settings. In Canada, the 2013 coroner's inquest into the death by self-strangulation of Ashley Smith, a young woman with a history of mental health issues who was subjected to extended periods in solitary confinement while held in the corrections system, recommended strict

111. Ontario *Mental Health Act*, *supra* note 1, s 41.1(2).

limits on the use of seclusion.[112] Two *Charter* challenges to solitary confinement in the prison context have also been initiated, one in British Columbia and one in Ontario.[113] The United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has concluded that even short periods of seclusion may constitute torture and ill-treatment for people with mental disabilities.[114] The Special Rapporteur also noted that there can be no therapeutic justification for the prolonged use of restraints.[115]

The use of restraint and seclusion in psychiatric hospital facilities is a well-known phenomenon. These measures continue to be used in Canadian psychiatric facilities, including in Ontario.[116] These measures are subject to government and hospital policies and protocols, but concerns have long been expressed that the mechanisms for enforcing compliance with policies are

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112. See Correctional Service Canada, "Response to the Coroner's Inquest Touching the Death of Ashley Smith" (11 December 2014), online: Correctional Service Canada <http://www.csc-scc.gc.ca/publications/005007-9011-eng.shtml#4.0>.
113. See John Ivison, "Group launching legal challenge to limit use of solitary confinement in Canadian prisons", *National Post* (19 January 2015) online: National Post <http://news.nationalpost.com/news/canada/group-launching-legal-challenge-to-limit-use-of-solitary-confinement-in-canadian-prisons>; Sean Fine, "Ontario government sued for putting youth in solitary confinement", *Globe and Mail* (4 November 2015) online: Globe and Mail <http://www.theglobeandmail.com/news/national/ontario-faces-lawsuit-for-putting-young-offenders-in-solitary-confinement/article27107663/>.
114. UN General Assembly, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UNGAOR, 23rd Sess, UN Doc A/HRC/22/53 (2013) at para 63, online: United Nations Human Rights Office of the High Commissioner <http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf>. "The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment (A/66/268, paras. 67-68, 78). Moreover, any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment. It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions." *Ibid*.
115. UN General Assembly, *Torture and other cruel, inhuman or degrading treatment or punishment: Note by the Secretary-General*, UNGAOR, 63rd Sess, UN Doc A/63/175 (2008) at paras 55-56. The Special Rapporteur notes that there can be no therapeutic justification for the prolonged use of restraints, which may amount to torture or ill-treatment. The Special Rapporteur also notes that prolonged solitary confinement and seclusion of persons may constitute torture or ill treatment.
116. Tina M Mah, et al, "Use of control interventions in adult in-patient mental health services" (2015) 28 Healthcare Mgmt Forum 139.

informal and uneven.[117] If additional powers are to be given to mental health tribunals, it would seem appropriate to include the ability to review, report on, and direct changes with respect to the use of these highly invasive and largely unreviewable measures.

B. CHARTER JURISDICTION OF MENTAL HEALTH TRIBUNALS

The discussion of restraint and seclusion leads to an issue that was raised before the Court of Appeal in *PS*: whether the tribunal should be given jurisdiction to grant section 24(1) *Charter* remedies. An intervener in *PS,* the Mental Health Legal Committee, asked the Court of Appeal to order that the CCB be given this jurisdiction. The Court declined to make such an order, in part because it would involve overruling an earlier decision of the Divisional Court.[118]

The idea of extending *Charter* jurisdiction to civil mental health tribunals is an intriguing one. Section 24(1) authorizes a "court of competent jurisdiction" to order such remedies "as the court considers appropriate and just in the circumstances" to address the breach of an individual's *Charter* rights by state action.[119] The Supreme Court of Canada has stated on several occasions that section 24(1) contemplates the power to order creative remedies, responding to the wide range of circumstances in which an individual may have his or her rights infringed by statutory delegates (but not by legislation).[120] The appeal of recognizing section 24(1) jurisdiction in a civil mental health tribunal like the CCB is that it would permit a flexible response to those situations in which civilly committed individual's *Charter* rights, including section 7 liberty interests, are implicated. It would obviate the need for statutory definition and anticipation of

117. H Archibald Kaiser, "Restraint and Seclusion in Canadian Mental Health Facilities: Assessing the Prospects for Improved Access to Justice" (2001) 19 Windsor YB Access Just 391. For a recent discussion of the constitutional implications of the use of restraint and seclusion in the US, see Jeremy Weltman, Roderick MacLeish and Jacquelyn Bumbaca, "Deference Does Not Equal Abdication: Application of Youngberg to Prolonged Seclusion and Restraint of the Mentally Ill" (2015) 26 Stan L & Pol'y Rev 239.

118. *Ontario (Attorney General) v Jane Patient*, [2005] O.J. No. 631, 250 DLR (4th) 697 [*Jane Patient*].

119. *Supra* note 4, s 24(1).

120. See *e.g. Doucet-Boudreau v Nova Scotia (Minister of Education*), 2003 SCC 62, [2003] 3 SCR 3; *Vancouver (City) v Ward,* 2010 SCC 27, [2010] 2 SCR 28.

the myriad circumstances in which such a violation might occur, including such circumstances as over-reliance on restraint and seclusion measures.[121]

This begs the question of how civil mental health tribunals might come to possess section 24(1) powers. Civil mental health tribunals will be presumed to be "courts of competent jurisdiction" for purposes of section 24(1) provided that they have jurisdiction over issues of law.[122] That presumption can be rebutted by express legislative withdrawal of *Charter* jurisdiction or by a clear implication of such intent derived from statutory limits on a tribunal's role and logistical functioning.[123] The legislatures of Alberta and British Columbia have enacted blanket provisions withdrawing *Charter* jurisdiction for most tribunals within their jurisdiction, including civil mental health tribunals.[124] Ontario has also withdrawn *Charter* jurisdiction from the CCB with respect to civil commitment and CTO reviews.[125] It would appear then that these tribunals are precluded from having the power to order section 24(1) remedies so long as the legislature maintains its prohibition.[126] However, there is an issue whether this denial of *Charter* jurisdiction to civil mental health tribunals is constitutional and therefore

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121. For an excellent discussion of the *Charter* jurisdiction of civil and forensic mental health review tribunals prior to *PS v Ontario*, see Joaquin Zuckerberg, "Jurisdiction of Mental Health Tribunals to Provide Positive Remedies: Application, Challenges and Prospects" (2011) 57:2 McGill LJ 267. Zuckerberg concludes that despite the broadening of *Charter* jurisdiction from administrative tribunals in general, promised by *Martin* and *Conway*, nothing has significantly changed with respect to civil mental health tribunals. He notes that civil mental health tribunals in Canada generally lack the jurisdiction to make rulings about ongoing treatment and supervision matters that are granted to forensic review boards under the *Criminal Code*. "Rather," he states, "their jurisdiction is generally restricted to confirming decisions to civilly commit a person and findings of incapacity to consent to medical treatment." *Ibid* at 281. This underlies the ruling in *Jane Patient*, *supra* note 118.
122. *Conway*, *supra* note 80 at para 78.
123. *Martin*, *supra* note 109.
124. *Administrative Procedures and Jurisdiction Act,* RSA 2000, c A-3, s 11; *Designation of Constitutional Decision Makers Regulation*, AB Reg 69/2006, s 2; *Administrative Tribunals Act*, SBC 2004, c 45, ss 44, 45, and BC *Mental Health Act*, *supra* note 1, s 24.2.
125. *Health Care Consent Act*, SO 1996, c 2, Sched A, s 70.1, enacted pursuant to SO 2006, c 19, Sched L, s 2.
126. Kaiser has argued that the logic of *Conway* extends to provincial mental health tribunals. He argues that the availability of the *Charter* "should provide enhanced access to justice in settings where it has been difficult to invoke the protection of the law, let alone the *Charter*. These tribunals vitally affect the dignity, liberty and living conditions of institutionalized persons. Before *Conway*, the exercise of discretion by clinicians and administrators was virtually invisible and unchallengeable." Kaiser, "*Conway*: A Bittersweet Victory," *supra* note 85 at 243.

whether a challenge to that statutory withdrawal could provide tribunals with section 24(1) jurisdiction.

In *Nova Scotia (Workers' Compensation Board) v Martin*, the Supreme Court of Canada based its finding of a rebuttable presumption that tribunals with general jurisdiction over questions of law have *Charter* jurisdiction on the logic of section 52(1) of the *Constitution Act, 1982*.[127] Section 52(1) states that any law that is inconsistent with the Constitution is invalid and of no force or effect. The Court stated that this means that statutory decision-makers who have the authority to interpret and apply law must refuse to enforce a law they deem unconstitutional. This is inconsistent with the idea that legislators have *carte blanche* to decide whether any particular tribunal has *Charter* jurisdiction (or constitutional jurisdiction generally), irrespective of the tribunal's place in the legal system, its importance with respect to access to justice, and the breadth of its role in interpreting law. Justice Gonthier, writing for the Court in *Martin*, appeared to acknowledge this problem in the following passage:

> I refrain, however, from expressing any opinion as to the constitutionality of a provision that would place procedural barriers in the way of claimants seeking to assert their rights in a timely and effective manner, for instance by removing *Charter* jurisdiction from a tribunal without providing an effective alternative administrative route for *Charter* claims.[128]

The reference to an "effective alternative administrative route" appears not to include recourse to superior courts on constitutional matters, which is otherwise always available. As noted by Justice Sharpe in *PS*, individuals detained in psychiatric facilities face particular challenges in asserting their rights and in accessing the courts:

> In a second and related submission, Ontario argues that where a patient wishes to challenge a committal on grounds that fall outside the powers of the CCB, there are alternate procedures available to fill any perceived gap. The patient can initiate proceedings in the Superior Court, resort to internal complaint procedures within the hospital, complain about doctors and nurses to the appropriate professional colleges or invoke the process established by the *Human Rights Code*, R.S.O. 1990, c. H.19, with respect to complaints about a failure to accommodate a disability.
>
> If we were to accept this submission, the appellant, a person who suffers from a mental disorder and a serious disability and who is held in a maximum security institution, would have to initiate proceedings in two or more different tribunals. This solution is fatally flawed; it is legally inadequate and practically unworkable. It

127. *Supra* note 51.
128. *Martin*, *supra* note 109 at para 44.

> would be prohibitively costly, very slow, seriously inconvenient and almost certainly ineffective.[129]

While Justice Sharpe's comments were directed to the absence of an administrative mechanism to raise issues related to overall treatment planning, access to a forum to pursue *Charter* rights encounters the same barriers for individuals confined in a psychiatric facility. A constitutional challenge might well be available with respect to the denial of *Charter* jurisdiction to mental health tribunals or to any other administrative agency with supervisory authority over psychiatric facilities, if those entities do not provide "effective alternative administrative" routes. The arena in which these tribunals and agencies operate is one in which *Charter* rights, particularly section 7 rights, are implicated on a regular basis. The populations whose rights are at risk of infringement are particularly vulnerable and have limited means to access other avenues for recourse or even to access legal counsel.[130] Therefore, it might be that the CCB and other review tribunals are precisely the kind of entities that should be able to rule on and remediate individual *Charter* breaches.

IV. CONCLUSION

The decision in *PS* has the potential to prompt amendments to civil commitment statutes across Canada, since no mental health statute currently meets the criteria that the Court of Appeal has prescribed. We would hope that provincial legislatures would treat this decision as a message that it is time to move towards treating civilly committed individuals as rights holders, entitled to the same procedural protections as other individuals detained by the state. However, if past experience is any indication, doing nothing is the more likely response of most provincial legislators, as the rights of civilly detained individuals have rarely been given priority. Failure to respond proactively to *PS* would put the onus on those detained in psychiatric facilities to initiate *Charter* challenges to bring about reform. There has been a dearth of litigation regarding mental health tribunals outside of Ontario. Even the refusal to allow competent civilly committed individuals to decline treatment in British Columbia and Newfoundland,

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129. *PS*, *supra* note 9 at paras 118-119.
130. A case has recently been filed in the British Columbia Supreme Court challenging the refusal of the Legal Services Society to provide funding for lawyers to represent clients before Review Panels under the Mental Health Act. http://bcpiac.com/mental-health-review-board-legal-aid/.

a denial that raises serious *Charter* concerns,[131] has not yet been subject to a *Charter* challenge despite the compelling reasoning of the Ontario Court of Appeal in *Fleming* v *Reid*.[132] There are huge institutional barriers to having these matters litigated, not the least of which is a profound lack of funding as well as difficulties with mootness where potential plaintiffs are decertified or released before their cases are heard by a court.[133]

As a result of the *PS* decision, the legislative scheme for long-term detainees in Ontario has changed for the better. However, the government chose reforms that gave rights to the smallest possible number of civilly-committed individuals and left open the possibility of manipulating the regime by decertifying individuals for a short period of time. A better option for all committals would be to develop a civil mental health tribunal with a role and structure similar to that which now exists in forensic psychiatric systems across this country. The tribunal should have explicit *Charter* jurisdiction and detained individuals should be guaranteed the right to paid counsel. Ontario's recognition of the need for a tribunal to play a role in protecting the liberty interests of long-term involuntarily detained individuals should serve as a beacon for that evolution.

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131. Simon Verdun-Jones & Michelle Lawrence, "The Charter Right to Refuse Psychiatric Treatment: A Comparative Analysis of the Laws of Ontario and British Columbia Concerning the Right of Mental Health Patients to Refuse Psychiatric Treatment" (2013) 46 UBC L Rev 2.

132. The Ontario Court of Appeal in its landmark decision in *Fleming v Reid*, *supra* note 4, put significant constraints on the province with respect to limiting prior expressed wishes of a competent individual regarding psychiatric treatment.

133. This in fact happened in *PS* with the appellant's involuntary status allowed to lapse and the CCB thus losing jurisdiction over his detention. The appellant argued unsuccessfully that he would be recertified if he attempted to leave and thus that the Board should have taken jurisdiction. Because this is such a common practice, courts are sometimes willing to decide moot cases in this context. See *e.g. McCorkell*, *supra* note 7.