**MENTAL HEALTH LAW – LAW 383C-001 – ISABEL GRANT – 2013W – NIKKI ALVAREZ**

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# INTRO TO MENTAL HEALTH LAW

## What do we mean by mental disability?

* biological/medical component 🡪 impairment with cognitive, emotional, intellectual, perceptual capacities
  + often treated w drugs (rarely address origins of illness, only symptoms)
* social component 🡪 barriers/obstacles created by society limiting person’s ability to function (eg. stigma, fear, failure to accommodate, schools)
* used in Charter and Human Rights leg., includes psychiatric, developmental, neurological injuries/conditions

## Policy reasons – why mtnl health law is important

* 1/5 people affected
* constitutes over 15% of illness in Canada; 2nd leading cause of disability/premature death
* nearly 30% of disability claims are for mntl health – costly to society.

## Legal Framework for Mntl health law

* *Charter* ss. 7, 9, 15
* UN Convention on the Rights of Persons with Disabilities (ratified by Canada in 2010)
  + Not the force of law but useful as tool of interpretation and influential
* Human rights legislation – protect against discrimination on disability
* Mental Health statutes - exclusive provincial jurisdiction under ss. 92(7) and (13) of the Constitution
* Criminal Code
* Case law
* Peter Carver stipulates 5 dimensions through which law plays a role in social response to mental disability:
  + (1) Public Safety Dimension (eg. committal for NCRMD persons)
  + (2) Therapeutic Dimension (laws re: treatment/consent)
  + (3) Individual Autonomy Dimension (laws re guardianship, sub. Decision-makers
  + (4) Social Welfare Dimension (laws re. social benefits programs)
  + (5) Human Rights Dimension (laws re equality rights, discrimination)

## Course Themes

**1. Protection of Society vs. Autonomy of the Individual**

* balancing game. Peter Carver and Archibald Kaiser discuss pendulum in Canada swinging between the two ends of the spectrum
  + in BC mid 1980 civilly committed people when they required it for own good
  + late 1980s, move towards greater respect for autonomy, only commit those posing a danger to society (Charter was influential)
  + late 1990s, swung back towards protection, commitment criteria included people who needed it for mental deterioration (welfare standard)
  + generally pendulum swings towards paternalism
* Gerald Robertson describes how mental health patients are infantilized, leads to ethic of paternalism; also says fear of mentally ill is most common attitude
  + *Ogg-Moss v Queen* – SCC held 21 yr old mentally disabled not a child

**2. Social vs. medical model of disability** (Archibald Kaiser article – says not necessarily mutually exclusive)

* Approach depends on how you see role of law
* Medical model – power to psychiatry – Kaiser: “critical elements of medical model portray indvl as having health problem in which suffering is diagnosed/treated by physicians. Disability becomes “defect or sickness which must be cured through medical intervention wherein physician becomes authority figure/decision-maker w wide discretionary powers granted by legislation to ensure that ill indvl can be forcibly assessed/hospitalized/treated
  + Wide discretion is problematic b/c physicians/psych. Not experts in statutory interpretation, civil liberties, human rights
* Social model – views law as tool for improving lives of people w mntl disability, challenges barriers they face (stigma, discrimination etc.)
  + Good b/c it pushes for change in the law

**3. Role of law in improving vs. disadvantaging mentally ill** (Robertson article)

* Does law follow social attitudes, or lead them? (eg. eugenics)
* Robertson argues it does both – law was used to institute social policy of eugenics
* But law also used to direct social change – see *Re Eve* (held that can’t sterilize women with mental disabilities for non-therapeutic reasons)
  + Belief that physical illness is diff. than mental illness
  + Law enforced this social belief by denying competent individuals the right to refuse treatment in the psychiatric context only
* Law is positive – legislation allowing people to make decision about future incompetency has drastically improved
  + *Fleming v Reid* – ONCA – forced treatment cant be administered contrary to prior competent wishes (not binding in BC)

## Barriers to Charter Litigation

* litigation often brought by advocacy groups rather than individuals (due to incompetence)
* mootness (no long a dispute, person has been released, too stressful/costly to follow through

# DIAGNOSIS OF MENTAL DISORDER

## History of Diagnosis

* used to diagnose non-conformist behaviors – eg. drapetomania (slave who had compulsion to run away)
* power for psychiatrists to create labels gives them social control of the nature of mental health (eg. label of homosexuality)
* takes hindsight to see political dimension behind certain diagnoses
* DSM 5 (May, 2013) - desire to make psychiatry more scientific; controversial changes
  + Eg. cannabis withdrawal, caffeine withdrawal, hoarding, excoriation (skin picking), restless legs syndrome, premenstrual dysphoric disorder
  + DSM 5 got rid of Axis methodology
  + See below in implications for new DSM 5 problems

## What is a diagnosis and what are the implications

* attaching psychiatric label to cluster of symptoms based on required, duration & number of symptoms, and exclusion of other causes
* once diagnosed, treated with drugs
* benefits/services often contingent on diagnosis
* other consequences: social assistance, educational support, family law consequences (child custody), autonomy to make decisions, civil commitment, forced treatment, criminal responsibility, labeling/stigma (This American Life psychopath show), difficulty obtaining job, life insurance.
* Detriment: can mean civil commitment

## Benefits of diagnosis: Employment and *Assistance for Persons with Disabilities Act*

Act defines person w disability who is of at least 18 yrs old, severe physical/mental impairment expected to continue for at least 2 years and who

* is significantly restricted in his or her ability to perform daily living activities
* requires assistance with daily living

Specifically includes ppl w mntl health disorders and individuals with episodic illnesses that restrict daily life

## This American Life Psychopath Podcast

* UBC prof did not want to release test.. once labeled, always labeled, never released from jail
* Being administered by unqualified people and the same person often gets varying results with different people testing them.

## DSM 5 Problems

* New DSM 5 definition of autism is narrower – may deprive people of benefits/services
* Stigmatizes and diagnoses arguably normal aspect in life – grief, anxiety, eccentricity, bad eating habits

# CIVIL COMMITMENT

**Civil Commitment –** forcible detention in psychiatric facility of an individual apparently suffering from mental disorder

* most significant deprivation of liberty in Canada without judicial process sanctioned by our society – we have elected to leave the issue of involuntary commitment almost entirely to discretion of doctors
* mental health law is area of exclusive provincial jurisdiction under ss. 92(7) and (13) of the Constitution so every province has its own Act.. quite a bit of difference b/w provinces re: civil commitment (discussed in *Gray & O’Reilly* article)
* See **Involuntary Commitment** below
* Isabel Grant article – civil commitment rationales relate to paternalism vs. autonomy dichotomy
  + Paternalism assumes that all parties have common interest, assumption that psychiatrist best person to make decision
  + *Parns Patriae* – US, power to protect those within its jurisdiction who can’t protect themselves

**Carver article**

* usually 3 criteria for committal: (1) diagnosis, (2) dangerousness, (3) require treatment in facility and not suitable as voluntary

**Gray & O’Reilly** **article:** - illustrates how same person may not be committed in all provinces because of differing legislation

* some provinces have dangerousness requirement
* some don’t allow for treatment refusal, others do
* in some provinces her mental health will have to deteriorate before she gets any help
* PROBLEM: early intervention may prevent progression of underlying disease, easier to treat

s. 34(2) of *Mental Health Act* sets out rights to be given in writing to patient on civil commitment, renewal or transfer:

(*a) the name and location of the designated facility in or through which the patient is detained;*

*(b) the right set out in section 10 of the Canadian Charter of Rights and Freedoms;*

*(c) the provisions of sections 23 to 25, 31 and 33;*

*(d) any other prescribed information*.

s. 34(3) – if person incapable of understanding, must be given rights again when capable.

## BC Mental Health Law

* don’t need psychiatrist to sign committal certif – any 2 *doctors* will do.
  + How can we ensure power not used inappropriately? Safeguards?
  + Study found alarmingly high % of certifs. Did not meet reqs. of *Mental Health Act* (over 50% had at least 1 invalid certif.)
* Nothing one can do to immediately question doctor’s decision, no recourse until a minimum of 2 weeks.

In BC, 2 types of institutions can admit involuntary patients – provincial mental health facilities and psychiatric units (ward in hospital).

* person may be admitted to observation unit, but must be transferred into one of the above 2 within 5 days
* individuals from correctional facilities and police lockups sent ONLY to provincial mental health facility, NOT psychiatric unit.

## Power to Director in BC

Person in charge of mental health facility = director; responsible for ensuring each patient is provided with professional service, care and treatment appropriate to their conditions (*Mental Health Act* s. 8)

* have the power to order involuntary treatment
* in practice, directors delegate much of their authority to physicians/staff
* no requirement for director to be physician

## Voluntary and Underage Admission in BC

Every provincial mental health statute provides for voluntary admission (in BC – s. 20 *Mental Health Act*)

* must be under 16+ to request admission; if under 16, parent/guardian must request admittance.
* Director must be satisfied person has been examined by physician and has a mental disorder, as defined in s. 1.
* If admitted under 16 on basis of guardian’s wishes, patient must be re-examined by physician at reg. intervals (s. 20(2))
* If young person asks to leave facility, entitled to review panel under s. 21 (right normally reserved for those involuntarily committed)

## Impact of Standard/Breadth of Mental disorder definition

Discussed in *Applebaum* article

* assumption that broader definition of mental disorder = more civil commitments and narrower def = less.. not the case, number of commitments seems to have a set points, settles back to the norm after about 1 year.
  + Why? Applebaum argued people act according to morality and what they think is right, rather than law per se.
  + Courts ask “does this person need to be committed or not?” rather than looking at commitment standards
* Role of lawyers according to Applebaum
  + Lawyers want to protect people by getting them the treatment they need, regardless of what individual wants
  + Troublesome b/c they are not really acting as advocates for client

## Involuntary Commitment

Requires 1 certif. by physician to commit someone for 48 hours, and two certifs. for long-term

Set out in s. 22 of *Mental Health Act*:

* 22(1) The director of a designated facility may admit a person to the designated facility and detain the person for up to 48 hours for examination and treatment on receiving one medical certificate respecting the person completed by a physician in accordance with subsections (3) and (4)
  + (absolutely no review mechanism for this!!!)
* 22(2) On receipt by the director of a second medical certificate completed by another physician in accordance with subsections (3) and (5) respecting the patient admitted under subsection (1), the detention and treatment of that patient may be continued beyond the 48 hour period referred to in subsection (1)

## Emergency Commitment

admission for 48 hrs requires only 1 certif but can be extended for long term

* ranges across Canada from 24 hours to 72 hours

3 mechanisms under BC *Mental Health Act* for emergency short-term committal:

1. One medical certif filled out by any physician (MOST COMMON)

* Must show criteria for civil commitment have been met
* S. 22(4) - Physician must have examined patient not more than 14 days before the date of admission and must indicate reasons for believing that criteria under s. 22(3) are met
* Criteria for this certificate are the same as those for long-term certifs
* One certif provides authority for *anyone* to bring person to designated facility (ambulance, police, family, etc.)

1. Police Apprehension – s. 28(1)

* Police must be satisfied person is likely to endanger their own safety or that of others (more strict than civil commitment standard).. physical/mental deterioration is not included as grounds for police intervention
* Police takes person to physician to sign certif. – s. 28(2)

1. Warrant of provincial court judge (very unusual)

* S. 28(3) – may apply to provincial court judge or justice of the peace if there are reasonable grounds to believe that a person meets substantive criteria set out in s. 22(3) for certif.
* Person may be committed for 48 hours, then require 2 certifs from physician for longer term.

## Criteria for Long-Term Committal – s. 22(3)

1. *statement by physician that he has*
   1. *examined person on date set out, and*
   2. *is of opinion that person has mental disorder (See s. 1 below)*
2. *the reasons in summary form for the opinion*
3. *a statement, separate from that under para (a), by physician that he is of the opinion that person to be admitted*
   1. *requires treatment in designated facility*
   2. *requires care (including nursing care – SSC), supervision and control in designated facility to prevent person’s substantial mental or physical deterioration or for the protection of the person or the protection of others*
   3. *cannot suitably be admitted as voluntary patient.*

s. 1 definition of **mental disorder** - *person who has a disorder of the mind that requires treatment and seriously impairs the person’s ability*

* *(a) to react appropriately to the person’s environment or*
* *(b) to associate with others*
* \*\*\* person who is untreatable thus do not met definition but quite likely that they are treated as though the can be\*\*\*

**Breakdown of each Branch of the Criteria**

*22(3)(a) must have mental disorder* – this requirement is in some form present in every Canadian Mental Health Act

* definition presupposes that treatment is available

22(3)(c)(ii) *requires treatment, care, supervision, and control*

* most controversial part of criteria
* **care** includes nursing home (SCC)
* ***protection*** – in ***McCorkell*** Donald J. set out parameters for purposes of civil commitment:
  + protection involves the notion of harm
  + can include social, family, vocational or financial life, physical safety of patient.
* ***Deterioration*** – no case law on meaning in BC. Ont courts have said that deterioration suffered must be “considerable, consequential, ample, significant, sizeable”.
  + No where does it say how long deterioration should take
* ***Cannot be admitted as voluntary patient***
  + Carver suggests that purpose behind this is to ensure commitment is absolute last resort
  + BC’s criteria here almost identical to Alberta’s – Alberta’s discussed in Robertson article (2010)
    - Problem - not all patients willing to stay voluntarily are appropriate for it.. some leave hospital contrary to medical advice which mitigates treatment
    - If dr. wants to put limits on person’s ability to come and go as they please from hospital in order to be properly treated then maybe they’re not suitable for voluntary status
    - Another problem: some ppl incapable of consenting to voluntary stay but may be appropriate as voluntary patient. Same probably with some who are unwilling to consent – might still be appropriate voluntary patient.

## Nature of Examination – s. 22(4)

Certif not valid unless both it and examination done in last 14 days

Act does not define examination (= wide range in practice)

* BCCA held that Dr. does not have to personally interview patient to meet requirements of examination – intern is ok (***Mullins v Levy, 2009 BCCA***)
* Court held physician’s decision is ultimately “question of medical judgment”
* Court’s ought not lightly interfere with medical decision provided it is made in good faith and w reasonable care.

## Status Change

* distinction b/w voluntary/involuntary not fixed – voluntary patients often become certified and made involuntary if they try to leave against medical advice or refuse treatment
* involuntary patients may be *decertified* (eg. ***McCorkell***)

## Renewals of Detention

First renewal (s. 24(1)(a)) – one month extension

* to extent hospitalization beyond one month (for one more month), physician examines person and completes renewal certificate *before other certificate(s) expire*

Second renewal (s. 24(1)(b) – 3 month extension

All subsequent renewals (s. 24(1)(c)) – 6 month extensions

Reqs. for all examinations – s. 24(2.1)(a) *Mental Health Act*:

* written report must state reasons why criteria under s. 22(3) continue to exist
* physician must consider all relevant evidence include history of hospitalization, compliance with treatment during and after hospitalization (history of non-compliance?)
* assessment of whether significant risk, because of mntl disorder, that patient if discharged will fail to follow trtmt plan necessary to minimize possibility of future detention under s. 22

\*\*\*Patient has right to review panel for first month within 14 days, same for second month, and during the remaining renewal periods, within 28 days (*Mental Health Regulations*)

## Transfer of Prisoners

s. 29 *Mental Health Act* – prisoners can be committed once in jail, in order to forcibly treat them

* preventative - often, prisoners who finish sentence and are up for release are committed if they are thought dangerous (almost exclusively sex offenders)
* ***Starnaman v Penetanguishene mental health cntr, [1995 OAC]*** – ONCA rejected argument that civil commitment after sentence amounts to “de facto dangerous offender proceeding – Dr’s apply *Mental Health Act* in good faith.

Must get two medical certifs under s. 22, then Lieutenant Gov. can order person to be moved to mental health facility (not a psychiatric unit)

## NCRMD Patients

Civil commitment used for those NCRMD under *Crim Code* – the *Code* does not provide for non-consensual treatment of those found NCRMD so civil commitment of them = mandatory treatment provisions of *Mental Health Act* can be applied

## Leaves

* director/authorized physicians can place involuntary patient on leave from hospital (authorization to be absent from hospital): used to treat elsewhere, day passes, overnight visits, trial placements in community, and extended leave (14+ days)
* s. 37: Subject to section 40 and the regulations, if the director considers that leave would benefit a patient detained in the designated facility, the director may release the patient on leave from the designated facility providing appropriate support exists in the community to meet the conditions of the leave.
* S. 40 – NO LEAVE available to prison transfers or those detained under crim code.

**s. 39 - Extended Leave – most significant in BC**

* some who are civilly committed are released on extended leave and usually live in community housing facility or private home
* s. 39 – despite being on leave, still subject same authority as though they were in the health facility/ward
* can be recalled at any time, warrant issued for apprehension – s. 9 of *Regulations*
* director/physician must be satisfied from examination, personal observations OR info received that (a) requires treatment in a designated facility, (b) requires care, supervision and control in a designated facility to prevent the patient's substantial mental or physical deterioration or for the protection of the patient or the protection of others, and (c) will not voluntarily return to a designated facility.
* PROBLEMS with extended leave
  + 1. if someone is living at home, do they really need to be committed?
    - BC has no *forcible community treatment* (latest movement in Mntl health law)
    1. No Max. time limit on which person may be held on leave
* Safeguard in s. 25(1.1) – review panel chairperson must review file once person on leave for 12 or more consecutive months and order review panel if it is likely that person would be released
  + 1. Person on extended leave still civilly committed, can be treated without consent under Act under ongoing possibility of rehospitalization

## Charter and Civil Commitment

Earliest challenge – ***Thwaites v Health Sciences*** – Manitoba struck down commitment criteria which were too broad, just a drs opinion

* criteria failed to establish objective criteria related to mental condition, risk of harm.. criteria exposed ppl to arbitrary detention and violated s. 9 of charter
* statute amended to include standard “likelihood of serious harm” – standard later upheld in ***Bobbie v Health Sciences (1998, Man]***

### McCorkell v Riverview, [1993, BCSC]

**Facts:** M Suffers from bipolar disorder and had been committed (not anymore).At review panel, they transferred him to voluntary status and eventually discharged him. Moot case but court when through with it for public interest reasons. At the time, legislation for commitment read “requires care, supervision, and control in health facility *for his own protection and protection of others*” (deterioration standard not yet legislated)

**Issue:** Do civil commitment provisions infringe on Charter rights s. 7 (liberty) and 9 (arbitrary detention) because of vagueness?

**Held:** civil commitment provisions are constitutional, strike an appropriate balance

**Analysis:**

* McCorkell argued that only criteria for dangerousness should meet the standard for civil restriction of person’s liberty, otherwise, arbitrary detention
* Donald J. held that strikes reasonable balance b/w rights of individual to be free from restraint by state and society’s obligation to help/protect mentally ill. Interest of society vs. patient not opposed.
* Unlike being jailed, purpose of civil commitment is to *help* person, to their benefit
* Reject argument that because mentally ill are innocent victims of disease they should have their liberty interfered with as little as possible – culpability is irrelevant
* Criminal case law does not apply because criminal law is penal and mental health protective (problem – isn’t crim law also rehabilitative? Not just punitive?)

\*\*\* recent case in Ontario, where civil com. Reqs. are more detailed – did not prove on BoP that it violated the Charter and suggested a ministerial review of criteria

# TREATMENT AND THE RIGHT TO REFUSE IT

## Common Law Rule

Only forcibly treat those civilly committed; do not force treat those that are voluntary

**Treatment** defined in s. 1 of *Mental Health Act* 🡪 safe and effective psychiatric treatment and includes any procedure necessarily related to the provision of psychiatric treatment”

* is force feeding psychiatric treatment?
* ***Starson/ Gray & O’rielly article (Canada’s beautiful mind case)*** 🡪 he stopped eating hospital food because he though hospital was poisoning him. Court decided Starson was able to decide for himself, stopped treatment and he quickly deteriorated

Problem – why do we treat mental health different than physical health? We don’t force treat anywhere without consent except for mental health context

* competence is threshold/determining factor – must be able to understand consequences of treatment/no treatment… must weigh factors and be able to decide
* if no competence then state has obligation to protect person (aka treat)

CL rule – right of any *competent* adult to refuse treatment is basic premise of Canadian Law. Even where person is unconscious, if prior wishes are known, those wishes are to be respected, event if refusal of treatment could result in death (***Malette v Shulman, 1990 ONCA***)

* Jehovah’s Witness brought into hospital needing blood transfusion or death. Dr. knew she was JW, saw her card that said she would refuse blood transfusion and gave her one anyway. She sued and was successful
* ONCA held this was tort of battery
* Cited ***Starson v Swayze*** – competent person has right to make foolish decision, as well as good ones (reflects CL – must be able to reasonable understand foreseeable consequences)

**BC: *Health Care (Consent) and Care Facility (Admission) Act*** 🡪 s. 2 codifies CL BUT expressly states that it does not apply to those who are civilly committed.

## Incompetence

Right to refuse premised on notion of autonomy – notion not applicable if person incapable of making decision and state has corresponding obligation to protect person

If incompetent, substitute decision-maker (SDM) appointed (usually family) to make decision on person’s behalf

* generally legislation requires SDM to decide based on what person would have wanted if competent

If person is mentally ill and detained, every province has a provision that allows for compulsory treatment in some contexts (BC has broadest powers of compulsory treatment)

**Are civilly committed patients always incompetent?**

Majority in ***Starson*** warned against assuming mentally ill are incompetent – so no, not necessarily

## Treatment Refusal

Studies suggest most patients with right to refuse, actually do not refuse (and if they do, only for a short period of time)… but voluntary patients who refuse treatment run the risk of being civilly committed and force-treated.

**Carver Article summarizes provincial approaches:**

* right to refuse 🡪 Ontario, NWT, Nunavut
* No right to refuse 🡪 BC, Newfoundland
* Right to refuse, subject to “best interests” override 🡪 Alberta, Manitoba, and ~NB, PEI, Yukon (right to appeal decision)
* Excluding capable individuals from civil commitment 🡪 Sask, NS

## Models for Compulsory Treatment

1. **Status Based Model 🡪** Currently in BC.. decision based on whether patient is voluntary/involuntary. Voluntary have CL right to refuse. Involuntary who refuse consent will have treatment ordered without consent. Presupposed that involuntary patient who refuses treatment is *incompetent*.
2. **Competence Model** 🡪 *Competent* patients have right to refuse. Incompetents have SDM appointed but may be force-treated. If SDM refuses consent, refusal will be respected for voluntary patients, but if involuntary then there may be access to a review board which can override SDM
3. **Mixed Model (most common)** 🡪 looks at whether voluntary/involuntary. If voluntary then you can refuse. If involuntary, then look to whether competent/incompetent. SDM appointed for incompetents and may be access to review Board that may override SDM’s refusal or competent’s refusal.

## BC Legislation

**BC: *Health Care (Consent) and Care Facility (Admission) Act*** 🡪 s. 2 codifies CL BUT expressly states that it does not apply to those who are civilly committed.

***Mental Health Act,* s. 31** 🡪(1) if patient detained under s. 22, 28, 29, 30, 42 or is released on leave or transferred to approved home, treatment authorized by the director is deemed to be given with the consent of the patient (aka. Committal = director gives consent to treat)

(2) patient may request second medical opinion for treatment but (3) director has final say.

* patient has to pay for their own second opinion (s. 8 of Regs)
* policy reason: to get out of bias found within same hospital.. but is it really gone if director has final say?

**Arguments for constitutionality of s. 31:**

* can argue it violates s. 15 of Charter because it is comparable to voluntary vs involuntary patients and saying voluntary have right to refuse, but involuntary cannot so disadvantaged group OR people with physiological disabilities have right to refuse treatment even if it seems illogical so it disadvantages people with mental illness
* saved by s. 1?.. maybe… compelling objective but not really the least restrictive way of accomplishing it
  + - might need review mechanism/tribunal
    - can argue that getting rid of this rule would result in people being committed for longer periods of time than would otherwise be the case which could effectively become “imprisonment”

## Form 5: Consent to Treatment for Involuntary Patients

2 options on form:

1. patient signs and physician indicates that to best of knowledge patient was capable of consenting
2. patient refuses and physician indicates that patient is involuntary and incapable of appreciating nature of treatment/need for it and therefore incapable of consenting

PROBLEM: not really consent – you’re being treated either way.. incompetent if you refuse and force treated… no option for a competent involuntary patient to refuse (must accept treatment).. suggests that anyone who refuses treatment = incompetent

### Fleming v Reid [1991 ONCA]

**Facts:** both Ps NCRMD but being treated under *Mental Health Act* for schizophrenia. Labeled by psychiatrists as *incompetent* (lost appeal to review board). Appointed a SDM - both Ps had expressed previous competent desire to refuse neuroleptic drugs in the past so SDM refused consent. Dr. appealed to review board to override refusal based on best interest (legislation based on mixed model)

**Issue:** Does provision allowing prior wishes expression while competent to be overridden by review board infringe on s. 7 Charter right?

**Held:** Yes, breach of charter to force someone to take drugs that have serious side effects

**Analysis:** CL right to bodily integrity and personal autonomy deserved highest order of protection, entrenched in traditions of our law. This right forms an essential part of security of the person and must be included in the liberty interests protected by s. 7.

* few medical procedures more intrusive than forcible injection of powerful mind-altering drugs with severe side effects (neuroleptic drugs = tardive dyskinesia)
* legislative scheme that allows competent wishes to be overriding without affording hearing as to why SDM refusal should not be honored violates basic tenets of legal system
* not saved by s. 1- state has not provided any compelling reason for eliminating this right, without any hearing or review, to further the best interests of involuntary incompetent patient contrary to their competent wishes.
* Defeats purpose of having SDM, if SDM’s decision is not even considered upon review – complete lack of consideration of competent wishes at review level is violation of principle of fundamental justice; *best interest* should not be only thing considered

**Ontario’s Response (illustrated in *Verdun-Jones* article):**

* added absolute right to refuse for competent patients
* added right to appoint SDM for incompetents
* added right of review of decision of *incompetence*
* nothing similar happening in BC just *McCorkell* (Carver says *McCorkell* had chilling effect on BC Charter Challenges)

## Community Treatment Orders

Movement not yet in BC (just have extended leave) but defs a trend elsewhere

* in US, referred to as “outpatient committal”
* purpose of CTO is to avoid civil commitment an to treat people before commitment is necessary.. allows people to learn to function in community, not just hospital

Problems with this in Ontario (discussed in *Carver* article – “Brian’s Law and problematic implications of CTOs”):

* addresses specific group of individuals – revolving door patients
* two parts to legislation:
  + new standard for commitment addresses only revolving door patients who have shown pattern of going off meds
    - deterioration standard
    - in BC, deterioration standard is used for first-time committals.
  + Requires that patient or SDM consent to CTO – if they consent then why do you need an order?
    - If you don’t consent then you will be committed on broader standard, or if you withdraw consent, dr. automatically given right to review case for committal
* is this really consent then? Carver says its not really less restrictive than Hospitalization.. not voluntary

***Thompson and Empowerment Council v Ontario* [2013, ONSC]** 🡪 challenged deterioration and CTO standard

* CTO’s upheld as constitutional but called for ministerial review because of concerns that they may do more harm than good – coercive in nature
* Coercive nature undermines effectiveness and that the people who are doing well were not forced to do CTO because they would have agreed to it anyway.

# MENTAL CAPACITY AND DECISION-MAKING

**Options for obtaining Legal Authority for SDM**

Applicable only to *adults* (in BC, anyone 19+)

Falls under provincial jurisdiction so no guarantee that diff. provinces will respect arrangements made by someone in another province.

**Relevant Statute:**

*Power of Attorney Act*

*Adult Guardianship*

*Health Care (Consent) and Care Facility (Admission) Act*

*Representation Agreement Act*

*Power of Attorney Act*

*Patients Property Act*

**Two ways to obtain legal authority:**

1. SDM appointed by patient
   1. Historically, mentally ill patients could not pass test for power of attorney by proving that they understood significance of the relationship, so they often fell under committeeship (SDM court appointed, see below)
2. SDM imposed on patient (committee = Personal Guardian)

* *Patients Property Act*, s. 2 – Attorney general or near relative of person may apply for order declaring person is incapable of managing own affairs because of mental disorder
  + Amounts to civil death, lose right to refuse treatment or make any decisions at all, can’t get married, etc.
  + Committee of the person (personal and health decisions)
  + Or Committee of the estate (legal and financial matters)
* Certificate of incapability (ONLY RELATES TO COMMITTEE OF THE ESTATE) granted by public guardian or trustee, issued by director of provincial mental health facility; says that adult is incapable of managing affairs due to mental infirmity and PGT becomes committee of the estate
* Note that once certificate of incapability has been issued, it is almost impossible to get committee reversed. You have to go to court and prove that you now have *no* mental disability whatsoever, if you wanted to instead make a rep agreement (which you would be able to because you can have a mental disability and be capable). Most people fail because they still have some mild form of mental disability.

## Project to Review Adult Guardianship Legislation

*Adult Guardianship Act,* s. 2 sets out guiding principles:

*(a) all adults are entitled to live in the manner they wish and to accept or refuse support, assistance or protection as long as they do not harm others and they are capable of making decisions about those matters;*

*(b) all adults should receive the most effective, but the least restrictive and intrusive, form of support, assistance or protection when they are unable to care for themselves or their financial affairs;*

*(c) the court should not be asked to appoint, and should not appoint, guardians unless alternatives, such as the provision of support and assistance, have been tried or carefully considered.*

## New legislation

In 2000, legislation package was passed. Now there is Committee of estate (financial and legal matters), Committee of the person (health and personal matters), *Representation Agreements Act* (one of the best mental health statutes in the world), and enduring power of attorney (only for financial and legal matters; enduring = power of attorney effective even with mental deterioration)

2011 was last time this area of law was revised. Allows for *advanced directives* which serve to cover only health care.

* must specify hypothetical situation and say “I accept/refuse this type of treatment if X happens to me”

## Types of decisions:

1. Health care 🡪 consent or refusal to consent to proposed healthcare treatment, such as medications, surgery, chemotherapy, etc.
2. Personal care 🡪 living arrangements, personal support staff/services, diet, personal safety, spiritual matters, care of pets, etc.
3. Financial 🡪 submitting taxes, managing bank account, applying for gov. benefits, pensions, buying/selling real estate
4. Legal 🡪 hiring/instructing lawyer, accepting insurance settlements (often arises in car/brain injury cases)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Health** | **Personal** | **Legal** | **Financial** |
| Imposed Decision Maker | Committee of the Person | | Committee of the estate | |
| Personal Planning Documents | Representation Agreement | | | |
| Advanced Directive |  | Enduring power of Attorney | |
| Imposed Decision Maker | TSDM |  | |

### Health Care

Committee of person decides OR:

Drs must obtain consent for proposed treatment with some exceptions (eg. urgent/prevention of extreme pain, but s. 12.1 of *Health Care Consent* *Act* says no emergency treatment if against prior wishes.. also, if guardian or rep exists, must ask them first – ***Mallette***)

* *Health Care Consent Act*, s. 4 grants rights:
  + - Every adult who is capable of giving or refusing consent to health care has
      * (a) the right to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death,
      * (b) the right to select a particular form of available health care on any grounds, including moral or religious grounds,
      * (c) the right to revoke consent,
      * (d) the right to expect that a decision to give, refuse or revoke consent will be respected, and
      * (e) the right to be involved to the greatest degree possible in all case planning and decision making.
* *Health Care Consent Act* does NOT apply to those committed (s. 2), or for psychiatric treatment (s. 2).
* *Health care Consent Act*, s. 5 – Cannot provide healthcare without consent (does not apply to psychiatric treatment for those civilly committed)
* *Health Care Consent Act*, s. 6 – elements of consent:

(a) the consent relates to the proposed health care,

(b) the consent is given voluntarily,

(c) the consent is not obtained by fraud or misrepresentation,

(d) the adult is capable of making a decision about whether to give or refuse consent to the proposed health care,

(e) the health care provider gives the adult the information a reasonable person would require to understand the proposed health care and to make a decision, including information about

(i)  the condition for which the health care is proposed,

(ii)  the nature of the proposed health care,

(iii)  the risks and benefits of the proposed health care that a reasonable person would expect to be told about, and

(iv)  alternative courses of health care, and

(f) the adult has an opportunity to ask questions and receive answers about the proposed health care.

* Substitute consent: adult guardian (*Patient’s Property Act*), then Representative (*Rep. Agreement Act*), then advanced directive (*Health Care Consent*)

s. 16 of *Health Care* Act -If person does not have pre-planned decision, then as last resorted they are assigned a Temporary SDM (TSDM) – see below. S. 16 of *Health Care Act*

Note that s. 3 of *Patients Property Act* effectively kills all civil rights of mentally ill patient (civil death – can’t marry, etc.)

#### Representation Agreement Act

* progressive for promoting rights of people with disabilities’ primary objective = help person make own decisions (rep has duty to help person make decision on their own, and if they can’t, then decide how they most likely would have decided)
  + it is *supportive* decision making; NOT substitute decision making
* trump Advanced directives unless expressly stated in Rep K.
* no test for mental capacity for standard powers (s. 7 powers)
  + someone who has been committed can still make K, even though rep can’t make decisions about psychiatric care.. helpful for getting medical records
* to make rep K for s. 7 powers, you must pass capability test of understanding nature of K under s. 8 (very easy to pass)
  + KEY: is person able to say that they want to make s. 7 agreement? Are they able to say I’d rather have X happen than y?
  + Obviously can’t make a K if you’re unconscious
* safeguard – Act imposes idea that there is safety in numbers, can appoint multiple people in your Rep agreement (ss. 5, 6, 12 (monitor))
  + s. 12 – monitor – generally someone from patient’s personal support network. Don’t make any decision; sole role is to review the decision of representative. Check and balance.
* 2 levels of authority you can put into K:
  + S. 7 🡪 Standard powers
    - minor/major health care (be able to find def. in *Health Care Act*), personal care decisions, financial and legal matters (eg. obtaining legal services, instructing counsel to commence proceedings except divorce, can’t make will on behalf)
    - health care is as defined in *Health Care Admissions Act* and not what is *prescribed* under act (so powers do not include what is *prescribed*)
    - cannot authorize refusal of life-saving health care or physical restraints
  + s. 9 🡪 broad powers
    - more authority you can give your rep, includes prescribed treatment
    - ability to refuse consent to treatment that is sustaining your life.
    - Allows you to give rep authority to override your own later refusal of treatment (sounds invasive but would prevent commitment) – AKA *Ulysses Agreement* – power must be specifically given.. helps avoid civil commitment
    - Authority to determine where adult lives, works, participates in education, contact with others, diet/dress, physical restraints, moving, managing adult
    - Cannot consent/refuse consent to abortion, psychosurgery, ECT, experimental treatment with risks – *Health Care Act Regulations*
    - Can only arrange for care/education of children is Rep K expressly says so
* S. 10 🡪 capability req. to make s. 9 rep agreement (must understand nature and consequences of proposed agreement)… remember that s. 3 presumes people are capable

#### Advanced Directives

* Governed by s. 2.1 of *Health Care Consent Act*, ONLY applies to *health care*.
* Similar to “living will” but no legal authority for living will in Canada; don’t appoint a person, just give or refuse consent
* If adult incapable of understand nature (scope and effect of health care instructions) of K, then cannot make advanced directive (s. 19.1 of Act)
* Rep K trump Advanced directives unless expressly stated otherwise in Rep K (advanced directive becomes an expression of wishes for Rep)
* Must state specific scenario and where you would consent/refuse to specific treatment.
* S. 19.8 – can’t use directive if:
  + Instructions don’t address decision to be made, instructions unclear, adult’s values/wishes have changed, significant changes in medical knowledge/technology
  + If one of these factors present, then appoint a TSDM
* Retroactive – docs made before 2011 can be considered advanced directive, but must meet form/execution reqs. of *Health Care Consent Act*

#### Temporary Substitute Decision Maker

* means patient does not have any outstanding agreements.
  + Healthcare provider appoint TSDM under s. 16 of *Health Care Consent Act,* in this order of priority: (1) spouse, (2) Child (over 19), (3) parent, (4) sibling, (5) any other relative, (6) close friend, (7) anyone related by marriage (in-laws?)
* Authority is temporary – only decide that one decision, then authority is revoked
* TSDM has no authority to make end of life treatment decision.
* Must be 19+, in contact with adult during last 12 months, no dispute with adult, capable of giving/refusing consent, willing to comply w s. 19 duties
* If no one on the list, then go to person at Public Trustee’s office
* S. 17 and 19 relate to authority of TSDM

### Personal Care:

If patient incapable of making personal care decision, committee (guardian) or rep has authority to make decision

* rep w. s. 7 authority will cover most personal decisions
  + on decision not found in s. 7 (only s. 9) is decision re: arrangements of care for minor children
* no default scheme where no rep K or committee

### Financial and Legal Matters

* to make legal decision, only option is *Rep. Agreement* or *enduring power of attorney*, or committee of the estate
* Rep. K does not explicitly trump enduring power of attorney, but given that rep is supposed to *help* person make decision on their own, then that person’s decision should trump (except for decision re: selling/buying real estate, where only attorney has power)

#### Enduring Power of Attorney

See *Power of Attorney Act*, s. 12 🡪 adult may make *enduring* power unless incapable to understand significance of K

* cant make health care or personal decisions (if it does, it is invalid and struck)
* s. 14 - if you don’t make *enduring* then it is assumed that upon deterioration, power ends.
* S. 13 – can do anything re financial affairs
* Requires detailed test of capability before you can make a power of attorney
* S. 18 allows for selection of alternate attorney
* S. 19 outlines duties – best interests of adult taking into account their wishes – diff than a rep!
  + Can run a business, buy/sell real estate – rep can’t do this.

#### Representation Agreement Act

s. 7 – routine management of financial and legal affairs… covers almost everything except buying/selling real estate and managing a business

* if you own property, best to have a rep K for health/personal care, and enduring power of attorney for legal and financial
* can’t make divorce decision

#### Committee of the Estate

* *Patients Property Act…* most extreme, can make all legal and financial decision for individual

## *Bentley* Decision

**Facts:** woman who in ’91 wrote a doc. Expressing her wishes about future med. Care, before all of this statute. Now she has advanced alzheimers and is being spoon fed. Her document expressed she refused consent to any heroic/artificial measures of keeping her alive and liquid good.

**Issue:** Is this health care? Or personal care?

**Analysis:** did she mean only IV feeding? She shows preference for dessert so she is in some ways consenting

* If it is determined that feeding is *health care* then the family would get to make the decision (stop the feeding). If it is personal care, then they would be out of luck
* Note that *Rasouli* decision in Ontario has held that withdrawal of treatment falls under health care (does not apply to BC but similar legislation)

# FORENSIC MENTAL HEALTH

* change to fed. Gov.-uniformity across Canada
* value of “dangerousness” and protection of the public is a lot more visible in criminal context
* courts way more involved in criminal context
* forensic psychiatry system applies to those found NCRMD pursuant to s. 16 on *Criminal Code*, those found unfit to stand trial, and those on remand for assessment (under court order to assess fitness to stand trial)

## Civil Commitment of Forensic Patients

**Only** those found unfit to stand trial under Crim Code can be forcibly treated (only if it is likely to make them fit to stand trial)… CANNOT force treatment for those that are NCRMD

Prisoners can be civilly committed, transferred to provincial mental health facility (DON’T go to psychiatric ward)

## History

Prior to 1992 amendment, verdict of not guilty by reason of insanity led to automatic and indefinite detention (up to lieutenant gov.) and strict custody in forensic psychiatry facility (regardless of dangerousness)

* recommendations for released made by Order in Council Review Board; final decision made by Social Services Committee of provincial cabinet
* could be detained longer than prison sentence

stereotype that people with mental illness are dangerous, despite no correlation

* *WInko* cites study arguing that social dislocation and economic decline that often follow mental illness is what leads to the tendency for criminalization (homelessness, drug abuse, unemployment, poverty, etc)
* No support for idea that they have greater risk of recidivism than non-mentally ill offenders

### R v Swain [1991 SCR] and Legislative Changes

**Facts:** Swain clearly mentally ill when he assaulted his wife. Found NGRI, automatically detained in psychiatric facility. No flexibility, indefinite time. Defense of insanity was forced upon him by the crown

* By the time of disposition, he had voluntarily undergone treatment and improved significantly, yet he was to be detained indefinitely (judge has no choice)

**Issue:** was it constitutional for the *Code* to require the TJ to order Swain detained in strict custody without any assessment of his present dangerousness? (s. 7 – right to liberty)

**Held:** no – not minimally impairing

**Analysis:**

* Judge had no discretion to look at current circumstances of individual – what is no longer dangerous?
* Saved by s. 1? Objective of protecting public from crime in compelling and while there was a *rational connection* by automatically detaining NGRI, it was not *minimally* impairing (under *Oakes* test)
  + Once sentenced to strict custody, it took a lot of time for lieutenant Gov. to review case.. minimal impairment would mean people be detained no longer than necessary to determine dangerousness

**Gov Response:**

Gov. had already drafted new legislation but *Swain* made it come out faster.

* Lieutenant Gov. warrant system abolished
* Determinations about release, level of custody to be made by statutorily defined board – Criminal Review Board, set up in each province
* Board making disposition may offer an *absolute discharge* (only for NCRMD, not used for *unfit*), a conditional discharge, or indeterminate detention in a forensic psychiatric facility
* If detained, or conditional discharge, decision will be regularly reviewed by board.

## Criminal code Review Board:

* set up under s. 672.38 in *Crim Code*
* at least 5 members, each hearing must have at least 3 present
* 1 must be licensed to practice psychiatry and there is only one psychiatrist, another person must have expertise in mental health and be a psychologist (s. 672.39)
* chairperson must be a judge or retired judge
* more attention to who sits on these boards than on civil panels.
* Where court finds someone NCRMD or Unfit to stand trial, court may hold a disposition hearing (s. 672.45(1)). If court does not hold a hearing, it sends transcripts to the review board and review board has jurisdiction of matter (s. 672.45(1.1)

**Court sends to review board:**

* where court does not make disposition, board must make one within 45 days… may be extended to 90 days
* 672.47(3) – where court has made disposition other than absolute discharge, review board has 90 days to review and make its own disposition (review board makes final decision, not court)
* if unfit, board must determine whether person currently fit to stand trial, if yes, sent back to court

**Review Board Disposition Hearings:**

* should be informal
* AG may be a party so may be anybody who has substantial interest in protecting accused
* Board can exclude public where in best interest of A
* A has right to be present under s. 672.5(9) but (10) permits chair to remove A where he is disruptive, life/safety of someone else is endangered or A’s recovery is endangered by hearing certain evidence.

## Court and Review Board Dispositions

S. 672.54 – court/review board much take into consideration the need to protect public from dangerous persons, the mental condition of A, the reintegration of A into society and other needs of A and make disposition that is least onerous and restrictive to A:

* + (a) where a verdict of NCRMD has been rendered in respect of the A and, in the opinion of the court or Review Board, the A is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely; (NOT AVAILABLE FOR SOMEONE UNFIT TO STAND TRIAL.. still must be tried)
  + (b) by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or
  + (c) by order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.

If court/review board unsure, then A is entitled to absolute discharge if *not a significant threat to safety of public*. (significant = real risk of serious physical or psychological harm to the public; risk must be CRIMINAL)

Gov. trying to get rid of *least restrictive* requirement; wants to focus only on public safety

***Winko*** – no burden on A to prove he is not a significant threat.

## Review of dispositions by Review Board

**s. 672.81 – review of disposition** – anyone on conditional discharge or hospitalized must have disposition reviewed every year.

\* board may extend this time to every 24 months (672.81(1.1)).. (1.2) allows them to extend it if someone has been convicted of serious personal injury offence if board is of opinion person is unlikely to improve in a year.

## Treatment

No disposition order can include treatment as condition unless A has consented (s. 672.55) (also unless person unfit to stand trial, then they can force treat)

s. 672.58 - Before disposition made, crown can apply to court for someone unfit to stand trial to undergo treatment for a period not exceeding 60 days, purpose of which is render A fit to stand trial

* no ECT or psychosurgery
* consent of hospital is required for treatment, but consent of unfit A is not

### Winko, [1999 SCC] 🡪 dangerousness is appropriate basis for forensic committal

**Facts:** W had mental disorder, arrested for attacking pedestrian with knife (aggravated assault). At trial, he was gound NCRMD. Eventually he was given conditional discharge, but he appealed, wanting absolute discharge

**Issue:** whether s. 672.54 of CC which grants review board the power to give discharges a violation of s. 7 and 15 of the Charter (indefinite nature was discriminatory to those with mental disorders)

**Held:** Constitutional; Charter challenges of s. 7 and 15 rejected

**Analysis:**

* Board must consider the need to protect the public from dangerous persons, the mental condition of the accused, his or her every integration into society and the other needs of the accused and then ask does the evidence disclosed prove that the accused is a significant threat to the safety of the public?
* SCC held that *dangerousness* in terms of posing a sig. threat to public safety is the appropriate basis for forensic committal
* No presumption that NCR A’s pose a significant risk
* S. 7 argument (liberty)
  + *Overbreadth* – protects liberty to max. extent by ensuring absolute discharge if no sig. threat, and by requiring least restrictive option
  + *Vagueness* – “sig. threat to public safety” sufficient precision for legal debate (must be *criminal*)
  + *Improper onus* – no burden on A to prove not threat
* S. 15 (equality)
  + Argument rejected because new regime was enacted to eliminate stereotyping/stigmatization of mentally ill
  + Takes into account actual needs/circumstances of A, human dignity
  + NCRMD don’t have to be treated the same as criminal offenders b/c restrictions on liberty imposed for rehabilitatve, not penal purposes
* **Significant threat -** significant threat to the safety of the public means a real risk of physical or psychological harm to members of the public that is serious in the sense of going beyond merely trivial or annoying. The conduct must be criminal. No presumption of sig. threat
* **Inquisitorial nature of proceeding** – Not adversarial, but rather inquisitorial. No burden on A to prove not a threat. Board has duty to find all relevant evidence since A may not be in position to present all relevant material. Must gather evidence on: (1) public protection, (2) the mental condition of A, (3) the reintegration of A into society, (4) the other needs of A
  + A past offence committed while A suffered from mental illness is not by itself evidence that A continues to pose threat, but relevant in showing pattern of behavior
* If significant threat, then detain in custody or conditional discharge – considering needs of public and protection, choose least restrictive means.

## Fitness to stand trial

*Unfit* defined in s. 2 of Crim Code – unable on account of mental disorder to conduct a defence at any stage of the proceeding before a verdict is rendered or to instruct counsel to do so, in particular unable on account of MD to understand nature, consequences of proceedings and communicate with counsel.

Presumption that A IS fit to stand trial – party alleging unfit must prove on a BoP

* 2 competing values raised by unfitness – (1) interest in trying A within reasonable time, vs. (2) ensuring we don’t try someone who can’t meaningfully participate

**Who raises fitness?**

Crown, defence or judge can raise it any time before verdict, prove it on a BoP. If raised, A must be referred for assessment within no more than 5 days and returned to court.

* assessment orders apply for up to 30 days (s. 672.14) but for fitness the max is 5 days unless parties agree otherwise
* s. 672.14(3) – court has power to order assessment order up to 60 days if compelling circumstances
* court must be satisfied custody is necessary; presumption against custody
* s. 672-21 protects statements made by A during assessment (not used in trial)

**Finding of Unfitness**

* court may then decide whether to hold disposition hearing (option of conditional discharge, detention, treatment order (for up to 60 days), or referring matter to review board).. ABSOLUTE DISCHARGE NOT AVAILABLE FOR UNFIT
* if no court disposition, then review board must make disposition within 45 days (s. 672.47)
* review board must review court’s disposition within 90 days
* if fit, sent back to court

### R v Demers [2004 SCC]

**Issue:** someone who is permanently unfit will be tied to criminal process indefinitely even if no significant threat to public safety – does this violate s. 7 charter?

* lack of availability of an absolute discharge is justifiable for someone who can potentially become fit to stand trial b/c of public interest in being able to try person
* minority held that it is *ultra vires* parliament – dealing w treatment of temporarily unfit A is legitimate criminal law power. Where A is permanently unfit, parliament loses jurisdiction and it becomes a matter of health which is provincial.
* Majority – appeal allowed, provisions are overbroad and violate the s. 7 rights of permanently unfit As who do not pose a sig. threat to society

**Gov response to this case: s. 672.851**

* review board can make recommendation to court if review board has held hearing and is of opinion that (i) A remains unfit and unlikely to ever become fit, and (ii) A does not pose sig. threat to public
* (8) Court must consider:
  + (a) the nature and seriousness of the alleged offence;
  + (b) the salutary and deleterious effects of the order for a stay of proceedings, including any effect on public confidence in the administration of justice;
  + (c) the time that has elapsed since the commission of the alleged offence and whether an inquiry has been held under section 672.33 to decide whether sufficient evidence can be adduced to put the accused on trial; and
  + (d) any other factor that the court considers relevant.
* (9) if stay is granted any disposition from review board ceases to have effect.

## Tension b/w hospital and review boards

In ***Penetanguishene Mental Health Center v Ontario [2004 SCC]***, Ontario review board held that “least onerous and least restrictive to A” direction extends to ALL of the board’s order, not just which disposition it imposes (ie. Absolute, conditional, detainment)

* SCC affirmed this – least restrictive/onerous requirement applies to EVERY condition imposed on A

**To what extent should review boards become involved in treatment?**

***Mazzei v BC [2006 SCC]*** – Mazzei had been returned to custody on several occasions after violating conditional discharge. He was aboriginal and wanted to attend First nations residential rehab program. Board made order regarding review of his medication and treatment plan. Director appealed arguing that it is up to treatment team, not the board to make those decisions

* SCC decided that order was valid and reasonable in ordering the director to try to enroll M in culturally appropriate rehab. Director could have said no after investigation
* **Review board cannot order a specific treatment but it can supervise treatment to the extent that it can require the hospital to make an assessment, come up with a plan or explore an alternative if it does not think the hospital is doing that adequately.**

***R v Conway [2010 SCC]*** – A was detained in forensic hospital in Ontario, he applies to review board for remedy on basis that several of charter rights being violated because of shitty conditions of hospital.

* SCC confirmed that Criminal Code Review Board *does* have the jurisdiction to grant *Charter* remedies
* Court clarified that jurisdiction *does not* extend to granting an absolute discharge as a remedy for violation of *Charter* right if person remains significant risk to public

## Psychiatric Gating

Practice of civilly committing (almost exclusively sexual) offenders as their about to finish their prison sentence if they present a risk.

* appropriateness of civil commitment for this purpose? Just being used as detention, not treatment… challenged in *Starnaman*
* civil commitment requires that the person needs treatment.. presupposed that sexual offenders can be treated

### Starnaman v Penetanguishene Mental Health Center [1995 ONCA]

* A was civilly committed 5 days before expiry of his sentence… he challenged this
* ONCA upheld civil commitment and rejected argument that it was disguised dangerous offender proceeding that lacked protections of Crim Code
* Drs can make assessment and they act in good faith. If A meets requirements for civil commitment, then he can be committed.

## Bill C54 – Not Criminally Responsible Reform Act

**3 main components:**

1. Safety of the public becomes paramount consideration in the disposition – no longer has to be the ‘least restrictive/onerous’

* Currently review board must give absolute discharge unless A poses *sig. threat to safety of public*
* Instead, dispositions would be ‘necessary and appropriate in the circumstances’

2. New category of high risk NCR Accused who won’t be reviewed as often

* Label when found NCRMD of serious personal injury offence where there is substantial likelihood for further violence or the acts were of such a brutal nature as to indicate risk of grave harm to public
* Must be held in custody and cannot be considered for release until their designation is revoked by court
* Review periods could be extended up to 3 years, not entitled to day passes etc.
* Does not apply to people found unfit, only NCRMD
* CBA criticism: say its backward looking, regardless of what drs say now, you will become high risk. Looks to triggering event to determine likelihood of future. Does not allow for possibility that A may be treated and become non-dangerous. Assumes we can predict just from one offence who will become dangerous in the future
  + Even in *WInko*, McLachlin held that “past offence committed while NCR A suffered from a MD is not, by itself, evidence the A continues to pose a significant risk to the safety of the public”
  + Also, no appeal mechanism of designation of high risk.
  + Also say that this will keep more people in the forensic system for longer rather than shift to civil system
  + May discourage people from going via NCR plea – will leave more people with serious mental illness in penitentiary

3. Alerting victims when NCR accused are discharged

* Victim will have an opportunity to participate in process
* Allows non-communication orders b/w NCR A and victim

# CRIMINALIZATION OF MENTAL DISORDERS

## Mental Health Association reasons for criminalization:

1. **Insufficient community supports**

* Supports are available, but much harder to access for those with MD
* 1/3 of homeless have a MD

1. **Co-occurring substance abuse**

* Can be a problem during treatment because comorbid conditions require special treatment, not many places offer specialization

1. **Previous criminalization**

* Previous experiences with justice system
* Services will turn people away who have a criminal record (might conclude that they are a high risk even though their past offences were non-violent)

**Other factors:**

* lack of overlap in training with criminal justice and mental health professionals; not enough communication between the two systems
* lack of access to treatment in general, let alone specialized treatments
  + timing of treatment big factor as well – the longer one waits, the harder to recover
* treatment may be ineffective, unsustainable, or simply refused
* not uni-directional – being in the justice system can exacerbate MD (not just MD leading to jail)… jail is isolating which exacerbates MD and may lead to recidivism
* criminal law is not very rehabilitative (Even though s. 7.18(d) of *CC* says it should be)… it’s more punitive

Argue for an exception for those with MD problems in sentencing.. there should be amendments allowing for offenders to be remanded and assessed for mental disorders

* tension between wanting to punish for crime and treating disorder
* eg. ***R v Smith* 2004 –** aboriginal woman, diagnosed with antisocial and borderline personality disorders, assaulted her husband when he was drunk after he made derogatory comments. She had a lengthy criminal record and a pattern of this behavior but she had always been abused and suffered domestic violence and could only defend herself when the other was too drunk. Judge ordered intensive rehab, but it is only available through federal system.. said paramount concern was protection of public, failed to recognize her victimized history.

## Presentence Reports:

If author of psych assessment says person presents a substantial risk to the public, it carries a lot of weight (recommendation often adopted by judge 🡪 prison)

Incarceration is held is to be the most valuable source of treatment, despite fact that community treatment may be available.

**Ultimately, there is not much that can be done within penitentiary system to improve things for mental disorder. Best thing to do is work on trying to keep people with MD *outside* of penitentiaries**.

### Centre for Addiction and Mental Health v Ontario [2012 ONCA]

**Facts:** Mr C charged with sexual assault and was given treatment order under *CC*, requiring him to submit involuntarily to anti-psychotic drug therapy when he was found unfit. Hospital could not accommodate him immediately because no bed for 6 days. Facility wanted to set aside order requiring treatment, given that the order was made without consent of the facility and in circumstances where the judge knew there would be no beds available.

* If someone is in such a condition that they have to be the subject of a treatment order, where they are being forced to take medication…. and I have made that determination based on expert evidence…. *then that means now, it does not mean that a treatment order is necessary next Monday*

**Issue:** Does the requirement for facility consent in s. 672.62 violate an accused’s s. 7 charter rights?

**Held:** order inappropriate and overturned, BUT consent requirement is not unconstitutional

**Analysis:**

* consent was designed to ensure that the patient would get adequate and safe treatment; thus, overriding this through a treatment order could not be justified unless It was in the patient’s best interests.
* If facility does not consent then it means patient was be detained in prison. Recognized seriousness of consequences. While jails are not adequate, it forced an entire institution to prioritize a single patient over those who have been waiting, concerns of fairness.
* Even though Mr. C’s charter rights may have been violated by the refusal to consent, the unconstitutionality aspect would have been triggered if the violation had been unjustifiable under s. 1. (refusal to consent was reasonable and thus is justified)

# SEXUAL ASSAULT OF WOMEN WITH MENTAL DISABILITIES

* women and men with disabilities are victimized at much higher rate than those without MDs, extreme difference seen with women in particular
* conflicting values: protecting MD patient from sexual exploitation vs. allowing them to make autonomous decision re: sexuality.
  + Women with MDs are NOT children and have right to non-exploitative sex. Activity which causes this tension with protection
* Barriers at all stages of trial process:
  + Reporting, deciding whether to lay charges, gathering evidence, competence to testify, analysis of consent, difficulties with cross, credibility assessments as witnesses and complainants

**Infantilization**

* Historically, women with MD infantilized; case law is replete with references to women with mental age of X (3- 6 years old)

**Stereotypes about sexuality**

* because we analogize to children, see women with MDs as asexual
* long history of eugenics – not fit to be parents or reproduce therefore they should be asexual
* hypersexuality – infantilization of women has led to contradictory stereotype; if no sexual activity is appropriate, then *any* sexual activity is scrutinized, deemed inappropriate (eg. *Alsadi*)
  + historically rooted in “animal instincts” that allegedly made these women sexually indiscriminate

**Data**

* women with MD at risk of sexual assault 2-10X higher than other women
* institutionalized women at even greater risk, very dependent
  + the more significant the disability, the higher rate of sex. violence
* sex. Assaults generally not reported, and when they are, victim less credible.. even when they are credible, difficulties arise at each stage of prosecution
* most vulnerable to assault at hands of caregivers/people they meet through caregiver (study shows 44% of perpetrators were known through caregiver)
  + may be highly dependent on caregiver.. may not understand they have right to say no
  + denial of services can limit complainant’s activities (eg. of exploitative bus driver)
  + Caregivers include doctors, residential workers, teachers, those providing care in the home, special bus service drivers
* may believe complying in sexual demands is necessary to be socially included (eg. of woman who was gangbanged and then waited for guy at park because he said he would be her bf)

## Response of Criminal Law: History

* because rape involved evidence of resistance and these instances did not, law just made it illegal to have sex with any woman that had a disability - female idiot, imbecile, insane, or deaf and dumb
* had a lower punishment than rape – only 4 years prison as opposed to max sentence for life for rape
* non-consent not an issue – sex simply illegal
* 1982 amendments and reform – rape abolished and replaced with *sexual assault*
  + incapacity to consent added in s. 273.1(2)(b) – no consent is given where a woman is incapable of consenting (for any reason, including disability) – does not specify grounds of incapability – intoxication, unconsciousness, MD, etc.
* 1998 – sex. Exploitation of person with disability added:
  + Every person who is in a position of trust or authority towards a person with a mental or physical disability or who is a person with whom a person with a mental or physical disability is in a relationship of dependency and who, for a sexual purpose, counsels or incites that person to touch, without that person’s consent, his or her own body, the body of the person who so counsels or incites, or the body of any other person, directly or indirectly, with a part of the body or with an object
  + Exploitation provision is more onerous for crown (must complainant has disability; A is in position of trust/authority; non-consent to touching) AND punishment is less severe (5 years) than *sexual assault* provision so this one is never used
    - Concern that if no non-sent req. law would criminalize non-exploitative sexual relationship bw people with disabilities and their caregivers… so this was added to protect sexual autonomy of these women
  + Provision is just symbolic and of no real material difference – you can charge A with both (like in *Alsadi*), but can only convict him for one of them, so exploitation charge disappears since it is easier to convict for assault and punishment is heftier.

## Competence to Testify

***Canada Evidence Act:***

**Witness whose capacity is in question**

**16.** (1) If a proposed witness is a person of fourteen years of age or older whose mental capacity is challenged, the court shall, before permitting the person to give evidence, conduct an inquiry to determine

(*a*) whether the person understands the nature of an oath or a solemn affirmation; and

(*b*) whether the person is able to communicate the evidence.

**Testimony under oath or solemn affirmation**

(2) A person referred to in subsection (1) who understands the nature of an oath or a solemn affirmation and is able to communicate the evidence shall testify under oath or solemn affirmation.

**Testimony on promise to tell truth**

(3) A person referred to in subsection (1) who does not understand the nature of an oath or a solemn affirmation but is able to communicate the evidence may, notwithstanding any provision of any Act requiring an oath or a solemn affirmation, testify on promising to tell the truth.

**Inability to testify**

(4) A person referred to in subsection (1) who neither understands the nature of an oath or a solemn affirmation nor is able to communicate the evidence shall not testify

**Judicial History**

* historically, courts interpreted s. 16(3) as allowed TJ and defence counsel to examine the complainant about ability to understand promise to tell truth, but this changed with ***DAI***)
  + have you ever told a lie? What happened when you tell a lie? Will you go to jail if you tell a lie? (abstract questions are difficult for persons with MD)
  + s. 16(7) dealing with *child* witnesses, explicitly prohibits such questioning.

### R v DAI [2012 SCC] 🡪 cannot question ability to understand promise

**Facts:** A charged w sexual assault against 3 complainants, all with MDs. All 3 testified that A had sexually assaulted them. In each case the A was dating/living with their mother at time of alleged assault. They testified he played game involving him touching her beneath PJs

**Issue:** Whether adult witnesses can be examined on their ability to differentiate between truth and lies

**Held:** TJ held they were not competent to testify; SCC yes competent

**Analysis:**

* TJ: complainant was able to communicate evidence and answer correctly various questions about her life, as questions got more abstract, she couldn’t answer question she previously could. She did not understand meaning of promise to tell truth (even though she never lied, she only said “I don’t know”)
  + Also excluded hearsay evidence of convo w teacher
  + Case never got to trial, A acquitted
* SCC: all that matters is that complainant can communicate evidence and promise to tell truth; do not read in further reqs. Parliament does not say W should be questioned on understanding of promise. Promise may have meaning even if W cannot articulate it in abstract terms
  + Dissent: promise is empty gesture if you cant investigate to ensure that they understand meaning of promise

## *Crim Code Accommodation for some Barriers at Trial*

Accommodations for certain Ws began in 1987. All have been challenged by the A as infringing right to fair trial, and all have been upheld as constitutional

* testifying behind screen
* use of support person (s. 486.1)
  + rarely used! Support person does not answer, just supportive
  + countries like Australia have full on intermediaries, who translate a lawyer’s question so that it is easier to understand for the W
* possibility of testifying from another location by video link (s. 486.2)
* admission of videotaped evidence (s. 715.1)

Problem: these tend to deal with comfort of W but not root problems.

## Problems with Content of Testimony

* no accommodation gets to the difficulties around testimony itself (other than perhaps videos of earlier interviews)
* cross is challenging for Ws with MDs; essence of cross is to challenge/lead W in particular directions
* data shows Ws with MD do better with open ended questions
* Ws may have tendency to say yes if they don’t know the answer and agree with questioner, thus tendency to lead in cross is problematic

## Consent

* s. 273.1(1) – voluntary agreement of complainant to engage in sexual activity in question
* ***R v Ewanchuk (SCC)*** states that *actus reus* is to be assessed from the perspective of the complainant – did she *want* the sexual activity to take place?
  + No implied consent from behavior
  + Submission, silence and passivity are NOT consent

**Problems around consent:**

Complainant may not remember events, may not be able to communicate state of mind, may not have understood she had right to say no, may have complied b/c she was afraid she would lose access to caregiver or bus service, etc.

**Incapacity Negating Consent:**

s. 273.1(2) No consent is obtained for the purposes of ss. 71-273, where:

(b) the complainant is incapable of consent to activity

Incapacity = unconsciousness, intoxication, mental disability, etc.

* has been interpreted as all or nothing phenomenon – ex. A woman either has capacity to consent to sexual activity with *anyone* in *all* circumstances, or does not have capacity to consent to *anyone*.
* In Canada, don’t require much capacity to be able to consent
* England has broader approach (HL) – situational – can consent to particular person in particular context. Eg. woman might be able to consent to sex with bf, but not to sex with her psychiatrist who is exploiting relationship

Capacity to say yes, vs capacity to say no

* capacity to say no to sexual activity is even lower than capacity to say yes
* a woman may understand that she does not want sexual activity to take place, but may not understand the implication to sex. activity enough to meet test for competence to consent

**Problems with Global Incapacity Approach**

* if capacity is all or nothing, we limit the ability of women with MDs to engage in non-coercive sexual activity with partner of choice
* raises the stakes of an incapacity finding – it means that any sex with that woman is criminalized
* eg. *Alsadi* case where court said woman could consent to sex with anyone because she had a bf

**Nuanced approach: situational consent (*Isabel Grant and Janine Benedet Article*):**

* consent should be considered situationally – one does not consent to sex in the abstract, but situationally – like UK and US courts are starting to recognize
* dangers of expanding concept of incapacity:
  + danger of getting into scrutinizing the decisions of women with MDs in a way that we don’t scrutinize the decision of other women
  + women w/o disabilities are free to consent to sex even if it is exploitative
  + important to scrutinize capacity to make decision, and not decision itself.

## Power, Trust & Authority

s. 273.1(2) No consent is obtained for the purposes of ss. 71-273, where:

(c) the accused *induces* the complainant to engage in the activity by abusing a position of trust, power or authority

### R v Alsadi [2012, BCCA]

**Facts:** A charged with sexual assault and sexual exploitation of person with disability. Woman had been civilly committed 20+ times in her life (49 yrs old) and was now committed in psych ward at VGH. She suffered from schizoaffective disorder, bipolar type. She went out for smoke where she met security guard, doing his routine patrol. He persuaded her to go into dayroom, where he had key, and they had oral sex. He admitted that she did not want to go into day room, but he persuaded her b/c he was worried about being seen. He knew she was committed, but she “looked normal” (testified that having sex with a “normal woman” takes [more time than 15 minutes]”)

**Issue:** Was she competent to consent to someone with authority?

**Held:** Overturned acquittal and ordered new trial

**Analysis:**

* TJ: found that complainant was sexual aggressor and since she had a bf, she was able to consent to sexual activity, therefore crown failed to prove non-consent
  + Relied on problematic myths/stereotypes… complainant had impulsive sexual encounters (impermissibly bringing in sexual history evidence, contrary to *Evidence Act*)
  + Said there were no signs she was forced to go into day room, no signs of injury
  + She did not report assault to group of security guards she saw right away (even though established law that failure to report immediately does not vitiate credibility)
  + After finding consent, TJ considered power, trust & authority – A was in position of authority to enforce obedience but when he met complainant, he was conducting routine patrol and would not have had authority to restrain her.
  + TJ said they only knew each other for 15 minutes, so no time for relationship of trust to develop, and also since complainant was older than A, no trust relationship
* BCCA: TJ should have looked at power, trust and authority as *distinct elements*, each one independently
  + Question is whether she was *induced* to agree to sex because of one of the 3
  + Left open possibility that she could have consented in this context despite trust, power and authority

**Isabel’s comments:** incredibly difficult for woman to separate out *why* they agreed – was it only because he was security guard? Inducement hard to prove.

* another issue – courts only go to inducement IF they first find consent – problematic because it misunderstand the power/trust relationship which may have meant that there is no consent to begin with. Saying that there was consent may taint how you see the entire encounter.
* If situation consent analysis had been applied by TJ, instead of saying she had a bf so she could consent, maybe would say that it is different when you are civilly committed and the man in question has the authority to restrain you, and having been committed 20+ times, she may very well have seen him restraining others or herself
* Maybe the msg should be if you work in hospital, do not have sex with patients, especially those you know have limited cognitive capacity
* Problem: issue boils down to whether we protect women from exploitation or support them in making sexual autonomous decisions.

# MENTAL HEALTH LAW PROFESSIONAL RESPONSIBILITY

Explaining rules of relationships with lawyers to patients/clients:

1. strictly confidential
2. act only on client instructions
   1. you don’t act in their “best interest” the way most people do
   2. notion of confidentiality is often surprising for MD clients – generally, the most important info was least subject to confidentiality as the whole psych team would be aware
   3. these clients are used to others doing things for them, not taking into account their opinion or wishes (used to paternalism, this is more autonomous)

## Canons of Legal Ethics

1. to the state
2. to courts and tribunals
3. to the client
4. to other lawyers
5. to oneself

These are the things you must always juggle as a lawyer – problem if that the 5 duties are not always harmonious and there is no indication as to what is paramount if there is a conflict

The following are sources of guidance for professional responsibility:

* international instruments (UNCRPD)
* Canadian Charter (Eg. s. 15)
* Legislation (mental health related or not, legal profession-related or not (eg. immigration, family, legal profession act, criminal code)
* Professional handbook for BC
* Common law (eg. fiduciary duty)

Must maintain confidentiality – cannot disclose of anything even if child is in danger (the only exception in *Child, Family and Community Service Act* (s. 14(2)(a))

Cannot represent a client that lies. You can warn them of this but if they still lie, you have to withdraw. Try to do so in a way that does not draw attention to the lie

**A practical Ethical Road**

* remember every precept of professional responsibility applies to you as a lawyer
* never allow your client to lie or mislead a court or tribunal
* try to be helpful without practicing social work
* be conscious of the power dynamics that likely exist between you (as privileged) and your client (the influence that you can have)
* realize the gravity of concluding that your client is not competent to instruct counsel

## Mental Disorder Criminal Courts

* these courts are better equipped to deal with people who have MDs, better able to serve particular population
* benefit: cooperative team effort between crown, defence, probation officers. May be doctors and health professionals around
* Negative: A must plead guilty!