Mental Disabilities, Litigation and the Courts: Recent Charter Issues; Evolving Doctrines and the Court Process

Mary MARSHALL*

INTRODUCTION 91

I. CRITERIA FOR INVOLUNTARY COMMITTAL 93

II. TRANSFERS 98

III. FORCED TREATMENT 100

CONCLUSION 106

* Solicitor, Office of the Ombudsman, Edmonton, Alberta (as she then was) presently with Cook Duke Cox, Edmonton, Alberta.

The Courts have used the *Canadian Charter of Rights and Freedoms*[1] to interpret provincial mental health legislation, to nullify legislative provisions that contravene the *Charter*, and to examine government policies and procedures governing psychiatric hospitals.

To realize the potential of the *Charter*, the results and reasoning in decisions must be more than what is required to achieve procedural fairness. This principle has been expressed in several Supreme Court of Canada decisions.[2] In *R.* c. *Morgentaler*[3] then Chief Justice Dickson noted that Canadian courts are charged with the crucial obligation of ensuring that the legislative initiatives pursued by Parliament and the Legislatures conform to the democratic values expressed in the *Canadian Charter of Rights and Freedoms.* Section 7 imposed upon courts the duty to review the substance of legislation once it has been determined that the legislation infringes an individual's right to life, liberty or security of the person. Chief Justice Dickson concluded that state interference with bodily integrity and serious state imposed psychological stress constituted a breach of security of the person. Thus far, when analyzing mental health legislation, the Canadian courts have tended to use the *Charter* to determine whether the legislature has achieved procedural fairness. When analyzing mental health legislation and procedures to determine whether there has been a breach of section 15(1) of the *Charter*, courts often refer to the historical precedent of society caring for those who are mentally ill. However, they rarely refer to the necessity to scrutinize carefully legislation relating to the mentally ill because of society's traditional prejudices and misconceptions about mental illness.[4] In addition, many critics of psychiatric treatment have noted that women (and other groups enumerated in section 15(1) of the *Charter*) receive inappropriate treatment based on stereotypical assumptions about proper behaviour.[5] The Supreme Court of Canada in *Andrews* c. *Law Society of British Columbia*,[6] invites us to examine these underlying prejudices and assumptions. In that case, Mr. Justice McIntyre notes that the concept of equality is a comparative concept, the condition of which may be only attained or discerned by comparison with the condition of others in the social and political setting in which the condition arises. He clearly notes that identical treatment may produce serious inequality:

> *It must be recognized at once, however, that every difference in treatment between individuals under the law will not necessarily result in inequality and, as well, that identical treatment may frequently produce serious inequality. This*

---

1. *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

2. *Reference re: S.94(2) of the Motor Vehicle Act (B.C.)*, (1985) 18 C.R.R. 30, [1985] 2 S.C.R. 486, 69 B.C.L.R. 145, 23 C.C.C. (3d) 289, 48 C.R. (3d) 289, 24 D.L.R. (4th) 536, 36 M.V.R. 240, 63 N.R. 266, [1986] 1 W.W.R. 481.

3. *R.* c. *Morgentaler*, [1988] 1 S.C.R. 30 (hereinafter *Morgentaler).*

4. In *Not on Our Street* (Pion 1982) Michael Dear and Martin Taylor outline many of these misconceptions, including the tendency to believe that mentally ill people are generally dangerous.

5. See, for example, "Women & Mental Health in Canada: Strategies for Change," Canadian Mental Health Association, National Office, Toronto, 1987; R. Cooperstock, "Special Problems of Psychotropic Drug Use Among Women", (1980) (28)(2) *Canada's Mental Health*, 3-5; Smith, W. Edwin & A. Richman, "Electroconvulsive Therapy: A Canadian Perspective", (1984) Canadian Journal of Psychiatry, 29, 693-699.

6. *Andrews* c. *Law Society of British Columbia*, [1989] 1 S.C.R. 143 (hereinafter *Andrews*).

> *proposition has found frequent expression in the literature on the subject but, as I have noted on a previous occasion, nowhere more aptly than in the well-known works of Frankfurter J. in Dennis v. United States, 339 U.S. 162 (1950), at p.184:*
>
> *"It was a wise man who said that there is no greater inequality than the equal treatment of unequals."* [...]
>
> *In simple terms, then, it may be said that a law which treats all identically and which provides equality of treatment between "A" and "B" might well cause inequality for "C", depending on differences in personal characteristics and situations. To approach the ideal of full equality before and under the law — and in human affairs an approach is all that can be expected — the main consideration must be the impact of the law on the individual or the group concerned. Recognizing that there will always be an infinite variety of personal characteristics, capacities, entitlements and merits among those subject to a law, there must be accorded, as nearly as may be possible, an equality of benefit and protection and no more of the restrictions, penalties or burdens imposed upon one than another. In other words, the admittedly unattainable ideal should be that a law expressed to bind all should not because of irrelevant personal differences have a more burdensome or less beneficial impact on one than another.*[7]

In other words, Mr. Justice McIntyre rejects the "similarly situated test" because it excludes any consideration of the nature of the law. He notes that this test could be used to justify the Nuremburg laws of Adolf Hitler since similar treatment was contemplated for all Jews. A bad law will not be saved merely because it operates equally upon those to whom it has application. Similarly, a law will not necessarily be bad because it makes distinctions.

The next question considered by Mr. Justice McIntyre is what kinds of distinctions will be acceptable under section 15(1) and what kinds will violate its provisions? Section 15 spells out the four basic rights: the right to equality before the law; the right to equality under the law; the right to equal protection of the law; and the right to equal benefit of the law. Therefore, section 15 is designed to ensure equality in the formulation and application of the law. Mr. Justice McIntyre explains:

> *The promotion of equality entails the promotion of a society in which all are secure in the knowledge that they are recognized at law as human beings equally deserving of concern, respect and consideration. It has a large remedial component.*[8]

The right to equality before and under the law and the right to equal protection and benefits of the law are granted with the direction contained in section 15 that they be without

---

7. *Id.*, 164-165.

8. *Id.*, 171.

discrimination. Mr. Justice McIntyre states that "[t]he worst oppression will result from discriminatory measures having the force of law"[9]. He defines discrimination as follows:

> *a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual's merits and capacities will rarely be so classed.*[10]

Therefore, issues brought before the courts by psychiatric patients should be examined carefully to determine whether a distinction is based on personal characteristics attributed to a patient solely on the basis of associations with a group, or whether it is based on the patient's particular merits and capacities.

In this paper, I will review Charter challenges in cases dealing with criteria for involuntary committal, transfers between psychiatric institutions, and forced treatment. In each section, I will begin with case summaries of the decisions, and then draw conclusions about trends in judicial decision-making.

I. CRITERIA FOR INVOLUNTARY COMMITTAL

One of the first cases to use the *Charter* to review criteria for involuntary committal in provincial mental health legislation was *Lussa* c. *Health Sciences Centre*[11]. The Manitoba Court of Queen's Bench used the *Charter* to interpret the *Mental Health Act*[12], and to order the release of the patient. In that case, Lussa was involuntarily committed under section 9(1) and (2) of Manitoba's *Mental Health Act.* She was committed on the grounds that she had a mental disorder and had manifested some irrational and difficult behaviour in the past. She was not alleged to be of danger to herself or others. The court held that Lussa had been denied her liberty under section 7 of the *Charter*. The process of detention allowed little opportunity for review, except for an appeal by trial de novo in the County courts. Based on the fact that there was not substantive evidence establishing any kind of danger, risk or harm, the court found that Lussa's continued confinement without some sort of interference from the courts would not be in accordance with the principles of fundamental justice. The court also found that the applicant's detention was in contravention of section 9 of the *Charter*. Even though

---

9. *Id.*, 172.

10. *Id.*, 174.

11. *Lussa* c. *Health Sciences Centre*, (1983) 9 C.R.R. 350 (Man. Q.B.), 5 C.H.R.R. D/2203.

12. *Mental Health Act*, R.S.M. 1970, c. M-110.

the original detention might not have been arbitrary, Lussa's present condition indicated that continued detention would be arbitrary.

Manitoba's involuntary committal provisions were ultimately struck down by the Court of Appeal in the case of *Thwaites* c. *Health Sciences Centre Psychiatric Facility*.[13] In that case, Thwaites applied to the court for a declaration that her detention pursuant to Manitoba's *Mental Health Act* was arbitrary, and in violation of section 9 of the *Charter*. She was not successful upon the initial hearing of the application and she appealed. As a result of her appeal, the Court held that several sections of the *Mental Health Act* were unconstitutional. The *Thwaites* decision is the only decision that has used the *Charter* to nullify a provision of a provincial *Mental Health Act*.[14] The Court held that the criteria for committal were arbitrary within the meaning of section 9 of the *Charter*. A person could be detained for medical examination where he or she "is or is suspected or believed to be in need of examination and treatment in a psychiatric facility".[15] Such detention could be prolonged if one medical practitioner, not necessarily a psychiatrist, believed that the person "should be confined as a patient at a psychiatric facility".[16] The only objective criterion was an implied requirement that the individual was suffering from a "mental disorder", defined as "mental illness, mental retardation, psychoneurosis, psychopathic disorder, addiction, or any disability of mind caused by disease, senility or otherwise".[17] This category included many individuals for whom civil committal was unnecessary. The criteria were thus lacking in specificity to a degree that rendered them arbitrary within the meaning of section 9 of the *Charter*.

The provisions could not be saved by section 1 of the *Charter* because the means chosen in overriding the right or freedom were not reasonable and demonstrably justified in a democratic society. The means were arbitrary. The Act did not contain a "dangerousness" standard for involuntary committal and, as such, the provision did not impair the freedom under consideration as little as possible. Finally, sections of the Act struck the wrong balance between the liberty of the individual and the interests of the community. The affected sections of the Act were therefore held to be unconstitutional.

After the *Thwaites* decision, Manitoba's amended *Mental Health Act*[18], was challenged in *Bobbie* c. *Health Sciences Centre*.[19] In that case, the applicant was apprehended for an involuntary medical examination pursuant to a Magistrate's Order. Bobbie was taken to the Health Sciences Centre and certified as an involuntary patient. Among other arguments, Bobbie stated that his detention was arbitrary and breached section 9 of the

---

13. *Thwaites* c. *Health Sciences Centre Psychiatric Facility*, (1988) 40 C.R.R. 326 (Man. C.A.), (1988) 48 D.L.R. (4th) 338, (1988) 51 Man. R. (2d) 196, [1988] 3 W.W.R. 217 (hereinafter *Twaites* cited to W.W.R.).

14. F.L. Morton, G. Solomon, I. McNish, D.W. Poulton, "Judicial nullification of statutes under the Charter of Rights and Freedoms, 1982-1988", vol. XXVII, n° 2, Alberta Law Review.

15. *Id.*, 225.

16. *Id.*, 226.

17. *Id.*, 223.

18. *Mental Health Act*, R.S.M. 1987, c. M-110.

19. *Bobbie* c. *Health Sciences Centre*, [1988] 2 W.W.R. 153.

Charter. He also argued that the deprivation of his liberty was not done in accordance with the principles of fundamental justice, and was therefore contrary to section 7 of the Charter. The court held that the applicant's apprehension and detention were not arbitrary, and the deprivation of Bobbie's liberty was not contrary to the principles of fundamental justice. The court concluded that it must receive the opinion and guidance of expert psychiatrists under any definition of mental disorder, and the definition of mental disorder in the *Mental Health Act* combined with the dangerousness criteria indicated that the detention procedure was not arbitrary. Although Bobbie was deprived of his liberty under section 7 of the *Charter*, the deprivation was in accordance with the principles of fundamental justice because the legislature had exercised reasonable judgment in determining a pragmatic compromise. The rights of the individual were balanced with the need to protect society as a whole. There was an objective standard for compulsory admissions. The concept of dangerousness had been accepted as appropriate by the legislatures of other jurisdictions, by many law reform commissions, and other knowledgeable groups. The phrase "likelihood of serious harm" established the appropriate test in the circumstances. "Likely" was construed to be a synonym for "probable", and it was determined one should not have to wait for an event to happen before acting if there is a reasonable apprehension that it would happen and where the failure to act could cause serious harm.

In *Azhar* c. *Anderson*,[20] the Ontario District Court used the provisions of the *Charter* to determine whether the actions of the attending physician and the Review Board were appropriate. In that case the applicant Azhar was an involuntary patient at the Queen Street Mental Health Centre. He was assigned to the care of the respondent physician. Azhar applied to the Regional Review Board for a review of the grounds for his committal. The Board held that the applicant should remain as an involuntary patient because he met the criteria for committal found in the *Mental Health Act*.[21] The Board determined that the applicant was suffering from a mental disorder of a nature and quality that likely would result in serious bodily harm to the patient or another person. Azhar's diagnosis was chronic schizophrenia that had required medical attention since 1971. He had various visual and auditory hallucinations including hallucinatory commands that were often harmless, some of danger to self (to kill himself), and others of danger to others (to kill his brother and his children). Azhar had listened to these delusional voices since 1981 and had ignored instructions to harm himself or others. Azhar's grounds of appeal were that the Board erred in finding that he suffered from a mental disorder of a nature or quality that could likely result in serious bodily harm to himself or other persons; the Board failed to consider evidence that treatment provided to Azhar was harmful to him; and Azhar's involuntary committal without evidence that he presented a danger to himself or to others contravenes sections 7, 9 and 12 of the *Charter*. He argued that based on these grounds the decision of the Board should be set aside and he should be released. The applicant did not argue that the *Mental Health Act* was incompatible with the *Charter*, but that the acts of the attending physician and the Board violated the *Charter*. The court held that section 9 of the *Charter* was not violated because the attending physician had complied with all of the procedural requirements of the *Mental Health Act*. In addition, the court held that section 7 of the *Charter* was not infringed. The

---

20. *Azhar* c. *Anderson*, Ontario District Court, June 18, 1985, D.C.J. Locke, (unreported decision, hereinafter *Azhar*).

21. *Mental Health Act*, R.S.O. 1980, c. 262.

determination by the attending physician and the Board that Azhar should continue as an involuntary patient was done in accordance with the principles of fundamental justice, and the procedures used were fair. If it was found that his treatment was cruel or unusual or was both cruel or unusual, section 12 of the *Charter* would have been violated. In this case, the treatment was not excessive and it did not infringe standards of decency and morality. The court held that the treatment was not inhumane, repulsive or offensive, and there was no element of malevolence, bad intent, or malice. The court concluded that section 12 was not breached in the circumstances of this case.

In *Dayday* c. *MacEwan*[22], the Ontario District Court used sections 7 and 15 of the *Charter* to examine the procedures used by the Review Board when considering whether there were appropriate grounds for involuntary committal. Among other arguments, Dayday stated that the Board's admission of hearsay evidence and other reliance upon such evidence resulted in the violation of the applicant's rights guaranteed by sections 7 and 15 of the *Charter* and was contrary to the rules of natural justice. The evidence was admitted pursuant to section 17 of the *Statutory Powers Procedure Act*[23], which provided that a tribunal may admit as evidence at a hearing, whether it was or was not admissible as evidence in the court, any oral testimony and documents or other things relevant to the subject matter of the proceedings. Given that the *Mental Health Act* required that hearings before the Board be held expeditiously, it might not be possible to obtain direct evidence. The person affected by the evidence could require the original sources of the hearsay evidence to attend at the hearing. The detention of persons on the basis of hearsay evidence could be justified within the confines of the *Charter* in limited circumstances. In addition, mentally disordered persons fall into a special class of persons who require special legislative treatment for their own protection and that of society, and this special treatment did not violate section 15 of the *Charter*. The court held that the Board did not err in the circumstances of this case in its decision to admit and rely upon hearsay evidence.

In *Re Jenkins*[24], the Prince Edward Island Court of Appeal confirmed that the remedy of habeas corpus was available to a patient involuntarily detained in the psychiatric facility pursuant to section 10 of the *Charter*, which guarantees to all persons the right of habeas corpus to determine the validity of detention. The court further held that the provision of the *Mental Health Act*[25], did not infringe section 15 of the *Charter* because the restrictions placed on persons with a mental disability could be justified under section 1 of the *Charter* as being "reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society". The thrust of the *Act* has been the safety, support, and succour of those who suffer from a mental disorder and who, as a consequence, require hospitalization for their own safety or the safety of others. From the earliest days, persons suffering from a mental disorder have been treated as a separate class, and their freedom of conduct has been restricted. In light of this historic precedent, the court found that the restrictions in the *Act* could be justified under section 1 of the *Charter*.

---

22. *Dayday* c. *MacEwan*, (1987) 62 O.R. (2d) 588 (Ont. D.C.) (hereinafter *Dayday*).

23. *Statutory Powers Procedure Act*, R.S.O. 1980, c. 484.

24. *Re Jenkins*, (1984) 8 C.R.R. 142 (P.E.I.C.A.), 5 D.L.R. (4th) 577.

25. *Mental Health Act*, R.S.P.E.I. 1974, c. M-9.

These cases show that the courts will allow a fair amount of latitude to the provincial legislatures in determining the criteria for involuntary committal. However, the case of *Thwaites* shows that there is a minimum standard, and if the province does not meet that minimum standard, its statute is subject to being struck down under the *Charter*. In general, however, the provisions of the *Charter* are used to interpret the legislation such as *Azhar* and *Dayday*. In addition, section 15(1) of the *Charter* cannot be used to argue that all the distinctions found within a *Mental Health Act* are discriminatory. These conclusions are in line with the way in which section 15 has been interpreted in *Andrews*. However, the courts have not gone the extra step of examining the legislation to determine whether the distinctions are necessary and appropriate. For example, in *Jenkins* the court notes that historically, persons suffering from a mental disorder have had their freedom of conduct restricted. However, the court does not delve into the fact that their freedom was too severely restricted in the past, and that there should be constant vigilance to ensure that their problems are not repeated.

One of the issues examined by the court in *Morgentaler,* when determining whether the infringement of security of the person was accomplished in accordance with the principles of fundamental justice, was whether it was necessary for all therapeutic abortions to take place in hospitals instead of free-standing abortion clinics. It is arguable that one of the issues that the courts should be considering when examining involuntary committal is whether psychiatric hospitals must handle psychiatric emergencies, or whether there should be independent crisis centres.

II. TRANSFERS

The *Charter* has been used to determine whether a transfer was appropriate and fair. Prior to the enactment of the *Charter*, the question of whether a transfer was appropriate was left to hospital administration.[26] However, the case of *Ontario (Attorney General)* c. *Grady*,[27] shows that the courts will scrutinize transfers between psychiatric hospitals to determine whether they are in compliance with the *Charter*. In that case, Grady was charged with the first degree murder of his wife and found not guilty by reason of insanity. He was remanded to the Penetanguishene Mental Health Centre, Oakridge division (PMHC). He was soon transferred to Brockville Psychiatric Hospital (BPH). The Lieutenant Governor issued a warrant dated July 9, 1986 maintaining Grady at the BPH. In addition to setting out other conditions, the warrant required Grady to refrain from the non-medical use of alcohol; allowed the administrator of BPH the discretion to allow Grady to enter the community; and had a general clause providing for Grady's return to PMHC if necessary in the view of the administrator. On June 4, 1987, the Board held a meeting at BPH to review Grady's status. The evidence before the Board indicated that Grady had consumed alcohol and lied about the consumption to BPH's administrator; Grady was required to submit itineraries before leaving BPH, but was reluctant to submit them and periodically failed to follow them; Grady's attitude

---

26. *Kowalski* c. *Peekanguishene Mental Health Centre (Oakridge division)*, Ontario High Court of Justice, June 12, 1980, Henry J. (unreported judgment).

27. *Ontario (Attorney General)* c. *Grady*, (1980) 34 C.R.R. 289 (hereinafter *Grady*).

towards the warrant and the conditions for leaving BPH was cavalier; and Grady was involved in an incident on May 5, 1987, when he consumed alcohol and argued with a girlfriend. No notice was given to Grady prior to the hearing that he would be sent to PMHC. BPH recommended that the warrant be maintained to permit Grady to remain at BPH. The only reference during the hearing to a possible transfer to PMHC occurred when the administrator of BPH stated that he was aware of his ability to transfer Grady but that this possibility had not been seriously considered. Following the hearing, the Board recommended to the Lieutenant Governor that Grady be transferred to PMHC. On June 16, 1987, the Lieutenant Governor issued a warrant directing the administrator of BPS to transfer Grady to PMHC. Grady applied for habeas corpus with certiorari in aid to quash the warrant of June 16, 1987, and to return him to BPH according to the terms and conditions in the warrant dated July 9, 1986. In addition to making other arguments, Grady stated that the transfer from BPH to PMHC resulted in a breach of his Charter rights. Grady also submitted that the warrant should be quashed because of the failure of the Lieutenant Governor to hold a hearing prior to issuing the warrant constituted a breach of rights under section 7 of the *Charter.*

The court ordered that the warrant dated July 16, 1987 be quashed. Grady should be returned to BPH and detained there according to the terms of the warrant dated July 9, 1986. One of the grounds for the decision was that the rules of fairness, which arose under common law and section 7 of the *Charter*, were denied because the Board's recommendation to transfer Grady to PMHC could not have been reasonably anticipated. Therefore, there was no opportunity to make submissions. Normally, the failure to give notice prior to a hearing that a transfer to PMHC is possible is without significance since the issues usually are clear from reading the material. However, in the case of Grady's hearing, the issue of a transfer to PMHC was not raised in the material before the Board or in the course of the hearing.

In addition, Grady was denied fairness because he did not have an opportunity to speak to an expert's proposed disposition. The Criminal Code established the Board and indicated the required quorum with specific reference to the expert qualifications of its members. The Board was expected to make use of its expertise in disposing of the matters before it. However, the Board should have indicated that, as a result of its view of the facts, it was considering a transfer to PMHC and asked for submissions in respect of that opinion. An expert board which comes to a conclusion that could not have been anticipated from the evidence denies the right of *audi alteram partem (that is, the right to know the issue that has to be addressed).*

The Court also held that the Lieutenant Governor breached his duty to exercise his power fairly by relying on the recommendation of the Board that was arrived at through a process in which procedural fairness was denied. The Lieutenant Governor had a duty to inquire and satisfy himself that the Board proceeded fairly when considering a recommendation that diminished liberty or liberty interests. It would be within the Lieutenant Governor's discretion to determine whether a hearing was warranted in the circumstances. Grady's transfer to PMHC affected his direct and indirect liberty interests. At BPH, Grady was allowed to leave the grounds subject to certain conditions. At PMHC, Grady could not leave the grounds. Access to treatment at PMHC was more limited than the treatment opportunities available at BPH. Grady's right to liberty hinged on his access to treatment because he would not be discharged until he had recovered. Therefore, to the extent Grady was denied treatment opportunities, he was indirectly deprived of his liberty.

Subsequent cases indicate that courts continue to be reluctant to interfere with decisions to transfer. In *Able* c. *Ontario (Attorney General)*,[28] the administrator of a psychiatric hospital transferred a patient under a warrant of the Lieutenant Governor pursuant to a provision in the warrant that permitted the administrator to transfer the patient if the transfer was in the interests of the public or the patient (the so-called yo-yo clause). Despite the fact that no hearing was held prior to or after the transfer, the Court held that the patient's transfer to PMHC without a hearing was lawful. The transfer was made with the patient's knowledge, consent and concurrence and also with the knowledge, consent and concurrence of his counsel. Neither Able nor his counsel requested a hearing. Both Able and his counsel knew the reasons for the transfer. There was no requirement to hold a hearing. Even accepting there was some legal requirement to hold a hearing, Able and his counsel waived such a hearing while knowing all the facts. The Court held that in view of these findings, it was unnecessary to determine whether the yo-yo clause breached the *Charter*. In *Cook* c. *Ontario (Attorney General)*,[29] the administrator ordered that Cook be transferred to PMHC pursuant to the yo-yo clause. While making other arguments, Cook applied for a writ of prohibition that prevented the administrator from transferring him. The Court noted that the Chairman of the Lieutenant Governor's Board of Review undertook to the Court that if the patient was transferred, a hearing would be held forthwith. In view of the fact that there was strong medical evidence that there would be danger to the public and other inmates if the transfer order was not implemented, the Court dismissed the application for prohibition.

In *Grady,* the court recognized that a transfer should be carefully examined because of its significant impact on a patient's liberty. As a result of a transfer to PMHC, the patient's freedom of movement is restricted, and the opportunities for treatment are limited. Therefore, the possibility of a patient's release into the community is diminished. The importance of these concerns, and ways of addressing them, were not explored in *Cook* and *Able*.

III. FORCED TREATMENT

The Charter implications of forced treatment have been considered in two Ontario decisions. In *Re Howlett & Karunaratne*,[30] the appellant was first admitted to London Psychiatric Hospital (LPH) in 1965. Her most recent admission occurred on September 8, 1967, when she was detained as an involuntary patient until September 11, 1987. After that date, she remained at LPH as a voluntary patient. A physician determined that she was not mentally competent to consent to or refuse treatment, and she challenged the determination of mental incompetency in a hearing before the Review Board. The Board determined that she was not mentally competent to consent to psychiatric treatment.

28. *Able* c. *Ontario (Attorney General)*, Ontario Supreme Court, September 21, 1989, O'Driscoll J. (unreported judgment).

29. *Cook* c. *Ontario (Attorney General)*, Ontario Supreme Court, February 1, 1990, Potts J. (unreported judgment, hereinafter *Cook*).

30. *Re Howlett & Karunaratne*, (1988) 64 O.R. (2d) 418 (Ont. D.C.A.).

She appealed on a number of grounds including the argument that sections 1a and 35 of the *Act*, which provided for treatment without her consent, violated sections 7, 12 and 15(1) of the *Charter*. The District Court dismissed the appeal, and held that sections 1a and 35 of the *Mental Health Act*,[31] did not violate sections 7, 12 and 15(1) of the *Charter*. The framework erected under the *Mental Health Act* with respect to obtaining consent to treatment for patients who are not mentally competent is in accordance with the principles of fundamental justice in matters of procedure and substance. It is a fundamental principle of our society that the state has an obligation to care for disabled persons who are unable to care for themselves. The legislative intention is that treatment will be the least intrusive possible, and will be administered in accordance with the best interests of the patient. If the wishes of the patient when mentally competent are known, the substitute consent giver must give or refuse consent in accordance with the patient's wishes. Historically, the courts have recognized the fairness and appropriateness of turning to a family member in certain circumstances to provide substitute consent to treatment.

Section 12 of the *Charter* can include medical treatment. Treatment could be cruel and unusual if it was administered by an agent of the government without the consent of the patient, if it was highly intrusive, and if it was administered not for the benefit of the patient but for the benefit of the government agency. However, in view of the purpose of sections 1a and 35, the safeguards to the rights of the patient at every stage of the process, and the mechanism for obtaining consent from a substitute decision maker, treatment will not be so excessive as to outrage standards of decency or be grossly disproportionate to what have been appropriate in the circumstances.

To determine whether section 15(1) was breached, it was necessary to conduct a three step analysis: identify the class of individuals who were alleged to be treated differently; demonstrate that the class purported to be treated differently from another class was similarly situated to that other class in relation to the purposes of the law; and show that the difference in treatment was discriminatory in the sense of a pejorative or invidious purpose in the effect of the impugned law.

The first element was established because the impugned provisions were designed to differentiate between those patients who were mentally competent to consent to treatment and those patients who were not mentally competent. Second, a patient who was not mentally competent and thereby unable to appreciate the consequences of giving or withholding consent was not similarly situated to a patient who was mentally competent. Third, the differential handling of incompetent patients was not invidious, unfair or irrational so as to constitute discrimination because of the importance of providing needed psychiatric treatment for the benefit of these patients.

The Court concluded that if the findings with respect to sections 7, 12 and 15 (1) were wrong, the legislative objective of establishing a mechanism to provide for the proper care of mentally incompetent persons was of sufficient importance to warrant overriding these constitutionally protected rights. The means used in the *Mental Health Act* were rationally connected to the legislative objective, impaired as little as possible the rights and freedoms infringed, and were proportionate to the legislative ends.

---

31. *Supra* note 21.

Another case considering the *Charter* and treatment was *Fleming* c. *Reid*.[32] In 1983, the appellant Reid was admitted to a psychiatric facility under the authority of a Warrant of the Lieutenant Governor. In September 1987 the appellant's attending physician made a determination that the appellant was not competent to consent to treatment, and that determination was confirmed by the Review Board. Reid's substitute decision maker under the *Mental Health Act,* the Official Guardian, refused consent to treatment on the grounds that Reid had stated a wish, while apparently mentally competent, that he not receive treatment with neuroleptic drugs.

Under section 35(2)(b)(ii) of the *Mental Health Act* the attending physician was not permitted to give Reid treatment unless the Board made an order authorizing the giving of specified psychiatric and other related medical treatment.

The attending physician applied to the Board for an order to treat Reid with "neuroleptic medication and related side effect medication" under the provisions of section 35a of the *Mental Health Act*, which permitted the attending physician to apply for an order authorizing the giving of "specified psychiatric and other related medical treatment." Section 35a(4) stated that the Board may authorize the treatment if satisfied that the mental condition of the patient will be or is likely to be substantially improved by the specified psychiatric treatment; the mental condition of the patient will not improve or is not likely to improve without the specified psychiatric treatment; the anticipated benefit from the specified psychiatric treatment and other related medical treatment outweighs the risk of harm to the patient; and the specific psychiatric treatment is the least restrictive and the least intrusive treatment that meets the three previous requirements. The Board made an order authorizing the administration of neuroleptic drugs and other related medical treatment.

On appeal to the District Court, Reid argued that sections 35a and 35(2)(b)(ii) of the *Mental Health Act* breached sections 7 and 15 of the *Charter*. The appeal was dismissed, and the Court held that the provisions of sections 35a and 35(2)(b)(ii) of the *Act* did not breach sections 7 and 15 of the *Charter*.

The Court concluded that a patient's security of the person is affected when a Board orders treatment under the provisions of section 35a of the *Mental Health Act*. However, this deprivation is accomplished in accordance with the principles of fundamental justice. The thrust of the *Mental Health Act* is consistent with the common law exercise of the *parens patriae* jurisdiction of the courts. The basic purpose of the Act is to provide protection, shelter and therapy for persons suffering from mental disorders, and the provisions are based upon the principle that authorized treatment shall be in the best interests of the patient and the least intrusive to his bodily integrity. The interests of the involuntary incompetent patient are protected procedurally by full disclosure, expert panels of medical-legal tribunals, and by the full deliberation of quasi-judicial and judicial persons. Reid's argument failed to prove that the legislation was procedurally flawed because there was no appeal to a review board from the decision of the substitute regarding treatment. The protection for the patient is provided by the professionalism of the doctors making the treatment proposals.

---

32. *Fleming* c. *Reid*, (1990) 73 O.R. (2d) 171 (Ont. D.C.A.).

The Act did not discriminate against incompetent involuntary patients by allowing an application to the Review Board to overrule a substitute decision maker's refusal when there were no comparable provisions in the Act affecting incompetent voluntary patients. It was illogical to compare as equals the condition and legal status of a competent voluntary patient, and involuntary competent patient, and an involuntary incompetent patient. The competent patient makes his or her own treatment decisions. The voluntary incompetent patient may leave when he or she wishes and thereby assumes responsibility for his or her own treatment. The vulnerability of the incompetent involuntary patient amplifies the obligation of society to care for and protect that patient. The special provisions of the Act for involuntary incompetent patients were created for their care, treatment and protection.

In *Howlett* and *Reid*, the court's analysis was largely procedural. There was no real consideration of the side effects of medication. The conclusions with regard to s. 15 in *Howlett* are largely outdated because the court used the "similarly situated" test, which was not accepted by the Supreme Court of Canada in *Andrews*. In *Reid* the court, when determining whether there is a breach of s. 15 of the *Charter*, noted that the vulnerability of the incompetent involuntary patient amplifies the obligation of society to care for and protect that patient. The Court did not deal with the issue of whether that same vulnerability requires additional protective measures in the legislation.

In addition, the Court placed little emphasis on the argument that Reid had expressed certain wishes while apparently mentally competent, and those wishes had been respected by the Official Guardian. Instead, it was noted that the important issue was the best interests of the patient. Madam Justice Wilson's interpretation of liberty in *Morgentaler* is instructive when reviewing the importance of a patient's wishes when competent. Wilson J. stated that an important component of the right to liberty in the *Charter* and, in fact, the basic theory underlying the *Charter*, was the premise that the state will respect choices made by individuals and to the greatest extent possible, will avoid subordinating those choices to any one conception of the good life. She stated that the *Charter* was founded on the right to make fundamental personal decisions without interference from the state. Liberty required the state to respect personal decisions made by its citizens, and guaranteed to every individual a degree of personal autonomy over important decisions intimately affecting their private lives. This component of section 7 is never explored by the judge in *Reid*. When examining Reid's wishes while competent, the court should have considered the importance of the right to choose, and the right to make wrong decisions.[33]

These types of arguments were explored by the Ontario Court of Appeal in *Fleming* c. *Reid; Fleming* c. *Gallagher*.[34] The issue in those appeals was whether the state may administer neuroleptic drugs in non-emergency situations to involuntary incompetent psychiatric patients who have, while mentally competent, expressed a wish not to be treated with such drugs.

---

33. *Institute Philippe Pinel de Montreal* c. *Dion*, (1983) 2 D.L.R. (4th) 234; *Clark* c. *Clark*, (1982) 40 O.R. (2d) 383.

34. (1991) 4 O.R. (3d) 74 (Ont. C.A.).

The Court considered the negative effects of neuroleptic medication in giving its reasons.

> *The use of neuroleptics in the treatment of various psychoses is generally effective in improving the mental condition of the patient by alleviating the symptoms of mental disorder. It is clear, however, that they may not be helpful in every case. Moverover, the efficacy of the drugs is complicated by a number of serious side effects which are associated with their use. These include a number of muscular side effects known as extra-pyramidal reactions: dystonia (muscle spasms, particularly in the face and arms, irregular flexing, writing or grimacing and protrusion of the tongue); akathesia (internal restlessness or agitation, an inability to sit still); akinesia (physical immobility and lack of spontaneity); and Parkinsonism (mask-like facial expression, drooling, muscle stiffness, tremors, shuffling gait). The drugs can also cause a number of non-muscular side effects, such as, blurred vision, dry mouth and throat, weight gain, dizziness, fainting, depression, low blood pressure and, les frequently, cardiovascular changes and, on occasion, sudden death. The most potentially serious side effect of antipsychotic drugs is a condition known as tardive dyskinesia. This is a generally irreversible neurological disorder characterized by involuntary rythmic and grotesque movement of the face, mouth, tongue and jaw. The patient's extremities, neck, back and torso can also become involved. Tardive dyskinesia generally develops after prolonged use of the drugs, but it may appear after short term treatment and sometimes appears even after treatment has been discontinued.*
>
> *In short, it appears that although these drugs apparently operate so as to benefit many patients by alleviating their psychotic symptoms, they also carry with them significant, and often unpredictable, shor term and long term risks of harmful side effects.*[35]

The Court of Appeal noted that the fact that serious risks and consequences may result from refusal of medical treatment does not vitiate the right of medical self-determination. The Court concluded that mentally competent patients:

> [...] *like competent adults generally, are entitled to control the course of their medical treatment. The right of self-determination is not forfeited when they enter a psychiatric facility. They may, if they wish, reject the doctor's psychiatric advice and refuse to take psychotropic drugs, just as patients suffering other forms of illness may reject their doctor's advice and refuse, for instance, to take insulin or undergo chemotherapy.*

---

35. See, generally, Donland's *Illustrated Medical Dictionary,* 26th ed. (Toronto: W.B. Sanders Co. 1981) at 887; Breggin, "Brain Damage Dementia and Persistent Cognitive Dysfunction Associated with Neuroleptic Drugs: Evidence, Etiology, Implications", (1990) 11 Journal of Mind and Behaviour 425; Moonasar, "Neuroleptic Malignant Syndrome", (1986) 79 South Med. J. 331; Kemna, "Current Status of Institutionalized Mental Health Patients' Right to Refuse Psychotropic Drugs", (1985) 6 Journal of Legal Medicine 107; and, Brooks, "The Right to Refuse Antipsychotic Medications: Law and Policy", (1987) 39 Rutgers Law Rev. 340. See also, *In the Matter of Guardianship of Richard Roe*, (1981) 421 N.E. 2d 40.

The Court concluded that a competent psychiatric patient's right to personal autonomy and self-determination was no less signigicant, and was entitled to no less protection, than that of competent persons suffering from physical ailments.

The Court held that the legislation permitting the Review Board to authorize psychiatric treatment without considering the patient's possible competently expressed wishes was contrary to the *Charter*. The Court concluded that to force involuntary patients to submit to medication against their "competent wishes and without the consent of their legally-appointed substitute decision makers, clearly infringes their Charter right to security of the person." As such, the competent wishes of an involuntary patient who subsequently becomes incompetent are, in effect, rendered meaningless when the substitute's refusal to consent to treatment is challenged at the level of the Review Board. The Court stated that the *parens patriae* jurisdiction of the Court to protect those who are unable to take care of themselves cannot be invoked to overrule a gtreatment decision made by a competent patient, or to authorize the treatment of a competent person who, while competent, had given instructions refusing to consent to the proposed treatment. The Court concluded that:

> *[...] a legislative scheme that permits the competent wishes of a psychiatric patient to be overridden and which allows the patient's right to personal autonomy and self-determination to be defeated without affording a hearing as to why the substitute consent giver's decision to refuse consent based on the patien's wishes should not be honoured, in my opinion, violates "the basic tenets of our system", and cannot be in accordance with the principles of fundamental justice: Re B.C. Motor Vehicle Act, [1985] 2 S.C.R. 486 at 503.*

Therefore the Court concluded that the question of whether the decision of the substitute should be set aside is a matter to be determined after a hearing in which the effect or scope of the patien's wishes can be properly considered in the light of all of the existing circumstances.

CONCLUSION

The courts have not dealt with many of the difficult substantive issues underlying mental health legislation. Involuntary committals, transfers to a more secure institution, and forced treatment have a significant impact on a patient's liberty and security of the person. The procedural steps required in each circumstance should be examined to determine whether they allow for sufficient examination of the important substantive issues outlined in this paper. Similarly, commentators have warned that s. 15 should not become simply another means of securing procedural due process.[36] The Supreme Court of Canada has given guidance with the type of analysis that is required to avoid these results. In additi9on, the decision of the Ontario Court of Appeal in *Fleming* c. *Reid*[37] provides a solid example of the way in which the courts can substantively review mental health legislation.

36. L.M.G. Clark, "Liberalism and the Living Tree: Women, Equality and the Charter", Vol XXVII, No. 2, Alberta Law Review, pp. 384 — 385.

37. *Supra* note 34.