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Psychiatry, the Inmate and the Law

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I. Introduction

In August of 1971, the Solicitor General of Canada appointed a committee of psychiatrists to advise him on the treatment of mentally ill inmates. The committee completed its work and reported in May 1972. The report, entitled *The General Program for the Development of Psychiatric Services in Federal Correctional Services in Canada*¹ developed in the space of sixty pages, including appendices, a general program for expanding psychiatric services and facilities in the field of corrections in Canada.

In his forward to the Report, the Solicitor General, Warren Allmand, announces that he is "profoundly impressed by the recommendations made by this authoritative body". Further, he has directed that the psychiatric services of the federal Correctional Services be developed as the Psychiatric Services Report suggests. At the same time he indicates that comments on the program would be welcome.

The decision to implement the Report has generated severe criticism from some quarters. Richard Ericson in an article in the *Globe and Mail* (February 23, 1974) argues that "if psychiatrists are allowed such power, as seems inevitable if their recommendations to the Solicitor General are accepted, then the criminal law will become a tool. It will become the most effective tool in the tinker's bag, for it will provide them with the means of acquiring a perpetual supply of objects to tinker with".² The Transition Society of Saskatchewan has called for a moratorium on the development and construction of new Regional Psychiatric Centres and a suspension on transfers of penitentiary inmates to existing facilities. And, an ex-inmate writing in *Transition* suggests: "The enthusiasm

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1. Advisory Board of Psychiatric Consultants, *The General Program for the Development of Psychiatric Services in Federal Correctional Services in Canada* (Ottawa: Information Canada, 1973). This report is hereafter referred to as the "Psychiatric Services Report".

2. The article is entitled "Psychiatrists in Prison: A Tinker's Paradise". It consists of excerpts from an article by Ericson in (1974), 22 *Chitty's L.J.* 29.

being shown for psychiatric centres for prison inmates in this country is frightening”³

What I have quoted is but a sample of critical comment which the Solicitor General’s announcement has stimulated. What then does the Psychiatric Services Report call for? And is the response referred to above justified?

II. The Psychiatric Services Report

The Report consists of six sections and eight appendices.⁴ However, the perspective of its authors and the central recommendations are set out in Sections II, III and VI. Consequently it is on these that I shall focus.

1. An Historical Review (Section II)

Three general points emerge from the historical review offered in Section II of the Report. First, officials responsible for the administration of Canadian penal institutions have for some time been calling for improved psychiatric facilities. Second, three Royal Commission reports since 1938, namely, the Archambault Report 1938, the Fauteux Report 1956, and the Ouimet Report 1969, have urged the provision of improved psychiatric services. Finally, services have not been improved as recommended because governments have consistently failed to provide funds and because there has been a constant shortage of trained personnel.

2. Psychiatric Services: A Statement of Objectives (Section III)

The Report goes on in Section III to recommend the creation of five regional psychiatric hospitals capable of offering the following:

1. Clinical Services: for those who are “manifestly clinically ill”; for those “who are not manifestly clinically ill but whose offence or offences appear to arise from underlying psychopathology”; “on a trial basis for those whose offences appear to arise from, or be

3. See *Transition*, Vol. 2, No. 2, March/April, 1974. The Transition Society publishes *Transition*, a bi-monthly publication edited by inmates and ex-inmates of federal penitentiaries. Address: 136 Ave. F., South Saskatoon, Saskatchewan.

4. The following is the table of contents of the Psychiatric Services Report: Section I, Terms of Reference, Membership, Methods of Work; Section II, Historical Review; Section III, Objectives of Correctional Psychiatric Services; Section IV, Present Developments in Other Nations; Section V, Developments Required in Canada at Federal Level; Section VI, Evaluation of Psychiatric Services.

related to, behaviour disorders".⁵ The committee estimates that the first group would comprise 750 inmates, and the second and third together 1000 inmates.

2. "Reports and recommendations when required for classification program assignments, temporary absences, releases on parole, etc."⁶ The authors of the Report do not indicate explicitly what they mean by the phrase "when required". But they imply that reports will be "required" "for every inmate" in as much as the role of the psychiatrist in correction services "is that of assigning the person requiring treatment to the 'right' treatment".⁷ Indeed, this is the interpretation given by the Solicitor General, it would seem, in as much as he calls for "full participation by psychiatrists in all relevant aspects of the penitentiary programs". He goes on to say:

Psychiatric reports and recommendations must be given due weight when rendering decisions on classifying inmates and assigning them to programs, and on temporary absence and parole.⁸

3. Provision of training and research facilities. Other recommendations are made in Section III of the Report, but these are key, and they have received the bulk of adverse comment.

3. A Need for Evaluation (Section VI)

Section VI, the last section I shall refer to in this summary, emphasizes the need for constant evaluation of the programs being recommended. It then describes the considerable (if not insuperable) difficulties to be encountered in pursuit of this objective.⁹

A good deal more reference will be made to Section VI at a later point.

III. Initial Comments

The Report has been accepted with approval by the Solicitor General, and is now being implemented. This is perhaps not surprising in as much as the general tone of the Report, together with its recommendations on facilities, are in broad agreement with

5. *Supra*, note 1 at 13.

6. *Id.* at 13, recommendation #6.

7. *Id.* at 15. See also at 16 and 25.

8. See Allmand's forward to the Psychiatric Services Report.

9. *Supra*, note 1 at 33 ff.

a series of reports dating back to 1938, as the authors of the recommendations make clear in their historical survey. Yet there are three areas of concern, consideration of which suggests that detailed scrutiny of the report is justified.

1. The Efficacy of Psychiatric Treatment

To begin, there is lying in the background of the Psychiatric Services Report itself, and the various other studies to which it refers, a concern with the efficacy of the psychiatric treatment of offenders.¹⁰ For example, although the authors of the 1972 Report do not say so explicitly, what they do say clearly implies that there is little, if any, evidence that present correctional programs are at all effective in achieving their objectives. It follows that there is little or no evidence that expansion of psychiatric services would increase the effectiveness of present programs; and where present programs are to be replaced with psychiatric treatment, there is no evidence that psychiatric treatment would be more effective than what now exists. This is the case because, as the Report indicates, the only way to evaluate the proposed programs is to compare them to present programs. What evidence there is as to effectiveness of present programs shows that such programs do relatively little to reduce recidivism.¹¹

To take a second example of this implied concern, in the one area where psychiatrists have played the central role in classification of offenders, namely in determining whether a sexual offender is a dangerous sexual offender, the Report notes that "clinical opinion" has now concluded that many who have been designated dangerous sexual offenders on the advice of psychiatrists have been wrongly classified and are not dangerous at all.¹²

A number of studies recently published show that the concern shown by the authors of the Psychiatric Services Report with the efficacy of psychiatric treatment as well as the accuracy of psychiatric diagnosis is well justified.¹³ Yet no account of this

10. See, for example, the comments of Dr. Louis Bourgoin, *id.* at 56.

11. *Id.* at 34. See also, K. Markinson, *What Works? — questions and answers about prison reform* (1974), 35 *The Public Interest* 22.

12. *Id.* at 35 *ff.*

13. R. Swchwitzgebel, *The Right to Effective Treatment* (1974), 62 *Calif. L. Rev.* 936, agrees with Eysenck's earlier conclusion regarding the effects of treatment: ". . . the therapeutic effects of psychotherapy are small or non-existent . . ." (H. J. Eysenck, *The Effects of Psychotherapy* (1965), 1 *Int'l. J. Psychiatry* 99 at

apparently well-founded concern has been taken by the committee in drawing up their recommendations.¹⁴ This fact has not gone unnoticed by the Report's critics.

2. *The Issue of Consultation*

In advising on the role of psychiatrists in federal correctional services, and on the need for expanded facilities, the committee which was itself comprised only of psychiatrists consulted only psychiatrists. Yet the Report makes judgments about the whole field of corrections including classification of offenders, parole, temporary absence leaves and the programs of rehabilitation. It is true that the recommendations of the committee are directed toward the welfare of those to be affected by them. But surely this is not enough. To quote Ronald Price:

It has long been known that one of the most debilitating 'pains of imprisonment' is the loss of autonomy, the regressive sense of dependency and helplessness that is engendered by a system where, . . . even 'explanation' is often withheld . . . Nor does the focal shift toward a rehabilitative orientation remove the problem.

Further:

It is this judgment that has persuaded correctional reformers that therapeutic considerations dictate the development of programs in which inmates have some voice in shaping and sharing decisions that affect them. However, if claims to an input into decisions are to be recognized, they must be meaningfully recognized . . . and this, in part, is what the rule of law is all about.¹⁵

The committee of psychiatrists did not consult those to be "assisted" by its recommendations. Neither did it comment on the role of offenders in determining the shape of the treatment programs, psychiatric and otherwise, which would occur under the

135-36). See also in the same volume of the California Law Review, D. Wexler, *Mental Health Law and the Movement Toward Voluntary Treatment* at 671 and B. Ennis and T. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom* at 693.

14. It is necessary to temper this statement with the observation that the authors of the report do say that once psychiatric services have been greatly expanded and five regional centres established, an attempt should be made to monitor their effectiveness.

15. R. Price, *Bringing the Rule of Law to Corrections* (1974), 16 Can. J. Corr. 209 at 210.

direction or on the recommendation of psychiatrists, given the proposed expanded services.

That this concern is a real one is evidenced by the generally very critical reaction of the contributors to the inmate and ex-inmate run publication, *Transition*, excerpts from which were quoted above.

3. A Final Concern

A third concern with the Report lies in the fact that though a very substantial literature which attempts a critical analysis of compulsory or coercive psychiatry has become available over the past quarter century, no reference of any kind is made to it in the Psychiatric Services Report.¹⁶ This would appear to be a serious short-coming.

4. Conclusion

These three concerns together provide grounds for undertaking a critical examination of the major recommendations of the Report. In what follows, I propose to make a contribution to such an examination by considering issues arising from admission to, treatment while in, and release from psychiatric treatment centres of the sort proposed by the Report under consideration.

IV. The Commitment of Inmates

As already mentioned, the Psychiatric Services Report calls for the creation of five regional psychiatric centres. It outlines the objectives of these centres and the role of psychiatrists attached to them. Yet at no point does it make reference to procedures for admitting inmates to them, in spite of growing concern with the potential for abuse associated with present methods of involuntary commitment. In fact, the Report's only comment on admission to these centres is its statement that one in five inmates in federal institutions would be candidates for treatment.

1. A Conflict of Interest: The Patient or the Public

The failure to make recommendations on procedures raises a number of serious difficulties. The authors of the Report describe psychiatrists as "committed to a healing tradition" and "bound by the responsibilities and constraints of the physician", all of which

16. References to that literature are found throughout this article.

gives the profession a “unique role in the treatment of social outcasts”.¹⁷ Surely this constant reference to the medical tradition is intended to convey the judgment that the profession of psychiatry has the best interests of its patients at heart. Yet, at the same time the psychiatrist is to work in a correctional system whose objective is to serve the public interest by protecting the public from those who break its laws. Can we easily assume that there is no conflict between these two roles? Consider the following evidence:

1. The medical fraternity has itself vigorously resisted even such measures as universal medical insurance on the grounds of possible incipient government control of the profession, something they regard as incompatible with an unencumbered ability to act for the benefit of their clients. Yet the authors of the Psychiatric Services Report appear to see no problem here, even though the services they are calling for would be provided by psychiatrists working as employees of the government in an institutional setting notoriously subject to public and governmental pressure with prisoners as clients.

2. It is clear that psychiatrists are to be consulted on all aspects of a prisoner’s treatment while he is in prison. These matters on which psychiatrists are to be consulted affect directly the interests of inmates. Take the question of parole, for example. The report recommends as follows:

There should be early joint planning and consensual agreement on the treatment, goals and requirements to be fulfilled established between the psychiatric staff and National Parole Service officers *in order that release of inmates will ensue at a meaningful time*, if the conditions of parole are met; (emphasis added)¹⁸

But the committee does not say what counts as a “meaningful time”. Does it consist of the point at which the possibility for rehabilitation for the offender is greatest, or the point at which the threat to public safety is least? The two are clearly not the same as a study of the recent activity of the National Parole Board would indicate.

But what is at issue here? The answer is simple. The Report casts psychiatry in the role of healer, and physician; persons who adopt this sort of role are committed to serving the interests of their

17. See the Psychiatric Services Report, *supra*, note 1 at 15-16.

18. *Id.* at 25.

clients. Hence it is crucial that those in psychiatric centres who assume this role present themselves as working on behalf of those they treat. Yet the information which is obtained by these persons from their inmate-clients can be used against those inmate-clients. The psychiatrist who has asked for the trust and confidence of the inmate is asked in turn to recommend on parole or temporary absence. His recommendation might lead to denial of parole, for example.

The situation can be illustrated in the following way. If the psychiatrist of Daniel Ellsberg had been working for the government and obliged to make recommendations on such things as national security matters, would it have been necessary to burgle his office? And if it is not the case that it is generally believed that information obtained by psychiatrists might be damaging to the client if available to authorities, why did a United States president or his advisors risk scandal by arranging the theft of psychiatric records?¹⁹

This leads to a third point.

3. There is growing evidence that a therapeutic approach to offenders is contrary to the interests of offenders in as much as it generally leads to longer periods of incarceration than would result if offenders were treated by the system on grounds other than therapeutic ones, *e.g.* on retributive grounds.²⁰ Indeed, the Report itself offers some initial evidence that this is the case. By labelling persons as dangerous sexual offenders, psychiatrists have been involved in judicial decisions which, for those labeled "dangerous", has resulted in greatly increased length of incarceration with no release date set. The Psychiatric Services Report indicates that in making their recommendations to the courts, psychiatrists involved have erred against offenders by recommending that offenders be designated dangerous where such designation was unwarranted.²¹ Thus, in one concrete situation, psychiatry has erred in favour of public safety rather than the well-being of those offenders with

19. See also, T. Szasz, *Law, Liberty and Psychiatry* (New York: Macmillan, 1963) at 161.

20. Law Reform Commission of Canada, *The Principles of Sentencing and Dispositions, Working Paper #3* (Ottawa: Information Canada, 1974) at 11, alludes to this fact. J. Hogarth's study, *Sentencing as a Human Process* (Toronto: University of Toronto Press, 1971) reveals the same phenomenon in a Canadian setting.

21. The Psychiatric Services Report, *supra*, note 1 at 16-17.

whom it has dealt. Had psychiatry solely the interests of its clients at heart in making its recommendations, one would assume that its recommendations would err in the opposite direction. Experience with indefinite sentencing in California indicates that the tendency of Canadian psychiatrists to opt for the public interest rather than the interests of their inmate-client is not an isolated phenomenon.²²

V. Conflict of Interest: Toward a Solution

It should be clear that the failure of the Report to discuss commitment procedures constitutes a serious deficiency. Yet the failure is not surprising. Until very recently, discussion of the rights of prisoners relative to treatment programs has been practically non-existent. However, two Canadian committees (the Ouimet Commission on Corrections and the Law Reform Commission) have suggested reforms which are relevant to the problems raised here. Their recommendations merit attention.

In 1969 the Report of the Canadian Committee on Corrections (the Ouimet Report) published its report entitled *Toward Unity: Criminal Justice and Corrections*.²³ Although it suggests many valuable reforms, *Toward Unity* fails to recommend any procedural protections for those who have been sentenced and who face compulsory psychiatric therapy based on administrative decisions. Indeed, the only recommendations made by this committee are aimed at facilitating transfers to psychiatric centres.²⁴ On the other hand, when considering pre-trial (fitness to stand trial) and post-trial pre-sentence (the dangerous offender) psychiatric classification, the Ouimet report recommends elaborate procedural safeguards including the guarantee of counsel, the right to be present when one's case is being heard, suitable notice, determination by an impartial body, the right to full answer and defence and the right to appeal.²⁵

22. See note 20. Also Szasz, *supra*, note 19, offers innumerable examples of psychiatric classification opting for public safety in a manner prejudicial to the interests of individuals subject to involuntary psychiatric examination and classification.

23. Canadian Committee on Corrections, *Report of the Canadian Committee on Corrections, Toward Unity: Criminal Justice and Corrections* (Ottawa: Queen's Printer, 1969).

24. *Id.* at 239.

25. *Id.* at 223 ff. and 259 ff. See also the article by R. Price, *supra*, note 15 at 224 ff. and T. Kittrie, *The Right to be Different* (Harmondsworth: Pelican Books, 1972) at 402-403 for similar ideas on related subjects.

The arguments developed by the Ouimet Commission in support of their recommendations are impressive. But they apply with equal force to administrative decisions leading to compulsory therapy. I have argued above that commitment to a regional psychiatric centre may very well mean more lengthy incarceration for the inmate than would otherwise be the case. Transfer to a psychiatric regional centre may also mean more severe treatment or punishment than would otherwise be the case. These are exactly the grounds offered by the Ouimet Report for recommending procedural safeguards in the pre-trial and post-trial pre-sentence situations mentioned above. If psychiatric treatment or classification of inmates carries with it similar dangers (and I have argued it does) then by parity of reasoning inmates have a right to similar protections.

The Canadian Law Reform Commission in its Working Paper #3, *The Principles of Sentencing* raises issues which are closely related to those under examination here. It points out that:

. . . rehabilitation . . . raise[s] ethical questions concerning the moral right of society to . . . give treatment to prisoners without their consent . . .²⁶

In a study paper "Hospital Orders"²⁷ the implications of this view are examined at length. The authors conclude that while access to effective treatment is an inmate's right, treatment should be by consent only. A draft report on Hospital Orders concluded:

Bringing the decision to offer treatment within the judicial sphere, however, where the proceedings are in the open should assist in protecting basic human rights and securing integrity of the person. As developments in neurology, biology, and the use of drugs bring society closer and closer to the day when behaviour may be conditioned and manipulated, it seems increasingly necessary that decisions affecting treatment be made before a judicial officer who can ensure that no treatment will be imposed without the informed consent of the offender. Judicial decisions arrived at in public surrounded by safeguards and subject to review, are to be preferred in this instance to administrative decisions arrived at behind closed doors and inaccessible to review.²⁸

26. *Supra*, note 20 at 12. See also the comments of the Commission at 17, "Supervising the Execution of Sentence".

27. Law Reform Commission of Canada, *The Criminal Process and Mental Disorder, Working Paper #14* (Ottawa: Information Canada, 1975) at 46ff.

28. Draft copy of the report entitled "Hospital Orders" (available from the Commission) at 7. This section now constitutes section vi. c.(i) of the report, *supra*, note 27.

The arguments developed above lend support to the conclusion of the Law Reform Commission's study paper. As we shall see, there are additional reasons for thinking that the approach offered in "Hospital Orders" is sound.

VI. The Inmate and Treatment Programs

The role and the rights in the determination of treatment programs of those to be transferred to psychiatric centres is a crucial issue for a number of reasons, some of which have already been introduced and some of which I wish to set out now.

1. Almost certainly, the image which the public has of psychiatric treatment focuses largely on psychiatric counselling. Of course, this is one of the tools available to psychiatry. But there are a number of other tools available which have been used in the past and which are presently in use as well. As Thomas Szasz indicates, psychiatric treatment includes "lobotomy, convulsions induced by insulin, metrazol and electricity, and most recently, the chemical straitjackets".²⁹ And Kittrie, writing from a legal perspective and, having described in graphic terms the history of lobotomy and sterilization, goes on to describe "the new therapies":

Given an increasing disaffection with indeterminate commitment as the primary tool of therapy for deviants, new methods of controlling human behaviour have been discovered. Hormone injections can alter the intensity of sexual drives and modify the response to sexual stimuli. Drugs that act on the brain and central nervous system to modulate moods and alter states of consciousness are in use in many mental institutions. Psychosurgical techniques have advanced in recent years beyond the early lobotomies. Brain stimulation by electronic impulses through implanted electrodes has proved capable of modifying human behaviour. Some electronic techniques leave overall patterns of personality and behaviour intact while eliciting specific desired responses by selective stimulation of pleasure or pain centres, using miniaturized devices permanently implanted and remotely operated. Psychopharmacology and neurosurgery have generated a process for implanting areas of the brain with cannulae of drugs which slowly release their contents for long-term control without the need for continuous medications.³⁰

The Psychiatric Services Report clearly envisages the use of the whole range of available techniques in the proposed psychiatric

29. Szasz, *supra*, note 19 at 55.

30. Kittrie, *supra*, note 25 at 301.

centres.³¹ This fact, together with the type of therapies presently in use, clearly raise questions about the rights of inmates in the determination and imposition of psychiatric treatment programs.

2. I have already raised the issue of the accuracy of psychiatric diagnosis as well as the efficacy of psychiatric treatment. Additional evidence need not be introduced here.³² Suffice it to say that in as much as inmates may find themselves in psychiatric treatment programs which have no known efficacy, it seems clear on grounds of fairness alone that they should be consulted on the nature of any treatment program to which they might find themselves subjected.

3. It is a widely known fact that once it has been recommended by a judicial or administrative authority that a person submit to psychiatric examination and perhaps treatment, his objection to doing so is in itself viewed as evidence that the examination or treatment is required. A former inmate, writing in the March/April 1974 issue of *Transition* puts the point rather well. He states:

The convict/patient has no position from which to defend himself. If the psychiatrist says that he should be treated and he refuses, he kisses off his parole. If he goes to the psychiatric centre, they can do anything they want to him. If he argues, they take his argument as a sign that he's still ill and "treat" him all the more. If he manages to argue publicly, whether right or wrong, psychiatrists cite the fact that the man is in a bug factory and therefore must be nuts (if he wasn't, he wouldn't be there) so you can't believe it after all the labelling and tinkering, the convict/patient screws up again, he is blamed for their failure.³³

Thus there is a *prima facie* case for procedural safeguards to which an inmate may appeal if faced with an administrative decision that he be transferred to a psychiatric centre.

4. It would appear that, under present regulations, an inmate is required to give up any implicit right he might have to be consulted in his own treatment on admission to a centre. The March/April 1974 issue of *Transition* contains a copy of the "90 day assessment period resident covenant" of the Regional Medical Centre, Abbotsford, B.C.. Residents are described as entering the agreement voluntarily though, as the previous quotation in #3 indicates, the distinction between voluntary and involuntary

31. The Psychiatric Services Report, *supra*, note 1 at 56.

32. See *supra*, note 13 for examples. See also H. J. Eysenck, *The Effects of Psychotherapy: An Evaluation* (1952), 16 J. of Consulting Psychology 319.

33. R. A. White, *Concern of a Research Subject (who believes he is human)* in *Transition*, *supra*, note 3 at 29. See also Szasz, *supra*, note 19 at 161 and 189.

programs in a prison setting is suspect.³⁴ Literally buried amongst a number of innocuous provisions is the requirement that the inmate “take all medication and treatments as they are prescribed by the doctors”.³⁵ This provision effectively requires that the inmate approve of all prescriptions or treatments he might be asked to take before he knows what they are. In addition, the inmate is asked to agree to a system of “rewards” for good behaviour which grants the institutional authorities the right to cut off all communication with other persons and to deprive the inmate of “any item in your room other than those prescribed by the doctor”.³⁶ If these provisions were invoked by the authorities and an inmate deprived of the right to communicate with others and deprived of the right to reading material, radio, or other communication, and at the same time confined to his room, the authorities would have imposed solitary confinement and isolation in the name of treatment or therapy. It is hard to think of an agreement which would transfer to the authorities more power over the inmate than that set out by the medical centre in Abbotsford. Further, there is no reason to believe that this agreement will not set the pattern followed across the country by other psychiatric centres. Surely an inmate should have the right to petition some impartial body for relief, a right no one should be allowed to remove.

5. The Psychiatric Services Report recommends that the proposed regional centres be used for research purposes. Given that the centres are medical centres, this constitutes a clear shift in policy. Unlike what goes on in the United States, in Canada, inmates in the past have not been used for medical research purposes.³⁷ This is now to change. What is at issue here is the morality of subjecting prisoners, whose lives are controlled in large measure by others, to treatment the efficacy of which is largely unknown.

VII. The Basis For a Solution

Is there an approach to these problems which acknowledges the

34. See the interesting judgment *Kaimovitz v. Michigan Department of Mental Health*, July 10, 1973, #73-19434-A.W. (Cir. Ct. of Wayne Cty., Michigan). The court concludes that no consent given by a confined patient is voluntary. See (1974), 62 Calif. L.Rev. 671 at 675. See also, an editorial, *The Prisoner as Patient in Transition*, *supra*, note 3 at 29.

35. *Supra*, note 3 at 31.

36. *Id.* at 32.

37. See Can. H. of C. Debates (March 28, 1973), Hansard question no. 1490,

benefits of psychiatric treatment of offenders while providing adequate protection at the same time? The answer once again would appear to lie in a logical extension of the arguments and recommendations of the report of the Canadian Committee on Corrections.

As already pointed out, the Canadian Committee on Corrections makes no reference to the rights of offenders with respect to psychiatric treatment once they have been sentenced. Yet where they see the interaction of the therapeutic and criminal systems resulting in a potential threat to the rights and interests of individuals, they call for a series of procedural safeguards for those who have been committed as a result of contact with the judicial system. These include the recommendation that

there be adequate review, provision for which is made by statute, of every person in Canada who is detained under the authority of an order made by a lieutenant-governor.³⁸

They go on to indicate that reviews should be automatic; that they should take place at least once a year; that the review body should be multi-disciplinary in composition; and that review procedures should have due regard for civil rights including the right to be represented by counsel.³⁹ And again, in considering dangerous offenders who have been given indeterminate sentences, the committee recommends:

that the proposed dangerous offender legislation, if enacted, provide in addition to an automatic yearly assessment and review by the Parole Board, that a person sentenced to preventive detention as a dangerous offender be entitled to have a hearing every three years before a superior, county or district court judge or judge of the court of sessions of the peace, for the purpose of determining whether he should be further detained or his sentence should be terminated if he has been released on parole.⁴⁰

It is difficult to see why a protection which it is felt ought to be extended to those committed to psychiatric centres by the courts or by the lieutenant-governor should not be extended to those who are

which relates directly to this issue. This can be contrasted with the situation in the US as described for example by Mills and Morris in *Society* (New Brunswick, New Jersey: Rutgers University, 1974). (My thanks to Keith Couse, Executive Director of the John Howard Society of Ontario, who helped me to track down these references).

38. *Supra*, note 23 at 231.

39. *Id.* at 232.

40. *Id.* at 262.

also committed to a psychiatric centre but as the result of an administrative decision. If a person is committed against his will, surely, from his point of view, it does not matter who required his commitment.

An extension of the relevant recommendations of the Ouimet report would result in an approach to psychiatric treatment which many have called for. Let us take just three examples. The Transition Society of Saskatchewan has argued for the “creation of review and advisory panels for every [psychiatric] Centre which is comprised of non-medical authorities”. They go on: “all members [of the proposed committees] should have free access to every patient upon the patient’s request and to every staff member and should be empowered to investigate and act upon any allegation of irregularities with respect to treatment and individual rights”.⁴¹ Second, Thomas Kittrie (*The Right to be Different*) has drawn up a “bill of therapeutic rights” which includes

Man’s innate right to remain free of excessive forms of human modification shall be inviolable.

And:

All committed persons should have direct access to appointed counsel and the right, without any interference to petition the courts for relief.⁴²

Finally and most recently, the Law Reform Commission study paper, “Hospital Orders”, argues that an offender once committed should “have the right, upon request, to be discharged from the hospital back to the correctional system even if he could still benefit from further treatment at the psychiatric institutions”. He should also “have the right to apply to a review board . . . for a transfer to another hospital”.⁴³

The principles lying behind the suggestions drawn from the various sources are the same though, for example, the “Hospital Orders” paper differs from my proposed extension of the Ouimet Report on matters of detail. All the sources referred to are in agreement on the need to protect the rights of an offender who is undergoing treatment. For reasons set out above, such protection is indeed required.

41. *Supra*, note 3 at 22.

42. Kittrie, *supra*, note 25 at 402-403.

43. *Supra*, note 28 at 13 and 14.

VIII. Release and the Termination of Treatment

In commenting on the question of release from psychiatric centres, the editors of *Transition* say:

The legal rights of inmates with respect to being released from Regional Medical Centres, is fairly clear-cut. . .

And:

Basically the present situation provides that if an inmate is 'cured' he may be released back to the penitentiary, or if he is eligible for parole he may be released on parole. Given current legislation, i.e. the Penitentiary Act, once an inmate's sentence has ended he must be released.⁴⁴

A comment by Dr. Coburn, one of the authors of the 1972 Report, appears to confirm this view. He states:

No patient transferred to the Centre can be kept any longer than his sentence and it is anticipated that in many cases a good response to treatment will lead to earlier consideration for release by the parole board.⁴⁵

However, a few notes of caution must be interjected. First, Dr. Coburn's statement is at least partially misleading. He says that ". . . a good response to treatment will lead to earlier consideration for release . . ." Earlier than what? Expiration of one's sentence? But everyone is eligible for parole after having served only a portion of his sentence. If he means "earlier than would be the case without treatment" then he should provide some evidence for his view. Until he does, it is worth repeating that where in the past release has been based on "humanitarian" therapeutic considerations, the result has been that the offender is incarcerated for a longer period than would otherwise be the case contrary to what Dr. Coburn appears to imply.

Second, one of the somewhat ominous features of the Ouimet Report is that, in discussing the provision of psychiatric facilities for inmates of federal penitentiaries, one of only two concerns voiced is that persons in the proposed psychiatric centres not be released too soon. Its authors write:

The Committee is aware of the understandable concern that there is, in some cases, a risk of an extremely dangerous offender being released at the expiry of his sentence. Legislation in all provinces protects, to some extent, the public from the risk

44. *Supra*, note 3 at 36.

45. *Id.* at 19.

involved in the release of an offender who is mentally disordered and dangerous. Prior to such a release, the custodial authorities may arrange psychiatric examination and invoke the application of civil 'commitment' proceedings, thereby ensuring the continuing protection of the public.⁴⁶

This concern that commitment proceedings be used against inmates by prison authorities indicates the need for safeguards which others have also concluded, on these and other grounds, to be necessary.⁴⁷ In this connection, Kittrie suggests that:

Those submitting to voluntary treatment should be guaranteed that they will not be subsequently transferred to a compulsory program through administrative action.⁴⁸

The Ouimet Committee itself suggests administrative procedures which would place all inmates transferred to psychiatric centres in danger of having a determinate sentence converted to an indeterminate one. That being the case, it is clear that the Ouimet Committee's own recommendations as quoted above should apply to all who face the possibility of involuntary commitment to psychiatric centres by any authority. This implies that those committed to psychiatric centres should have the right of regular review of their status while under psychiatric treatment and the right of access to the courts with the right to counsel, particularly in the event that any change in that status, which would result in lengthened incarceration, is contemplated. And clearly those who are voluntarily admitted must have the protection of regulations preventing their transfer, by administrative action while under treatment, to compulsory treatment.⁴⁹

IX. Conclusions

I have tried to argue through an appeal to actual cases and to the literature, that the Psychiatric Services Report is unsatisfactory in a real and fundamental way. I have argued that some of the deficiencies can be overcome by an extension of some recommendations of the Canada Committee on Corrections on related issues. But more is needed. I have tried to suggest that certain recommendations made by inmates and ex-inmates writing in *Transition* and by

46. *Supra*, note 23 at 238.

47. See editorial comment of *Transition*, *supra*, note 3 at 37.

48. Kittrie, *supra*, note 25 at 402.

49. As recommended in the draft report, *supra*, note 28 at 13.

the Law Reform Commission are sound if judged against the arguments and recommendations of a wide range of studies.

In conclusion, it is important to emphasize that concern with the legal or procedural, rather than administrative, regulation of therapy does not imply hostility toward psychiatry or its use in a penal setting. It implies only that we should recognize the potential for both error and abuse which exists wherever individuals, regardless of their training or profession, are given or acquire control over the lives of others. If we are to acquire the respect of those who break our laws, surely an essential ingredient in any rehabilitative program, then respect for and protection of the rights and legitimate interests of those individuals is something which we must not overlook or ignore.

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