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EXODUS: 40 YEARS OF DEINSTITUTIONALIZATION AND THE FAILED PROMISE OF COMMUNITY-BASED CARE

TED FRANKEL[†]

ABSTRACT

The increasing number of Canadians with mental illness who are left uncared for and roaming the streets represents a huge failing that is not being seriously addressed in our society. Initially thought to be humane and progressive, “deinstitutionalization” has resulted in a very different reality for thousands of people with mental illness who have been released into the community. Many of those liberated from mental institutions and asylums have made an uneasy transition to life on the “outside”, sometimes with tragic consequences.

The question for consumers of mental health services now is not whether the current system is failing but rather what is the best route to programs and entitlements that are routinely granted to other disadvantaged groups, such as people with physical disabilities. Claims grounded in Charter section 15 jurisprudence that mentally ill populations are underserved by existing aftercare programs are one possibility, although Canadian courts have shown a marked reluctance to interfere in the realm of policy-making. In the end only a restructuring of priorities – political, social and attitudinal – can fully address the needs of some of our least understood and empowered citizens, as the experience of one Canadian jurisdiction, Nova Scotia, demonstrates so well.

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I. INTRODUCTION

Moses said to the people, “Remember this day, when you left Egypt, that slave-pen; for sheer strength the Eternal brought you out of this place...(and) swore to your fathers He would give you a land abounding in milk and honey...”

Exodus 13:3

The themes of enslavement and bondage are ones familiar to individuals who suffer from mental illness. There is the bondage of the *mind*, especially for those who suffer from depression, mood swings, hallucinations, delusions, and other afflictions. There is the bondage of the *spirit*, occasioned by prejudice, discrimination, stigma, and marginalization – the result of hatred, intolerance, and simple misunderstanding of mental disability by those who have never felt its grip. Finally, and perhaps most devastating of all, there is the bondage and subjugation of *body and soul* which comes when one is institutionalized, a process which involves not only the physical aspect of living apart from family, friends, and neighbours but also the psychological trauma of subordinating one’s autonomy – one’s very free will – to the interests of treatment, rehabilitation and recovery.

For the last forty years there has been a movement afoot to end the bondage of forced hospitalization and move towards treatment alternatives which are less restrictive and more humane. Called “deinstitutionalization” by some, this movement has seen a veritable exodus of psychiatric in-patients from hospitals to seek a new life in the community. Yet deinstitutionalization for the thousands who have been liberated from psychiatric institutions has meant something more than the simple act of leaving. It has meant the promise of community-based care with the ultimate goal of reintegration, and it has meant the challenge of moving forward when these promises have proved hollow.

This article will endeavour to unpack the many dimensions of deinstitutionalization and assess how far we have come in realizing the goal of effective, benevolent community-based care and treatment. In doing so, deinstitutionalization will be examined as a social construct, a policy choice, a legal right, and as a legacy of thousands of individuals with mental illness, to be measured in human terms. Although I will look at deinstitutionalization broadly as a social and legal phenomenon

taking place across Canada and the United States, the efforts of Nova Scotia to implement community-based care as a viable substitute for institutionalization will be examined more closely.

Part II will look at the foundations of deinstitutionalization, including legislative efforts made to provide for individuals in the community, and the often dire consequences of failing to live up to these responsibilities, which include homelessness and violence.

Whether or not a right to community-based care and/or basic after-care¹ exists at all for disabled people in Canada will be addressed in Part III, with a comparison made between claims made under the *Charter of Rights and Freedoms* and jurisprudence from the United States on the same topic.

Since deinstitutionalization cannot be fully understood apart from its context in Canadian lives and communities, Part IV fixes a critical gaze on Nova Scotia, examining the legislative framework for mental health services in the province, how this has translated into uncertainty for Nova Scotians who have been discharged from hospitals and institutions, and what efforts have been made to restructure priorities and make more of existing resources.

The paper will conclude with a look at the potential for individuals with mental illness who have been wronged by the system to bring civil actions against the government and/or care providers. Possibilities for legislative reform, such as inserting a guarantee of the "least restrictive alternative" in relevant provincial statutes or passing a Patients' Bill of Rights, will also be canvassed in Part V.

II. DEINSTITUTIONALIZATION, PAST AND PRESENT

The traditional asylum system, favoured throughout the 19th century, became even more entrenched after the turn of the century. Mental hospitals had already grown considerably by the end of World War

¹ The term "aftercare" is used to denote a panoply of care and treatment services individuals may require after being discharged from hospital including: counseling, case management, vocational and skills training, substance abuse therapy, education, crisis management, help with daily living, etc..

Two, when thousands of new beds were added to accommodate an influx of patients from the battlefields of Europe and Asia.² Nine thousand new psychiatric beds were introduced in Ontario alone during the period from 1932 and 1948.³

While reliance on the system increased at a rapid pace, funding levels did not. Mental institutions quickly became overcrowded and patients suffered as a result – a fact that did not go unnoticed by social reformers and journalists of the day. In the United States, Albert Deutsch wrote about appalling conditions in mental hospitals in his book *The Shame of the States*.⁴ His sentiments were echoed by newsmen across the U.S., some of whom compared the mental wards of hospitals to Nazi concentration camps.⁵

Criticism of the asylum approach also began to surface within the medical profession. Some, like Dr. Harry Solomon, President of the American Psychiatric Association, wondered aloud whether institutions that housed people with mental illness had not become “antiquated, outmoded and...obsolete.”⁶ Thanks to new and revolutionary psychotropic medications, psychiatrists observed a new sense of calm prevailing in mental wards. New medications also helped control many of the violent behaviours which made doctors reluctant to prescribe anything other than long-term confinement for patients with schizophrenia and severe mood disorders.⁷ If medication could put to rest many of the “worst” symptoms of mental illness, psychiatrists hypothesized that even their most chronic patients would now be able to function in the community. With public administrators chafing at the high costs of maintaining and staffing psychiatric facilities, the pressure was on to get the “social experiment” underway. The deinstitutionalization movement was born.

² See M. Drassinower & S. Levine, “More Sinned Against Than Sinning: Housing, Mental Illness and Disability” (1995) 6 Windsor Review of Legal and Social Issues 91 at 101-103 [Drassinower & Levine, “Sinned”].

³ *Ibid.* at 102.

⁴ Albert Deutsch, *The Shame of the States* (New York: Harcourt Brace, 1948).

⁵ R.J. Issac & V.C. Armat, *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill* (New York: The Free Press, 1990) at 68 [Issac & Armat].

⁶ *Ibid.* at 69, quoting from Dr. Solomon’s 1958 presidential address to the American Psychiatric Association.

⁷ Chlorpromazine, thought to be a miracle drug for the treatment of schizophrenia, was first introduced in 1952. Issac & Armat, *supra* note 5 at 20.

1. Civil Rights and the Mentally Ill

Thousands of anti-war and equality rights protesters took to the streets during the 1960s, seeking more accountability from government and an end to the tyranny of the majority. Many in the counter-culture saw the mentally ill as sharing in the same struggle. Calling mental illness a myth, civil libertarians argued that mental institutions were little more than holding bins for dissidents and others who threatened the existing power structure.⁸ They viewed psychiatry as a tool of oppression and called for mental hospitals to be shut down and its population set free.

Although their strength in numbers was new, much of the rhetoric employed by civil libertarians was not. Over 100 years earlier, John Stuart Mill wrote that “the only purpose for which power can rightfully be exercised over any member of a civilized community, against his will, is to prevent harm to others.”⁹ This message resonated with activists and also with prominent philosophers like Michael Foucault, who spoke out against the “moral imprisonment” brought on by institutional living.¹⁰ If mental illness was little more than an unorthodox way of seeing the world, and posed no threat except to the establishment itself, then the coercive power of the state could not be justified.

The libertarian teachings of Mill also struck a chord with what R. J. Issac and V. C. Armat call the “anti-psychiatry” movement.¹¹ Composed of renegade psychiatrists like R.D. Laing and Thomas Szasz, anti-psychiatrists theorized that what other scientists considered a “brain disease” was better explained as a social phenomenon brought on by a host of familial, cultural, and socio-economic factors. Accordingly, “anti-psychiatrist” psychiatrists argued that locking individuals away in

⁸ Issac & Armat, *supra* note 5 at 26-27.

⁹ J.S. Mill, “On Liberty” in S. Collini, ed., *On Liberty and Other Writings* (Cambridge: Cambridge University Press, 1989) 8 at 13. Mill goes on to qualify that self-determination “is meant to apply only to human beings in the maturity of their faculties. We are not speaking of children or of young persons below the age which the law may fix as that of manhood or womanhood” (*ibid.*) This passage is sometimes cited by those who favour paternalistic interventions for the mentally ill. Like children, the argument goes, mentally disordered persons lack insight and the ability to make reasoned decisions about their own lives. This makes it necessary for the state to intervene.

¹⁰ Issac & Armat, *supra* note 5 at 52, citing M. Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Pantheon, 1965) at 247-248.

¹¹ Issac & Armat, *supra* note 5 at 19-64.

order to “rescue them from themselves” only served to perpetuate feelings of low self-esteem that caused psychic disturbances in the first place. This notion was also given credence by literary works of the day, most notably Ken Kesey’s *One Flew Over the Cuckoo’s Nest*.

2. Legislative Action and Inaction

Legislators were quick to respond to calls for deinstitutionalization, and the effects were immediate and long-lasting. For example, between 1965 and 1975 the in-patient population at Hamilton (Ontario) Psychiatric Hospital went from 1750 to 700. By 1995 only 211 in-patient beds remained.¹² Similar developments occurred across the country, including at the Nova Scotia Hospital in Dartmouth, where beds have been reduced from over 1000 in the 1960s to only 186 today.¹³

In the United States, the federal government helped champion deinstitutionalization efforts. In 1963, during the Presidency of John F. Kennedy, Congress passed the *Mental Retardation and Community Mental Health Centers Construction Act*.¹⁴ The centrepiece of the new legislation was federal funding for thousands of Community Mental Health Centers (CMHCs) where former in-patients could receive counseling, vocational training and a variety of other services aimed at easing the transition from hospitalization to community living. Kennedy’s plan envisioned the CMHCs assuming a dominant role in mental health care, making hospitalization, for all but the most chronic patients, a thing of the past.¹⁵ Sure enough, state hospitals began to phase out beds as CMHCs were introduced.¹⁶

¹² F. Vallance-Jones, “Left adrift in the community” *The [Hamilton] Spectator* (13 May 2000) A13 [Vallance-Jones].

¹³ R. Bland & B. Dufton, *Mental Health: A Time for Action* (Province of Nova Scotia: Submitted to the Deputy Minister of Health, 2000) at 32 [Bland & Dufton].

¹⁴ 42 U.S.C.A. § 2674 (1963).

¹⁵ See Issac & Armat, *supra* note 5 at 77-81; J. Bach, “Requiring Due Care in the Process of Patient Deinstitutionalization: Toward a Common Approach to Mental Health Care Reform” (1989) *The Yale Journal* 1153 at 1155 [Bach, “Deinstitutionalization”].

¹⁶ For example, the average population at psychiatric hospitals in the state of Maryland declined from 7,114 to 1,200 between 1970 and 1997: *Williams v. Wasserman* 164 F. Supp. 2d. 591 (D.Md. 2001). This trend was replicated across the country. The number of inpatient beds in state mental hospitals decreased from 559, 000 to 132, 000 between 1955 and 1980. See Bach, “Deinstitutionalization”, *ibid.* at 1155-1156.

While regulators made good on their promise to close down mental hospitals, they were slow to provide the kind of support and case management former patients needed to adjust to their new surroundings. The pace of deinstitutionalization outstripped the development of new community-based resources. By 1970, consumer-rights groups in Ontario were already publicizing the fact that out-patient services were lacking in the province.¹⁷ In the United States, fewer than 700 of the 2,500 planned CMHCs had been built as of 1989.¹⁸ By the end of the 1980s, lawsuits had been launched in twenty-one states, demanding state governments provide more services for the mentally ill.¹⁹

3. The Aftermath of Deinstitutionalization

Deinstitutionalization was premised on the notion that people with mental illness would be better served in the community than they had as shut-aways in psychiatric wards. Instead of psychiatrists and nurses, people with mental illness could take comfort in friends, neighbours, employers, social workers, and family doctors. Instead of enduring cramped and chaotic hospital living, newly liberated patients could live in their own apartment or semi-autonomously at a supervised care home.

For many of those who have left institutions in the last forty years, however, deinstitutionalization has delivered much less than it promised. More often than not, the transition to community living has proved to be difficult, even disastrous. Instead of the welcoming arms of the community, many leaving mental institutions have found themselves increasingly shunned, isolated, and marginalized. The reality of the “outside” has, in fact, often proven to be more harsh than what many experienced in the institutional care system. According to consumer advocate Carol Tooton, the situation is so bleak for some people there is a temptation to romanticize their time in hospital where “at least I had a roof over my head and food in my stomach.”²⁰

¹⁷ Drassinower & Levine, “Sinned”, *supra* note 2 at 105.

¹⁸ Bach, “Deinstitutionalization”, *supra* note 15 at 1156.

¹⁹ Issac & Armat, *supra* note 5 at 309.

²⁰ Interview of Carol Tooton, Executive Director of Canadian Mental Health Association (CMHA), Halifax Branch (14 February 2002) by author [Tooton].

One of the more visible by-products of deinstitutionalization gone wrong is homelessness. As Issac and Armat write of the American experience: “many of our modern institutions for the mentally ill exist in the open air: parks, alleys, vacant lots, steam grates on our city pavements.”²¹ The situation is no different in Canada. Recent studies estimate that between 20-25% of individuals living on Canadian streets suffer from some form of mental illness.²²

Certainly not all formerly institutionalized patients have found themselves left in the lurch by an uncaring system. In Ontario alone there are 335 community-based mental health agencies providing a range of crisis management and treatment programs, as well as helping people with mental illness find shelter.²³ Recognizing the appalling lack of affordable housing across Canada, the federal government pledged millions in December 1999 towards building new community-based homes for the mentally ill as part of its “Homeless Initiative.”²⁴ The Initiative has already benefited some previously left out in the cold. For example, with the assistance of nearly \$1.4 million from the Government of Canada, a new apartment building recently opened on Gottingen Street in Halifax, complete with independent quarters for eighteen individuals described as “difficult to house”, and a live-in staff person available twenty-four hours a day.

Still, it remains more common to find discharged psychiatric patients living in sub-standard boarding homes, eating rancid sardines, and getting little or no attention from psychiatrists (as Dr. Nancy Herman observed in her 1985 doctoral thesis), than living in comfortable apartments like the units described above.²⁵ Wait lists are common for most

²¹ Issac & Armat, *supra* note 5 at 1. Studies estimate that 20-25% of homeless people in America have a “serious mental illness.” Online: National Resource Center on Homelessness and Mental Illness <<http://www.nrhcmi.com>> (date accessed: 23 March 2002).

²² Online: CBC Frontline <<http://www.tv.cbc.ca/witness/mental/mentalhome.htm>> (date accessed: 23 March 2002).

²³ Vallance-Jones, *supra* note 12 at A13.

²⁴ Human Resources and Development Canada, News Release 01-09, “New Housing Facility in Halifax to receive funding” (12 March 2001). Of the \$753 million devoted to the Homeless Initiative, \$305 million was designated for the Supporting Communities Partnership Initiative (SCPI), a plan to “develop local solutions to...the homeless challenges (of local communities) and establish a seamless web of supports for the homeless population.”

²⁵ Vallance-Jones, *supra* note 12 at A13. See also P. Capponi, “Legal issues in psychiatric boarding homes” (1986) 4 Just Cause No. 1 at 18.

placements and programs in Nova Scotia.²⁶ Where there are available spots, patients are often at the mercy of care facility administrators who get to “pick-and-choose” the residents.²⁷ This sort of discrimination is actually facilitated by the *Homes for Special Care Act*, which gives maximum discretion to administrators to determine who is suitable.²⁸

The frustration of being stigmatized as unmanageable or dangerous by a care home operator, living in slum-like conditions, or spending your days in a cardboard home beneath the Gardiner Expressway in Toronto,²⁹ is palpable to anyone who has ever met a mentally ill person in these circumstances. Sometimes this frustration manifests in self-destructive behaviour. Unfortunately, this is the side of deinstitutionalization best known to the general public, propagated through splashy headlines about discharged patients throwing themselves in front of subways and wandering aimlessly through the streets.³⁰ Contrariwise, the general public does not often hear about individuals who have adjusted well, become consumer advocates, or started their own business, for example.³¹

The sense of despair engendered by years of being ignored and marginalized has also driven some ex-psychiatric patients to extreme acts of violence. Some of these cases have been high profile and have prompted criticism of deinstitutionalization policies. In 1985 a public outcry resulted when former psychiatric patient Andrew Leyston-Hughes murdered 23-year-old heiress Nancy Eaton.³² Concern was similarly widespread in 1995 after Jeffrey Arenburg shot Ottawa sports-caster Brian Smith while suffering from paranoid delusions.³³

²⁶ Interview of Pam Townsend, A. Supervisor at the Department of Community Services, Community Supports for Adults Division (15 March 2002) by author [Townsend].

²⁷ Bland & Dufton, *supra* note 13 at 18.

²⁸ N.S. Reg. 73/93, s. 15(5). According to s. 13, the Minister “may” appoint a committee to review admission decisions if there is a dispute over what level of care is appropriate for a given individual.

²⁹ These observations are based on my experiences in Toronto as a volunteer at the Queen Street Mental Health Centre in 1998-1999 and as a low income advocate at the Daily Bread Food Bank in 2000.

³⁰ Issac & Armat, *supra* note 5 at 157.

³¹ For a list of “Psychiatric Survivor Economic Initiatives” in Ontario see online: The Ontario Council for Alternative Businesses <<http://www.icomm.ca/ocab/psced.htm>> (date accessed: 17 April 2002).

³² K. Harris, “Delicate Balancing Act; Ontario Review Board Weighs Rights to Freedom, Safety” *The [Ottawa] Sun* (8 July 2001) 8.

³³ K. Harris, “Troubled Road to Tragic Act; The warning signs of a desperately sick man were there, yet Arenburg remained untreated” *The [Ottawa] Sun* (31 May 2001) 4.

In the wake of Smith's death, debate intensified over when and how psychiatric patients with violent pasts should be released into the community. In response, the Ontario government amended the *Health Care Act* to allow psychiatrists to issue Community Treatment Orders (CTOs) for individuals who have been hospitalized on more than one occasion after being released – what some call the revolving door syndrome.³⁴ Known as “Brian's Law” the amendments make it possible for police to take someone into custody if they fail to comply with a treatment order.³⁵

While answering the need for greater supervision of individuals released from the hospital, the new amendments did not address many of the root causes of the “revolving door” syndrome; such as, failing community supports, a lack of early intervention, and little or no affordable housing. In fact, in some ways, CTOs stand in the way of healthy community treatment. According to a Position Paper by the Ontario Division of the Canadian Mental Health Association (CMHA), imposing a treatment order without the patient's consent “diminishes trust and true cooperation between caregiver and patient and may be a deterrent to the formation of a therapeutic relationship” because of the debilitating side effects of many medications.³⁶ Still, when CTOs and leave certificates³⁷ are issued in conjunction with a plan to utilize community supports, they have proven to be a positive step in the lives of patients.³⁸

III. DO DISABLED INDIVIDUALS HAVE A RIGHT TO COMMUNITY-BASED CARE?

The failure of provincial governments to deliver on community care begs the question of whether the right to community-based care exists at

³⁴ *Mental Health Act*, R.S.O. 1990, c. M.7, as am. by S.O. 2000 c. 9. Repeat hospitalization must occur within a three-year span to a CTO to be issued.

³⁵ *Ibid.* at s. 33.3(3).

³⁶ Canadian Mental Health Association, *Position Paper Regarding the Use of Community Treatment Orders for Persons with Mental Illness* by the Public Policy Committee (Ontario Division, 1998) at 3.

³⁷ Unlike CTO's, leave certificates are issued only with the patient's consent. Currently, five provinces and one territory have leave provisions within their mental health legislation.

³⁸ J. Gray, M. A. Shone & P. Liddle, *Canadian Mental Health Law Policy* (Toronto: Butterworths, 2000) at 221-223 [Gray, Shone & Liddle].

all, or whether this is merely a “political” question which the courts should not address. In this respect, the experience of physically disabled claimants who have sought additional rights and entitlements through the courts is instructive. This part considers whether people with mental illness have a “right” to comprehensive aftercare, or at least a right to treatment on par with that offered to others, and whether sections 7 and 15 of the *Charter* can be relied on to assert these rights. In order to contrast the largely unsuccessful experience of disabled Canadian claimants, this part will also look at the right-based approach of American courts.

1. Section 15 Jurisprudence

Efforts to secure a greater commitment by the government vis-à-vis community care and programming might be pursued by way of *Charter* challenges. A claim that mental health consumers are being underserved by existing aftercare treatment programs, for example, could be supported by s. 15 of the *Charter*, which states that:

- (1) Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on...mental or physical disability.
- (2) Subsection (1) does not preclude any law, program, or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those who are disadvantaged because of...mental or physical disability.³⁹

In order to lodge a successful s. 15 claim, the mental health claimant would have to demonstrate that she is being denied “equal benefit of the law” as a result of her mental disability. Since discriminatory treatment is judged through a comparative approach, it would be necessary to contrast the experience of mentally ill persons with that of another “similarly situated” group.⁴⁰ The relevant comparator group would

³⁹ *Canadian Charter of Rights and Freedoms*, s. 15, Part I of the Constitution Act, 1982, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [*Charter*].

⁴⁰ See *Law v. Canada (Minister of Employment and Immigration)* [1999] S.C.J. No. 12 (S.C.C.), (QL) [Law].

likely be people with physical disabilities who are also in the position of requiring aftercare upon release from hospital. Where public housing and/or social assistance is concerned, the relevant comparator would be all others entitled to the benefit.⁴¹

In Nova Scotia in particular, some consumer advocates make the claim that individuals with physical disabilities have better access to aftercare programs and services than individuals with mental illness, although there is little quantitative evidence to back this up. For example, in his report on the Nova Scotia Community Based Options system of housing, Dr. Michael Kendrick notes a “net preference and priority in terms of people who get served” for individuals with intellectual or physical impairments.⁴² This imbalance is also evident in vocational and skills-training programs which are better equipped to assist those with physical disabilities, although enrollment is often higher among the mentally ill.⁴³

Still, using s. 15 to demand services on par with individuals who are physically disabled would be an uphill climb for mental health consumers. To succeed, differences in treatment would have to be tied directly to the functional values of the legislation. If the differential treatment reflects a stereotype about mentally ill persons or promotes the view that these individuals are less worthy of respect or dignity a *Charter* remedy may be granted, but otherwise the court will not “second guess policy decisions.”⁴⁴

⁴¹ See e.g. *Alcoholism Foundation v. Winnipeg* [1990] M.J. No. 212 (M.C.A.) (QL), where a city by-law making it illegal to build two group homes within a hundred metres of each other was found unconstitutional.

⁴² M. Kendrick, *An Independent Evaluation of the Nova Scotia Community Based Options Community Residential Service System* (Province of Nova Scotia: Prepared for the Nova Scotia Department of Community Services) at 153 [Kendrick]. Dr. Kendrick goes on to say that “[i]t was not possible for this evaluator to statistically verify this possibility though such an exercise would be useful.”

⁴³ Tooton gives the example of Nova Scotia’s Employability Assistance for People with Disabilities Initiative (EAPD) program which helps persons with disabilities accomplish secondary education. Although the majority of people in the program have mental health issues, Tooton notes that only one expert on staff specializes in this area. “When is the light going to go on?,” she says.

⁴⁴ Per Iacobucci J.: “human dignity is harmed when individuals and groups are marginalized, ignored, or devalued, and is enhanced when laws recognize the full place of all individuals and groups within Canadian society.” Law, *supra* note 40. See also *Law Society British Columbia v. Andrews* [1989] S.C.J. No. 6 at para. 65 (S.C.C.), (QL).

Recent s. 15 jurisprudence on the rights of physically disabled claimants demonstrates the pitfalls of using the *Charter* to challenge administrative decision-making with respect to aftercare. In the vast majority of these cases, the court has paid deference to ministerial judgment in allocating funds and developing service priorities. As long as discretion is exercised in a reasonable, non-capricious manner, the director or administrator of a social assistance plan,⁴⁵ extended care programme,⁴⁶ or nursing home⁴⁷ will escape *Charter* scrutiny.

Budget considerations are also given significant weight by the court. Canadian courts have consistently held that limited resources will excuse the government from accommodating everyone or accommodating everyone to the extent they would like.⁴⁸ This was the case in *Fernandes v. Manitoba (Director of Social Services)* where the Court held that it was not discriminatory to withhold funding for the severely disabled plaintiff to hire an expensive home care attendant, even though it meant an extended hospital stay for an individual who qualified for a government-sponsored program which would have enabled him to live in the community. *Fernandes* is one in a long line of cases where the Court has taken a hands-off approach where “political” decision-making and choices that “affect the public purse” are on the table.⁴⁹

Another possibility for mental health consumers would be to follow the *Eldridge* line of cases and argue that, although most aftercare programs do not *purposely exclude* the mentally ill, the manner in which these services are carried out has the *effect* of discriminating against people with mental health issues.⁵⁰ As LaForest J. notes in *Eldridge*: “the government will rarely single out disabled persons for discrimina-

⁴⁵ See *Conrad v. Halifax (County)* [1993] N.S.J. No. 342 (N.S.S.C.) (QL) [*Conrad*].

⁴⁶ See *R.R. v. Alberta (Child Welfare Appeal Panel)* [2000] A.J. No. 580 (A.Q.B.) (QL) [*R.R.*].

⁴⁷ See *Ontario Nursing Home Association v. Ontario* (H.C.J.) [1990] O.J. No. 2042 (O.H.C.J.) (QL).

⁴⁸ See e.g. *Lovelace v. Ontario* [2000] S.C.J. No. 36 (S.C.C.) (QL).

⁴⁹ (1992), 78 Man. R. (2d) 172 [*Fernandes*]. See also *Law*, supra note 40; *Lovelace*, *ibid.* note 48; *Miron v. Trudel* [1995] S.C.J. No. 44 (S.C.C.) (QL); Compare *Egan v. Canada* [1995] 2 S.C.R. 513.

⁵⁰ So-called “adverse effect” discrimination has been recognized by the Court in a number of s. 15 *Charter* challenges. See e.g. *Eldridge v. British Columbia (Attorney General)*, [1997] S.C.J. No. 86 (S.C.C.) (QL) [*Eldridge*]; *Eaton v. Brant County Board of Education*, [1997] 1 S.C.R. 241; *Vriend v. Alberta*, [1998] 1 S.C.R. 493.

tory treatment.”⁵¹ More common is when the state offers a benefit, but does so in an under-inclusive way. This is the case when a program purports to help *all* adults with disabilities, but dedicates more resources to one group than another.⁵²

A challenge along these lines would be possible, but may prove difficult and costly to litigate. Even if differential treatment could be shown, the claimant would still have to establish that discrimination is at the source of the distinction and that the benefit in question is “essential” and not merely “ancillary” to the right.⁵³ The problem is, of course, that few Canadian jurisdictions consider aftercare to be an essential service. This is reflected in the low priority given to community supports for adults and the fact few provinces make the legislative guarantee of the “least restrictive alternative”.⁵⁴ Accordingly, falling short in the provision of aftercare services would not engage section 15 in the same way it did in *Eldridge*, where access to medical care itself was at issue.

2. No Affirmative Right to Community Care

Unlike their American counterparts, Canadians with mental and physical disabilities do not have an affirmative right to receive support from the community so they can live independently or at least semi-autonomously. In fact, it is debatable whether informal patients have the right to treatment at all. Some claimants have suggested that not having the option of less restrictive care deprives them of “security of the person” and thus violates s. 7 of the *Charter*. The section reads as follows:

(7) Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.⁵⁵

⁵¹ *Eldridge*, *ibid.* at para. 64.

⁵² The EAPD program mentioned in note 43 is a prime example.

⁵³ *Eldridge*, *supra* note 50 at para. 71. The Court held that being able to communicate with doctor is essential to getting medical treatment, and thus sign language translators do not amount to an “ancillary” service.

⁵⁴ This is discussed at length in part three – Nova Scotia as a Case Study.

⁵⁵ *Charter*, *supra* note 39 at s. 7.

Unfortunately, the vast majority of these claims have failed, largely because of the Supreme Court's conservative stance on s. 7 rights. In the monumental decision of *Irwin Toy Ltd. v. Quebec (A.G.)*, the Court made it clear that s. 7 does not include property rights or rights of a purely economic nature.⁵⁶ While there are some exceptions, they are extremely limited. For example, the Court has held that a person's right to "psychological integrity" (which is included in the s. 7 guarantee) may have an economic component, but this aspect cannot be dominant.⁵⁷

The Court's rigid position makes it highly unlikely that an individual with mental illness would be able to rely on s. 7 to assert a right to community care, and recent s. 7 claims brought by physically disabled claimants have done nothing to suggest otherwise. If the court in those cases was not convinced that entitlements like social assistance,⁵⁸ home nursing,⁵⁹ and summer camp for children with cerebral palsy⁶⁰ were anything other than pure "economic rights," it is unlikely similar claims by mentally ill individuals would be viewed any differently. While the *Charter* is able to provide "freedom from" discrimination that affronts the dignity of individuals; it is less likely to guarantee "freedom to" a range of entitlements which might improve the lives of these same individuals.

3. The American Experience

The situation for claimants is more promising in the United States, largely because of the *Americans with Disabilities Act (ADA)* which became law in 1990, and the "due process" clause of the Constitution.⁶¹ Similar to our section 15, Title II of the *ADA* proscribes that no qualified individual with a disability be denied benefits and services "by reason of

⁵⁶ [1989] S.C.J. No. 36 (S.C.C.) (QL).

⁵⁷ *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man.)*, [1990] S.C.J. No. 52 at para 57 (S.C.C.) (QL). In this case, Lamer J. makes a distinction between the right to work, which is strictly economic, and the right to pursue a livelihood which has non-economic aspects.

⁵⁸ *Conrad*, *supra* note 45 at para. 70.

⁵⁹ *Fernandes*, *supra* note 49.

⁶⁰ *R.R.*, *supra* note 46.

⁶¹ *Americans with Disabilities Act of 1990*, 42 U.S.C.A. § 12101 (1990).

such disability.”⁶² The *ADA*, however, goes beyond the “*freedom from*” justice offered by the *Charter*, mandating that all “public entit(ies)...administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”⁶³

The *ADA* makes treatment in the least restrictive manner a right, albeit one subject to limitations. According to *Olmstead v. L.C.*, the U.S. Supreme Court’s authoritative interpretation of section 35.130 (the so-called “integration regulation”), states are required to provide community-based resources when:

- (a) The State’s treatment professionals determine placement to be appropriate;
- (b) The affected persons do not oppose such treatment;
- (c) Placement can be reasonably accommodated taking into account the resources to the State and the needs of others with mental disabilities.⁶⁴

If each of these criteria are met, the State is required to accommodate the disabled person in “a setting that enables (the) individual...to interact with non-disabled persons to the fullest extent possible.”⁶⁵

Of the three *Olmstead* requirements, the third poses the greatest obstacle to claimants. Budgetary constraints, however, may relieve the State of its duty to accommodate the plaintiff only temporarily. Once the State can fulfill its obligations to the claimant without sacrificing the interests of other mentally disabled persons, it must proceed with the placement.⁶⁶ In the meantime, the State is expected to demonstrate that it has an “effect(ive) working plan” and a “waiting list that (moves) at a reasonable pace.”⁶⁷ This is a far cry from s. 15 *Charter* jurisprudence, where virtually any claim pertaining to underinclusive legislation can be trumped by the government playing the financial stringency card.

Determining whether or not the State has the funds to make good on reintegration efforts involves a delicate calculus. Rather than looking at

⁶² *Ibid.* at §12132.

⁶³ *Code of Federal Regulations* 28 C.F.R. §35.130 (1990).

⁶⁴ *Olmstead v. L.C.*, 119 S. Ct. 2180 (1999) [*Olmstead*].

⁶⁵ *Ibid.* at 2185

⁶⁶ *Ibid.* at 2189.

⁶⁷ *Ibid.*

only how much it would cost to reintegrate the claimant, the court will consider the expense of modifying the State's programs to accommodate others who fit into the same category. If "the requested modification would cause a 'fundamental alteration' of a state's services and programs," the State will be able to justify the delay in placement.⁶⁸ Justice Ginsburg refers to this as the State's "affirmative defense."⁶⁹

IV. NOVA SCOTIA AS A CASE STUDY

Despite a long-standing commitment to using community programs to assist and rehabilitate Nova Scotians with mental illness, complaints that many of these individuals are falling through the cracks are as pervasive as ever. In May 2000, Dr. Roger Bland and Dr. Brian Dufton released *Mental Health: A Time for Action*, a detailed report prepared on behalf of Nova Scotia's Department of Health (DoH).⁷⁰ Considering the no less than thirty-six white papers and studies that came before it, the report was aptly named: "[T]he title of the report captures a strong theme...that it is high time to take action and that there has been enough talk and more than enough analysis of problems."⁷¹

Bland and Dufton found a system that is in many places underfunded, poorly organized, and out of touch with the mental health consumer. Due to the split jurisdiction between the Department of Health (which handles psychiatric in-patient care and treatment) and the Department of Community Services (which handles aftercare services like housing and welfare), there is a sense of fragmentation which can be dizzying to the consumer. With few legislative guarantees in place, Nova Scotians with mental illness have had to rely mainly on political pressure and activism to encourage the government to address shortcomings in the system. As one might expect, this has been a slow and grueling process. While some have found supportive community housing, effective counseling services, and long-term treatment programs,

⁶⁸ *Ibid.* at 2188.

⁶⁹ *Ibid.* note 64.

⁷⁰ Bland & Dufton, *supra* note 13.

⁷¹ Bland & Dufton, *supra* note 13 at 5.

many others have been neglected, lost in the shuffle, and left to fend for themselves.

1. Few Legislative Guarantees

Nova Scotians with a mental illness who have been discharged from the hospital face an uncertain future. While there are programs to ease the transition from hospital to community living, there are few statutory assurances where aftercare services are concerned. For those committed as involuntary patients under the *Hospitals Act*, there is no promise of the “least restrictive alternative” and no guarantee of treatment consistent with mental health “best practices”.⁷²

The *Hospitals Act* provides for methods of discharge but is silent on what happens to the patient following release.⁷³ Once a review board determines that a patient should not continue to be detained: “the facility shall take such action as is required to give effect to such determination” or the patient may remain as an informal patient,⁷⁴ subject to the written consent of a qualified medical practitioner.⁷⁵ Presumably, the actions required to effect release are something more than a handshake and a shove in the right direction, but neither the *Hospitals Act* nor the Regulations enacted pursuant to the *Act* elaborate on this.

Once returned to the community, discharged patients will in many cases receive income support pursuant to the *Employment Support and Income Assistance Act (ESIAA)*.⁷⁶ Under the *ESIAA*, benefits for individuals with disabilities are calculated on the same scale as “normal” adults, with additional funds for medication and other special needs. Individuals who qualify for housing assistance through the Department of Community Services (DoCS) may be placed in a licensed group home or small option home, depending on availability. Many care

⁷² *Hospitals Act*, R.S.N.S. 1989, c. 208. For admission procedures, see sections 34-36 in particular.

⁷³ *Ibid.* at ss. 47, 63-65.

⁷⁴ *Ibid.* at s. 68

⁷⁵ *Ibid.* at s. 34(4)

⁷⁶ *Employment Support and Income Assistance Act*, R.S.N.S. 2000, c. 27.

homes in Nova Scotia are administered under the *Homes for Special Care Act*, which provides for licensing procedures and basic care standards.⁷⁷

2. Mental Health Programs and Policies

i. Housing and Residential Care

Before an individual can receive a housing placement, they must first be approved by the Community Supports for Adults section of the DoCS. This involves a lengthy classification process which Bland and Dufton call “cumbersome and antiquated.”⁷⁸ The potential recipient is expected to disclose current financial information as well as undergo a twelve-page psychosocial assessment.⁷⁹

Based on the results of the assessment, a case worker determines whether the individual qualifies for placement. If so, they are assigned to an appropriate care home. The process, however, is a lot less scientific than it might appear. Since there are long wait lists for virtually all placements and programs, the matching process usually comes down to “not what’s the best option, but what’s available,” in the words of one DoCS case worker.⁸⁰ As a result, consumers often find themselves in large, institutional-seeming residences which are unable to meet their individualized needs, forced to live with other people who have been stamped with the “same label.”⁸¹

Funding for licensed group home and long-term residential care homes is provided on a *per diem* basis,⁸² meaning there is constant pressure to fill beds as soon as they become available. This encourages home operators to accept individuals blindly, regardless of whether their residence would make a good “fit”. Those unhappy with their placement

⁷⁷ N.S. Reg. 73/93, ss. 29-55.

⁷⁸ Bland & Dufton, *supra* note 13 at 16.

⁷⁹ Townsend, *supra* note 26. Examples of typical questions asked: “can you dress yourself” and “can you do your own toileting”?

⁸⁰ Townsend, *supra* note 26.

⁸¹ Kendrick, *supra* note 42 at 85-87.

⁸² “Per diem” refers to the set amount the care home receives from the DoCS for each additional resident.

or unwilling to live in a “highly structured” group home setting⁸³ can choose instead to find their own accommodations. More often than not, this can mean living in a slum-like apartment, boarding home, or worse still – on the streets.

ii. Treatment

Studies indicate that continuity of treatment can vastly improve chances of successfully reintegrating into the community following release.⁸⁴ For mental health consumers in Nova Scotia, aftercare treatment is available on a variety of fronts. The DoH offers adult out-patient programs which include drug dependency programs, while the DoCS offers emergency services and legal services. Help is also available from non-profit agencies like the Canadian Mental Health Association, which offer advocacy and skills training.

Although outreach programs such as the “Clubhouse” network run by the Department of Health tend to be comprehensive and well-run, there are not enough of these programs to meet the need, especially in rural areas.⁸⁵ Especially lacking are assertive community treatment programs, to ensure that discharged patients continue to take their medication and meet their recovery schedule.⁸⁶

Without an adequate system of case management, it is common for psychiatrists and nursing staff to “lose touch” with a patient once they leave the hospital. The problem is compounded by the “split jurisdiction” between Health and Community Services. In the event an individual is forced to return to hospital, their file will be passed back to the DoH, only to be passed back again to the DoCS upon discharge. This elaborate game of departmental “hot potato” only serves to confuse patients and disrupt recovery efforts.

⁸³ Tooton, *supra* note 20. While some find the regimen imposed by many group homes to be “comforting” others find these arrangements to be overly paternalistic and at times disrespectful. At some care homes, for example, residents are asked to leave in the morning and are not allowed to return until 5 pm.

⁸⁴ H. Branswell, “Patients benefit from continuity of care, researchers show readmittance less likely with access to discharge records” *The [Halifax] Chronicle-Herald* (2 March 2002) A9.

⁸⁵ Bland & Dufton, *supra* note 13 at 20.

⁸⁶ Bland & Dufton, *supra* note 13 at 16.

iii. Reintegration

As Justice Ginsburg suggests in *Olmstead*, the most “integrated setting” is one where there is ample opportunity to interact with non-disabled individuals. Unfortunately, this is often not possible in Nova Scotia where highly structured, congregate settings are the norm and smaller, more personalized options are increasingly scarce. As Kendrick suggests in his report on Community Based Options⁸⁷ (CBOs), the province has gone from being a leader in the field and emphasizing CBOs, to shelving many of these efforts in favour of group homes and long-term care facilities.⁸⁸

The lack of CBOs creates a ripple effect throughout the system: individuals in group homes have to wait for a more integrated placement, individuals in hospital have to wait for a space to open in a group home, and individuals in the criminal justice system deemed not criminally responsible (NCR) have to wait in jail⁸⁹ until a psychiatric bed becomes available. For psychiatric patients and NCR offenders especially, the waiting game can entail a significant loss of freedom. NCR offenders spend their time behind bars, while psychiatric patients are forced to remain in acute units or are placed under adult protection until a community placement becomes available.⁹⁰ This is unpleasant and can further stigmatize an individual as “crazy”, making it even more difficult to gain acceptance in the mainstream.

The DoH established the “Clubhouse” system to help ease the transition process and foster a sense of belonging and community often missing in large, impersonal residences. At the Connections Clubhouse in Halifax for example, members can sign up for a job placement service, get computer training, buy second-hand clothes, find an apart-

⁸⁷ This term refers to housing arrangements where two or three disabled individuals live together, sometimes with a supervisor or non-disabled person(s) as well. CBO’s are often unlicensed and sometimes nothing more than a room rented out in a family home. Small group homes, supported apartments, adult shared living, and adult family care are all examples of CBO’s.

⁸⁸ Kendrick, *supra* note 42 at 14, 51-52.

⁸⁹ This has become increasingly rare since a new forensic psychiatric hospital opened near Halifax in October 2001.

⁹⁰ Bland & Dufton, *supra* note 13 at 17. Pam Townsend says people waiting to be discharged may be given priority over individuals outside the formal system awaiting placement – but only if the person is considered “high risk”.

ment, as well as socialize with friends in the common room or barbecue on the back deck. Being able to drop in for support and friendship makes facing life post-discharge more manageable and imbues a sense of hope. As one member puts it, “this is the place people go to find out they can do something.”⁹¹

3. Restructuring Efforts

Health system reform has been on the government agenda for nearly a decade, but mental health services in Nova Scotia have changed very little during this time. In 1994, the *Blueprint for Health System Reform* recommended that significant changes be made to the way health services are administered in the province, noting “our health system needs substantial renovations, not just minor changes.”⁹²

i. Community Support Model

Among suggestions for improving mental health services in the province, the *Blueprint* Committee recommended adopting the “Community Support Model”. The Model stresses a collaborative approach to planning and implementing care initiatives, with maximum flexibility to accommodate the needs of individual consumers.⁹³

The government responded to the *Blueprint* by completely overhauling the administrative structure of health care in the province. Responsibility for planning and implementing health services was placed in the hands of nine District Health Authorities (DHAs), with a network of Community Health Boards (CHBs) at the ground level. This helped make the system more responsive to the needs of particular regions and freed up resources in the provincial capital to focus on high level planning.

⁹¹ Interview of “Leanne” and “Patrick”, Clubhouse members, (1 March 2002) by author.

⁹² Nova Scotia, *Blueprint for Health System Reform* (Blueprint Committee, 1994) (Chair: D. R. MacLean) at 8 [*Blueprint*].

⁹³ *Ibid.* at 32.

Unfortunately, the new structure has not had much effect on the lives of Nova Scotians with mental illness, nor has it brought the province any closer to achieving the Community Support Model. In fact, Tooton suggests we are not even “1%” towards recognizing this goal.⁹⁴ In 2000, Bland and Dufton called on the province to make good on their pledge to bring the Community Support Model to life in Nova Scotia.⁹⁵

The reality is that institutionalization and rehabilitation, rather than community-based treatment, continue to be the primary focus of the Department of Health. Despite calls to enlarge the role of informal caregivers such as friends, family, and neighbours, the government has not introduced mechanisms or incentives to make this happen.⁹⁶ Suggestions by the *Blueprint* Committee to establish a tax credit system for those who care for loved ones in the home, and to provide service allowances so that families can afford to hire a trained attendant, for example, have yet to materialize.⁹⁷

There continues to be a feeling that consumers do not have a voice in the process of designing and implementing mental health care. The introduction of CHBs has helped because there tends to be grassroots support for mental health initiatives at this level.⁹⁸ Still, the consumer perspective can only truly be taken into account when it comes straight from the consumer/survivor. There have been few concerted efforts to make sure this happens.⁹⁹ Without the input of survivors who can attest to the need for community-based care, many of these initiatives are doomed to fall victim to cost-cutting bureaucrats.

ii. Funding

Limited funding continues to stand in the way of new initiatives. Of the \$626 million designated for the DoCS in the 2001-2002 Budget estimates, \$124 million was supposed to go towards “community supports

⁹⁴ Tooton, *supra* at note 20.

⁹⁵ Bland & Dufton, *supra* note 13 at 16.

⁹⁶ See *Blueprint*, *supra* note 92 at 35; Kendrick, *supra* note 42 at 49-52.

⁹⁷ *Blueprint*, *supra* note 92 at 37.

⁹⁸ Bland & Dufton, *supra* note 13 at 24.

⁹⁹ Tooton notes that on one committee assembled to look at consumer-led initiatives, fewer than 50% of committee members are consumers!

for adults”.¹⁰⁰ These numbers are roughly in line with spending over the last few years.

Kendrick suggests that significant cost savings could be achieved by diverting more money to CBOs instead of into residentializing people, which he considers an unsustainable practice.¹⁰¹ The DoCS insists this is already happening. One case worker told me that “all of our gross has been in the smaller settings,” with the real problem being “there are not enough resources to go around.”¹⁰²

To make better use of existing funds, the *Blueprint* suggests integrating all sources of provincial funding for mental health services into a single envelope to be administered by the CHBs.¹⁰³ Bland and Dufton disagree, contending that segregating mental health from other health care services would produce a shortfall because money would inevitably gravitate to more “glamorous” health care priorities.¹⁰⁴ Regardless of which option is preferable, only a shift in spending priorities will accomplish what aftercare services in the province need most – a fresh infusion of funds.

iii. Continuity, Coordination and Cooperation

Psychiatric in-patients discharged in Halifax hospitals are more likely to receive effective aftercare treatment today than they would have five years ago, thanks to recent hospital-led initiatives. The “Share Care” program run by Queen Elizabeth II Hospital (QEII) in downtown Halifax is a prime example. Working in association with general practitioners and social workers from the Connections Clubhouse, QEII psychiatric nurses visit local shelters to monitor progress and distribute medications where necessary.¹⁰⁵ This prevents discharged patients from “losing touch” with the formal system. Greater continuity of care in turn

¹⁰⁰ Nova Scotia, *Estimates for the fiscal year 2001-2002* (Nova Scotia: Department of Finance, 2001) (The Hon. N.J. LeBlanc, Minister of Finance).

¹⁰¹ Kendrick, *supra* note 42 at 49-52.

¹⁰² Townsend, *supra* note 26.

¹⁰³ *Blueprint*, *supra* note 92 at 34.

¹⁰⁴ Bland & Dufton, *supra* note 13 at 22-24.

¹⁰⁵ Tooton, *supra* note 20.

helps prevent “revolving door” syndrome and tragic stories like that of Jeffrey Arenburg.

The drawback of Share Care, like many programs of this type, is that it only serves those classified as having a “severe and persistent mental disorder,” while leaving less chronic patients without much assistance.¹⁰⁶ To be sure, there are many concerned hospital staff who go out of their way to help patients chart the next steps on the road to reintegration. This sort of assistance, however, is not mandated by the DoH – it is strictly voluntary. The unfortunate reality, says housing expert Carol Evans, is that clinicians reach out to staff at agencies like the Metro Community Housing Association “only if they have the will” to do so.¹⁰⁷

A lack of coordination between the DoH and the DoCS serves as a further obstacle for mental health consumers. Despite criticism of fragmentation brought on by Nova Scotia’s split jurisdiction for mental health services, there have been few attempts to make the system more seamless. Kendrick’s suggestion of administering treatment and after-care within a single Mental Health Commission has gone ignored by all but consumer advocates.¹⁰⁸ As a result, discharged patients have to cope with needless bureaucracy and the run-around of dealing with several different offices. Few know this better than individuals who have returned to hospital after time in the community. Once hospitalized for more than thirty days, a patient ceases to be the responsibility of the DoCS, meaning the individual’s housing placement is lost. Even upon leaving the hospital the discharged patient cannot pick up where they left off – the DoCS requires that they be reclassified and sends them to the back of the line for a residential placement.

V. POSSIBILITIES FOR REDRESS

There are several avenues open to mental health consumers who feel they are not being adequately served by the present system. Where an

¹⁰⁶ Tooton, *supra* note 20.

¹⁰⁷ Interview of Carol Evans, Executive Director of the Metro Community Housing Association in Halifax (27 February 2002) by author [Evans].

¹⁰⁸ Kendrick, *supra* note 42 at 156.

administrative decision is the source of the problem, an individual can appeal to a provincial ombudsman and ask for relief directly from the government.¹⁰⁹ There is also the possibility of taking “matters into one’s own hands” by pursuing litigation. This option might appeal to an individual who has been hospitalized past the date of being cleared to leave, or to someone who has been discharged but has floundered in their new surroundings – both situations arising due to a lack of community placements and supports.

While successful tort actions may spur on legislators wary of future lawsuits, statutory reform provides a more direct route to increasing the level of community-based supports. Two possible reforms are explored here: amending mental health legislation across the country to include a promise of the “least restrictive alternative”, and fleshing out this guarantee through a “Patients’ Bill of Rights” for individuals with disabilities. The notion of achieving both through Comprehensive Mental Health Legislation (CMHL) will also be examined.

1. Civil Actions

There are at least three possible scenarios in which a disgruntled psychiatric in-patient or former in-patient might bring a civil action. The first scenario involves a standard “medical malpractice” claim, arising from negligent treatment on the part of a psychiatrist or other care professional. Since this scenario does not speak to the issue of community-based care it will not be explored further.

The second scenario is a variation on the first. Here, the psychiatric in-patient has been cleared to leave the hospital but cannot do so because of financial constraints, either his own or the department responsible for community placements. Adducing evidence about the deleterious effects of institutional confinement, the would-be plaintiff contends that he has been harmed by a course of treatment not suited to his needs, and that the government or hospital’s failure to provide a less restrictive option amounts to negligence. This was essentially the

¹⁰⁹ Gray, Shone & Liddle, *supra* note 38 at 59. Where the individual is being discriminated against in the provision of private services and/or accommodation, they might also bring a complaint pursuant to relevant provincial Human Rights legislation.

appellant's position in *Fernandes*, although that case was framed in constitutional terms.¹¹⁰

There have been few attempts in Canada to seek damages where hospitalization has carried on for too long, although claims of this sort have been brought in the United States.¹¹¹ The reason is that few Canadian courts acknowledge the "least restrictive alternative" as the standard of care owed to psychiatric in-patients. This might change if the "least restrictive alternative" was given expression in provincial mental health statutes, or in separate legislation dealing with patients' rights. Both these possibilities will be discussed in the next section.

Should "over-hospitalization" claims become viable, it may be advantageous, where legislation permits, for several plaintiffs to raise their grievances together in a class action suit.¹¹² If one person is denied a placement in the community owing to limited social service resources, it is likely that others are similarly affected. Lynn Pierce argues in favour of the class action route, noting that "strength in numbers" is especially important for mentally ill claimants who may lack the financial resources to bring a challenge on their own.¹¹³ Class actions would also make sense for mental health consumers because the awareness generated by such claims might encourage legislative reform.

The third scenario where a psychiatric in-patient might bring a civil action involves harm that occurs after treatment, once an individual has been released into the community. As discussed earlier, moving from an institution to the community is a leap that many do not make successfully. Little or no emphasis on discharge planning and continuity of treatment following release stack the odds against smooth reintegration. Some are able to make the transition and never look back; others flounder in their new surroundings and end up living in filth and squalor, penniless and without hope.

¹¹⁰ *Fernandes*, *supra* note 49. Although the plaintiff Mr. Fernandes is physically disabled, not mentally ill, his case is still germane to a discussion of civil remedies for those who remain institutionalized against their will.

¹¹¹ See e.g. *Brewster v. Dukakis*, 544 F. Supp 1069 (1982); *New York ARC v. Carey*, 393 F. Supp. 715 (E.D.N.Y. 1975).

¹¹² Currently only British Columbia, Ontario, and Quebec have legislation that provides for class action lawsuits. See e.g. *Class Proceedings Act*, R.S.O. 1992, c. 6.

¹¹³ See L. Pierce, "Raising the Roof on Community Housing for People with Disabilities: Class Actions in Canada" (2000) 6 Appeal: Review of Current Law and Law Reform 22.

If the plight of someone in the latter category is the result of poor discharge planning or the non-delivery of aftercare services, it may be possible for the aggrieved individual to sue in tort. This sort of case would hinge on the plaintiff drawing a causal connection between the doctor or care provider's omission and the harm which ensued. The plaintiff's case would also rest heavily on the notion that support in the community is indispensable to coping with and recovering from mental illness – not a bold assertion in light of all the empirical evidence about the aftermath of deinstitutionalization, outlined above. Failing to plan for discharge or facilitate re-intake into the community would thus amount to a breach of professional responsibility by the attending psychiatrist or by the hospital itself.

Although few cases have been tried along these lines, the idea has support within academic circles. Jonathan Bach suggests that the common law "recognizes a continuing duty of care that extends beyond the technical termination of the patient's institutional stay," and that failing to plan for an in-patient's future past the date of release "exposes a recipient of aid to reasonably foreseeable harm."¹¹⁴ Similarly, Gray notes that community treatment requirements may exist in certain provinces by virtue of legislation relating to leave certificates and CTOs. For example, a leave certificate cannot be issued in Manitoba unless the course of treatment described in the certificate "can and will be provided in the community."¹¹⁵

Still, it is unlikely that these actions would succeed in Canada because of the court's reluctance to impose duties on administrative decision-makers that do not arise directly from statutes.¹¹⁶ Furthermore, where there is a duty to be met, the court will generally look to statutory standards to determine the level of care required – standards lacking in provinces like Nova Scotia.¹¹⁷ In other words, unless a physician acted with complete disregard for the interests of his patient, it is unlikely the court will view his inaction as tortious, even if it is indisputably "negligent" in the colloquial sense.

¹¹⁴ Bach, "Deinstitutionalization", *supra* note 15 at 1161.

¹¹⁵ Gray, Shone & Liddle, *supra* note 38 at 309-310.

¹¹⁶ Gray, Shone & Liddle, *supra* note 38 at 310.

¹¹⁷ The position most frequently taken in Canadian courts is that "breach of a statutory provision is *prima facie* evidence of negligence." See A.M. Linden & L.N. Klar, *Canadian Tort Law: Cases, Notes & Materials*, 11th ed. (Toronto: Butterworths, 1999) at 191-193.

2. Legislative reform

i. The Least Restrictive Alternative

The “least restrictive” or “least intrusive” alternative refers to a set of circumstances in which the psychiatric patient’s freedom and autonomy is interfered with only to an extent commensurate with his or her medical need.¹¹⁸ The “least restrictive alternative” is not the same thing as the “ideal” or “perfect” alternative because this would necessarily entail not having an illness in the first place. Rather, the “least restrictive alternative” is a workable compromise between the paternalistic impulses of the state and the liberty interests of the individual.

Among Canadian jurisdictions, Manitoba, the Northwest Territories, and Nunavut offer a legislative guarantee of the “least restrictive alternative”.¹¹⁹ The spirit of the “least restrictive alternative” is also represented in the Preamble to New Brunswick’s *Mental Health Act*,¹²⁰ and in Criminal Review Board hearings for individuals found NCR, where the Board must balance the interests of public safety with the rights of the accused to be placed in “the least onerous and least restrictive” setting.¹²¹ Principles of the least restrictive alternative have been given wide application in the United States, with fourteen states adopting the concept as part of their legislative framework.¹²²

Adding the least restrictive alternative to mental health legislation in Nova Scotia would help generate momentum for community-based care in several ways. First, it would send a message to health care providers that the rights of psychiatric in-patients matter, and that knee-jerk institutionalization is no longer an option. On a more operational level, patients seeking discharge could rely on a least restrictive clause to buttress their case for release. For example, mandating that psychiatric review boards consider the least restrictive alternative would have a

¹¹⁸ At least, this is how I wish to define the “least restrictive alternative” for the purposes of this paper.

¹¹⁹ See Preamble of the *Mental Health Act*, R.S.N.W.T. 1988, c. M-10; *Mental Health Act*, R.S.M. 1998, M110, s. 28(5)(d).

¹²⁰ S.N.B. 1997, c. M-10.2.

¹²¹ *Criminal Code*, R.S.C., c. C-46, s. 672.54.

¹²² Bach, “Deinstitutionalization”, *supra* note 15 at 1160.

significant influence on these proceedings.¹²³ The legislation could even go so far as creating a presumption of community care, unless it is otherwise shown that the individual is a danger to herself or others.¹²⁴

A guarantee of the least restrictive alternative would also encourage better aftercare planning and treatment, by raising the standard of care expected of hospitals and care providers (discussed in the previous section). The standard set by the statute, although not determinative, would at least influence the court's perception of what is "reasonable." For example, if an individual's needs are best met in the community, but there has been no attempt to accommodate individuals of this type in their area of settlement, the local municipality or social service department might be held accountable. This could inspire lawmakers to get serious about community care and the provision of affordable housing.

The Law Reform Commission of Nova Scotia recently considered the possibility of adding a "least restrictive" clause to the *Hospitals Act*, but found doing so would "create the potential for confusion" because the notion of the least restrictive alternative is "unduly broad".¹²⁵ This may very well be the case, but only if the least restrictive clause was introduced on its own, without any other changes or additions to Nova Scotia's mental health laws. A more comprehensive approach would answer to the Commission's criticism, as well as help bring the *Hospitals Act* in line with *Charter* values.¹²⁶ This would include a clear enunciation of principles by which mental health care will be measured, as well as a set of "best practices" for hospitals in particular to help realize this vision.

ii. *Patients' Bill of Rights*

Introduced on its own, it is unlikely that creating a statutory right of the least restrictive alternative in Nova Scotia would provide the necessary

¹²³ For example, the clause could be inserted under s. 63 of the *Hospitals Act* which explains the "function and authority of (a) review board": *Hospitals Act*, *supra* note 72.

¹²⁴ The presumption of community care exists in New Zealand where hospitalization is only resorted to if it can be shown that a Community Treatment Order would be inappropriate in the circumstances. See Gray, Shone & Liddle, *supra* note 38 at 241-242.

¹²⁵ Nova Scotia, *Discussion Paper: Mental Health Provisions of the Hospitals Act* (Halifax: Law Reform Commission of Nova Scotia, 2000) at 95.

¹²⁶ J. Galipeault, J. Hughes, H.A. Kaiser, "A Giant Step Backwards" (22 November 2000) [unpublished; submitted to the Nova Scotia Law Reform Commission].

impetus for a restructuring of service priorities by the provincial government. In order to move things in this direction, the government's commitment to community-based care must be set down in a quasi-constitutional document, such as a Patients' Bill of Rights, or what Gray refers to as Comprehensive Mental Health Legislation (CMHL).¹²⁷

Although space does not permit a full discussion of what a Patients' Bill of Rights or CMHL should include, there are certain fundamentals that can be touched on briefly. A Patients' Bill of Rights should affirm the dignity of all individuals with mental illness. It should acknowledge the duty of the state to protect individuals with mental illness from exploitation and abuse, while at the same time respecting the right of these individuals to live freely in the community.¹²⁸ It should recognize that mental health is closely connected to other aspects of daily life, such as work, education, diet, and recreation.¹²⁹ There must be a commitment to preventative care and early intervention, as well as to offering the "least restrictive alternative" in the event compulsory treatment is required. A Patients' Bill of Rights should allude to the fact that discharge planning is indispensable to making the transition from hospital to the community, while CMHL could provide for administrative mechanisms needed to ensure this planning takes place.

In addition to a general Patients' Bill of Rights, Nova Scotia should follow Kendrick's recommendation of adopting specific standards which will govern the operation of CBOs.¹³⁰ In November 1996, the DoCS released a set of interim standards for CBOs¹³¹ but have yet to settle on a final version. It is imperative that specific guidelines be imposed on CBOs, especially because many of these arrangements are unlicensed and not subject to inspections like other residences under the *Homes for Special Care Act*.

¹²⁷ Gray, Shone & Liddle, *supra* note 38 at 313.

¹²⁸ B. Hoggett, *Mental Health Law*, 4th ed. (London: Sweet & Maxwell, 1996) at 205-206 in *Ibid.* at 314.

¹²⁹ Gray, Shone & Liddle, *supra* note 38 at 315.

¹³⁰ Kendrick, *supra* note 42 at 152.

¹³¹ Department of Community Services, News Release, "Interim Standards Released" (26 November 1996).

VI. CONCLUSION

So the Eternal's anger blazed against Israel, and he made them wander up and down the desert for forty years, till all the generation that had done evil in the sight of the Eternal had perished.

Numbers 32: 13

It has been a long and often painful forty years for Canadians with mental illness since deinstitutionalization efforts got underway on a wide scale in the 1960s. While some have reached the "promised land" and found healthy, productive lives in the community, many others have been "left adrift" by a health care system which has often failed to recognize that community support and nurturing are as essential, or more essential, to well-being than all the world's psychotropic drugs put together. Still others have seen their hopes and dreams of living in the "mainstream" or receiving the "least restrictive alternative" dashed by inadequate funding or shortsighted legislative priorities.

Justice for these individuals, it seems, starts with the recognition that community-based care and treatment is a right, not just some loosely-worded promise which is subject to endless qualification. Since it is unlikely this right will emerge from *Charter* jurisprudence or test cases, it is incumbent on Canadian lawmakers to take the lead and pursue 21st century solutions for people with mental illness, rather than quick fix "institutionalizing" or "residentializing". Passing a comprehensive Patients' Bill of Rights would be a step in the right direction as would amendments to provincial mental health legislation which create a presumption of the "least restrictive" care and make discharge planning mandatory.

In Nova Scotia, the writing is on the wall: the current system is failing mental health consumers. Another report or white paper need not be unveiled to tell the government what Nova Scotians with mental illness have known for a long time – that housing and aftercare services in the province, while excellent where they can be found, are nowhere close to meeting their need, and that "a deep sense of despair" exists as a result.¹³² It is only when a true path is created for these individuals that they will be able to end their wandering, and experience the "milk and honey" of justice and opportunity.

¹³² M. Lightstone, "Disabled bemoan inaction on group homes" The [Halifax] Chronicle-Herald (15 February 2002).