Dalhousie Law Journal

Volume 5 | Issue 2 Article 11

5-1-1979

New Developments in Nova Scotia Psychiatric Legislation

Lorne E. Rozovsky

Lorne E. Rozovsky*

New Developments in Nova Scotia Psychiatric Legislation

1. *Background*

Depsite advanced developments in the treatment of mental illness, Nova Scotia has until recently possessed some very archaic mental health legislation. The law treated the mentally ill patient differently depending on the institution in which he happened to be placed regardless of his diagnosis. Patients in general hospitals for psychiatric disorders fell within the jurisdiction of the Public Hospitals Act, and were treated no differently than physically ill patients.[1] Patients who were sent to the Nova Scotia Hospital, a psychiatric institution owned by the province fell within the Nova Scotia Hospital Act.[2] It contained provisions on compulsory and voluntary admission, quite different from those under the Public Hospitals Act, where compulsory admission was not possible.

The criteria for compulsory detention and treatment under the Nova Scotia Hospital Act were broad. It was necessary for the patient to be considered to have a mental disorder and that he should be admitted to the Nova Scotia Hospital, either because he required the in-patient facilities for observation, diagnosis or treatment, or that he required care that could not adequately be provided outside the hospital for his own health or safety, or for the protection of others. In addition, it was necessary that the patient, in the opinion of a medical practitioner, be certified because his mental status and lack of insight was such that he did not understand or was unwilling to accept the fact that he required admission to the hospital. Two medical certificates stating these factors were required.[3]

Therefore compulsory admission was effected by physicians outside the hospital itself. There were no provisions for regular reviews except that of a review by the hospital itself, prior to the anniversary date of the admission. There was, however, provision for judicial review on application.

---

*Lorne Elkin Rozovsky, B.A. LL.B., former Legal Counsel to the Nova Scotia Department of Health. This paper was originally presented before a national meeting of the Provincial Directors of Mental Health Services in St. John's Newfoundland, on June 14, 1978.

1. R.S.N.S. 1967, c. 249
2. R.S.N.S. 1967, c. 210, ss. 13-21
3. *Id.* at s. 16

If however, the patient was suffering from a long-term psychiatric illness he could be committed to one of three municipal mental hospitals and fall under the jurisdiction of the Municipal Mental Hospitals Act.[4] The criteria for admission under that act were even broader than those under the Nova Scotia Hospital Act. They were that the person was mentally disordered, was not a suitable person to be admitted to the Nova Scotia Hospital and was suitable to be admitted to a municipal mental hospital.[5] The only check on this very broad discretion of a physician outside the hospital was that a provincial official, the Inspector of Municipal Mental Hospitals, had to agree to all admissions. This Act as well had provisions for judicial review.

Neither the Nova Scotia Hospital Act nor the Municipal Mental Hospitals Act specifically outlined any particular civil rights and as a result the percentage of patients detained against their will was extremely high.

As a result of these problems and certain abuses which were uncovered by the MacKeen Royal Commission[6] it was felt necessary to begin research into new mental health legislation. This work commenced in 1967 and finished with the passage of amendments to the Public Hospitals Act in 1977 and the subsequent drafting of regulations leading up to proclamation.

II. *Principles*

The new psychiatric legislation is based on two principles. The first is that legislation should treat mental illness as much as possible as physical illness. While it is recognised that there are certain major differences, any attempt to treat mental illness or those suffering from it differently from the physically ill should be taken only with extreme caution, and circumscribed with legal safeguards.

The second principle is that legislation should treat psychiatric hospitals in the same manner as general hospitals, except where the nature of their speciality requires unique provisions. For this reason it was felt that there should not be a special statute dealing with mental illness. Nor should hospitals specializing exclusively in psychiatric disorders fall under a different statute than general

---

4. R.S.N.S. 1967, c. 202
5. *Id.* at s. 11(3)
6. Report of the Royal Commission on the Halifax County Hospital, Hon. H.P. MacKeen, Commissioner, Halifax, N.S., 1970

hospitals. Similarly the patient being treated in the general hospital for mental illness should not fall under different legislation than one who is being treated in an exclusively psychiatric institution. The adoption of this principle resulted in psychiatric legislation becoming part of general hospital legislation. The Municipal Mental Hospitals Act and the Nova Scotia Hospital Act were repealed, with the exception of the corporate structure in the Nova Scotia Hospital Act. The Public Hospitals Act was changed to a Hospitals Act, and broadened.[7]

III. *Recognition of the Differences*

Despite the acceptance of the above principles, it was recognized that mental illness is not the same as physical illness. Therefore, there are certain problems encountered by the psychiatric patient and the institution caring for him which are not encountered by other patients or other institutions. It was felt, however, that only those legislative provisions which are absolutely necessary as a result of such differences should be enacted.

Considering these differences, the first question which arose was whether it is necessary at any time to forcibly detain persons suffering from mental illness and to treat them against their will. It is a widely accepted principle of law that a patient cannot be treated without his consent.[8] To do otherwise would be an infringement of his basic civil rights to bodily integrity. The only exception to this rule is in an emergency where the patient is not in a condition to be able to either refuse or consent, and where any delay would endanger his life or health.[9] This principle has long been established by the courts. However, two other conditions have been established in many jurisdictions throughout the world by statute. The first is a communicable disease under which an individual, because he is a danger to the public, can be forcibly treated against his will.

The second case is that of mental illness. The justification for laws forcibly treating the mentally ill against their will has traditionally rested on two beliefs. The first is that the mentally ill are *per se* dangerous and therefore are in the same classification as those suffering from communicable diseases. It is now generally

---

7. S.N.S. 1977, c. 45
8. *Mulloy* v. *Hop Sang*, [1935] 1 W.W.R. 714 (Alta. S.C., App.Div.)
9. *Marshall* v. *Curry*, [1933] 3 D.L.R. 260 (N.S.S.C.)

accepted that a very small proportion of patients suffering from serious psychiatric disorders are dangerous either to themselves or to other people. The second rationale for involuntary treatment of the mentally ill is that the patient's mind is disordered and that therefore he does not have the mental capability of either consenting to or refusing treatment. The rationale was that this placed him in a different position from the cardiac patient or anyone suffering from any physical disorder. In fact a vast number of psychiatric patients are capable of either consenting to or refusing treatment for mental illness.[10]

However, although the two reasons upon which involuntary treatment of the mentally ill is based have decreased in importance, they have not totally disappeared. Some psychiatric patients are in fact dangerous to other people. Obviously this does then place them in the same classification as those suffering from communicable diseases, in that legislative action must be taken in order to protect the public. It is also recognized that some patients are not mentally capable of determining their own course of treatment. However, the Nova Scotia House of Assembly was not prepared to forcibly treat individuals who were incapable of consenting simply for that reason alone. The dangers of such an enactment are too great a threat to the civil liberties of the citizens. Therefore, the force of law would only be brought to bear in cases in which the individual was a danger to his own safety, or the safety of others. One of the dangers of this restriction is that the community may rebel against the idea of having even non-dangerous mental patients who cannot be forcibly treated.

Despite the fact that the grounds for forcibly treating individuals have been considerably narrowed, the legislature took very specific steps to protect individuals from such action where it was not justified by law.

IV. *Right to Liberty vs. Medical Needs*

Once the principle has been established that there are situations, however narrow, whereby an individual could be removed from society and forcibly treated for an illness against his will, legislative efforts were made to limit such power against the overriding right of

---

10. Z. M. Lebonsohn, "Problems in Obtaining Informed Consent for Electroshock Therapy" in R.C. Allen *et al.*, ed., *Readings in Law and Psychiatry* (Baltimore: John Hopkins University Press, 1975) at 387

the individual to his freedom of movement and bodily integrity. On the other hand, the Nova Scotia legislators seem also to have accepted the principle that the citizens have, if not a right, at least a very strong interest in receiving prompt medical and hospital attention for their illnesses, even in situations where they do not want such attention or are incapable of refusing or consenting to it.

In passing psychiatric legislation, it is necessary to deal with this conflict between the right to liberty and the interest in medical care. Many American states have taken the approach that the right to liberty is paramount and cannot be removed without what they refer to as the due process of law. This often entails a judicial proceeding either with or without a jury. The result is that the medical needs of the individual will not be met until his right to liberty has been dealt with.[11] The criticism of such a procedure is that it places the family and physician of an individual in an adversary situation when they should be in a supportive role. It also may delay treatment, resulting in harm and even death.

The approach in most other countries in the world, including the United Kingdom and Canada, has been the opposite. While judicial proceedings are provided for in most mental health acts of Canada, the usual approach is to provide for an individual's medical needs as quickly as possible, followed by proceedings to protect his civil rights, including his right to liberty. This traditional Canadian approach was not changed in the new Nova Scotia legislation. However, the protection of the right to liberty and bodily integrity was enforced by restricting the grounds of involuntary detention and treatment, and by providing a complicated procedure which must be followed commencing immediately upon the removal of such a basic civil right. The establishment of such a priority is strictly a political and philosophical decision and can be argued from both sides.

V. *From G. P. to Specialist*

In furtherance of the principle that mental illness should be treated as similarly as possible as physical illness, the Nova Scotia legislation attempts to conform to the style of medical practice generally. It recognizes that most psychiatric and physical illnesses are treated by family physicians. If the illness becomes more

---

11. S. J. Brakel & R. S. Rock, eds., *The Mentally Disabled and the Law* (Chicago: Univ. of Chicago Press, 1971) at 49

serious, the family physician refers the patient to a specialist. The patient may then be referred to an out-patient mental health centre. At the next stage the specialist admits the patient to hospital for treatment. With psychiatric illness, the preference is gradually becoming that of a department of psychiatry in a general hospital. As the illness becomes more serious the final stage would be forcible detention and treatment in a psychiatric hospital. In other words, the legislation is based on the philosophy that forcible detention and treatment in a psychiatric hospital is the last and least preferable of all forms of treatment and should only be employed in extremely circumscribed situations.

VI. *The Police*

The police in any community are often faced with the difficulty of dealing with an individual who is obviously suffering from mental illness, but who may not be involved in criminal activity. Unless legislation specifically allows the police to remove an individual to a hospital for examination purposes, the only authority which the police would have would be to arrest the individual under the *Criminal Code* or some provincial statute. It was felt that the police are often placed in a situation in which they must remove an individual to a hospital without any legal authority. On the other hand, there was the danger that if the police removed an individual to a jail or lockup, injury and even death may result. While these dangers were recognized, there exists the fear that power given to the police to remove an individual to a hospital could be abused, since the ordinary provisions of the *Criminal Code* would not be available. However, on balance it was felt by many that it would be preferable to err in the direction of removing to a hospital an individual who should not be there and then subsequently transferring him to a jail or lockup, rather than to place a mentally ill person in a jail when in fact immediate medical attention may be required.[12]

VII. *Criteria for Committal*

The basic criteria for committal under the legislation consists of two separate concepts, both of which must be in evidence.[13] The first is that the individual suffers from a psychiatric disorder. Psychiatric disorder has been defined as any disease or disability of the mind

12. Hospitals Act, S.N.S. 1977, c. 45
13. *Id.* at s. 34(3)

and includes alcoholism and drug addiction.[14] Any abuses owing to an unjustified expansion of the words "any disease or disability of the mind" would have to be left to the medical profession. Since there are checks and balances, such dangers would hopefully be minimized. Also, due to the very flexible nature of psychiatry and mental disorder, it is difficult, if not impossible, to adequately define psychiatric disorder in more specific legislative terms.

There was considerable controversy before the Law Amendments Committee of the House of Assembly as to whether alcoholism and drug addiction should be included. Many psychiatrists would consider these matters as a disease or disability of the mind in any case, or might say that they could consist of a disease or disability of the mind in some cases, but not in others. In order to make the matter more certain so that alcoholics and drug addicts would not automatically be excluded from the category, they were specifically included by law.

The second criterion is that the person should be admitted to the facility because he is a danger to his own safety or to the safety of others.[15] Similarly the word "safety" was not defined because of the difficulty of doing so. Hopefully, the development of any excessive practices would be controlled by the built-in review system.

The procedure by which these criteria operate can commence in one of three ways. The first is by two medical certificates, each signed by a physician who has reasonable and probable grounds to believe that the criteria exist. Such certificates must be signed within forty-eight hours of an examination and have effect only within seven days of the time of the signature.[16]

The second method is via a magistrate who, when given information under oath by a person who has reasonable and probable grounds to believe any person is suffering from a psychiatric disorder and that that person is a danger to his own safety or to the safety of others, may direct and authorize any two physicians to examine the individual, or to issue a warrant for the individual's apprehension for examination. The procedure then follows the standard procedure commencing with the medical certificates.[17]

---

14. *Id.* at s. 1(q)
15. *Id.* at s. 34(3)
16. *Id.* at s. 28
17. *Id.* at s. 29

The third possibility is via a police officer who has reasonable and probable grounds to believe that a person suffers from a psychiatric disorder and is a danger to his own safety or the safety of others, *or* is committing or about to commit an indictable offence. There was an attempt in the Law Amendments Committee to restrict the officer to taking only persons for medical examination who in addition to being a danger was committing or about to commit an indictable offence. The difficulty would be that an endangered individual not committing an indictable offence could not be taken for examination. As an additional protection every police officer who apprehends a person under this section is required to file a full report with the Attorney General within twenty-four hours.[18]

The second stage of the procedure is that the individual is then admitted to hospital for a period of observation.[19] Such a period applies to all persons whether they enter hospital voluntarily or not.

During the period of observation a staff psychiatrist may make a declaration stating that the patient suffers from a psychiatric disorder and is a danger to his own safety or the safety of others.[20] It is this declaration which authorizes the detention of the patient for treatment.[21] The declaration is valid for one month but may be renewed for subsequent periods of three months and six months.[22]

VIII. *The Stigma*

Despite all attempts to remove the pejorative stigma of mental hospitals, much still remains to be done in the public relations field. Until a change in public attitude comes about, it was necessary to recognize the stigma that could remain with an individual for his entire life of having been a patient in a mental hospital. While nothing could be done about a person who was in fact a patient in a mental hospital, concern was expressed over an individual who had been removed to a psychiatric hospital for observation only, either against his will or voluntarily, but who had been released and who never had been treated as a patient. In later years, it would be unjust for such an individual to be forced to answer a question on a visa application or an employment form that he had been a patient in a mental hospital when in fact he was never there for treatment. This

18. *Id.* at s. 30
19. *Id.* at s. 26
20. *Id.* at s. 34(3)
21. *Id.* at s. 36(1)
22. *Id.* at s. 36(2), (3)

is the reason for the maximum seven day period of observation for all individuals who enter hospital. During this time, the legislation never refers to the individual as a patient, but as a person under observation.[23] As a result, if the individual never does in fact become a patient, he can truthfully answer questions to this effect in the negative.

IX. *Remands Under the Criminal Code*

One of the problems that had been experienced in the past by psychiatric hospitals in Nova Scotia was that of patients who were remanded for examination by the courts under the *Criminal Code* for a period of thirty days.[24] In many such cases, the patients were assessed in a relatively short period of time, but could not be returned to the court and thus remained in the hospital for the full thirty day period. Since such remands fall within the *Criminal Code* of Canada, they are outside the legislative jurisdiction of the Province of Nova Scotia. Therefore, the manner in which they are conducted cannot be changed by the Province. However, one of the reasons that the patients remained unnecessarily in hospital was that there was no official notification of the Department of the Attorney General that the patient could be returned to the courts. The new legislation requires such reports, not only for remands under the *Criminal Code,* but also pursuant to persons who are transferred to the facility under the *Penitentiaries Act*[25] or the *Prisons and Reformatories Act* of Canada.[26]

X. *Civil Rights*

The legislation attempts to protect civil rights by three means. The first is by a complicated system of renewal documents which are required at specified intervals following a patient's detention with each document requiring a review of the case.[27]

The second is a list of very specific rights, including the right to send and receive letters, the right to make and receive phone calls, visiting rights and the right to counsel.[28]

23. *Id.* at s. 26(1)
24. R.S.C. 1970, c. C-34, s. 465(1) (c)
25. R.S.C. 1970, c. P-6, s. 19(2)
26. R.S.C. 1970, c. P-21, s. 25
27. Hospitals Act, S.N.S. 1977, c. 45 (to come into force April 1, 1979 with the exception of s. 8 of c. 45 which came into force Dec. 29, 1977, and except s. 4 of c. 45 O/C 79-12 [9 Jan. 1979]).
28. *Id.* at s. 62

The third method is by means of a review by an outside review board,[29] as well as the right to have any matter reviewed by a County Court.[30] Reviews can take place with respect to the person's detention, as well as any decisions relating to the individual's capacity to consent to treatment of his competency to manage his own affairs. In addition to a review at the request of the patient, the legislation is unique in that it requires a review by the Review Board every six months for the first two years of detention and at least once every twelve months thereafter, regardless of whether or not the patient requests the review.[31] It is hoped that this provision will be one of the strongest elements to guard against any unjustified detention.

The fourth provision relating to civil rights provides for the right to legal counsel at all stages, and in connection with any matter which is of concern to the patient.[32]

Because of public concern regarding psychosurgery, there are also specific provisions relating to such procedures.[33]

XI. *Consent to Treatment*

The entire problem of consent to treatment for mentally ill patients has long been one which has plagued psychiatric institutions. Under the common law, an individual can only consent to treatment if he is mentally capable of understanding the nature and the risks of the procedure and the risks of not undergoing the procedure. These criteria have now been specifically outlined in legislation.[34] If an individual is not being detained and treated by force of legislation there are no legislative provisions which can overrule the necessity for his consent, except in an emergency in which the patient is incapable of consenting. In cases in which he is unable to consent because of his mental disability, and this would not apply to a great number of psychiatric patients, it would have been necessary to make an application to a court to have the individual declared incompetent and a guardian appointed.[35] From an administrative point of view, this is extremely time-consuming and expensive.

---

29. *Id.* at s. 55
30. *Id.* at ss. 39 & 50(2)
31. *Id.* at s. 56
32. *Id.* at ss. 62(8) (a) (iv), (8) (c)
33. *Id.* at s. 52
34. *Id.* at s. 44(2)
35. Incompentent Persons Act, R.S.N.S. 1967, c. 135

Where the individual is detained, it is usually possible to infer from the legislation that treatment may be given without the individual's consent, at least for procedures required for the purpose for which he was detained.

Legislation has seldom dealt effectively with the individual who is incapable of consenting apart from these situations. Since for minor procedures it would delay treatment to make a court application, a legislative response was required. The new legislation does this by requiring a psychiatrist, having examined a person in the hospital, to determine his capacity to consent to treatment and to complete a declaration of capacity.[36] If he has been found incapable of consenting to treatment he may be treated after obtaining the consent of his guardian, if he has one, or if he has no guardian, upon obtaining the consent of his spouse or next of kin, or where the spouse or next of kin is not available, or consent is unable to be obtained, upon obtaining the consent of the Public Trustee.[37] This procedure is not restricted to individuals who are confined in psychiatric hospitals, but extends to patients in all hospitals.

XII. *Competency to Administer an Estate*

At the same time that the psychiatrist determines the patient's capacity to consent to treatment, he is also required to determine whether the individual is competent to administer his estate.[38] A psychiatrist completes a declaration of competency in which he states his opinion, based on the criteria outlined in the legislation.[39] If the individual is unable to administer his estate, and the circumstances are such that the Public Trustee should immediately assume management of the person's estate, the administrator of the hospital shall notify the Public Trustee as soon as possible. The Public Trustee may then take possession of the property and effects. As with the declaration of capacity, this declaration also must be performed at least once every three months for the first year and at least once every twelve months therafter.[40] This provision also overcomes the difficulties of obtaining a declaration of incompetency from a court, which is time-consuming and often results in the wasting of an individual's property in the interim.

---

36. Hospitals Act, S.N.S. 1977, c. 45, s. 45(1)
37. *Id.* at s. 46(2)
38. *Id.* at s. 45(3)
39. *Id.* at s. 44(3)
40. *Id.* at s. 47

XIII. *Standards*

While it is impossible to build standards into legislation if the facilities, financial resources and personnel are not available, certain restrictions were built into the legislation to make certain that at least minimum standards are maintained. The first of these is that any decision with respect to an individual's detention, his capacity or his competency can only be made by a psychiatrist, rather than a general practitioner, within the hospital. The legislation defines a psychiatrist as a person who is recognized as a specialist in psychiatry by the Provincial Medical Board or who on or before the 31st day of December, 1977 is eligible to write for a Canadian Fellowship in Psychiatry of the Royal College of Physicians and Surgeons (Canada).[41]

The second standard of note concerns psychosurgery.[42] No psychosurgery shall be performed unless the patient to be treated has been assessed at a facility designated by regulation. There will be very few facilities that will be given the authority to do such assessments. Furthermore, the psychosurgery must be recommended by a psychiatrist who is treating the patient at the facility, along with two psychiatrists who are not associated with the facility where the patient to be treated has been assessed. In addition, the psychosurgery can only be performed at a hospital designated by the Governor in Council. Such designations will be very restrictive. In addition, all psychosurgery will have to be reviewed by the review board to determine whether there is compliance with the requirements of the legislation before it is allowed to proceed.

XIV. *Conclusion*

The new Hospitals Act cannot be regarded as a successful breakthrough in the field of mental health until it has been in operation for several years. At that time it will be necessary to determine whether the percentage of involuntary patients has decreased significantly. A study will be required of the appeals to the Review Board and the courts to determine whether patients are being deprived of their basic rights improperly. Equally, studies should be made to determine whether the law is interfering with the individual's need for treatment, care and protection.

---

41. *Id.* at s. 1(5)
42. *Id.* at s. 52

Most important of all however, it will be necessary to determine whether the attitudes of the public and those who work in psychiatric services are in accordance with the spirit of the law. Without such support, the legislation will have broken new ground on paper only.