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Involuntary Psychiatry in Nova Scotia: The Review Board Reports (1979-1983) and Recent Proposals for Legislative Change

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I. *The Board and Its Functions*

The Nova Scotia Psychiatric Facilities Review Board, appointed under s. 53 of the Hospitals Act[1], fulfils many vital functions affecting the treatment and liberty of the patient involuntarily confined in the psychiatric hospitals of the Province.[2] Although its proceedings are held *in camera*,[3] the Board fortunately publishes an Annual Report which is tabled in the House of Assembly.[4] Neither lay persons nor lawyers are likely to scrutinize these documents and this Comment is intended in part to redress this regrettable disregard as well as to offer some critical remarks. They contain material which will both hearten and disturb the reader, the character and extent of one's reactions likely varying widely according to such complicated variables as one's outlook on the causation of mental illness and on the primacy of constitutionally enshrined rights and freedoms. None the less, the Reports present an important, if only partial, record of the attention accorded the mentally ill in Nova Scotia by the legal system. The Reports are also worthy of examination in that many of the recommendations contained therein may have a major influence on the future of mental health law in Nova Scotia. As discussed in Part C (*infra*), current Ministerial proposals closely resemble some of the Board's propositions. As the courts are empowered under the Hospitals Act[5] or the *Charter of Rights and Freedoms* or the prerogative writs to review some mental health issues, one might have expected to see cases appearing regularly, but the Board

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**These reports are available, free of charge, from the offices of the Minister of Health or of the Director of Psychiatric Mental Health Services, Department of Health, Box 488, 8th Floor, 1690 Hollis Street, Halifax, Nova Scotia, B3J 2R8. They are also held in the Legislative Library of the House of Assembly, Halifax.

1. Cited as R.S.N.S., 1967, c. 249.
2. The Board was constituted following the last major amendment to the Hospitals Act, S.N.S. 1977, c. 45, which came into force for the most part on April 1, 1979. These charges were discussed in Lorne E. Rozovsky's article *New Developments in Nova Scotia Psychiatric Legislation* (1979), 5 Dal L. J. 505-517.
3. S.N.S. 1977, c. 45, s. 58(8).
4. *Id.* at s. 61.
5. *Id.* at s. 50(2).

would seem to be the only place of significant legal activity for the civilly committed in the Province outside the Legislature.

Involuntary hospitalization of the mentally ill would appear to be on the decline generally in Canada.[6] For that matter, the number of traditional psychiatric hospitals is decreasing, with greater emphasis on community and social support systems outside institutions,[7] although the number of voluntary admissions may be increasing, with patients being treated in more disparate types of facilities.[8] In the face of these overall trends, recent statistics show that Nova Scotia still has an involuntary patient population which is large enough to support the initiation of between 38 and 65 reviews[9] yearly over the period covered by these four Annual Reports in its four mental hospitals. Involuntary commitment is now less prevalent but it has not disappeared, nor is it likely to be eliminated. Its review by the board is therefore still of significance.

The statutory functions of the Board[10] slightly paraphrased are to:

(a) determine whether a patient shall continue to be detained;
(b) determine that the Hospitals Act has been complied with before psychosurgery is performed;
(c) review a declaration concerning the patient's capacity to consent to treatment;
(d) review a declaration regarding the patient's competency to administer his estate;
(e) make treatment or care recommendations with respect to a patient; and
(f) advise when a patient should be transferred to another facility.

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6. "The data indicate a moderate decline in involuntary admission rates." Rodney Riley and Alex Richman, *Involuntary Hospitalization in Canadian Psychiatric Inpatient Facilities, 1970-1978* (1983), 28 Can. J. Psychiatry 536.

7. *Mental Health Statistics, 1979-80, Volume 1, Institutional Admissions and Separations,* Statistics Canada Publication Number 83-204, at 11.

8. *Supra,* note 7 at 537.

9. The statistics, obtained by adding the number of automatic and requested reviews processed by the Board each year, will be discussed more extensively, *infra.* Prior to the enactment of the 1977 amendments, Nova Scotia showed the highest percentage of commitments compared to voluntary admissions (31.9%). *Supra,* note 7 at 540. Since then, the absolute numbers, if not these ratios, have been quite considerably reduced according to the Board in its First Annual Report at p. 13. A written inquiry (sent November 28, 1985) to the Director of Psychiatric Mental Health Services requesting contemporary data on the in-patient population, both voluntary and involuntary, remains unanswered at the time of writing (late February, 1986). However, some data is available to suggest that Nova Sotia still has comparatively high rates of involuntary admissions and that at least in the 1983-85 period, the proportion of unwilling admissions may be increasing. This was the position of Dr. Alex Richman, Dalhousie University, in his "Brief to the C.M.H.A. Forum on Proposed Revisions to the Nova Scotia Hospitals Act, 7 March, 1985", based on figures for mental hospitals only, as opposed to general hospital psychiatric units. Copy available. See note 23, *infra,* for an explanation of the Forum.

10. *Supra,* note 3, s. 55.

II. *Activities*

The four Reports which are the subject of this comment are basically similar in structure. A brief introduction began the 1979-80 and 1980-81 versions, mainly discussing the composition and functions of the Board. Each Report then presents statistics concerning the "activities" of the Board as the legislation specifically directs in s.61(1). Of particular interest is the data pertaining to the file reviews and hearings which were initiated and cancelled, and which, if proceeded with, may have resulted in the patient's status being changed from formal (involuntary) to informal (voluntary) with the patient thereby having the option, as opposed to the obligation, of staying in the facility.[11] The review process may be commenced at the patient's request (or on the initiative of other designated persons), under s. 57. Alternatively, an involuntary patient's file is reviewed automatically under s. 56, every six months during the first two years of hospitalization and every year thereafter.

Table 1 below represents an effort to summarize the activities of the Board as revealed in its four Reports.

TABLE 1 SUMMARY OF ACTIVITIES

	1979-80	1980-81	1981-82	1982-83	Totals
1. REQUESTED REVIEWS	19	26	9	9	63
(a) Cancellations					
(i) Status Changed Before Review	8	16	1	3	
(ii) By Patient	2		0	0	
(b) Hearings Held	11(9)[12]	10	8	6	33[16]

11. Pursuant to s. 60 of the Act, when the Board determines that a person should not continue to be detained, the facility must release the person or the person may choose to remain as a voluntary patient.

12. Both figures are indicated at p. 3 of the 1979-80 report.

13. For 1979-80, the Report does not distinguish between the two categories of Review with respect to changes in status. Therefore, these figures represent an aggregate of requested and automatic reviews.

14. Of course, the rate of success with respect to hearings actually held, compared to proceedings which were merely initiated would be significantly higher, given the numbers of cancellations. With regard to automatic reviews, this observation is not as salient, as fewer matters were terminated before the review by the Board.

15. The Reports may be assumed to be silent where this sign is utilized in the Table. In other instances, a "0" indicates that the Board recorded that there was no activity concerning the relevant criterion or that the figure necessarily derives from other data.

16. 9 was the number used for the 1979-80 calculations. See *supra*, note 12.

(c) Status Changed to Informal (% of total requested reviews initiated)	14 (26.4%)[13]	3 (11.5%)[14]	4 (44%)	3 (33%)	10 (29.5%)[17]
2. AUTOMATIC REVIEWS	42	49	39	29	159
(a) Cancellations					
(i) Status Changed Before Review	3	0	0	0	
(b) Reviews Completed	39	49	39	29	156
(c) Status Changed to Informal (% of total automatic reviews initiated)	[see 1(c) above]	8 (16.3%)	6 (15.4%)	5 (17.2%)	19 (16.3%)[17]
3. PSYCHOSURGERY					
(a) Requests	1	2	1	0	4
(b) Approvals	1	2	1	0	4
(c) Rejections	0	0	0	0	0
4. TRANSFER REQUESTS					
(a) Requests	1	1	–[15]	—	2
(b) Approvals	0	0	—	—	1
(c) Rejections	1	1	—	—	1

It is difficult to make reliable and fair judgements on the implications of the data, as the author has neither attended the proceedings which are summarized therein nor had access to the decisions of the Board.[18]

17. This total and average percentage excludes 1979-80. See *supra,* note 13.

18. Section 59(1) of the Act requires the Board to "forward a written decision, setting out fully the conclusion of the review board" to the person requesting the review and the patient, among others. Section 59(2) requires records of each review to be kept. In its 1979-80 Report, at p. 10, the Board stated that it interpreted s. 59(1) to require it to state only whether "formal status will be continued", without either giving reasons for its conclusions or even stating whether the stipulations in the Act of dangerousness and psychiatric disorder are present. The basis for this reading of the Act by the Board was to avoid the harm which might be caused to the patient by his being made fully aware of the Board's reasons and judgements on his/her disorder and dangerousness. Although one may be sympathetic with the Board's motivations, this is not to say that its perspective on the patient's welfare is supported by logic and evidence.

However, one can readily observe that the number of automatic reviews is declining, which is presumably consistent with a reduction in the number of long term involuntary patients. Further, the success rates (measured of course by a change in status) for even automatic reviews are by no means insignificant, hovering in the 15% range. These figures offer some *prima facie* indication that the Board has not merely rubber-stamped the decisions of hospital personnel. With respect to requested reviews an even greater proportion of patients saw their status change, about 30% on average. One wonders what accounts for these variations in success rates between the two categories. It could easily be a function of the more legally marginal nature of the commitment of persons who actually complain of their status or, perhaps equally plausible, the greater vigour inherent in a review by way of a hearing, as mandated by s. 58(2) for s. 57 reviews, whereas a file review (under s. 56) need not involve an actual hearing.

The psychosurgery requests made pursuant to s. 52 were all granted, which is not surprising given that the Board seems to be mainly confined to a role of scrutinizing compliance with the requirements of the Act (s. 52(1) (f)). Although it does have some authority under s. 52(3) to require additional information or opinions, there is no record of this power having been used by the Board to look behind the various recommendations from physicians needed under s. 52(1)(c) and (d). Beyond these observations, it would be more instructive for the Minister, the Legislature and the public if the Board offered more data on its deliberations. For example, it might be useful to record the average duration of each hearing or file review, to note the number of cases in which counsel represented patients, or to see graphically the length of stay of the patient population whose reviews regularly do not result in a change in status. Further, an appendix containing several written decisions (s. 59(1)), records of reviews (s. 59(2)) and relevant case summaries would provide the reader with far more qualitative material concerning the functioning of the Board.

III. *The Recommendations of the Board*

In the four years commented upon herein, the Reports of the Psychiatric Facilities Review Board contain numerous recommendations regarding issues which were of special importance in the view of the Board. This is mildly curious in the face of an occassionally expressed reluctance in the

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Further, it is arguable that this assessment of the statute is in violation of the intention of the Legislature. The author maintains that neither a clear reading of the section or its apparent purpose are consistent with the Board's perspective and that amendments to the legislation would be required to support the actions of the Board.

Reports to become involved with "matters of policy".[19] On the other hand, although the Act merely requires the Board to report on "its activities",[20] it does not seem inappropriate that the Annual Reports include more than just a quantitative summary of the reviews and decisions of the tribunal, (which, by contrast to earlier Reports, is all the 1982-83 version contained), given the rich experience with patients that the Board must acquire in its ongoing work.

An effort will be made herein to outline and evaluate many of the recommendations of the Board over the years, selecting those which appear most frequently or which could more readily be predicted to influence the House of Assembly. There is a strong element of consistency in the Reports which clearly evinces that the recommendations are based on the Board's *bona fide* struggle to see the legislation changed for the benefit of patients and the mental health care system. None the less, the author concludes that neither the individual suggestions or their trend in aggregate augur well for the civil liberties of the mentally ill in Nova Scotia, a fault which is particularly disturbing in the post-Charter era. The Board does not consider such issues to be of pivotal significance, as it showed by the tenor of its recommendations and as it stated in more than one Report. Thus, in the 1981-82 edition, the Board cautioned:

> The Review Board would like to mention that this [the review system and its prospective expansion] really is a costly process and one should wonder if the risk to the civil liberties of the patients are really so great that the funds devoted to enlarging the scope of the Review Board are better expended in that direction than in added treatment facilities.[21]

Real liberty for the mentally ill may well be a chimera. Mental illness must at least in part be attributable to socioeconomic variables, which may remain unchanged after discharge regardless of any legal (or for that matter, medical) measures taken on behalf of the patient. This perspective still does not justify an indifference to civil liberties but if anything argues for more vigorous defence of the rights of the mentally ill, who are in so many ways deprived of what others consider entitlements in society. The Board never adequately explained its apparent willingness to make the Hospitals Act more restrictive. The additional factor of at least three of the Board's major recommendations seemingly being used by the Government as the basis of its consideration of the revision of the

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19. By way of illustration, the Board, at p. 6 of the 1979-80 Report, discussed its attitude to danger to property being included as an additional ground for adjudging a person a formal patient: "Whether or not the Act should be amended to take in such situations is a matter of policy beyond the jurisdiction of the Board."

20. Section 61(1).

21. 1981-82 Report, at 8.

Hospitals Act makes the discussion of the Board's outlook all the more salient.[22]

1. *Expansion of formal admission criteria*

The Hospitals Act now provides basically that a person may be admitted to a facility if two qualified medical practitioners certify that the person suffers from a psychiatric disorder and should be admitted because he requires in-patient services and care unavailable outside the facility, due to his being a danger to his own safety or that of others.[23] The Board repeatedly[24] both implicitly and explicity urges that the Legislation be revised to expand these latter categories which must be met to detain a person. They would include as formal patients the partially treated patient, the passively dangerous patient and persons who pose other serious dangers besides the present orientation towards physical safety.[25] The Board feels that such alterations are suitable as many people are not certified as formal patients due to the "absence of immediate physical dangerousness",[26] with attendant dire consequences because of their not being treated. The presently circulating proposals for revision of the Legislation reiterate this theme, but add that there should be a mandatory review of the status of a patient admitted under the new criteria within thirty days of admission.[27]

Nowhere does one see any real awareness of the adverse effects of these plans. This is not the place to fully explore the issue. However, the author would argue that there has been no justification presented for such an enlargement of state power over the individual. Neither is there any obvious demonstration of familiarity with the rich legal materials dealing

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22. On March 1, 1985, the then Minister of Health, the Honourable G. Sheehy, D.V.M., circulated "four proposals for amendment of the Hospitals Act" to various interested citizens and community groups, including the Nova Scotia Civil Liberties Association, from which organization the author obtained a copy of the proposals and on whose behalf the author prepared a brief to be submitted to the Minister: "A Preliminary Review of Proposals for Amendment of the Hospitals Act." Mr. Sheehy stated in his covering letter that the Department of Health was reviewing the proposals and sought views which "will be taken into consideration before the Department makes its decision". A further measure of the concern manifested in the face of the proposals is the request by the Canadian Mental Health Association (N.S. Div.,) noted in a January 14, 1986 public announcement, that the Minister delay the amendments until the C.M.H.A. has completed a public forum (March 6 and 7, 1986) and a review by a special committee. The Minister has reportedly agreed. Additional comment will be presented to the forum by the author, speaking independently of any organization.

23. Act, s. 28(2).

24. 1979-80, at 6; 1980-81, at 4; 1981-82, at 2 and 7.

25. The 1980-81 Report, *id.*, contains the best summary.

26. 1981-82, at 2.

27. *Supra,* note 22 at p. 1 of the Minister's proposals.

with dangerousness and the difficulty of predicting harm[28] or the conceptual and procedural obstacles inherent in depriving citizens of their liberty when they are merely "ill",[29] with all the further problems that the appellation "mentally ill" itself raises.[30] Reports to the Legislature or proposals for legislative change should not be written as law review articles, but they should do more to disclose the extent and spirit of debate on such matters as dangerousness and commitment. These concerns are not to be dismissed as esoteric and ought, to a greater degree, to be reflected in the Board's decisions and annual reports. Finally, the Board fails to mention once that the *Charter of Rights and Freedoms* must be considered in any regime purporting to regulate mental health issues in the new constitutional environment, of which more *infra*.[31]

2. *Release on parole*

At several points[32] in the Reports, the Board laments that there are only

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28. Indeed, at 5 of the 1979-80 Report, the Board maintains that "the definition of dangerousness in the Act should be kept current with developments on the subject in the field of *psychiatry*". (Emphasis added) Here, as in note 30 and 31 *infra*, a very small but representative selection of authorities is submitted. See S.A. Shape, ed., *Dangerous Behavior* (Washington, D.C., 1978); David Simpson, *Involuntary Civil Commitment: The Dangerousness Standard and Its Problems* (1984), 63 N.C.L. Rev. 241-56, or H.J. Steadman, *Predicting Dangerousness Among the Mentally Ill: Art, Magic and Science* (1983), 6 Int. J. of Law and Psychiatry 381-90.

29. See Karen Matheson, *Involuntary Civil Commitment: The Inadequacy of Existing Procedural and Substantive Protections* (1981), 28 U.C.L.A. L. Rev. 906-951; Sandra Coleman, *Standard of Proof Necessary in Involuntary Civil Commitment of the Mentally Ill* (1980), 25 S.D. L. Rev. 379-91, or S.J. Morse, *A Preference for Liberty: The Case Against Involuntary Committment of the Mentally Disordered* (1982), 70 Cal. L.R. 54-106.

30. See S. J. Morse, *Crazy Behaviour, Morals and Science: An Analysis of Mental Health Law* (1978), 51 So. Calif. L.R. 527-654; Kathleen Jones, *The Limitations of Legal Approach to Mental Health* (1980), 3 Int. J. of Law and Psychiatry I, or James Hardisty, *Mental Illness: A Legal Fiction* (1973), 48 Washington Law Review 735-762.

31. In the instance of the 1979-80 Report, submitted to the Minister of Health on November 12, 1980, this omission is excusable. The same might be said, although less strongly, with regard to the Second Annual Report, submitted on March 23, 1982. However, the other two Reports were sent to the Minister after the coming into force of the *Charter of Rights and Freedoms* on April 17, 1982 and this constitutional document is never mentioned. The 1981-82 Report was submitted August 4, 1983 and the 1982-83 Report on February 8, 1984. The 1983-84 Report had not been tabled in the House of Assembly, as of January 15, 1986, according to the Legislative Library for the Province of Nova Scotia.

There is no obvious reason for the delay between the end of the reporting year (March 31) and the much later dates when the Reports are submitted and tabled. Perhaps the legislation (*supra*, note 4) should be amended to provide a mandatory schedule for annual reporting, with the benefit that the Reports would regularly appear sooner than one sees in these first four versions. Of course, additional resources may be required by the Board to comply with such stipulations.

32. 1979-80, at 6 and 12; 1980-81 at 4; 1981-82, at 2.

two statuses of patients under the Hospitals Act, one (informal) denoting freedom to leave the hospital and the other (formal) indicating detention. The Minister's proposals[33] also echo this theme. The Board suggests that there should be a period or parole of trial discharge for some patients who would, upon release from hospital, be subject to following certain conditions laid down by the hospital. Failure to adhere would result in the patient being quickly returned to hospital as a formal patient.

Although one may comprehend the Board's intentions that treatment might beneficially continue even in the face of reluctance or non-compliance, its uncritical acceptance of the penal analogy (the 1979-80 Report observes at p. 12 ". . . it is similar to the system that would apply if the same person were discharged from a penal facility") should cause some re-examination. One should remember that the Hospitals Act contemplates assistance of those diagnosed as sick and the protection of society from the dangerous, not the control of persons convicted of crimes. The spectre of a new class of citizens is not to be welcomed. Beyond the free and the lawfully detained, there would be a third group who could be deprived of their liberty for such behaviour as refusing to take medication or drinking, when these kinds of actions are not proscribed for the rest of the population.

The virtue of the free/detained split in the current legislation is that the state or persons seeking to invoke its power must take certain statutorily mandated steps to force a person to remain in the hospital or to accept treatment therein. The Board's recommendations would leave a greater number of such momentous decisions to the discretion of physicians and other hospital personnel. The citizen, even the mentally ill citizen, is better left without State interference until a higher threshold of unacceptable conduct or emotional deterioration is reached, at least as high such as one sees in the present legislation.

3. *Consent to treatment*

The Hospitals Act now provides that no treatment shall be administered without consent,[34] unless a person is incapable of consenting, in which case substitute consent may be given by his/her guardian, spouse, next of kin, or in instances of agreement by these persons not being available, by the Public Trustee.[35] Of course, it is possible to mount good arguments to the effect that treatment should never be given without the patient's

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33. *Supra,* note 22 at 3. At 4, the Minister recommends that any continuation of formal status be a matter concerning which the patient could request a review.
34. Section 46(1).
35. Section 46(2).

consent.[36] The Board takes a totally divergent perspective and repeatedly[37] urges that even the limited legal thresholds in the Act be lowered or dismantled. The potential for delay inherent in the existing legislation is the main concern, as it is said that the patient's condition may worsen while consent is being sought. The Board first suggests that someone else (without saying who) should be able "to authorize necessary treatment in the face of such refusal and that such authority should be able to be obtained speedily in the case of an emergency".[38] In a later Report, the Board contends that it should have responsibility for this decision. The Minister's proposals[39] adopt the thrust of these notions. The first suggestion is that formal patients *with* capacity to consent who refuse to be treated be compelled to accept treatment, as long as two psychiatrists (one from the hospital and one from outside the institution) agree on the treatment proposals and the Review Board, after a hearing, consents. Also, the Minister would include the Review Board as a last alternative to the Public Trustee, should all other substitute consents be unavailable or refused, when a person lacking capacity will not agree to be treated.

The author contends that any system of substitute consent that results in treatment being forcibly administered to the unconsenting patient has the potential for abuse and may offend s. 7 (among others) of the *Charter,* guaranteeing security of the person, unless the deprivation is in accord with principles of fundamental justice.[40] Rather than loosening the

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36. For nearly two decades, the right to refuse treatment has been perhaps the most contentious issue in the mental health law literature in both the United States and the United Kingdom. See G. H. Morris, *Dr. Szasz or Dr. Suess: Whose Right to Refuse Mental Health Treatment?* (1981), 9 J. Psych. L. 283-303; J. Jacob, *The Right of the Mental Patient to his Psychosis* (1976), 39 Modern L.R. 17-42 or M. D. Wade, *The Right to Refuse Treatment: Mental Patients and the Law* (1976), Detroit College of Law Review 53-81.

37. 1979-80, at 7; 1981-82, at 3-4 and 7.

38. 1979-80, at 7.

39. *Supra,* note 23 at 2.

40. The full potential of s. 7 has yet to be illuminated by the Supreme Court of Canada, although its recent decision in the *British Columbia Motor Vehicle Act Reference,* [1985] S.C.C. No. 73; 63 N.R. 266 would seem to indicate that it will have great influence as new challenges are brought to the courts of procedure *and* substance. The mental health area should afford some prime instances where the provision may be invoked. A useful introduction to some of the issues inherent in this and other sections is offered in Todd Wellsch, *The Right of the Civilly Committed Mental Patient to Refuse Treatment* (1984), 48 Saskatchewan Law Review 269. See also, Robert Gordon and Simon Verdun-Jones, *The Right to Refuse Treatment: Commonwealth Development and Issues* (1983), 6 Int. J. of Law and Psychiatry 57, which presents some contemporary comparative perspectives. The latter authors call for substantial restructuring of mental health regimes, but are quite pessimistic about the forcefulness of the *Charter,* given its limiting provisions. One wonders whether the authors (writing in 1983) would see more hope in 1986, following 3 years of general *Charter* (and some mental health, see *infra*) litigation and comment.

current strictures, studies should be undertaken of the adequacy and propriety of consents (particularly those of the Public Trustee) used to override the patients' express wishes. Merely mentioning issues relating to delay, even on the avowed foundations of fears of patient deterioration, places too much emphasis on convenience and administrative efficiency, potentially ignoring the significance of personal autonomy and its constitutional protection. Neither is any data offered in support of any of the assertions of the Board and the Minister. Further, the logic of the suggestion that the Board itself should be capable of authorizing treatment in the face of a refusal by a patient is not apparent. Surely the Board would compromise its position as a review body by becoming involved in such basic treatment decisions. Patient interests might better be protected by a statutorily reinvigorated Public Trustee or an official guardian, with special training in mental health law and practices.

4. *The mental health care system*

At several junctures, the Board emphasizes the need to ensure sufficient hospital staff to meet patient needs[41] and to plan carefully for the evolution of the mental health care system.[42] Although one might prefer to see the existing model of the delivery of psychiatric services examined more critically, it must be remembered that the Board is principally responsible for formal patients and to some extent therefore it is not surprising that institutional care is taken for granted. Surely the general plea for the commitment of resources and planning does deserve support, notably from the legal community, which like many groups in society, is relatively unfamiliar with the problems of the mentally ill. Large sums of public money are spent on psychiatric services,[43] but it is important to ask whether all the needs of the populace are met by these allocations, whether more funds should be diverted to this direction and whether the most cost-effective methods of treatment are being employed. For definitive answers to these issues, an in-depth study is required, perhaps by an efficient, prompt, well-funded, non-partisan and innovative Royal Commission.

IV. *Time for reappraisal*

In its 1981-82 Report, the Board contends that "it is time to launch a re-

41. *E.g.*, 1979-80, at 13; 1980-81, at 3; 1981-82, at 7.

42. *E.g.*, 1980-81, at 5 and 1981-82, at 7.

43. For the recent years during which Department of Health Reports are available, the following rounded sums were spent on psychiatric services, with the total expenditures of the Department in brackets: 1979, $17,250,000 ($250,300,000); 1980, $18,620,000 ($280,720,000); 1982, $27,260,000 ($408,800,000); 1983, $30,100,000 ($462,121,000); 1984, $33,850,000 ($504,445,000); 1985, $38,000,000 ($536,000,000).

evaluation of our Hospitals Act as it applies to mental hospitals".[44] With this suggestion the author heartily concurs. However, should the Minister's proposals (commented on in part herein) or any other revision be seriously contemplated, it is essential that the Canadian *Charter of Rights and Freedoms* be kept in the foreground. Further, close attention must be paid to the lively debate which has characterized American and European scholarly and judicial attention to mental health law issues in the past twenty years.

That the *Charter* applies to the present and any new Hospitals Act is beyond all doubt, given s. 52 and 32 of the *Charter* which state respectively that the *Charter* is the supreme law of Canada and that the *Charter* applies to all matters within the authority of the legislature of each province. More difficult for legislators, psychiatrists and for that matter lawyers, judges and Board members to grasp will be the specific sections which must be respected in the relatively unusual setting of the psychiatric hospital. A thorough review of the applicable *Charter* provisions is not within the intended scope of this comment, but it is clear that s. 2 (fundamental freedoms, especially those which guarantee freedom of thought, belief, opinion and expression) are relevant. In the Legal Rights provisions (ss. 7-14), s. 7 (commented upon *ante*) and s. 9 (right not to be arbitrarily detained) should provide the basis of some *Charter* litigation or legislative guidance for the involuntarily confined. Section 10, providing for the right on being detained to be informed of the reasons therefore, to retain counsel and to use *habeus corpus* to attack the validity of the detention are conspicuously apposite, as is s. 12, protecting the citizen against cruel and unusual treatment. The equality rights (s. 15) which include the prohibition of discrimination based on mental or physical disability, must also be adverted to by judges, Board members and legislators.

Professional and scholarly commentators have since the coming into force of the *Charter* consistently urged its applicability for mental patients, as Morris Manning, for example, maintained in 1983:

> The Constitution Act, 1982 . . . will impact greatly on law and psychiatry. Procedures that have been followed in the past will have to be re-examined in light of the Charter and may have to be changed. . . . The rights of those subjected to involuntary commitment as either being mentally ill, unfit to stand trial by reason of insanity, or having been found not guilty on account of insanity, are now all protected by the *Charter*.[45]

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44. 1981-82, at 8.

45. Morris Manning in his early post-Charter work, *Rights, Freedoms and the Courts: A Practical Analysis of the Constitution Act, 1982,* (Toronto: Emond-Montgomery, 1983) at 559 and throughout a special chapter devoted to these themes (*The Impact of the Charter on*

More recently, observers have continued to emphasize the usefulness and challenge of the new Constitution:

> The arguments are not easily made, and certainly not easily won. Yet there are few areas of practice that hold greater intrigue for the practising advocate who is seeking to try out his *Charter* wings than the area of civil commitment.[46]

So too have the courts been met with Charter-based assaults on mental health law or procedures. There has been no deluge of litigation, which is not surprising given the allocation of legal resources in Canada and the relative powerlessness of the mentally ill, but some cases have already been brought in other provinces.[47] Further instances will surely emerge, even if the Legislature makes a genuine effort to bring the Hospitals Act into conformity with the *Charter*.

The author does not contend that it is an easy exercise to reconcile all aspects of a revised Hospitals Act with the *Charter*. Indeed, the limiting provisions of section 1 and arguably elsewhere within discrete sections of the *Charter* will inevitably have to be considered by those who draft and interpret the laws of the Province. The results of this interaction of rights and limits are even harder to predict in the mental health setting than one has begun to witness in other fields, but this should not result in continued inactivity.

For their part, the Psychiatric Facilities Review Board in its first four Annual Reports has shed light on the heretofore dark field of the involuntarily hospitalized and the legal system in Nova Scotia. Despite the obvious solicitude of the Board for the welfare of the mentally ill, many of its observations and recommendations deserve critical attention. At least in the requirement that the Board's activities be reported upon to the Legislature, the public has acquired a focus for debate. Perhaps this process should have been undertaken sooner, but the need for change now seems urgent. If the Board's future regular deliberations and Reports do not incorporate some awareness of the many difficult *Charter* issues which arise in mental health law, then the Board will be running a substantial risk of constitutional challenge, this assuming that mental patients have access to sensitive legal counsel. If the Legislature does not incorporate Charter-related revisions in the Hospitals Act, it will be

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Psychiatry and the Law, 550-585) adopts an optimistic outlook on the effects of the *Charter* in the mental heath field.

46. Elaine Newman, *Charter Implications for Procedures under the Ontario Mental Health Act* (1985), 5 Health Law in Canada 60-64, at 64.

47. By way of illustration only of cases generally emerging from the mental health area and without herein evaluating them, one might profitably examine: *Reference Re Procedures and the Mental Health Act* (1984), 5 D.L.R. (4th) 577 (P.E.I.C.A.); *Clark* v. *Clark* (1982), C.R.R. 342 (Ont. Co. Ct.); *Lussa* v. *Health Sciences Centre* (1983), 5 C.H.R.R. D/2203 (Man. Q.B.)

continuing to tolerate a situation wherein a law substantially affecting the rights of the citizenry pays no obvious heed to the *Charter*.[48]

It is surely plain that the Minister's proposal for revising the Legislation ought not to get beyond the conceptual stage in their present guise and that indeed the Minister should return to the task of law reform with an altered spirit. With the stimulus of the *Charter*, the Board and the House of Assembly should soon address these unfortunate anomolies in the administrative practice and statutes of the Province.

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48. Some provinces have already begun this process of revising mental health statutes to conform to the Constitution. For example, without evaluating whether it fully complies with the *Charter,* Ontario amended its s. 30(A) to its Mental Health Act (effective March 1, 1984) to provide that notice of each involuntary admission should be given to the Area Director of the Legal Aid Plan. This is a start, if nothing else, toward the provision ofthe right to counsel for those detained under mental health laws, pursuant to s. 10(b) of the *Charter.*

Parenthetically, despite the obvious importance of counsel for the involuntary patient, the Board does not demand that patients be represented at its hearings, whether requested or automatic. Nor does the Board make any broader recommendations regarding availability of legal services. The author found only one relevant reference to the participation of lawyers in the Reports, when in the 1979-1980 edition (at p. 9) the Board basically observed that counsel was moderately helpful in its proceedings, although they impliedly admonished ". . . one lawyer who acted as if he were in court and who appeared to want the question of formality dealt with on the same basis as guilt in a ciminal case, that is, by proof beyond a reasonable doubt." Although that lawyer's perspective is readily defensible, it is not proposed to pursue the substantive issue herein. (See R. Slovenko, *Criminal Justice Procedures in Civil Commitment* (1977), 24 Wayne L. Rev. 1 or *The 'Crime' of Mental Illness: Extension of 'Criminal' Procedural Safeguards to Involuntary Civil Commitments* (1975), 66 J. Crim. L. 255). Rather, the Board's comments emphasize the necessity of counsel for all Board proceedings. The author has argued elsewhere for the necessity of expanded legal services for the mentally ill in Canada (See *Legal Services for the Mentally Ill: A Polemic and a Plea*, to be published in 1986 University of New Brunswick Law Journal).