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The Trials of Mental Health Law: Recent Trends and Developments in Canadian Mental Health Jurisprudence

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Robert M. Gordon*
and Simon N. Verdun-Jones**

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I. *Introduction*

Orandum est ut sit mens sana in corpore sana.

Juvenal, *Satires*

Mental health law in Canada has traditionally shared many common themes with the mental health law of such other Commonwealth countries as Britain, Australia and New Zealand but is only a distant cousin of the system of mental health law that has emerged in the United States. The existence of an entrenched *Bill of Rights* in the United States has fashioned a situation in which many major issues relating to the rights of mental health patients have been dealt with as constitutional matters of great import. Consequently, the 1960s and 1970s witnessed a burgeoning of an exciting body of case law establishing a number of critical rights for a constituency that had tragically been largely neglected and abused in the backwaters of American psychiatric warehouses. In countries such as Britain, Australia, New Zealand and Canada, on the other hand, developments in the field of mental health law have, of necessity, occurred largely as the result of legislative reform and the judicial interpretation of mental health legislation rather than the application of constitutional imperatives by the courts. As a consequence, the structure of mental health law in these Commonwealth countries is very different from that which has emerged in the United States.¹

However, Canada is now standing at an important crossroads in the evolution of its legal structures and traditions as a consequence of the enactment of the *Constitution Act, 1982*² and the entrenched *Canadian Charter of Rights and Freedoms*. Advocates in the mental health law

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1. R.M. Gordon and S.N. Verdun-Jones, "Mental Health Law and Law Reform in the Commonwealth: The Rise of the 'New Legalism'?" in D.N. Weisstub, ed., *Law and Mental Health: International Perspectives*, Vol. 2 (New York; Pergamon Press, 1986) 1.

2. As enacted by the *Canada Act 1982* (U.K.), c.11.

field are anxiously waiting to see whether the advent of the *Charter* will fashion major changes in the nature of Canadian mental health law. As yet, there are no clear indicators as to what the future might bring to this field. There have been relatively few cases, in the civil law area, that deal with the rights of mental health patients. At least a couple of those cases which have come to the attention of analysts suggest that the *Charter* may well exert a significant impact in the years ahead, although it will be necessary to wait for more decisions to be made at the appellate, rather than the trial, level before any clear trend may be identified. However, in the criminal justice sphere, one is constrained to suggest that the *Charter* has, to date, shown itself to be a major disappointment as a potential vehicle for the enhancement of the status of mentally disordered individuals who fall into the abyss of the criminal justice system. The impact of the *Charter* is a theme to which we shall return at the conclusion of our analysis.

II. *The Rise of a New Legalism?*

In a recent, detailed study of the evolution of mental health law in a number of (British) Commonwealth jurisdictions³ Gordon and Verdun-Jones examined the thesis that a "new legalism" is emerging as a dominant characteristic of law reform in this area. The concept of the "new legalism" was coined by Larry Gostin,⁴ primarily in connection with the passage of the *Mental Health Act, 1983* in England and Wales. The "new legalism" encompasses such trends as the introduction of a right to effective mental health services, protection against unjustifiable deprivation of liberty, and the prevention of discrimination by maintaining the civil and social status of patients. In particular, the term reflects an approach that embodies a central role for law in ensuring that the state provides effective health services for patients, effective facilities and resources for mental health professionals and protections for patients by placing clear limits upon such psychiatric procedures as compulsory treatment and admission. Gostin emphasizes that the "new legalism" does not envisage the resurrection of traditional legal formalism but rather the evolution of a new form of legalism that is active in creating new social policy:

It is important to remain vigilant to any attempt by the legal profession to erect a superstructure of technical procedures or cumbersome legal

3. See Gordon and Verdun-Jones, *supra*, note 1.

4. L. Gostin, "The Ideology of Entitlement: The Application of Contemporary Legal Approaches to Psychiatry", in P. Bean, ed., *Mental Illness: Changes and Trends* (London: John Wiley, 1983) 27, and "Contemporary Social Historical Perspectives on Mental Health Law Reform" (1983), 10 *Journal of Law and Society* 47.

regulations; nor should the discretion of lawyers and courts be substituted for that of mental health professionals on matters of treatment. The modern function of law . . . does not usurp the role of caring professionals. It seeks to alter social perceptions of the mental health services which should place an emphasis on the person distressed and not on the concerns of society or the professional⁵.

Gostin's "new legalism" serves as a counterfoil to what he terms "professional discretion", a phrase designed to characterize the essential nature of the mental health legislation that has held sway since the 1950s in Commonwealth jurisdictions. The salient feature of the "professional discretion" concept is the application of a policy that renders access to treatment and the administration of mental health care matters entirely within the discretionary decision-making powers of mental health professionals. Underlying the concept of "professional discretion" is the perspective that mental health professionals can only provide effective services to their patients if they are left alone, especially by the legal profession, which does not have the "experience or expertise in areas of health and social services to enable them to identify needs and to propose workable solutions"⁶. Of course, it is important to emphasize that the "new legalism"/"professional discretion" dichotomy is a useful, heuristic device insofar as it locates the opposing poles of mental health law reform. However, in practice, there are few (if any) jurisdictions that can be located close to either of these poles; indeed, nearly all jurisdictions contain elements of both "legalism" and "professional discretion". In short, Gostin's dichotomy is useful primarily as a means of identifying the direction of reform (*i.e.*, towards one pole or the other) rather than a blueprint for constructing models of mental health law systems.

In the review by Gordon and Verdun-Jones of Commonwealth jurisdictions an attempt was made to discover whether recent mental health law reforms lent support to Gostin's thesis that there is a discernible trend away from the "professional discretion" approach towards that of the "new legalism". It was ultimately concluded that the majority of Commonwealth jurisdictions surveyed lie somewhere in the middle of the "new legalism"/"professional discretion" spectrum. The situation in these jurisdictions may best be described as "quasi-legalistic" in that legal requirements are clearly imposed in relation to such issues as civil commitment of patients and the periodic review of the status of detained patients; however, the actual application and interpretation of

5. See Gostin, "Contemporary Social Historical Perspectives in Mental Health Law Reform", *supra*, note 4, at 66-67.

6. *Id.*, at 49.

these legislative requirements is left firmly in the hands of mental health professionals. Furthermore, initial review of these professionals' decision-making generally falls to administrative tribunals rather than courts and these mental health review tribunals, in most provinces, are usually dominated by the mental health professionals themselves. There is some research that strongly suggests that such tribunals, in some jurisdictions at least, have often served as "rubber stamps" in the validation of decisions made by mental health professionals⁷. It was also concluded that mental health law reforms, in a number of the jurisdictions surveyed, have gradually moved mental health legislation towards the "new legalism" pole of the spectrum. However, with very few exceptions, it cannot be said that these developments have significantly altered the basic structure of the dominant quasi-legalistic approach. In the vast majority of jurisdictions, professional control over the commitment and treatment processes has been left largely unchallenged, and the hegemony of mental health professionals continues. In short, there has been very little change in the balance of power between patients and professionals.

III. *Mental Health Law Reform in Canada*

To what extent can we identify the emergence of a "new legalism" in the mental health law reforms that have taken place in Canada in the last two decades?

One of the central tenets of Gostin's "new legalism" is that mental health legislation must ensure that mental health patients are guaranteed a right to effective treatment. It would be difficult to claim that existing mental health legislation in the majority of Canadian provinces enshrines such a right. Only three provinces have established a statutory right to treatment. In Alberta⁸, British Columbia⁹ and Saskatchewan¹⁰, the applicable statutes place a duty upon the medical authorities to provide a detained patient with care and treatment although it should be noted that the right to treatment is, in each case, expressly limited by the resources currently available to the authorities. These limitations clearly prevent the courts from establishing a right to treatment which implies that provincial governments may be forced by judicial decree to provide resources to the mental health system (a form of right which has been

⁷. See, eg., J. Peay, "Mental Health Review Tribunals: Just or Efficacious Safeguards?" (1981), 5 *Law and Human Behavior* 161.

8. *Mental Health Act*, R.S.A. 1980, c. M-13, s. 13(1).

9. *Mental Health Act*, R.S.B.C. 1979, c. 256, s. 8(1)(a).

10. *Mental Health Services Act*, S.S. 1984-85, c. M-13.1, s. 27.

recognized by some courts in the United States).¹¹ In particular, it is important to recognize that no Canadian province has established a right to receive mental health services in the community. In England and Wales, for example, the *Mental Health Act, 1983*¹² places a duty upon the local authorities to provide after-care services in cooperation with the relevant voluntary agencies. As far as Canada is concerned, it seems that a broadly conceived right to effective mental health treatment is only likely to be established by generous interpretation of the *Charter*.

Another central element in the concept of the "new legalism" is the protection of mental health patients by the imposition of formal, legal controls upon the decision-making procedures of mental health professionals. Canadian mental health law has indeed witnessed a gradual increase in such controls in the ever-evolving body of provincial mental health legislation. In the area of civil commitment, one province (Ontario) has made a deliberate attempt to limit the range of persons who may be involuntarily detained in hospital and to control psychiatric discretion in the admission of patients¹³. It has done this not only by specifying the criteria for commitment in terms of dangerousness to oneself or others but also by legislating precise, behavioural indicators for establishing whether the "dangerousness" criteria exist in any particular case.¹⁴ However, it is important to emphasize that the criteria for commitment are, in most cases, applied by medical practitioners rather than a court and commitment is legitimate if they have "reasonable cause to believe" that the criteria have been established in any particular case. In other words, the application of the criteria is still largely a matter of professional opinion.¹⁵

11. *Wyatt v. Stickney*, 325 R. Supp. 781 (M.D. Ala. 1972); *Wyatt v. Aderholt*, 503 F.2d. 1305 (5th Cir. 1974); *Donaldson v. O'Connor*, 493 F.2d. 507 (5th Cir. 1974). The Supreme Court of the United States has not, to date, been willing to endorse the right to receive treatment; *O'Connor v. Donaldson*, 422 U.S. 563 (1975). See H. Savage and C. McKague, *Mental Health Law in Canada* (Toronto: Butterworths, 1987) 146.

12. S. 117.

13. *Mental Health Act*, S.O. 1978, c.50, now R.S.O. 1980, c.262.

14. This approach has also been adopted in the legislation of the Northwest Territories: *Mental Health Act*, S.N.W.T., 1985.

15. One recent case, however, suggests that the civil commitment criterion of "imminent and serious physical impairment" will be interpreted strictly by the courts: *Foran v. O'Doherty et al.* (Nov. 7, 1986, Ont. Dist. Ct., Fitzgerald D.C.J.), unreported, 2 A.C.W.S. (3d) 181. It was held that mere physical impairment is not enough to satisfy this criterion; the impairment must be both "serious" and "imminent". For further interpretation of this criterion, see also *Re G.G. and Swamy* (March 12, 1986, Ont. Dist. Ct., Kurisko, D.C.J.), unreported, No. 1179/1986, 36 A.C.W.S. (2d) 247; *Re L.B. and O'Doherty* (April 14, 1986, Ont. Dist. Ct., Kurisko, D.C.J.); unreported, No. 1226/86, 38 A.C.W.S. (2d) 152. For application of the criterion concerning "serious harm to others", see *Re Azhar and Anderson* (June 28, 1985, Ont. Dist. Ct., Locke, D.C.J.), unreported, No. 609/85, 33 A.C.W.S. (2d) 520.

In other provinces, there has been no equivalent attempt to specify precise, behavioural criteria for commitment. However, there is a clear trend (in Alberta, New Brunswick, Nova Scotia, Quebec and Saskatchewan) towards requiring a threat of danger or harm to oneself or others as a condition of commitment;¹⁶ however, these terms are left undefined and are, therefore, wide open to the exercise of the discretion of mental health professionals¹⁷. The remaining Canadian provinces have mental health statutes on the books that refer only to very broad and nebulous criteria for commitment, generally requiring only that involuntary detention be for the "health, welfare or safety" of the patient or others¹⁸. Whether the "Ontario approach" will be adopted by other provinces within the next few years remains to be seen; however, it is

16. See: *Mental Health Act*, R.S.A. 1980, c.M-13, sections 14 and 18; *Hospitals Act*, R.S.N.S. 1967, c.249 (Consolidated 1979, c. H-19), section 26; *Mental Patient Protection Act*, R.S.Q. 1977, c.P-41, section 11. These statutes refer to "dangerousness". In Saskatchewan, the reference is to "harm" to oneself or others: *Mental Health Services Act*, 1985, S.S. 1984-85, c. M-13.1, section 24.

In New Brunswick, amendments to the *Mental Health Act*, R.S.N.B. 1973, c. M-10, per S.N.B. 1985, c.59, made provision for a physician to issue an examination certificate where he or she believes that a person is mentally disordered and in need of hospitalization in the interests of that person's safety (s.6). Long-term commitment may only occur if, *inter alia*, the person's behaviour presents a substantial risk of imminent physical or psychological harm (s.7). This Act has still not been proclaimed, however.

17. Of course, it is now almost axiomatic that "dangerousness" is difficult both to establish or to predict in any sort of objective manner. See, eg., Pfohl, S. *Predicting Dangerousness: The Social Construction of Psychiatric Reality* (Lexington, Mass.: D.C. Heath, 1978); Monahan, J., *Predicting Violent Behavior: An Assessment of Clinical Techniques* (Beverly Hills, California: Sage, 1981); Hinton, J.W. (Ed.), *Dangerousness: Problems of Assessment and Prediction* (London: Allen & Unwin, 1983); Webster, C.D., M.H. Ben-Aron, and S.J. Hucker, *Dangerousness: Probability & Prediction, Psychiatry & Public Policy* (Cambridge: Cambridge University Press, 1985).

The Alberta Court of Queen's Bench has recently discussed the meaning of the term, "in a condition presenting a danger to himself or others". In *M. v. Alberta* (1985), 63 A.R. 14, McDonald J. was clearly dissatisfied with the manner in which psychiatrists interpreted the term and criticized the vagueness of the phrase as it appears in s. 18 of the provincial mental health statute. The Court was of the view that the term refers to the presence of a serious risk of physical (i.e., physiological) harm to self or others and did not encompass "mental or emotional" harm. In a case involving an application for a compulsory care order by the public guardian under the provisions of the *Dependent Adults Act*, R.S.A. 1980, c. D-32, the Alberta Surrogate Court interpreted the criterion that the dependent adult be "in a condition that presents a danger to himself or others" (s. 10.1(3); emphasis added). In this particular statutory context, the Court noted that the issue of whether the subject of the application was "in a dangerous condition" was strictly a judicial decision and declined to issue the order sought by the public guardian: *Re Johannasen* (1983), 48 A.R. 15. Both of these cases appear to indicate that, in Alberta at least, the concept of "dangerousness" may be interpreted quite restrictively by the courts.

18. See, eg., *Mental Health Act*, R.S.B.C. 1979, c.256, s. 1; *Mental Health Act*, R.S.M. 1970, c. M-110, s.2; *Mental Health Act*, R.S.P.E.I. 1974, c. M-9, s. 10.

significant that the Uniform Law Commission's draft *Uniform Mental Health Act* unequivocally espouses the approach.¹⁹

Finally, insofar as civil commitment is concerned, it should be noted that, while Canadian courts have emphasized that the onus of establishing that the criteria for commitment or continuing detention actually exist in any given case rests firmly on the mental health authorities, they have rejected the view of the U.S. Supreme Court that a special standard of proof applies to such cases. In *Addington v. Texas*²⁰, Burger C.J. held that, in civil commitment cases, there is a special "mid-standard", lying somewhere between the criminal standard of "beyond a reasonable doubt" and the ordinary civil standard of "on the balance of probabilities"; in short, it must be established that there is "clear and convincing" evidence that the commitment standards have been met before citizens may be deprived of their liberty for mental health reasons. This approach has been unequivocally rejected in Canada, where the appropriate standard of proof, in such cases, has been held to be the ordinary civil standard of "on the balance of probabilities".²¹ Therefore, insofar as the standard of proof is concerned, Canadian courts have declined to adopt the more "legalistic" approach, embodied in the *Addington v. Texas* decision.

One critical area in which we might discern the gradual emergence of the "new legalism" in certain of the Canadian mental health statutes is that of the right to refuse treatment. The clear majority of Canadian provinces permit the routine imposition of treatment upon all involuntary patients whether they are competent or not.²² However, the imprint of the

19. *Uniform Mental Health Act* (Discussion Draft, February 19, 1987).

20. (1979), 441 U.S. 418.

21. *Re Robinson and Hislop* (1980), 114 D.L.R. (3d) 620 (B.C.S.C.); *Re Hoskins and Hislop* (1981), 121 D.L.R. (3d) 337 (B.C.S.C.); *Robinson v. Kirby* (May 16, 1986, B.C.S.C., Taylor J), unreported, No. A840262; *M. v. Alberta*, *supra*, note 17; *Re Azhar and Anderson*, *supra*, note 15; *Re G.G. and Swamy*, *supra*, note 15. In *Re Robinson and Hislop*, Locke J. suggested that, in applying the civil onus of proof, attention should be paid to the gravity of the consequences for the patient.

22. *See* Gordon and Verdun-Jones, *supra*, note 1, at 16-27; M. Zajc, "The Right to Refuse Antipsychotic Medication: Who Decides?" (1987), 6 *Medicine and Law* 45. Explicit power to treat civilly committed patients is given in B.C., Alberta, Saskatchewan, Manitoba, New Brunswick, Nova Scotia and Newfoundland. In P.E.I., the power may be implied. The situation in Quebec is somewhat uncertain. While the involuntary patient may have a right to refuse treatment, he or she may be prevented from leaving the institution until treatment is taken (thus rendering any right of refusal of little *practical* value). Judicial decisions suggest that any right to refuse treatment in Quebec may be limited by a number of factors. In *Niemiec*, [1984] C.S. (Que. S.C.), forcible treatment of a non-mental health patient was authorized in an emergency and in *Institut Philippe Pinel de Montreal v. Dion* (1983), 2 D.L.R. (4th) 234, the Quebec trial court authorized compulsory treatment of a mentally ill man, who had been found unfit to stand trial. *See generally*, M.A. Somerville, "Refusal of Medical Treatment in 'Captive' Circumstances" (1985), 63 *Can. Bar. Rev.* 59.

"new legalism" may be clearly seen in the modifications of this approach made in the mental health legislation of Nova Scotia, Ontario, and (most recently) Saskatchewan. In Nova Scotia,²³ the legislation provides that no competent patient may be treated without his/her consent. However, it should be pointed out that a refusal to accept treatment may be swiftly overturned if a psychiatrist determines that the patient is incompetent (in which case substitute consent is required). In Ontario²⁴, the existing statute also provides that psychiatric treatment shall not be given to a competent patient without his/her consent. If the patient is incompetent, then the consent of the nearest relative is required. However, if such consent is not obtained, then the attending physician and two psychiatrists may apply to the Board of Review for an order authorizing treatment. The astonishing effect of these provisions is that the Ontario Board of Review is empowered to authorize the compulsory treatment of mental health patients, who are "competent" within the meaning of the Act.²⁵ Furthermore, the imposition of treatment upon a competent patient is not even limited to "emergency" situations. Clearly, what the Ontario legislature granted with one hand, it took away with the other. These particular provisions of the Ontario legislation were later amended in 1986²⁶ but the amendments had not been proclaimed into force, as of June 1987. Under the terms of the amendments, the Board's power to authorize the treatment of an involuntary patient is limited to those situations in which he/she "is not mentally competent" and "where there is no relative of the patient from whom consent may be requested to the provision of a specific psychiatric treatment or a specific course of psychiatric treatment of the patient".²⁷ These amendments certainly erased the power of the Board of Review to force treatment upon an unwilling involuntary patient who is competent to make treatment decisions, and they made specific provision for a patient who has been declared incompetent to apply to the Board of Review for an inquiry into the validity of such a determination.²⁸ However, the Ontario Government appears unlikely to proclaim the amendments into force, since it has proposed a new series of changes to the *Mental Health Act*.²⁹

23. *Hospitals Act*, R.S.N.S. 1967, c.249 (consd. 1979, c.H-19), sections 43, 44, 46.

24. *Mental Health Act*, R.S.O. 1980, c.262, section 35.

25. *Id.*, section 1(g).

26. S.O. 1986, c.64 (Bill 7).

27. *Id.*, s. 33(53), repealing the old (and enacting a new) s. 35(4)(a) of the *Mental Health Act*.

28. *Id.*, s. 33(52), enacting new subsections (2) (a-c) to s. 35 of the *Mental Health Act*.

29. Bill 190 was given first reading on January 28th, 1987. The provisions of this Bill would reverse the thrust of the 1986 amendments insofar as they would return power to the Board of Review to order treatment of involuntary patients, even if they are competent to make treatment decisions. The sole exception (other than, of course, psychosurgery) would be

It remains to be seen what will emerge from this re-opening of the issue in the Legislature.

The recent Saskatchewan Act³⁰ goes one step further than Nova Scotia and Ontario by specifying that one of the criteria for civil commitment must be that the patient is incompetent to make informed decisions regarding treatment matters³¹ and then states that, except in the case of an emergency, no diagnostic or treatment service or procedure may be imposed without the consent of the patient or (if he/she is incompetent) the consent of the nearest relative.³² The Act proceeds to require that any treatment administered must be "consistent with good medical practice"³³ (thus laying the basis for a potential legal action if such standards are not met). The Act also specifies that the attending physician must provide full information to the patient and must give due consideration to the views of the latter.³⁴

Another critical element in Gostin's "new legalism" is the imposition of legal controls upon the administration of certain forms of mental health treatments that are considered to be particularly hazardous and/or intrusive. In Canada, the first tentative steps have been taken in this direction by Nova Scotia, Ontario and Saskatchewan. Nova Scotia requires the authorization of the attending psychiatrist as well as that of two independent psychiatrists before psychosurgery may be performed and the Board of Review is required to determine that the various statutory requirements have been met.³⁵ Ontario³⁶ has prohibited the performance of psychosurgery upon any involuntary patient, as has the

electro-convulsive therapy. These provisions have been criticized on the basis that they represent a threat to civil liberties; see C. McKague, "Civil Rights Endangered in Mental Health Bill", *The Globe and Mail* (20 April 1987) A7. Since the writing of this article, Bill 190 was amended at the Committee stage, prior to third reading. The original proposal, to return to the Board of Review the power to override a *competent* patient's refusal of treatment, was removed from the Bill. On the other hand, the most recent version of the Bill returns to the Board the power to override the refusal of a substitute decision-maker in the case of an *incompetent* patient; the substitute decision-maker would be the nearest relative or the patient's appointed representative. See Ontario Legislative Assembly, *Debates and Proceedings*, at 1375-1386 (15 June 1987).

30. *Mental Health Services Act*, S.S. 1984-85, c.M-13.1.

31. *Id.*, section 24.

32. *Id.*, section 25(1).

33. *Id.*, section 25(2).

34. *Id.*, section 25(3).

35. *Hospitals Act*, R.S.N.S. 1967, c. 249, section 52.

36. *Mental Health Act*, R.S.O. 1980, c. 262, section 35. Note that, in an action before the Supreme Court of Ontario, it was ruled that E.C.T. was not a form of psychosurgery. Therefore, this procedure can be imposed compulsorily upon a competent, involuntary patient provided that the Board of Review issues the necessary approval: *Re T. and Board of Review for the Western Region et al.* (1983), 3 D.L.R. (4th) 442.

province of Saskatchewan,³⁷ which extends the ban to any form of "experimental treatment".³⁸ Cynics may well point out that the imposition of controls upon psychosurgery is a cheap sacrifice to offer on the altar of legalism since so few operations of this type are performed in Canada.³⁹ Saskatchewan has gone one step beyond controlling psychosurgery by adopting an approach manifested in the *Mental Health Act, 1983* of England and Wales. Indeed, the Saskatchewan Act⁴⁰ has established the machinery to designate certain treatments (such as electroconvulsive therapy) as requiring special approval procedures (presumably, these will include the requirement of at least one independent approval).

Although it was concerned with developmental incapacity, rather than mental illness, the case of *Re Eve*⁴¹ raises some important issues concerning the inviolability of *incompetent* persons in the situation where it is sought to impose *non-therapeutic* medical treatment. The *Eve* case involved an application by a mother for permission to consent to the non-therapeutic sterilization of her adult daughter, who was developmentally handicapped. Although it was accepted that Eve was a "mentally incompetent person", the trial Judge denied the application, noting that the Court had no authority or jurisdiction to authorize a procedure the sole purpose of which was contraceptive. However, the Supreme Court of Prince Edward Island, *in banco*, allowed the mother's appeal, stating that it had the power to authorize non-therapeutic sterilization for mentally incompetent persons under its *parens patriae* jurisdiction.⁴² The Supreme Court of Canada ultimately allowed the appeal of Eve's guardian *ad litem*. The Supreme Court stated unequivocally that courts should never authorize the non-therapeutic sterilization of mentally retarded persons under the *parens patriae* jurisdiction.⁴³ In delivering the judgement of the Court, La Forest J. said:

37. *Mental Health Services Act*, S.S. 1984-85, c. M-13.1, section 25(5).

38. The Northwest Territories legislation also provides that psychosurgery or "other irreversible forms of treatment" may not be administered without the consent of a *competent* patient. It also prohibits the administration of "experimental treatment involving significant risk of physical or psychological harm": *Mental Health Act*, S.N.W.T. 1985, s. 23.

39. Earp found that in all the provinces (with the exception of Quebec, for which no statistics were available), only five such operations had been performed between January, 1975 and April, 1977. See J.D. Earp, "Psychosurgery: The Position of the Canadian Psychiatric Association" (1979), 24 Canadian Journal of Psychiatry 353.

40. *Mental Health Services Act*, S.S. 1984-85, c. M-13.1, section 25(4).

41. (1987), 31 D.L.R. (4th) 1 (S.C.C.).

42. 115 D.L.R. (3d) 283, 27 Nfld. & P.E.I.R. 97, 28 Nfld. & P.E.I.R. 359.

43. For a case in which the B.C. Court of Appeal authorized the performance of a hysterectomy on a severely retarded child on the basis that it was *therapeutic* (the child had a phobic aversion to blood which, it was alleged, would seriously affect her upon the onset of her menstrual period), see *Re K. and Public Trustee* (1985), 19 D.L.R. (4th) 255.

The grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilization without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of the person. Accordingly, the procedure should never be authorized for non-therapeutic purposes under the *parens patriae* jurisdiction.⁴⁴

The impact of the *Eve* case will, probably, be quite limited insofar as it deals only with the *non-therapeutic* treatment of the developmentally handicapped. Whether the Supreme Court's willingness to uphold the principle of personal inviolability, in this particular context, will be extended to protect mental health patients who are being given allegedly *therapeutic* treatment remains to be seen; certainly, there is nothing in the judgement itself to indicate that the Court is, indeed, prepared to inject a greater degree of "legalism" into the relationship between mental health patients and mental health professionals.

To this point, we have looked only at mental health law reforms in the civil law area. It is now time to turn our attention briefly to developments in the sphere of criminal justice (an area which falls largely under the jurisdiction of the federal Parliament).

There are a number of areas in which it is possible to discern the impact of the "new legalism", although it must be stated that Canada has been less noticeably affected by this trend than its other Commonwealth partners.⁴⁵

Unfortunately, to date, there has been very little legislative reform in relation to the treatment of the mentally disordered in the criminal process in Canada. Despite frequent criticism, the Lieutenant Governor's Warrant system remains in force,⁴⁶ although it is most probable that major reforms will be made to the *Criminal Code* in the near future⁴⁷. In any event, under the existing system, those individuals acquitted of offences by reason of insanity or found unfit to stand trial continue to be

44. (1987), 31 D.L.R. (4th) 1, at 32.

45. See Gordon and Verdun-Jones, *supra*, note 1, at 75-76.

46. For an example of such criticism, see the Law Reform Commission of Canada, *A Report to Parliament on Mental Disorder in the Criminal Process* (Ottawa: Information Canada, 1976).

47. On June 25, 1986 the (then) Minister of Justice, Mr. Crosbie, introduced draft legislation to "modernize and clarify" the *Criminal Code* provisions relating to mentally disordered offenders. Parliament has since been prorogued. It is expected that the amendments will, eventually, be reintroduced in one form or another. See Minister of Justice, *Information Paper: Mental Disorder Amendments to the Criminal Code* (Ottawa: Minister of Justice and Attorney General of Canada, June 1986) and *Proposed Amendments to the Criminal Code* (Ottawa: Queen's Printer, 23-6-86). The substance of the proposed amendments is discussed, *infra*, in the section concerning the impact of the *Charter*.

held at the pleasure of the executive arm of government.⁴⁸ This situation compares unfavorably with a number of other Commonwealth jurisdictions (such as New South Wales, the Northern Territory of Australia and New Zealand), where the courts have been assigned a significant role in the supervision of the accused's indeterminate detention, or with England and Wales, where the *Mental Health Act, 1983* has granted the Mental Health Review Tribunal the right to release accused persons held at "Her Majesty's pleasure".⁴⁹ In Canada, the only significant reform, in recent years, has been the creation of Advisory Boards of Review in each province.⁵⁰ These boards review the cases of all individuals held under Lieutenant Governor's warrants on a regular basis. However, the recommendations of the boards do not bind the Lieutenant Governor in the exercise of his/her discretion and the individual accused person has absolutely no power to initiate a review of the detention on his/her own account.

The only major improvement in the legal status of those held under a Lieutenant Governor's Warrant has come from the courts, which have placed the Boards of Review under a duty to act fairly. This development is part of a larger trend, in which the courts have imposed a duty to act fairly upon all administrative decision-making bodies whose decisions or recommendations are likely to have significant impact upon an individual's legal rights.⁵¹ The duty to act fairly has been imposed upon the advisory boards of review despite the fact that their decisions are only recommendations made to the Lieutenant Governor. It has been held that it is part of the duty to act fairly that the boards make patients' files available to their counsel in advance of a hearing.⁵² Similarly, it has been ruled that a board acted unfairly when the two psychiatrists on the board examined the patient and then discussed the case with their colleagues in the absence of the patient or his counsel.⁵³ In *Re McCann and The Queen*,⁵⁴ the British Columbia Court of Appeal went so far as to set aside an order of the Lieutenant Governor because the Board of Review had not acted fairly in making its recommendation to him. Significantly, the duty of fairness has now been clearly extended to the Lieutenant

48 *Criminal Code*, R.S.C. 1970, c. C-34, sections 542, 543, and 545.

49. See Gordon and Verdun-Jones, *supra*, note 1, at 75-76.

50. *Criminal Code*, section 547.

51. See Gordon and Verdun-Jones, *supra*, note 1, at 34-36.

52. In *Re Abel et al. and Advisory Review Board* (1980), 56 C.C.C.(2d) 153 (Ont.C.A.).

53. In *Re Egglestone and Mousseau and Advisory Review Board* (1983), 6 C.C.C. (3d) 1 (Ont.D.C.).

54. (1982), 67 C.C.C. (2d) 180 (B.C.C.A.).

Governor him/herself as a consequence of the important case of *Re Jollimore and The Queen*⁵⁵. In this case, the Lieutenant Governor of Nova Scotia had ordered the transfer of an insanity acquittee to a penitentiary in New Brunswick *before* the Board of Review had completed its consideration of his case. Burchell J., of the Trial Division of the Nova Scotia Supreme Court, set aside this transfer on the basis that the canons of procedural fairness had not been followed. While the Lieutenant Governor is clearly not *obliged* to act on the advice of the Board, he/she may not arbitrarily cut off or pre-empt the legislatively prescribed role of the Board by acting before receiving its formal recommendations.

Another judicial development that has potentially enhanced the legal status of individuals held under a Lieutenant Governor's warrant is the *Dion* case,⁵⁶ in which the trial court rejected the contention of psychiatric authorities that they had the power to impose treatment without consent upon all those individuals held under such a warrant. The court ruled that each case must be looked at individually by the courts. In this particular case, the accused, who had been found unfit to stand trial but had not been involuntarily committed, was refusing all medication because he distrusted his doctors. If the accused continued to refuse treatment, the prospect was that he would not become fit to stand trial and would be likely to suffer detention "in perpetuity". In these particular circumstances, the Court believed it was appropriate to use its *parens patriae* jurisdiction to override the accused's refusal to take treatment.⁵⁷ The case does not appear to have turned on the question of the accused's incompetence to make treatment decisions on his own behalf, although the Court evidently thought that he was, in fact, incompetent.⁵⁸ The *Dion* case is of potentially great significance since the Court clearly rejected the notion that *all* accused persons held under a Lieutenant Governor's warrant may be forcibly treated merely because of their status.⁵⁹

Canadian judicial decisions in the area of criminal responsibility bear the imprint of the "new legalism" insofar as they reflect a policy of restricting the role of psychiatrists in this area. The Supreme Court of

55. (1986), 27 C.C.C. (3d) 166 (N.S.S.C.).

56. *Institut Phillippe Pinel de Montreal v. Dion* (1983), 2 D.L.R. (4th) 234 (Durand, J.)

57. Zajc, *supra*, note 22, at 54, indicates that the resort to a *parens patriae* jurisdiction was novel in the context of Quebec. See also Somerville, *supra*, note 22.

58. *Supra*, note 56 at 239-241.

59. *Id.*, at 242. It is interesting that the Court ruled that, in this particular case, the Institut was required to establish a "special medical committee to review the respondent's case regularly". An appeal was made to the Quebec Court of Appeal, but was dismissed in May 1984; see Zajc, *supra*, note 22, at 65.

Canada has recently adopted an increasingly restrictive interpretation of section 16 of the *Criminal Code*, which sets out the criteria for the insanity defence.⁶⁰ By so doing, the Court has unequivocally restricted the range of psychiatric evidence that may be considered relevant to the issue of insanity. Indeed, in one leading case,⁶¹ the Supreme Court went so far as to impose severe restrictions upon the type of opinion evidence that psychiatrists may give in insanity defence cases, leading to the suggestion that the defendant may be required to enter into the witness box to establish the nature of his/her alleged delusions. In addition, the Supreme Court has severely restricted the scope of the defence of non-insane automatism, a defence which leads to a total acquittal (as compared with the partial acquittal that occurs after a successful insanity defence). In order to achieve success in the assertion of a defence of non-insane automatism, the accused must satisfy the Court that his/her mental condition was not the consequence of some pathological condition or, in the terms of the *Criminal Code*, a "disease of the mind". If the Court rules that the accused's condition was, indeed, caused by a "disease of the mind", then he/she will be considered to have raised the defence of insanity rather than non-insane automatism and any acquittal will result in detention under a Lieutenant Governor's warrant. The Court has effectively reduced the range of psychiatric evidence that may be introduced in relation to the defence of non-insane automatism by emphasizing that the term "disease of the mind" is a *legal* rather than a *medical* concept and that the courts are not willing to defer to psychiatric determinations on this matter.⁶² In this sense, the approach of the Supreme Court may be termed "legalistic".

IV. *The Charter and Mental Health Law*

It is perhaps too early to evaluate the impact of the *Charter of Rights* upon the emerging field of Canadian mental health law. However, one important influence will be on the legislative process insofar as provincial legislatures attempt to revise their mental health statutes so that they are not perceived to be in contravention of the *Charter*. A clear example of

60. In particular, it has adopted a narrow interpretation of the phrase "nature and quality of an act"; *Regina v. Abbey* (1982), 68 C.C.C. (2d) 394 and *Kjeldsen v. the Queen* (1981), 64 C.C.C. (2d) 161. In addition, it has strongly rejected the relevance of irresistible impulse to the insanity defence under section 16; *Chartrand v. The Queen*, [1977] 1 S.C.R. 314. For consideration of these cases, see *Regina v. Kirby* (1985), 21 C.C.C.(3d) 31 (Ont. C.A.) and *Regina v. Swain* (1986), 24 C.C.C. (3d) 385 (Ont. C.A.).

61. *Regina v. Abbey* (1982), 68 C.C.C. (2d) 394. See also, *Regina v. Kirby*, *supra*, note 60.

62. *Rabey v. The Queen* (1980), 54 C.C.C. (2d) 1.

such a development is provided by the recently enacted Saskatchewan *Mental Health Services Act*, 1985⁶³

It is, however, somewhat surprising both that relatively little scholarly analysis has occurred in this specific area⁶⁴ and that so few judicial cases appear to have raised *Charter* issues. There have certainly been no landmark cases cast in the mould of the great mental health law cases in the American courts. As yet, there have been no Canadian cases establishing constitutional rights to treatment, to refuse treatment or to receive treatment in the least restrictive environment. Perhaps the relative paucity of such cases reflects the absence of a tradition of an adequately funded and aggressive system of delivering advocacy services on behalf of mental health patients in Canada as a whole.⁶⁵ However, it may also reflect the view that the *Charter* might not be interpreted in an expansive manner by a judiciary that has historically been reluctant to second guess the "good faith" decisions made by mental health professionals in the course of their work. As McQuaid J. said, on behalf of the P.E.I. Supreme Court in a recent case⁶⁶:

63. S.S. 1984-85, C. M-13.1. See also Minister's Advisory Committee, *Report on the Mental Health Act* (St. John's: Ministry of Health and Social Services, Newfoundland, 1982); Social Services and Community Health, Alberta, *Report of the Task Force to Review the Mental Health Act* (Edmonton: Ministry of Social Services and Community Health, Alberta, 1983); S.N. Verdun-Jones & R.M. Gordon, *Mental Health and Adult Guardianship Law in the Yukon* (Whitehorse: Department of Health and Human Resources, Yukon, 1985).

64. See R.M. Gordon & S.N. Verdun-Jones, "The Implications of the Canadian *Charter of Rights and Freedoms* for the Law Relating to Guardianship and Trusteeship" (1987), 10 *International Journal of Law and Psychiatry* 21; E. Newman, "*Charter* Implications for Procedures under the *Ontario Mental Health Act*" (1985), 5 *Health Law in Canada* 60; E. Keyserlingk, "Consent to Treatment: the Principles, the Provincial Statutes and the *Charter of Rights and Freedoms*" (1985), 33 *Canada's Mental Health* 7; E. Reichenfeld, "Elderly Psychiatric Patients in Institutions — Implications of the Canadian *Charter of Rights and Freedoms*" (1985), 5 *Health Law in Canada* 83; Savage and McKague, *supra*, note 11, at 248-256.

65. See generally, A. Kaiser, "Legal Services for the Mentally Ill: A Polemic and a Plea" (1986), 35 *U.N.B. Law J.* 89; R.M. Gordon, "Legal Services for Mental Health Patients: Some Commonwealth Developments" (1981), 4 *International Journal of Law and Psychiatry* 171; and "Legal Services for Mental Health Patients: Some Practical and Theoretical Observations on Canadian and Australian Developments" (1982), 1 *Australian Journal of Law and Society* 101. In recent years, Toronto has witnessed the advent of a greater degree of organization on the part of advocates working on behalf of a variety of disabled constituencies, including the mentally ill (eg. the Advocacy Resource Centre for the Handicapped (ARCH) and Committee on Legal Issues in Psychiatry (CLIP)). In many other areas of Canada, there have certainly been individual advocates who have been aggressively and ably asserting the rights of mental health patients but they have been acting without the benefits of an adequately funded organizational structure. See Savage & McKague, *supra*, note 11, at 239-240.

66. *Reference Re Procedures and the Mental Health Act* (1984), 5 D.L.R. (4th) 577 (P.E.I.S.C. *in banco*).

... the law, as I perceive it to be, leans in favour of the care and treatment of those who do suffer, even by involuntary detention if need be, when that illness has been diagnosed by those practitioners skilled in the discipline, and only for the gravest reasons should the court, or a board, an inquiry or review, substitute its lay opinion for the professional opinion.⁶⁷

To date, insofar as the civil side of mental health law is concerned, there still have been no major *Charter* cases that have been decided by the Supreme Court of Canada. Although *Charter* issues were raised before the Supreme Court of Canada in the *Eve* case,⁶⁸ they, unfortunately, received rather short shrift. To the contention that section 7 of the *Charter* protects a fundamental right to "free procreative choice", the Court ruled that this section was not applicable since it only operated to protect individuals from "laws or other state action that deprive them of liberty"; there were no such laws or state action in question in this particular case. The Court left open the question of whether the right to procreate would be protected by section 7 and its guarantees in relation to "life, liberty and the security of the person".⁶⁹

Most of the *Charter* cases involving challenges to the process of civil commitment have not advanced beyond the trial level, although the two cases that have reached the appellate court level have raised issues of considerable significance. In general, it is clear that Canadian courts are most unwilling to strike down any of the provisions of provincial mental health legislation, although it does appear, from at least one case, that they are prepared to provide a remedy to a particular individual whose constitutional rights have been infringed by the mental health authorities.

67. *Id.*, at 591. Illustrative of the somewhat lenient attitude of the courts towards mental health professionals is *Ketchup v. Hislop and R. in Right of British Columbia* (1984), 54 B.C.L.R. 327 (S.C.). In this case, it was found that the plaintiff had been committed to hospital unlawfully insofar as there were major irregularities in the certificates of commitment. The Court noted that "to be involuntarily committed to a mental health facility involves, of course, a very severe curtailment of the liberty of the person" (at 331). However, since the defendants had acted "in good faith" and the plaintiff had needed the care and treatment (from which she benefitted), she was awarded only \$500 in damages. The plaintiff had been forcibly treated and detained for five weeks before gaining her release.

68. *Supra*, note 41.

69. *Id.*, at 35. The Court also dismissed the rather strange argument, made by the respondents, to the effect that section 15 guaranteed the right of the mentally disabled to have a non-therapeutic sterilization. The Court pointed out that the issue of sterilization had not been raised by the person affected but rather by a third party (in this case, the mother).

Section 7 was also raised in a case involving a proceeding to determine whether an individual was mentally incompetent within the meaning of the Ontario *Mental Incompetency Act*. In *Clark v. Clark*, Matheson Co.Ct. J. held that the effect of section 7 was "procedural" rather than "substantive" in nature and that, therefore, it did not apply to the application. However, this narrow interpretation of the effect of section 7 has been rejected by the Supreme Court of Canada: *Reference Re British Columbia Motor Vehicle Act*, [1985] 2 S.C.R. 486.

The most dramatic *Charter* case has been that of *Lussa v. The Health Science Centre and Director of Psychiatric Services*⁷⁰. The case is highly significant in that it resulted in the release of an involuntarily committed patient on the basis of the infringement of her rights under three different sections of the *Charter*. An application for *habeas corpus* was made on behalf of Theresa Lussa after she had been civilly committed under the provisions of the Manitoba *Mental Health Act*. The Manitoba Court of Queen's Bench noted that the patient had been detained for 14 days and ruled that her continued detention would constitute an infringement of Section 7 of the *Charter*. The Court reached this conclusion on the basis that there was no evidence establishing that the patient was dangerous to herself or others or that she fell within any of the emergency situations provided for by the *Mental Health Act*. Therefore, in the view of the Court, her continued detention would not be in accordance with the "fundamental principles of justice" enshrined in section 7 of the *Charter*. The Court employed similar reasoning in ruling that continued detention would constitute "arbitrary" detention, contrary to section 9 of the *Charter*. Finally, it was held that the patient's rights under section 10 of the *Charter* had been infringed. This section requires that everyone who has been detained has the right to be informed promptly of the reasons therefor and to be informed of the right to retain and instruct counsel. The Court held that, for the purposes of section 10, it was not adequate for the hospital to post a sign in the ward. The authorities were under an obligation to ensure that the patient understood her rights or, alternatively, that she was not capable of understanding them because of her condition. Apparently, no such efforts were made in this case and, therefore, the provisions of section 10 had been infringed. Of course, this decision was made only at the trial level and it remains to be seen whether the Court's use of the *Charter* as a sharp instrument for challenging involuntary detention in a mental health facility will set the trend for future judicial incursion into this area of mental health law.

A second case in which the potential contribution of the *Charter* to the field of mental health patients' rights was highlighted is that of *In Reference Re Procedures and the Mental Health Act*,⁷¹ where the P.E.I. Supreme Court ruled that, as a consequence of section 10(c) of the *Charter*, a mental health patient maintains the right to challenge the validity of his/her involuntary detention by the remedy of *habeas corpus* despite the fact that it appeared that the provincial mental health statute⁷²

70. (1983), 9 C.R.R. 350 (Man. Q.B.).

71. (1984), 5 D.L.R. (4th) 577 (P.E.I.S.C. *in banco*).

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

precluded reliance upon this traditional common law remedy. This case is, therefore, of considerable significance since it apparently enshrines the right of mental health patients to the prerogative remedy of *habeas corpus* despite the attempt of a provincial legislature to substitute another (perhaps less efficacious) remedy of its own in its mental health legislation.⁷³ At the same time, however, the Court ruled that the provincial mental health legislation did not infringe the guarantees of equal treatment for the mentally disabled embodied in section 15 of the *Charter*. McQuaid J. pointed out that, from “the earliest days of English legal history”, the mentally ill had been “treated as a separate class, requiring and deserving of special care and consideration by the Crown itself but, by reason of their infirmity, subject to certain restrictions as to their freedom of conduct.” It could not be argued, in light of this historical precedent, that these restrictions were not “reasonable limits” insofar as section 1 of the *Charter* is concerned.⁷⁴ This approach to the constitutionality of the civil commitment provisions of provincial mental health legislation has been strongly echoed in the other recent cases in which *Charter* issues have been raised.

In *Thwaites v. Health Sciences Centre Psychiatric Facility and Health Sciences Centre*⁷⁵, an involuntarily committed patient applied for a declaration that section 15 of the Manitoba *Mental Health Act*⁷⁶, which made provision for civil commitment, was unconstitutional. Reference was made to sections 7, 9 and 10 of the *Charter*. Ultimately, Scollin J. ruled that the Manitoba legislation did not infringe any of the guarantees contained in the *Charter* and that, even if the civil commitment provisions did infringe any of these guarantees, they represented “reasonable limits” which could be justified in a free and democratic society within the meaning of section 1 of the *Charter*. The Court rejected the suggestion that the compulsory commitment process was arbitrary even though considerable reliance must be placed on the exercise of medical judgement:

The field of mental health is manifestly far from cultivated. As the various studies indicate, there is ample scope for genuine divergence of professional opinion and consequent differences and uncertainties in social and legislative policy. Incomplete knowledge and imperfect solutions may deny this legislation a place in the civil liberties hall of fame, but is it saved

73. McQuaid J. did make clear that he thought that the procedures contained in the *Mental Health Act* were perfectly adequate and that, given the existence of an alternate remedy, it was highly unlikely that a patient would be able to avail him/herself of the remedy of *habeas corpus* (at 584).

74. *Id.*, at 589-590.

75. [1987] 1 W.W.R. 468 (Man. Q.B.).

76. S.M., c. M-110.

from the brand of the arbitrary by the existence of a broad but ascertainable test and its ultimate dependence, in common with other legislation, on professional ability and integrity. In this case, both medical and judicial decisions are involved. . . . Given the standard as formulated, the committal process in the present type of case is not unreasonable, despotic, capricious or the like and does not fall within any of the other shades of meaning of the word "arbitrary".⁷⁷

The case of *Willis v. O'Reilly et al.*⁷⁸ raised an interesting procedural issue; namely, whether a patient may obtain an interlocutory injunction restraining the hospital authorities from continuing detention and administering treatment pending a determination of the constitutionality of the civil commitment legislation in question. Maurice J., of the Saskatchewan Court of Queen's Bench, recognized that, if the plaintiff were ultimately successful at trial, then "damages will not adequately compensate her for the harm she would have suffered through involuntary detention and treatment".⁷⁹ However, the Judge declined to grant an injunction on the basis, *inter alia*, that, if the plaintiff were successful in her application, all involuntary patients pursuant to the *Mental Health Services Act* would equally be entitled to their release pending the hearing of their cases:

Irreparable harm to the public would ensue from the release of patients who could cause harm to themselves or to others. There can be no injunction in the face of this danger.⁸⁰

The Judge also noted that the "balance of convenience" required that a law be considered constitutional until found otherwise.

The case of *Kohn v. Globerman and Shane; Kohn v. Winnipeg et al.*⁸¹ raises some potentially disturbing issues in the context of the potential contributions of the *Charter* to the evolution of patients' rights in the process of civil commitment. The plaintiff had been involuntarily committed to a psychiatric hospital but had been released two days later on the grounds that he was not a danger to himself or others. He commenced two separate, legal actions. The first action was against the

77. [1987] 1 W.W.R. 468, at 477. In *Clark v. Clark*, *supra*, note 69, the Court rejected the contention that the Ontario *Mental Incompetency Act* permitted arbitrary imprisonment, contrary to section 9 of the *Charter*. It was noted that the Act "is designed to *protect* those persons who by reason of arrested or incomplete development of mind need *protection*" (at 344). A challenge to the constitutionality of the Ontario *Mental Health Act*, on the basis of sections 7, 9 and 12 of the *Charter*, was similarly rejected without extended reasoning in *Re Azhar and Anderson*, *supra*, note 15.

78. (1986), 12 C.P.C. (2d) 257 (Sask. Q.B.).

79. *Id.*, at 259.

80. *Id.*

81. [1986] 4 W.W.R. 1 (Man.C.A.).

two psychiatrists, who had initially examined him and made committal orders. It alleged a conspiracy to falsely imprison him and sought a declaration that various sections of the Manitoba *Mental Health Act* infringed the *Charter*. The second action was against the two psychiatrists and others, alleging negligence, defamation, assault, false imprisonment and conspiracy. Section 96 of the Manitoba Act provided that a Judge of the Court of Queen's Bench may, upon summary application, stay proceedings brought against persons who were acting in pursuance of the legislation if he/she is satisfied that "there is no reasonable ground for alleging want of good faith or of reasonable care". In this case, the psychiatrists made a successful application to have the actions stayed. There was an appeal to the Manitoba Court of Appeal and, by a majority of 2-1, the decision of the Court of Queen's Bench was upheld. Of course, the immediate result of this decision was that the plaintiff was effectively precluded from having the merits of his constitutional challenges adjudicated. Speaking for the majority, Twaddle J.A. took a remarkably narrow approach to this particular matter and stated that the constitutional issues that had been raised did not involve the two defendant psychiatrists and that they were entitled to the protection of section 96 of the *Mental Health Act*.⁸² The Justice went on to say that:

The *Charter* thus ensures that no right guaranteed by it can be removed or restricted by legislative enactment, but it does not confer rights as between private citizens. Such rights must be determined by the ordinary law subject, of course, to the proviso that the statutory component of the ordinary law may be invalid to the extent that it purports to restrict the constitutional rights.⁸³

The Justice's judgement later concluded with the observation that the *Charter* does not prohibit the protection from liability of those who exercise statutory powers and asserted that such protection is not dependent on the validity of the power granting it:

It would be unjust to impose on these defendants a liability for carrying out the responsibilities imposed on them by the legislature because the legislature had exceeded its constitutional authority.⁸⁴

This line of reasoning is cause for considerable concern insofar as the future role of the *Charter* in the mental health law area is concerned. As O'Sullivan J.A. noted in dissent:

I agree that the *Charter* does not confer rights as between private citizens acting as such. But in the case before us it is alleged that the psychiatrists

82. *Id.*, at 16.

83. *Id.*

84. *Id.*, at 18.

misused state-given powers and I think that the *Charter* does apply to citizens who purport to exercise state-given powers where such exercise is in violation of constitutional rights.⁸⁵

The ruling of the majority clearly raises doubts as to the efficacy of *Charter* rights if they are not exercisable against mental health professionals acting under a statutory scheme of civil commitment. This particular case is also troublesome insofar as the plaintiff acted on his own behalf, without the benefit of counsel, and failed to challenge the constitutionality of section 96 of the *Mental Health Act*, a course which would have required the Court to determine this particular issue. One wonders if the majority would have adopted the same, highly restrictive approach had counsel appeared for the plaintiff.

V. *Dangerous Offender Legislation*

In the area of the notorious dangerous offender provisions of the *Criminal Code*, the *Charter* has merely fizzled, like a wet firecracker, instead of bursting like a bombshell. Indeed, there have been at least eight reported court decisions in which Part XXI of the *Criminal Code* has been attacked on the basis of the *Charter*, and in not one of these cases has such an attack even come close to being successful. Section 7 of the *Charter* is intended to guarantee the "life, liberty and security of the person" and to ensure that he/she will not be deprived of these "except in accordance with the principles of fundamental justice". A number of cases⁸⁶ have now held that the dangerous offender provisions of the *Code* do not violate this provision of the *Charter*. In one interesting case,⁸⁷ it was contended that evidence relating to the alleged future dangerousness of the accused should not be admissible because psychiatric or psychological evidence as to dangerousness is highly speculative at best and, as such, has very limited probative value. On this basis, it was contended that the dangerous offender provisions⁸⁸ offended the

85. *Id.*, at 8.

86. *R. v. Gustavson* (1982), 1 C.C.C. (3d) 470 (B.C.S.C.); *R. v. Langevin* (1984), 11 C.C.C. (3d) 336 (Ont.C.A.); *R. v. Lewis* (1984), 12 C.C.C. (3d) 353 (Ont.C.A.); *R. v. Lyons* (1984), 15 C.C.C. (3d) 129 (N.S.C.A.); *Re Moore and the Queen* (1984), 10 C.C.C. (3d) 306 (Ont. H.C.J.); *R. v. Vandale* (Ont. 31, 1984) 13 W.C.B. 173 (B.C.C.A.). Note that, in *Lewis*, leave to appeal to the Supreme Court of Canada was subsequently granted; however, the appeal was later abandoned owing to the death of the appellant ((1986), 25 C.C.C. (3d) 288 (S.C.C.)). The *Lyons* case subsequently reached the Supreme Court of Canada, which ruled (by a 5-2 majority) that the dangerous offender provisions of the *Code* do not contravene sections 7, 9, 11(f) or 12 of the *Charter*. See *Lyons v. The Queen* (1987), 37 C.C.C. (3d) 1.

87. *Re Moore and the Queen*, *id.*

88. In particular, s. 688(a) of the *Code*.

fundamental principles of justice, protected by s. 7 of the *Charter*, because they permit the admission of evidence that has little or no probative value. The Ontario High Court rejected this line of reasoning. While admitting that evidence as to future dangerousness may indeed be highly speculative, the Court held that the dangerous offender provisions were not in breach of s. 7 of the *Charter* because the National Parole Board would review the offender's case after three years and, at that stage, could consider any fresh evidence relating to his/her future dangerousness. The original three-year term of incarceration can be justified, said the Court, on the basis of the need to punish the accused for the offence(s) of which he/she has been convicted as well as the need to protect society from his/her "potential for dangerousness".⁸⁹

Another attack on the constitutionality of the dangerous offender provisions of the *Code* was launched under the banner of s. 9 of the *Charter*, which was designed to protect the citizen from arbitrary detention or imprisonment. In a case decided in the Supreme Court of the Northwest Territories,⁹⁰ it was held that the indeterminate sentence provided for by the dangerous offender provisions of the *Code* did not constitute arbitrary imprisonment because s. 688 made provision for a "rational and principled determination to be made by the courts".⁹¹ In this case, the Court did not address the issue of whether psychiatric predictions of future dangerousness could indeed provide the foundation for such a "rational and principled determination" by the trial Judge.

Section 12 of the *Charter*, which prohibits the imposition of "cruel and unusual treatment or punishment", has also been summoned in aid by those who would challenge the constitutionality of the dangerous offender provisions.⁹² The courts have lit a faint glimmer of hope in relation to section 12. In *Langevin*,⁹³ the Ontario Court of Appeal rejected the section 12 challenge, apparently on the grounds that the indeterminate sentence was not "cruel and unusual punishment", given Parliament's overall objective of protecting society, and that it was not likely that the offender would remain in custody "beyond the period of time during which he is considered dangerous" because the National

89. *Re Moore and the Queen*, *supra*, note 86 at 310-311. In *Langevin*, *supra*, note 86, the Ontario Court of Appeal ruled that studies indicating the unreliability of psychiatric predictions as to future dangerousness only affected the *weight* to be accorded to such psychiatric evidence and not its *admissibility*.

90. *Regina v. Simon* (no.3) (1982), 69 C.C.C. (2d) 557.

91. *Id.*, at 560.

92. *See generally*, W.S. Tarnopolsky, "Just Deserts or Cruel and Unusual Treatment or Punishment? Where Do We Look for Guidance", 10 *Ottawa Law Review* 1.

93. *Supra*, note 86.

Parole Board was charged with making periodical reviews of his/her detention.⁹⁴ No mention was made of the fact that the Parole Board also is forced to rely on unreliable psychiatric predictions of future dangerousness. However, other decisions have indicated that, while the dangerous offender provisions themselves do not contravene section 12 of the *Charter*, there may nevertheless be individual cases in which the particular offender is entitled to relief under the *Charter*. Indeed, In *Moore*,⁹⁵ the Ontario High Court clearly appeared to leave the door open to such a possibility.⁹⁶ In *Re Mitchell and the Queen*⁹⁷, a case involving a man who had been labelled an "habitual criminal" under provisions that were repealed in 1977, Justice Linden took an approach that could set the stage for the future use of section 12 of the *Charter* as a means of terminating excessively long periods of detention in *individual* cases. Mitchell had been detained as an "habitual criminal" for 12 years despite the fact that he had only been convicted of mainly "petty" property offences. Justice Linden ruled that Mitchell's detention might be in violation of section 12 of the *Charter*:

. . . I find that the continued detention of the applicant, if in fact he is no more than a social nuisance and not a danger to the public, satisfies the disproportionality test. To continue to detain such a man for more than 12 years surpasses all rational bounds of treatment or punishment and is so excessive as to outrage standards of decency.⁹⁸

However, it is interesting to note that Mitchell was not released at this point because the Court ruled that there was no evidence before it as to whether he was, in fact, dangerous. Justice Linden, therefore, ruled that a second hearing could be held, in which Mitchell would be invited to prove that he was not a danger to society.⁹⁹ Needless to say, it remains to be seen whether the approach embraced by Justice Linden will ever be applied so as to release an individual from continued indeterminate detention as a dangerous offender.

While there may be a faint glimmer of hope in the area of dangerous offender legislation, there is absolutely nothing to raise even this degree of hope in the courts' application of the *Charter* to the instrumentality of the Lieutenant-Governor's Warrant (LGW) that is responsible for the

94. *Id.*, at 359-363. See also *R v. Lyons*, *supra*, note 86 and *R. v. Noyes* (1986), 6 B.C.L.R. 306 (S.C.).

95. *Supra*, note 86.

96. *Id.*, at 311-314.

97. (1983), 6 C.C.C.(3d) 193 (Ont. H.Ct.).

98. *Id.*, at 219.

99. *Id.*, at 221. There is no subsequent report to indicate the outcome of such a hearing (if one was held).

indeterminate incarceration of those acquitted by reason of insanity or found unfit to stand trial. In a particularly instructive case, *R. v. Kieling*,¹⁰⁰ the accused had been confined for nine months under an LGW despite the fact that the maximum sentence for the offence, with which Kieling was charged, was only six months' imprisonment. However, the Ontario County Court ruled that this situation did not contravene section 12 of the *Charter*, which guards against "cruel and unusual treatment or punishment". It was held that the Review Board procedure prevented the possibility of unreasonable and unjustified detention and that the applicable provisions of the *Criminal Code*¹⁰¹ were intended both to ensure the treatment of the accused and the protection of the public and to place the accused in a position to make a full answer and defence as expeditiously as possible.

In *Re Rebic and the Queen*,¹⁰² the B.C. Supreme Court rejected an assault on the constitutionality of the LGW in a situation where the accused had been acquitted by reason of insanity in relation to a charge of threatening to use a weapon while committing an assault. It was contended, by the accused's counsel, that section 542(2) of the *Code* contravenes the equality of rights guaranteed by section 15 of the *Charter*. Murray J. swiftly rejected this contention by quoting from the judgement of the Ontario Court of Appeal in a case decided under the *Canadian Bill of Rights*, in 1980:¹⁰³

Society has a legitimate social interest in persons who have committed some serious social harm, but who have been found not to be criminally responsible on account of mental disorder; it is justified in subjecting those persons to further diagnosis and assessment, in exercising appropriate control over them, if necessary, and in providing them with suitable medical treatment.¹⁰⁴

However, Murray J. took the argument one step further by also holding that the applicable *Code* provisions should be considered as an affirmative action programme for the mentally disabled! Section 15(2) of the *Charter* permits unequal treatment of, *inter alia*, the mentally disabled, where such treatment occurs in the context of "any law, program or activity that has as its object the amelioration of conditions" of those who are disadvantaged by way of mental disability. The B.C. Court of Appeal subsequently upheld this decision, albeit adopting a somewhat different line of reasoning.¹⁰⁵ In dealing with the contention

100. (April 21, 1983), 9 W.C.B. 471 (Ont. Co. Ct).

101. Sections 543 and 545 of the *Criminal Code*.

102. (1985), 20 C.C.C.(3d) 196.

103. *R. v. Saxell* (1980), 59 C.C.C. (2d) 176.

104. *Id.*, at 187.

105. (1986), 28 C.C.C. (3d) 154.

that section 542(2) of the *Code* infringed section 15 of the *Charter*, the Court ruled that the true parallel to be drawn, in terms of equitable treatment, was between the insanity acquittee and a person *convicted* of an offence rather than between an insanity acquittee and a person acquitted of an offence in the normal fashion. In the Court's view, a person acquitted by reason of insanity must first be proved to have committed the conduct which constitutes the gist of the criminal charge and, once this has been done, he/she is only "acquitted" because of his/her mental condition at the time of the act in question. Therefore, it was held that there was no inequality of treatment between insanity acquittees and other acquitted persons.

A similar approach was adopted by the Ontario Court of Appeal in *Regina v. Swain*.¹⁰⁶ In this case, the majority of the Court ruled that section 542(2) of the *Code* must be viewed in light of the overall statutory scheme for dealing with those accused persons who have been acquitted by reason of insanity. In the majority's view, this overall scheme did not infringe upon the principles of fundamental justice, guaranteed by section 7 of the *Charter*. Thorson J.A. noted that the requirements of due process are met by the provisions found in sections 545 and 547 of the *Code*.¹⁰⁷ It was also held that section 542(2) did not violate the accused's protection against arbitrary detention or imprisonment, as guaranteed by section 9 of the *Charter*. Thorson J.A. stated, in this respect, that

... the finding of not guilty by reason of insanity raises what I accept to be a reasonable concern that the accused may remain a danger to the public and in need of further treatment. Under the statute, it is only after such a finding has been made that the State acquires the right to deprive him for the time being of his liberty in order that these matters may be properly assessed, under conditions that ensure the protection of the public.¹⁰⁸

The Court of Appeal also rejected challenges to section 542(2) based on sections 12 and 15 of the *Charter*. In any event, it was held that, even if section 542(2) did infringe any of the accused's rights under the *Charter*, it nevertheless constituted a "reasonable" limitation within the terms of section 1.¹⁰⁹

There is certainly a degree of irony manifested in the fact that, while the courts appear to have held consistently that the instrumentality of the LGW does not contravene the requirements of the *Charter*, the (former) Minister of Justice recently introduced draft legislation to "modernize

106. (1986), 24 C.C.C.(3d) 385.

107. *Id.*, at 408-415. Thorson J.A. noted that section 545 requires the Lieutenant Governor to make an order either for the accused's release or for his/her continued detention. It was also pointed out that section 547 requires periodic review of an accused's case by the review board.

108. *Id.*, at 415-416.

109. *Id.*, at 424-427.

and clarify *Criminal Code* provisions with respect to mentally disordered offenders".¹¹⁰ Among the most significant of the proposed reforms to the *Code* is the abolition of the role of the Lieutenant Governors in the disposition and review process for individuals acquitted by reason of insanity or found unfit to stand trial; the vacuum would be filled by the review boards, which would be granted full decision-making powers in relation to the disposition of such persons.¹¹¹ In addition, the proposed amendments contain a provision to "cap" or set a maximum limit upon the period during which such a person may be held in custody.¹¹² Interestingly, in each case, the rationale for these proposed reforms is based upon the perceived requirements of the *Charter*¹¹³. Since the introduction of the draft legislation, Parliament was prorogued and it remains to be seen whether the new Minister of Justice will re-introduce the proposed amendments in the new session.

In one other case¹¹⁴ involving the insanity defence and the *Charter*, the Manitoba Court of Appeal ruled that Section 16(4) of the *Criminal Code*, which places the burden of proof in relation to the insanity defence upon the accused, does not contravene section 11(d) of the *Charter*, which guarantees the presumption of innocence. O'Sullivan, J.A. noted that

...there is nothing in s. 16(4) of the *Code* contrary to the *Charter of Rights*. The onus remains on the Crown to prove every ingredient of an offence beyond a reasonable doubt but in doing so the Crown may rely on the presumption of sanity.¹¹⁵

Later, the learned Justice indicated that the presumption of sanity might well work to the accused's own advantage:

... I do not see any justification for holding that the *Charter of Rights* was intended to invalidate the presumption of sanity, a presumption which is

110. *Supra*, note 47.

111. It is proposed that the trial court may have a role to play in making an interim disposition in certain limited circumstances.

112. For those individuals who are acquitted by reason of insanity in relation to a charge of first degree murder, the maximum period of detention would be for life. However, for all other offences against the person or for offences that endanger public security, the limit on incarceration would be either ten years or the maximum possible sentence of imprisonment for such an offence, whichever is less. For all other offences, the limit would be ten years or the maximum sentence, whichever is less. If an acquittee requires further hospitalization after the maximum period of detention has been completed, then he/she must be civilly committed under the terms of the applicable provincial mental health legislation. These proposals would also apply to those defendants found unfit to stand trial.

113. See Minister of Justice, *Information Paper*, *supra*, note 47, at 1-2.

114. *Regina v. Godfrey* (1984), 11 C.C.C. (3d) 233 (Man. C.A.).

115. *Id.*, at 237.

available not only to the Crown in criminal prosecutions but also to accused persons who might otherwise be sent off to a hospital for the insane for an indefinite period even though their insanity is in doubt.¹¹⁶

VI. *Conclusions*

I am never better than when I am mad. Then methinks I am a brave fellow; then I do wonders. But reason abuseth me, and there's the torment, there's the hell.

Thomas Kyd, *The Spanish Tragedy* (1592)

In light of the preceding analysis, it can perhaps be argued that Canadian mental health law has, in a number of respects, experienced certain reforms that reflect the influence of the “new legalism”, although it is fair to say that only a minority of Canadian provinces have so far witnessed the emergence of this trend. However, the advent of the *Charter* may very well herald the expansion of this development throughout the various Canadian jurisdictions.

As noted earlier, it would seem that the “new legalism” has had little, if any, impact upon the day-to-day balance of power between mental health professionals and patients since the process of civil commitment is still effectively in the control of the professionals and the major mechanism for overseeing this process is the mental health review tribunal which is itself dominated (in most Canadian jurisdictions) by the professionals themselves. If the “new legalism” has, to date, not resulted in the imposition of effective legal controls upon mental health professionals, the question arises as to whether there may be other (perhaps less desirable) effects of this emerging trend.

One aspect of the “new legalism”, as it has unfolded, is that it seems to represent an attempt to limit access to public mental health services. Although Gostin's conception of the “new legalism” envisages the use of the law to render effective mental health services more readily available to mental health patients, there has been no evidence in Canada of a desire to establish an unequivocal right to treatment services, whether in public hospitals or in the community.

On the other hand, the evolution of stricter criteria for the involuntary commitment of mental health patients will render compulsory admission a more difficult option and is likely to reduce the numbers of persons who are treated on this basis. Similarly, the imposition of stricter controls upon the use of certain mental health therapies and the requirement that certain treatment decisions be subjected to independent review is likely to exclude marginal groups of patients from access to hospitalization. In an

116. *Id.*, at 239.

atmosphere of increasing legal regulation, it may well be that only those persons who are deemed to be "treatable" will be admitted to hospital. The expansion of the review board system may also persuade mental health professionals to detain and treat only those patients who are suffering from the most severe forms of mental illness. Furthermore, since it ultimately requires the evolution of a system of vigorous advocacy on behalf of mental health patients, it could be argued that the "new legalism" could result in a situation where mental health professionals become even more reluctant to treat patients under the civil commitment option. One possible interpretation of the trend towards the "new legalism", therefore, is that it reflects an attempt on the part of governments to reduce the rate of increase in its expenditures on the mental health system. It is presumably no coincidence that the England and Wales *Mental Health Act, 1983* (according to Gostin, the archetype of the "new legalism") was enacted during the regime of Prime Minister Margaret Thatcher. Indeed, if we cast a glance south of the border to California, it may be noted that the "grandfather" of legalistic mental health statutes in the United States (namely, the Lanterman-Petris-Short Act of 1967) was enacted when then-Governor Ronald Reagan was making an explicit attempt to reduce expenditures upon the state's mental health system. As Warren notes in her book¹¹⁷ concerning the Act:

LPS was intended to partially replace the more costly 24-hour state hospital care system with less restrictive and less expensive alternatives, such as board and care homes, day-care centers, and community health clinics.

As Gordon and Verdun-Jones have suggested,¹¹⁸ the increase of formal legal controls on the delivery of mental health services in public hospitals may ultimately have its roots either in a so-called "fiscal crisis" in social welfare systems or in a calculated policy of "fiscal reallocation" in support of monetarist economic policies.

As a final comment, it should be noted that the rise of a "new legalism" has taken place within the context of three other developments of major importance in the mental health sector; namely, de-institutionalization, non-institutionalization and privatization. Public hospitals are releasing their inmates into the less salubrious quarters of a number of Canadian cities and increasingly legalistic mental health statutes are restricting access to such facilities on the part of potential patients.

117. C.A.B. Warren, *The Court of Last Resort: Mental Illness and the Law* (Chicago: University of Chicago Press, 1982), at 22.

118. See Gordon & Verdun-Jones, *supra*, note 1, at 78.

As de-institutionalization from the public hospitals takes place under the banner of enlightenment and humanitarianism, patients are being turned over, in increasing numbers, to the private sector. This development has been dubbed the "privatization and profitization of social control"¹¹⁹ and, in the specific case of the mental health system, the "recommodification" of the mental health patient.¹²⁰ According to Andrew Scull,¹²¹ a new "trade in lunacy" is taking shape in which the mental health patient is becoming a "commodity" to be bought and sold by the private sector in the welfare marketplace, as this sector assumes many of the social control and welfare functions relinquished by the state because of changes in its fiscal policies.

The track record of the private sector, insofar as its treatment of ex-mental health patients is concerned, leaves much to be desired, particularly where services are provided for *profit*. For example, in talking of the situation confronting de-institutionalized patients in Toronto, a Professor of Social Work at the University of Toronto¹²² has declared:

Though many group homes are run by committed and highly effective non-profit agencies, the vast majority of discharged clients are housed by private entrepreneurs, often under conditions that should be utterly unacceptable in any civilized society.

In Lightman's view, the actual practice of de-institutionalization in Canada "must rank as one of the great frauds of our day".¹²³ Giving the responsibility for caring for de-institutionalized patients to the family and the community promotes disastrous conditions when the state does not provide the resources necessary to permit either the family or the so-called "community" to assume this responsibility. According to Lightman, the consequence is that "ex-patients are ghettoized in cheap rooming houses concentrated in certain neighbourhoods of major urban centres, without access to adequate support services".¹²⁴

119. S. Spitzer & A.T. Scull, "Privatization and Capitalist Development: The Case of the Private Police" (1977), 25 *Social Problems* 18.

120. Scull, A.T., "A New Trade in Lunacy: The Re-Commodification of the Mental Patient" (1981), 24 *American Behavioral Scientist* 741.

121. *Id.*

122. E.S. Lightman, "The Impact of Government Economic Restraint on Mental Health Services in Canada" (1986), 34(1) *Canada's Mental Health* 24. See also Social Planning Council of Metro Toronto, *Caring for Profit: The Commercialization of Human Services in Ontario* (Toronto: S.P.C.M.T., 1984).

123. *Supra*, note 122, at 26. It is, by no means, clear that the conditions described by Lightman in relation to the urban area of Toronto are duplicated in all other urban centres in Canada. Obviously, more research needs to be undertaken in order to determine the situation across Canada as a whole.

124. *Id.*, at 26.

Obviously, if the "new legalism" is to serve the interests of the mental health patient, as opposed to those of the state, it will be necessary for provincial legislatures to entrench a right to effective mental health services (as Gostin originally envisaged in coining the phrase "new legalism") and such a right should include an entitlement to effective treatment in the community, wherever possible. The need to ensure an entitlement to treatment in the community may assume considerable importance in the future, if the trend towards "restraint" in expenditures on the mental health system continues apace. Indeed, American evidence suggests that the major casualty of fiscal retrenchment in the mental health sector has been community services,¹²⁵ despite the evidence that community alternatives are more effective and less costly than mental hospitalization.¹²⁶ In addition, it will be necessary for the mental health law of the future to concern itself more deeply with the regulation of the private sector. Traditionally, mental health legislation has been almost exclusively concerned with the control of potential abuses in the public sector. However, the abuses of the future are far more likely to occur in the private sector and, if an extra dose of legalism is to be administered on behalf of mental health patients, it is in the private sector that it should be delivered. Interestingly enough, the Australian State of New South Wales, which in 1983 enacted what many would consider to be a paragon of the "new legalism" in its *Mental Health Act, 1983*¹²⁷, placed great emphasis upon the need to control the activities of the private mental health sector. Furthermore, the government has decided not to implement the legalistic provisions of the Act until adequate funding is made available to community mental health and housing facilities.¹²⁸ Hopefully, some important lessons may be gleaned by Canadians from this approach, particularly insofar as the provision of accommodation for mental health patients in Canada is concerned.

As de-institutionalization proceeds apace, it is likely that there will be an increasing demand for the provision of guardianship services.¹²⁹ Guardians may be responsible for making treatment decisions on behalf

125. R.W. Surber *et al.*, "Effects of Fiscal Retrenchment on Public Mental Health Services for the Chronic Mentally Ill" (1986), 22 *Community Mental Health Journal* 215.

126. C.A. Kiesler & A.E. Sibulkin, *Mental Hospitalization: Myths and Facts About a National Crisis* (Beverly Hills: Sage Publications, 1987), c.9.

127. See S.N. Verdun-Jones, "The Dawn of a 'New Legalism' in Australia? The New South Wales *Mental Health Act, 1983* and Related Legislation" (1985), 8 *International Journal of Law and Psychiatry* 95.

128. *Id.*, at 98-99.

129. See R.M. Gordon, S.N. Verdun-Jones & D. MacDougall, *Standing in Their Shoes: Guardianship, Trusteeship and the Elderly Canadian* (Report submitted to the Social Sciences and Humanities Research Council of Canada, June 1986).

of, or in conjunction with, disabled and disordered persons and may act in such a manner as to ensure that the latter are housed and cared for in humane surroundings. With the exception of the province of Alberta, which maintains a public guardianship system,¹³⁰ relatively little attention has been paid in Canada to this device. Ironically, and perhaps predictably, although guardianship of the person has been a matter that has not attracted the attention of provincial legislatures, trusteeship of the property of disabled and disordered individuals has. Each of the ten Canadian provinces has established a publicly funded and operated trusteeship service that provides protective services.¹³¹ A well-informed cynic might well point out that there are at least two reasons why the state has been more eager to furnish protective services for an individual's property than for his/her person. First, trusteeship services are paid for out of the disabled individual's estate and, in many provinces, either a profit is made from such fees or a substantial portion of the cost of providing services is recovered from the estate. Second, the state has a strong interest in managing and maintaining the disabled person's property so that he/she does not become a charge upon the public purse.

It remains to be seen whether the rise of the "new legalism" will result not only in the imposition of a greater degree of control upon the practice of the mental health professions but also in the enshrinement of a right to effective treatment both in the hospital and the community settings. While a number of Canadian jurisdictions manifest an increasing number of elements of the "new legalism", these elements relate almost exclusively to the imposition of controls upon mental health professionals. To date, little attention has been paid to the need to harness mental health law in the service of a campaign to combat the tragic fallout from the intertwined policies of de-institutionalization, non-institutionalization and privatization. Obviously, Gostin's "new legalism" has only been implemented, if at all, on a partial basis. From the point of view of Canada's mental health patients, it remains to be seen whether half a loaf is better or worse than no loaf at all.

130. J. Christie, "Guardianship in Alberta, Canada", in T. Apolloni & T. Cooke, eds., *A New Look at Guardianship* (Baltimore: Brookes, 1984).

131. R.M. Gordon & S.N. Verdun-Jones, "Privatization and Protective Services for the Elderly: Some Observations on the Economics of the Aging Process" (1986), 8 *International Journal of Law and Psychiatry* 311.