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Medicine and the Law: The Challenges of Mental Illness

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Introduction

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Introduction

In this lecture, I offer some thoughts on a medical/legal issue that is old, yet perennially pertinent; that is common, yet extraordinary; that is well-known, yet all too often swept under the carpet. I refer to the issue—or more accurately the plethora of issues—that surround mental health and the law.

Let me begin with a few facts that demonstrate the importance of mental health and the law. I will start with an anecdote.

A couple of years ago I found myself at a dinner at Rideau Hall in honour of recipients of the Order of Canada. I was seated next to a police officer who was in charge of the police precinct in a downtown area of Toronto where people were poor and crime was high.

“What,” I asked the officer, “is the biggest challenge you face?”

I expected him to reply that his biggest problem was the defense-oriented Charter rulings the Supreme Court of Canada kept handing down. But, he surprised me.

“Our biggest problem,” the officer answered, “is mental illness.”

My dinner companion went on to explain that a large proportion of the people arrested and brought into his police station were not “true criminals,” but people who were mentally ill. They were people who had committed some offence, usually minor, occasionally more major, for no other reason than the confusion in their disordered minds.

* The Right Honourable Beverley McLachlin, PC, was appointed Chief Justice of Canada on 7 January 2000. The Dr. Saul Green Memorial Lecture is in honour of Dr. Green, a graduate from Dalhousie University’s Medical School and fellow of the Royal College of Physicians and Surgeons in Canada. The lecture is presented by the University of King’s College and the Shaar Shalom Synagogue. This paper is an adaptation of the lecture given by Chief Justice McLachlin in Halifax, Nova Scotia in October 2010. It is printed with permission of the author.

Whatever the reason for these individuals' actions, the officer told me that the ordinary police processes did not respond well to their situations: how are the police, who are not doctors or nurses, to deal with continuing acts of derangement? How do they read a person their rights when they are not capable of listening to, or comprehending their situation? How do they find them lawyers and arrange appearances before judges? In the end, where the initiating incident is not of great consequence, often all that can be done is to hold the mentally ill person for a few hours and then return him to the street, where the cycle begins all over again.

We do not like to talk about mental illness, but as people like this police officer attest, it is a huge problem.

According to a Health Canada report, approximately twenty per cent of individuals will experience a mental disorder of one sort or another in the course of their lifetime. Of course, many of the remaining eighty per cent will be indirectly affected by the mental illnesses of family members, friends or colleagues.\(^2\) Statistics tell us that two per cent of our population suffers from schizophrenia or bi-polar disease, and eight per cent will experience major depression at some time in their lives.\(^3\) The link between individuals suffering from mental illness and their involvement in the criminal justice system is clear; it is estimated that up to fifty per cent of prisoners have anti-social personality disorder—often referred to as psychopathy.\(^4\)

The facts are clear. Mental health is a huge and all too common problem. Perhaps more than any other health problem, it engages the legal system and the general society in a host of different ways. It is a changing problem. Mental illness is probably much as it ever was, although there was so little study of it in past centuries that is hard to know for sure. What has changed are two things. First, we now realize that mental illness is just that—an illness. It is not madness, craziness, or possession of the devil, as people thought in the past. It is a sickness. We now know that major mental diseases, like schizophrenia, are concerned with chemistry in the brain and how it affects the transfer of impulses across the synapses. We now know that many major mental illnesses have a genetic component. (Not that this in itself is new. In the past people would say things like: "The family is crazy," or "she has bad blood lines.") We know that while sometimes psychotherapy can help, sufferers cannot will mental illness

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3. *Ibid* at 8.
away; like cancer or heart disease, it is there. It can be managed. But it is a stark fact at the core of the sufferer’s life.

Second, along with our growing understanding of mental health, our attitudes toward it are changing. Along with increased awareness and knowledge has come improvement in treatment. Drugs have been developed to control schizophrenia, bi-polar disease and chronic depression. Support therapy has been refined. The importance of community health is better understood. We no longer blame the person with mental illness for being ill, as we once did. We no longer think of the person with mental illness as less worthy, or less valuable. We no longer deal with mental illness by locking the person with mental illness away in institutions. Or so we like to think. The sad truth is that we still too often stigmatize people with mental illness. We still too often fail to provide the care and treatment and consideration they deserve as human beings. In this way, we commit the modern equivalent of the past sins of incarceration. Notwithstanding modern knowledge and modern treatments, we still have a long way to go in meeting the mental health challenge.

New knowledge and attitudes about mental health are confronting us with new moral and legal challenges. Mental illness raises difficult problems regarding how the criminal law system should treat people with mental illness. In civil law, it raises thorny legal problems relating to capacity and consent to treatment. We are confronted with how our supposedly just society deals with the person with mental illness as victim. One cannot delve very deeply into mental health issues without encountering fundamental questions. When is it just to hold a person responsible for their criminal acts? Can the law limit the right to refuse hospitalization and medical treatment, and if so, where do the limits lie? What rights do family and society have to impose treatment? And what obligation do we, the supposedly mentally healthy, owe to our brothers and sisters with mental illness?

I would like to discuss the challenge of mental health from these three perspectives: (i) the person with mental illness and the criminal law; (ii) the person with mental illness and the civil law; and (iii) the person with mental illness as victim.

The problems of the present are rooted in the past. To understand the present, we must know something of the past.

I. A look at the past
Even a brief glance at history demonstrates that mental illness, like war and poverty, has always been part of the human condition. Yet the history of the law does not show a parallel preoccupation with the rights and
responsibilities of the mentally ill and of society toward them. Rather, until the nineteenth century, mental illness was associated with evil. The person with mental illness was said to be possessed of the devil or evil spirits. At the very least, this person was a deviant, a substandard model of the human species which God had chosen not to endow with normal mental habits. Mental illness was largely a religious matter, which it was thought the law and medicine could safely ignore. To this general pattern of neglect there was one exception. Where the person with mental illness was seen as a general threat, the law might be brought in to get rid of her.

The scientific revolution which began in the eighteenth century and blossomed in the nineteenth and twentieth centuries brought a new way of looking at mental illness. The old idea that it was caused by the devil or by God gave way to scientific inquiry into the causes of mental illness. Thus emerged acceptance of the fact that mental aberration and malfunction were, like physical aberration and malfunction, sicknesses. Given the rudimentary state of brain science, pharmacology and psychiatry, usually little could be done to alleviate the problem. The solution was to confine the afflicted in mental institutions. It was this model that was imported to Canada, where it remained the dominant way of treating mental illness until the latter part of the twentieth century.

Without suggesting that care and treatment were absent, the dark aspects of the confinement paradigm must be acknowledged. People were sometimes confined on improper grounds. In a day before divorce was a practical or acceptable solution to a bad marriage, it was not unknown for sane but upset women to be confined to mental institutions under legal orders obtained by their husbands, on the affidavit evidence of casually convinced doctors. Indeed, one of the first cases I encountered as an articled student in Edmonton, Alberta began with a call from the wife of a professor at the University of Alberta who had been committed to a mental institution by her husband. The grounds upon which she had been committed were false and we quickly obtained an order for her release and filed for divorce. This woman was my client for the better part of a year. She was sane, rational, and one of the most reasonable divorce clients I have ever encountered.

How many other women, I wondered, had been similarly confined over the years? How many had not been lucky enough or determined enough to free themselves?

Even when people with mental illness were properly confined, they sometimes suffered abuse. Electric shock treatment was routinely administered in the 1950s and 1960s. It is now seen as having often been abusive. In the 1920s and 1930s the laws of Alberta, British Columbia and
numerous American states provided for the forced sterilization of people considered “mentally deficient” and had them confined to institutions.\(^5\) Some courts explicitly accepted the eugenic principles that informed such legislation. For example, in the infamous 1927 case of *Buck v. Bell*, the United States Supreme Court upheld the constitutional validity of Virginia’s statute providing for the sterilization of “mental defectives.”\(^6\) In that case, Justice Holmes, an otherwise highly respected judge, wrote these striking words: “Three generations of imbeciles are enough.”\(^7\) Once again, we see the law being used not to help people with mental disabilities, but to oppress them.

Alberta’s *Sexual Sterilization Act* was repealed in 1972.\(^8\) While it was in force, some 2,800 sterilizations were performed.\(^9\) We now know that the *Sexual Sterilization Act* was applied in a discriminatory manner and that it had a disproportionate impact on disadvantaged groups including women and people of minority ethnic backgrounds.\(^10\) We also know that the statute was not only misguided and based on faulty science, but on many occasions sterilizations were performed without even meeting the legislation’s basic requirements.

Take, for instance, the tragic case of Leilani Muir. In 1955, when she was ten years old, Ms. Muir was institutionalized in an Alberta training school for the mentally deficient. Although she is a woman of normal intelligence, at the age of 14 she was irreversibly surgically sterilized while told she was undergoing an appendectomy. Ms. Muir’s sterilization and the resulting inability to have children had a profound and devastating effect on her life. In the 1990s Ms. Muir brought an action against the government of Alberta for her improper sterilization and institutionalization. Ms. Muir was eventually awarded a total of $740,780 in compensatory and aggravated damages by the Alberta Court of Queen’s Bench.\(^11\) Subsequently, the government of Alberta settled similar claims from other victims of sterilization and made payments totaling about $142 million.\(^12\)

\(^6\) *Buck v Bell*, 274 US 200 (1927).
\(^7\) Ibid at 207.
\(^8\) The *Sexual Sterilization Repeal Act*, SA 1972, c 87.
\(^9\) *Muir*, supra note 5.
\(^10\) Ibid.
\(^11\) Ibid.
In the 1960s and 1970s, a reaction against the confinement model of treatment for mental illness took hold. It was fuelled by public reaction against the abuses that were coming to light. It was also abetted by a growing understanding of the causes of various mental illnesses and their treatment. Diseases like schizophrenia and bi-polar disorder were linked to chemical changes in the brain, helping to dispel the lingering medieval notion that mental illness was somehow evil. At the same time, new medications offered hope for alleviating the symptoms of these diseases and helping their victims to lead more normal lives.

The result was a move away from automatic institutionalization of persons with mental illness. The enormous, secluded compounds housing thousands of patients, conveniently tucked out of public view in the countryside, gradually disappeared. New hospitals for the most serious cases were constructed, often in or near urban centers. Many of the patients formerly housed in institutions were released into society on medication.

While a necessary step, the rapid de-institutionalization of mental health care of the 1970s and 1980s created new problems. Many newly released patients were ill-prepared for transition into society. Frequently, the medications had unpleasant side-effects. Lacking close supervision, patients all too often stopped taking these medications. The result? People with mental illness on the street, seemingly without care or hope.

We are still struggling with the problems flowing from de-institutionalization. They are the sort of problems that lead the police officer I mentioned at the outset to say that persons with mental illness are his biggest challenge. The downtown streets of our large cities are peopled by thousands of homeless men and women, many of whom are mentally ill. Once again, mental illness challenges the law. Whereas before the law locked them into institutions, now it must interface with them in society. Whereas once the legal solution to mental illness was simple, now it is complex and difficult and what is more, expensive. Drugs cost money. Decent housing costs money. Hospitals and psychiatrists cost money. With so many competing demands on the public health care budget, the claims of persons with mental illness, who still hover on the margins of society, are too easily overlooked.

All of this impacts on the law, both criminal and civil, and the situation of the person with mental illness as victim. Which brings me to the first of the three perspectives I mentioned earlier.

II. *The person with mental illness and the criminal law*

Generally, to find a person guilty of a crime, the prosecution must establish two elements: (1) the criminal act; and (2) a guilty mind. The second
requirement raises problems in the case of a crime committed under
the influence of mental illness. The person may not possess the mental
faculties necessary to find that he or she had a guilty mind. Put in broad
philosophical terms, how can the law hold a person responsible for his or
her criminal act, if the person’s mental illness deprived him or her of a
functioning, deciding mind? Is not criminal responsibility and punishment
appropriate only when “the actor is a discerning moral agent, capable of
making choices between right and wrong”?13

For many years, English criminal law, from which we derived our
criminal law, had little to say about persons with mental illness. It seems
they were treated much like ordinary accused persons. The fact that they
may have been acting under delusions or compulsions or mania provided
no defence.

In the nineteenth century, the law finally took formal note of mental
illness and the issue of whether it could provide a defence. The case, still
famous and still referred to in our courts, was M’Naghten’s Case.14 By all
accounts, Daniel M’Naghten suffered from delusions of persecution and
was mentally ill. He believed his chief persecutor to be the Prime Minister
of England, Sir Robert Peel. M’Naghten went to London with the intention
of assassinating Peel. His chosen moment was a procession. However,
the plan failed when, in the absence of Queen Victoria, Peel rode in the
royal carriage. Peel’s own vehicle was occupied by his secretary Edward
Drummond. Mistaking the secretary for the Prime Minister, M’Naghten
shot and killed Drummond. M’Naghten was tried for murder, but the
jury returned a verdict of not guilty, on the ground of insanity. Although
M’Naghten spent the rest of his life in mental hospitals, the jury’s verdict
caused quite an uproar in Victorian London.

In reaction to this case, the House of Lords sent a series of questions
relating to the defence of insanity to the judges of England. Lord Chief
Justice Tindal’s answers to these questions on behalf of fourteen judges
are known as the M’Naghten Rules. To establish the defence of insanity,
Chief Justice Tindal said, an accused must clearly prove that “at the time
of the committing of the act, [he] was laboring under such a defect of
reason, from disease of the mind, as not to know the nature and quality
of the act he was doing; or if he did know it, that he did not know he was
doing what was wrong.”15

13. Winko v British Columbia (Forensic Psychiatric Institute), [1999] 2 SCR 625 at para 31, 175
DLR (4th) 193.
14. M’Naghten’s Case, (1843), 8 ER 718 HL.
15. Ibid at 722.
The law in Canada has expanded the mental illness defence beyond a merely cognitive test. Under our law, a person with mental illness will be exempt from criminal responsibility if she is incapable of *appreciating* the nature and quality of her actions. "Appreciating" involves more than simply "knowing", the word used in the *M'Naghten Rules*. Under the Canadian test, "[e]motional, as well as intellectual, awareness of the significance of the conduct, is in issue." Appreciating the nature and quality of an act involves knowledge of the physical quality of an act and an ability to perceive its consequences, impact and results.

This includes the ability to know that an act is "wrong" according to the moral standards of society. The focus is on the moral wrongfulness of the particular act in the perpetrator’s mind. The accused must have the intellectual ability to tell right from wrong in an abstract sense and "the ability to apply that knowledge in a rational way to the alleged criminal act." Thus an accused may well appreciate that her act will result in death and know that to kill is both illegal and morally wrong, but be unable by reason of mental illness to apply that knowledge and hence be exempt from criminal responsibility.

Traditionally, a successful insanity defense gave rise to a verdict of not guilty on account of insanity. When such a verdict was rendered, the trial judge was required to order that the person be held in strict custody until the pleasure of the Lieutenant Governor of the province was known. This system, commonly known as the Lieutenant Governor Warrants system, resulted in the automatic detention of persons acquitted by reason of insanity for a potentially indeterminate period of time, without any hearing and irrespective of whether that person actually posed a threat to society.

In 1991, pursuant to a constitutional challenge brought by Owen Swain, the Supreme Court of Canada held that the automatic detention of persons acquitted by reason of insanity was unconstitutional. Mr. Swain had been found not guilty by reason of insanity in relation to criminal charges arising from bizarre assaults on family members apparently committed in order to protect them from evil spirits. Swain was detained under the Lieutenant Governor Warrants system. Because detention was imposed automatically, without any hearing and without the application of any standard or criteria,

17. *Ibid* at 1162.
the majority of the Supreme Court held that the system infringed both the right not to be arbitrarily detained and the right to liberty protected by the Canadian Charter of Rights and Freedoms.\(^2\)

In response to the Swain decision, Parliament substantially re-vamped the Criminal Code\(^2\) provisions dealing with mental illness. For example, we no longer refer to the defense as insanity. Under the new regime, a person may be found *not criminally responsible on account of mental disorder*.\(^4\) This change in terminology recognizes that mental illness may operate to exempt an accused person from criminal responsibility. It also signifies that we are no longer faced with a stark choice between acquittal and conviction of persons with mental illness.

The law now offers a third alternative under which mentally ill offenders are diverted into a special stream where the twin goals of protecting the public and treating the ill offender fairly and appropriately are pursued.

The 1991 amendments also did away with the Lieutenant Governor Warrants\(^2\) system. Accused person’s found not criminally responsible—or NCR for short—are now dealt with under Part XX.1 of the Criminal Code. Under the new system, we no longer presume that a person found not criminally responsible is dangerous and must be detained. There are now individualized and periodic assessments of the NCR accused’s circumstances. Review Boards have been set up for each province. Three options—or dispositions—are available to a court or Review Board examining an NCR accused’s situation. First, if that person is not a significant threat to the safety of the public, an absolute discharge must be ordered. An absolute discharge frees the NCR accused and bring an end to involvement in the criminal justice system. If the NCR accused does present a significant threat, the court or Review Board must choose between a conditional discharge or detention in a hospital. Unless and until an absolute discharge is ordered, the NCR accused’s case is examined by the Review Board every 12 months.

\(^{22}\) Swain, supra note 20.

\(^{23}\) Criminal Code, RSC 1985, c C-46.

\(^{24}\) Ibid at s 672.34.

\(^{25}\) See S Hodgins et al, “Canadian Database: Patients Held on Lieutenant Governor Warrants” in *Forum on Corrections Research*, vol 2:3 (Ottawa: Department of Justice, 1990), online: Correctional Service Canada <http://www.csc-scc.gc.ca/text/pbct/forum/e023/e023b-eng.shtml> which states as follows:

The Lieutenant Governor Warrant is employed when the accused is deemed unfit to stand trial or is found to have been insane when the offence was committed. The majority of patients held on warrant (nearly 90%) had been deemed not guilty by reason of insanity, and the remaining 10% had been found unfit to stand trial. The warrant was used most often for serious crimes, such as homicide and sexual assault. On average, the patients had been held on warrant for six years.
In making a disposition, the *Criminal Code* provides that the court or Review Board must consider the need to protect the public from dangerous persons, the mental condition of the accused, the accused’s reintegration into society and the other needs of the accused.\(^{26}\) Moreover, the Code further provides that the disposition must be the least onerous and least restrictive to the accused that is still consistent with public safety.\(^{27}\) If the court or Review Board is unable to positively conclude that the NCR accused is a significant threat to public safety, an absolute discharge must be ordered.\(^{28}\)

This new regime has withstood constitutional challenge. In the case of *Winko v. British Columbia (Forensic Psychiatric Institute)* the Supreme Court of Canada held that the system respects an NCR accused’s right to liberty protected by s. 7 of the *Charter* and her equality rights protected by s. 15 of the *Charter*.\(^{29}\) In particular, we found that the scheme interfered with an NCR accused’s liberty no more than strictly necessary to protect public safety.\(^{30}\) Similarly, because Parliament’s new regime does not presume dangerousness and provides for individualized assessment and treatment, “it reflects the view that NCR accused are entitled to sensitive care, rehabilitation and meaningful attempts to foster their participation in the community.”\(^{31}\) In this regard, the NCR system, although it may treat mentally ill offenders differently, respects their right to substantive equality. In short, the regime established in Part XX.1 of the *Criminal Code* appropriately balances the need to protect the public from those persons with mental illness who are dangerous and the liberty, autonomy and dignity interests of persons with mental illness.

One can see that the law has changed greatly in recent years in how it treats mentally ill offenders. Arguably it is much fairer and much more effective, geared as it is to rehabilitation. It is a flexible regime, designed to meet the offender’s needs.

A persistent problem, however, is the lack of adequate treatment facilities. Judges complain that they cannot refer mentally ill offenders for the assessments contemplated by the *Criminal Code*, due to lack of hospital facilities. The problem is particularly acute in Ontario where mentally ill offenders are often detained in jail while awaiting hospital beds for a psychiatric assessment. Not infrequently this results in the detention

\(^{26}\) *Supra* note 23 at s 672.54.

\(^{27}\) *Ibid.*

\(^{28}\) *Supra* note 13 at paras 47-49.

\(^{29}\) *Ibid.*

\(^{30}\) *Ibid* at para 71.

\(^{31}\) *Ibid* at para 90.
of individuals accused of relatively minor offences who otherwise would never be kept in custody. The consequences are sometimes tragic.

In November 2003, a man with a mental illness suddenly died in an Ottawa jail while awaiting an assessment in relation to an assault that actually had occurred while he was in the psychiatric wing of a local general hospital. This unfortunate man was apparently charged in order to facilitate his transfer to a specialized psychiatric hospital. Lack of hospital beds resulted in remand to the local jail of a man who desperately needed both physical and mental medical attention. A coroner’s jury looking into this death recently recommended that the practice of detaining persons with mental illness in jail while awaiting assessments should end. In another Ottawa case, a forty-five year old man with mental illness, who was arrested on minor charges, apparently “fell through the cracks” and was held in jail for six months without being brought to court and without his lawyer or family members being notified.

The courts in Ontario have also weighed in on this issue. In 2003, an application was brought before the Ontario Superior Court of Justice by two individuals challenging the practice of detaining accused persons in jail pending the availability of beds for psychiatric assessments. The Court ruled that this practice was contrary to the relevant provisions of the Criminal Code and offends the right to liberty protected by s. 7 of the Charter and the right not to be arbitrarily detained guaranteed by s. 9 of the Charter.

In another case that demonstrates that lack of mental health resources also affects children, charges against a mentally troubled thirteen year old girl were stayed by an Ontario Provincial Court judge. Although the Judge had ordered an assessment in a psychiatric hospital, the young person in this case was initially sent to a youth detention centre and held there for fifteen days without counsel, her parents, or the court being informed. Eventually, pursuant to further court orders, a psychiatric assessment was conducted at a local children’s hospital and completed while this young person was in youth detention. According to Judge Dorval, lack of appropriate facilities for persons under age sixteen meant that she received only a cursory psychiatric assessment and was given anti-psychotic


33. Rupert, supra note 32; see also Jake Rupert, “He Doesn’t Look Like the Person I Knew”, Ottawa Citizen (4 June 2004).


medication, not for medical reasons, but simply to control her difficult behavior. In Judge Dorval’s view, this was differential treatment based on age and an infringement of the young person’s equality rights under s. 15 of the Charter.

Cases like this demonstrate both the existence of a resource deficit, and that this problem potentially impacts on the constitutionally protected rights of individuals involved in the criminal justice system.

Governments, however, must be given credit for recognizing these difficulties and seeking to address them. One response has been the development of specialized courts, including mental health courts. These courts provide an alternative to criminal prosecution by diverting accused with mental health problems to treatment programs in the community. As Brian Lennox, Chief Justice of the Ontario Court of Justice, said at the opening of the Mental Health Court in Ottawa:

The Ottawa Mental Health Court is an example of a progressive movement within criminal justice systems in North America and elsewhere in the world to create “problem-solving courts.” These courts, with collaborative interdisciplinary teams of professionals and community agencies, attempt to identify and to deal with some of the underlying factors contributing to criminal activity, which have often not been very well-addressed by the conventional criminal justice process. The goal is to satisfy the traditional criminal law function of protection of the public by addressing in individual cases the real rather than the apparent causes that lead to conflict with the law.36

Mental health courts have opened in Ontario, New Brunswick and Newfoundland.37 Many other jurisdictions, including British Columbia, Manitoba, Nunavut and Yukon, are in various stages of developing these courts. Because mental health courts are a recent phenomenon, there is little data that can be used to assess their success. Nonetheless, a 2006 evaluation of the Brooklyn Mental Health Court indicated significant improvements in several outcome measures, including substance abuse, psychiatric hospitalizations, homelessness and recidivism.38 Anecdotal evidence from judges I have spoken to also indicates that these courts do much to alleviate the problems.

37. Ibid.
At the same time, the struggle for adequate facilities for people with mental illness under detention orders continues. The situation of persons with mental illness involved in each province’s criminal justice system is being addressed, but still haltingly.

III. The person with mental illness and the civil law

Issues raised by mental illness are not limited to the criminal law. Difficult ethical and legal problems also arise in the civil justice system. When can a person with a mental illness be forcibly hospitalized? When can people with mental illness be forced to take medication? These questions engage vital yet conflicting interests. On the one hand lies the liberty of the individual and the right of the individual to make decisions concerning his treatment. On the other lies the tragic reality that people with mental illness often cannot, because of their illness, rationally make the decisions which may be to their benefit. Surely, their loved ones argue, we should be able to impose treatment at least to the point where they are restored and have the capacity to make a rational decision for themselves.

The controversy is rooted in a bleak past. I mentioned earlier the case of my perfectly sane client whose husband had her committed to a mental institution, from which she escaped only by perseverance and dint of the law. Victorian literature is rife with similar tales. Too often family members, frustrated by behavior they found to be difficult, solved the problem by swearing a declaration that their wife, child, mother, or father was “incompetent,” as the law put it. The result was that the person was taken away to a mental institution, where, barring intervention, they might languish indeterminably.

This still may happen, where the person with a mental illness poses a danger to himself or to society. Sometimes the issue is not committal to a facility but whether the person may be forced to take treatment—usually drugs—to help restore him or her to sanity. In either case, the situation puts conflicting goals in play. Where the issue is committal, the conflict is between the freedom of a person with a mental illness, on the one hand, and the need to protect society or the ill person himself from harm, on the other. Sometimes, suicide may be likely if the person is let be. Where the issue is therapy, the conflict is between the ill person’s freedom on the one hand, and the desire to restore the patient to an unclouded mental state where he or she is in a position to make a rational choice as to whether to accept treatment, on the other. In practice, the two issues often intertwine.

Committal to a hospital must be approached with great caution. Historically, the criterion for forcible admission to hospital of persons
with mental illness was simply the need for treatment. In the late 1970s, provincial legislatures began to replace the need for treatment criterion with one that permitted involuntary hospitalization based only on dangerousness. Now all Canadian jurisdictions permit the involuntary hospitalization of persons who present a danger to themselves or others. Still, the test varies. In some provinces the danger must be of physical or bodily harm. In others, a broader notion of danger is used and the risk of serious mental, emotional, social or even financial harm may justify forced hospitalization. The medical profession takes this responsibility very seriously, aware as they are of the right of each person, absent clear justification, to be free—a right grounded in the Canadian Charter of Rights and Freedoms. When committal is necessary, the aim is to use the period of containment for treatment, with a view to releasing the patient as quickly as possible.

Many of the controversies in recent years have focused not on committal, but on mandatory medical treatment of a person who has been committed to hospital either under Part XX.1 of the Criminal Code, which I just described, or under the civil committal process of a province. The issue in such cases is whether the person with mental illness has the capacity to know and weigh the facts relevant to the decision to refuse or accept medication and other therapies.

The dilemma at the heart of such cases is dramatically illustrated by a case in our Court, known popularly as the Starson case. Scott Starson—or Professor Starson as he calls himself—is an exceptionally intelligent and unique person. Although not formally trained in physics, in the past he had achieved substantial accomplishments in this field and received recognition from some members of the academic community. He had published several papers and a Stanford University Professor had even described his thinking as ten years ahead of its time.

However, Professor Starson is also mentally ill, resulting in delusions. For instance, he believed that he was on the leading edge of efforts to build a starship, claimed to be a world-class skier and arm wrestler, insisted that he was the greatest scientist in the world, and professed to be in communication with aliens. Professor Starson’s illness had also resulted in threatening and aggressive behavior that caused conflict with the criminal justice system. At the time of the Starson case, he was being detained in a

40. Ibid at 115ff.
psychiatric hospital, as a result of a verdict of not criminally responsible flowing from charges of uttering death threats against his neighbours.

Professor Starson’s physicians believed that medication would likely restore his health and prevent further deterioration. However, Professor Starson objected to medication of any form, claiming that it dulled his thinking and prevented him from working on his scientific pursuits.

Professor Starson’s psychiatrist found that he was not capable of making a decision with respect to the proposed treatment and should be forced, pursuant to Ontario’s *Health Care Consent Act, 1996*, to take medication needed to prevent further deterioration of his condition. Professor Starson applied to Ontario’s Consent and Capacity Board to review that decision. The Board confirmed the psychiatrist’s finding of incapacity. According to the Board, Professor Starson was in almost total denial of his illness, and that without an acknowledgment of illness, he could not relate treatment information to his own particular disorder. He could not understand the consequences of a decision to either refuse or consent to medication, or appreciate the risks and benefits of a treatment decision.

The matter went to court, and the Board’s decision was reversed. The issue was whether the Board’s decision to compel treatment was reasonable. The Ontario *Health Care Consent Act* provides that all persons are presumptively capable of making treatment decisions. A finding of incapacity requires evidence that the person does not have the cognitive ability to process, retain, and understand information relevant to making a decision about treatment, or to appreciate the reasonably foreseeable consequences of such a decision. In other words, a capable patient must be able to understand the relevant information, apply it to his or her personal circumstances, and weigh the foreseeable risks and benefits of a decision or lack of decision.

The majority of the Supreme Court of Canada held that the Board had misapplied the legal test for capacity by improperly allowing its view of Professor Starson’s best interests to influence its decision. Professor Starson understood that his brain did not function normally, and that the proposed treatment would have a normalizing effect. This, it held, satisfied the decision making requirements of the *Act*, entitling Professor Starson to refuse medication. The dissent would have upheld the Board’s decision on the ground that the evidence supported its view that while Dr. Starson had the ability to understand that he was ill, his mental delusions prevented him from properly weighing the consequences of refusing treatment.

43. Starson, supra note 41 at paras 12 and 13.
Unfortunately, the story does not end here. After the Supreme Court's decision in 2003, with Professor Starson's mental health untreated, his condition, both mental and physical, quickly deteriorated. In 2005, his treating physician and the Ontario Consent and Capacity Board found him to be incapable with respect to treatment with anti-psychotic medication. With his mother providing substitute consent, doctors began medicating him. By 2007, his condition had improved to the point where he could be discharged to out-patient status. Nonetheless, Professor Starson continues to contest the finding of incapacity with respect to treatment.44

Professor Starson's case illustrates the difficult choices that may arise in the context of treating the mentally ill—the conflict between the liberty of the patient to decide his fate and the desire of physicians and loved ones to see him rehabilitated. The paradox is cruel—freedom to refuse "medication" may in fact result in institutional confinement and continued debilitation.

The law governing involuntary hospitalization and involuntary treatment must balance the autonomy of the patient against conflicting concerns in a way that is respectful of the dignity and needs of people with mental illness. Currently, the balance pivots on degree of dangerousness. Absent danger of harm, liberty must be accorded. However, the debate continues. Some contend that the law should never permit mandatory hospitalization or treatment—the absolute liberty view. Others contend that the powers to force hospitalization and treatment should be broader, arguing that the liberty to make irrational choices dictated by illness is no liberty at all. Canadian law now strikes an intermediate position—liberty can be curtailed only exceptionally. It can be curtailed where the person with mental illness poses a risk of harm to himself or to others, or where she is shown to lack the capacity to understand and to weigh the factors at play in deciding whether to reject treatment.

IV. The person with mental illness as victim
Recently an editorial was published in the Toronto Star entitled "System Fails Mentally Ill" and is as follows:

It goes without saying that no one should lose his life over a few stolen lemons. But our health and corrections system failed 28-year-old Byron DeBassige long before his fateful confrontation with police in a Toronto park on Feb. 16, 2008.

He was a schizophrenic who had quit taking his medication; he was having difficulty at his supportive housing facility; and police had picked

him up for sniffing glue. But his probation officer, who might have helped him, didn’t know about any of this.

Then DeBassige stole two lemons. He was shot and killed by police after they confronted him and he refused to drop his knife.

The coroner’s inquest into his death released its recommendations last week; all 15 focus on improving communication and coordination between agencies, expanding access to mental health services, and reviewing existing laws and policies to determine if they are adequate to help the mentally ill when they are in crisis.

DeBassige is not the first mentally-ill man brandishing a weapon who has been shot by Toronto police. There have been at least nine similar cases in the last two decades. As a result of inquests into those cases, improvements in police training and practice have been made.

But, as these latest recommendations make clear, much more must be done to provide the necessary services so that those suffering from mental illness don’t get into a confrontation with the police in the first place.43

Earlier in this lecture, we focused on the person with mental illness accused of a crime, and the person with mental illness as candidate for forcible hospitalization and treatment. In this, the concluding part of my lecture, I would like to shift the focus to millions of people with mental illness who do not break the criminal law, and who remain untreated and at liberty. Too often, they are simply victims—victims of discrimination, ignorance, societal inefficiency and sometimes, as in the tragic case of Byron DeBassige, of violence—violence that too often results in their death.

Section 15 of the Charter of Rights and Freedoms, as well as the human rights codes in force in every province and territory, guarantee freedom from discrimination on the basis of disability. Mental illness is a disability. It is not a sin, nor a moral wrong; it is just a disability. Yet, persons with mental illness are routinely the objects of discrimination. Discrimination means treating another human being as less worthy on the basis not of their actual merits, but on the basis of stereotypical beliefs, conscious or unconscious, that the person is less able, or less deserving. The stark truth is that too often we discriminate against people with mental illness. We pass them lying on the street, but ignore pleas for better housing for people with mental illness. We care less about research into mental illness than into other illnesses. We are reluctant to give people with mental illness

jobs, even when they have struggled valiantly to conquer their illness. The stigma, fear, and concern persist. And so, we continue to marginalize them.

Discrimination is grounded in ignorance. If the police had realized that Byron DeBassige was ill, they would not have shot him. Had his probation officer, who might have helped him, been aware of his situation, the story might have ended differently. We need to know more and talk more and more openly about mental illness, if we are to avoid the spectre of the persons with mental illness as victims.

Related to both discrimination and ignorance is lack of social coordination on behalf of the people with mental illness. Hospitals, police, probation officers—all who play a role in a particular person’s life—must find ways to communicate, to talk to each other. Too often, the people with mental illness fall through the cracks of the social system that ought to be helping them. As the editorial states, we need better communication and co-ordination between agencies if we are to prevent more people with mental illness from becoming victims.

Conclusion
The legal, moral, and ethical issues for criminal and civil justice raised by mental illness are enormously difficult and complex. They are far from being solved and we will continue to grapple with them for the foreseeable future. Nevertheless, we can say this: great progress in the treatment of persons with mental illness has been made in both medicine and law.

Because of advances in medicine, we no longer view persons with mental illness as evil, sinful, or possessed. We know that they are not deserving of punishment. And, we know that persons with mental illness may be successfully treated. As a result, we no longer ignore their needs by simply removing them from view and leaving them to their unfortunate plight.

Advances in medicine have helped dispel assumptions based on ignorance and prejudice. For instance, we now realize that most persons with mental illness are not dangerous. The law has incorporated this realization by abandoning the presumption of dangerousness reflected in the old Lieutenant Governor Warrants system. The law now treats mentally ill offenders in a more appropriate manner and does not provide for their automatic and arbitrary detention. Instead, we have adopted a system that accords mentally ill offenders as much freedom as is consonant with public safety. Likewise, our law governing hospitalization and consent continues to grapple with the challenges of appropriately balancing the autonomy and
dignity of persons with mental illness with their right to treatment and the important objective of protecting the public from dangerous individuals.

There is much left to do. Science is a long way from unlocking all of the mysteries of mental illness. There remains much to learn about causes and possible courses of treatment. Uncovering these secrets is an important challenge for medicine. The challenge for the law is to keep pace with medical developments and ensure that the legal regime governing persons with mental illness is responsive to the current state of scientific knowledge. Our common challenge as doctors, lawyers, and judges is to work together in addressing the problems posed by mental illness. Laws cannot heal people, only services and treatment provided by medical professionals can achieve that ultimate goal. But the law can create a social and regulatory environment that assists medical professionals in delivering their services in a manner that is both ethical and respectful of the rights and needs of persons with mental illness.