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EQUITABLE MENTAL HEALTH LAW AND POLICY:

AN IMPOSSIBLE DREAM

by

Walter Rose-Christensen

LL.B. University of Manitoba, 1959

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS (CRIMINOLOGY)

in the school

of

Criminology

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SIMON FRASER UNIVERSITY

December 1987

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ISBN 0-315-48871-9

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Equitable Mental Health Law and Policy: an Impossible Dream

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ABSTRACT

Over the past few years, there has been a growing awareness that all is not well with the manner in which the mentally ill of our society are treated. In Canada, the passage of the *Constitution*, of which *The Charter of Rights and Freedoms* is part, has served to remind governments and the courts of this minority group.

This thesis traces briefly the evolution of legislation from the 14th century to the legalistic model of care and commitment of the 19th century. With the gradual increase in scientific and medical knowledge during the first half of the 20th century came the medical model for the treatment of the mentally ill as exemplified by the English mental health statute of 1959. This Act embodied the then-current belief that untrammelled medical discretion would protect and cure these unfortunates and provided a model that was adopted in the various Canadian provinces.

The thesis discusses the right to receive and the right to refuse treatment by examining current legislation and court decisions. The position of non-psychiatric patients is studied with respect to these rights and then compared with involuntarily committed patients and those mentally ill persons who are involved in the criminal process. Studies cited show the difficulties faced by the mental health professionals - large numbers and the absence of a formal specific instrument by which

the degree of competence can be assessed. The issue of competence and the lack of legislative provisions requiring the determination of competence is discussed along with the medical tendency to make such assessments according to an informal, global perspective rather than on a functional basis.

The thesis points out that, generally, the courts recognized individual rights ahead of legislatures and the public. The *Constitution* and the *Charter*, being relatively new as the supreme law of Canada, have not yet had a great impact upon this segment of society. The present early trend is for the courts to act conservatively when interpreting legislative provisions, but to be more liberal when dealing with individual circumstances.

This thesis concludes that while there is more strict legal control of commitment requirements and procedures and a greater recognition of some rights in a number of Canadian jurisdictions, there continues to be little regard for the necessity of assessing competence as the basis for determining treatment rights.

ACKNOWLEDGMENTS

There are a number of people who have kindly assisted me in this endeavor.

Dr. Simon N. Verdun-Jones has been patient and offered valued comments. At times, I am sure he was exasperated by my failure to appreciate how a thesis ought to be done and by my tardiness. He was able to appreciate some of the difficulties which beset me along the way.

Drs. Cousineau and Jackson have given of their time to serve on the examining committee. Their assistance has been appreciated.

To Aileen Sams, I wish to say thank you for the assistance in explaining the intricacies of the computer and university bureaucracy in order to meet the multitude of requirements.

Without the assistance of Vern Loewen, none of this would have been possible. Thank you.

To my wife, this is an expression of gratitude for being able to put up with my irascibility during the researching and writing of this manuscript. Despite broken bones and all, we both survived.

DEDICATION

To Marion

Her understanding is beyond comprehension.

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No voice divine the storm allay'd
No light propitious shone
When snatch'd from all effectual aid
We perish'd, each, alone;
But I beneath a rougher sea
And whelm'd in deeper gulphs than he

-from The Castaway, Cowper, 1799.

CHAPTER I
INTRODUCTION

Cowper's words in *The Castaway*, allegorically depicting those afflicted with insanity as being "beneath a rougher sea whelm'd in deeper gulphs"¹ pictures the forelornness of mentally ill persons who are involuntarily committed under provincial mental health laws and those who are held under a warrant of a Lieutenant-Governor. Whitley observes that legislation does not sufficiently describe the principles which should apply to these people.

This descriptive study will examine historical material, legislation, court cases and relevant commentaries. The major concerns are the right to receive treatment, and the right to refuse treatment concurrently with the issue of competence to make treatment decisions. Essentially, the first four chapters are a background against which the concepts of autonomy and competence are examined in Chapter VI. The judicial approach to these concepts is examined in Chapter VII.

In order to show the evolution of mental health legislation there is a brief history of legislation in this context from early times to the 19th century legalistic model; to the early 20th century medical model and to the beginning of an approach called the 'new legalism' in the 1980's. The comments of Thomas

¹Cowper, 1799, *The Castaway*; cited by S. Whitley, "Watching The Hellibore: The Role of The Advisory Board of Review", 1981, 14 *Man. L.J.* 259

Madox, H.M.R. Pope, Daniel Hack Tuke and Sir William Holdsworth are considered along with Kathleen Jones, Andrew Scull, Thomas Grisso, Simon Verdun-Jones and others. Each describe the mental health system from their perspective. Early statutes and commentaries are briefly examined in an effort to show the extent of policy and legislative change. Chapter III is an examination of current mental health legislation in the various provincial jurisdictions. Chapters IV and V provide details of current and proposed legislation dealing with those persons who are involved in the criminal process and are mentally ill.

It is with this background that the issue of competence to make treatment decisions is examined in Chapter VI wherein Benjamin Freedman is cited, expressing his concern for the people he calls the 'marginally competent'. This concern is discussed having regard to an individual's right to personal autonomy. Richard Freedman and Simon Verdun-Jones note in an article entitled "*The Right to Refuse Treatment - The Other Side of the Coin*",² that patients outside the mental health system have the right to refuse treatment. This has been long recognized in common law jurisdictions. Every patient has the right to "decide what (if anything) should be done to his body"³. Verdun-Jones further notes that the medical practitioner who infringes this right of autonomy does so at the risk of a

²*Ethical and Legal Perspectives on Sexual Aggression*, Richard Freedman & Simon N. Verdun-Jones, Criminal Research Centre, Simon Fraser University, Burnaby, B.C., 1987 (forthcoming).

³*Hopp v. Lepp* [1980] 2 S.C.R. 192, 196 per Laskin C.J.C.

criminal charge or a civil suit. Lawrence R. Tancredi, writing about the right to refuse treatment in the context of some American cases, notes that these cases "rest upon the basic principle that the individual has the right of self-determination."⁴ Cardozo J. said "Every human being of adult years and sound mind has the right to determine what shall be done with his body;..."⁵ The courts have required that consent to treatment, by competent patients, be voluntary and based upon an informed choice which should be the result of adequate information, having regard to the nature of the treatment and emotional stability of the patient. This latter issue is described as therapeutic privilege and ~~discussed~~ by Margaret Somerville.⁶

Within the mental health system, there are voluntary and involuntary patients. Voluntary patients are those who seek admission to a mental health facility and who have the concurrence of their personal physician. When voluntary patients seek to leave a facility in Alberta or B.C. or Manitoba, notice of such an intention must be given to the the director of the facility. During that notice period, facility authority can act to convert the patient's status to that of an involuntary

⁴Lawrence R. Tancredi, "The Right to Refuse Psychiatric Treatment: Some Legal and Ethical Considerations", *J. of Health Politics, Policy & Law* 5:514, 1980

⁵*Schloendorf v. The Society of the New York Hospital* (1914) 211 N.Y.125 129

⁶ *Consent to Medical Care*, Law Reform of Commission of Canada, Minister of Supply and Services Canada, Ottawa, 1979.

patient. In Nova Scotia, an informal (voluntary) patient can discharge him/herself at any time without notice (R.S.N.S. 1967 *Hospitals Act* c.249 section 37(1))

The imposition of treatment upon formal or involuntary patients is examined to illustrate that some provinces have authority to treat regardless of consent or competence. Ontario makes use of a Review Board to override a refusal to consent and to give treatment to incompetent patients. The new Saskatchewan *Mental Health Services Act* (1985, c.M-13.1) requires that the physician has reasonable grounds to believe that the patient does not fully understand his situation and cannot make an informed decision.

The *Criminal Code* sets out the procedure by which those who are determined to be unfit to stand trial and those who are found to be not guilty by reason of insanity, are handled. Federal and provincial legislation describe the manner of treatment of mentally ill patients. Marc E. Schiffer's two books, *Mental Disorder and The Criminal Trial*⁷ and *Psychiatry Behind Bars*⁸ are examined and commented upon. The *Charter of Rights and Freedoms*⁹ is discussed in the light of existing legislation and court decisions.

⁷Marc E. Schiffer, *Mental Disorder and The Criminal Trial*, Butterworths, Toronto, 1978

⁸Butterworths, 1982

⁹Part I of *The Constitution Act, 1982*, being Schedule B of the *Canada Act 1982 (U.K.)*, c.11.

When treatment is given to prisoners, there are no legislated guidelines as to the nature and standard of treatment. Within prison populations, there are mentally disordered prisoners who may receive minimal treatment involving group therapy and some individual counselling. Sometimes towards the end of a sentence, a prisoner will be committed as an involuntary patient in a provincial psychiatric facility. The treatment program may be the same as in jail or prison¹⁰ - a legal, perhaps immoral, means of extending the time of incarceration. The effectiveness of treatment given in such circumstances may be questionable having regard to the nature of the disorder and the length of sentence. Also one is left questioning the timing of the involuntary commitment. The mentally disordered inmates in provincial jails are confronted with the fact that psychiatric treatment is wholly within the discretion of jail authorities with no express or implicit right to treatment¹¹.

Competence is a central concern when looking at the right to receive and the right to refuse treatment. Only in one province is the assessment of competence specifically required within a short specified period of admission to a facility: Saskatchewan recently passed legislation which requires that a patient be determined to be incompetent in order to be admitted to a facility as an involuntary patient. With the *Charter* setting out

¹⁰Schiffer, 1982

¹¹Schiffer, 1982

equality provisions, there ought to be consideration of whether a specific assessment procedure is required in order that a mentally ill patient be treated the same as an 'ordinary' patient. Unless there has been an assessment of competence of a mentally ill patient, how can it be said that such a patient cannot make treatment decisions in the manner of an 'ordinary' patient?

A 1984 study conducted in a large U.S. hospital by Charles W. Lidz *et al* is discussed in Chapter VI. It points out the difficulties which an 'informed consent strategy' faces in a large facility where a patient is seen by a number of professionals and the staff are not convinced of the need to secure an informed consent. The study points out that as the patient is seen by a number of professionals it is unclear as to who is responsible for securing the consent. The authors note that the advocates of the informed consent concept had visualized the ordinary doctor-patient relationship of one-on-one. With the technical and bureaucratic developments of the past few years and with large hospitals and government involvement, it would appear that such a relationship may no longer be practical in institutions for the treatment of the mentally ill.

The philosophy of informed consent and competence herein is derived largely from the writing of Benjamin Freedman and Stephen Wear with reference to other commentaries. It is contended that if there is moral authority to support the

concept of informed consent, which includes a determination of competence, then there is a need to develop a practical application of the concept. Thomas Grisso has written about the preparation of assessment instruments to which reference is made in Chapter VII. Grisso, in order to meet the many different circumstances presented by the multiple types of mentally ill patients, seeks instruments that are sufficiently general, yet also specific enough to provide a guide for a determination of competence to make treatment decisions.

It is submitted that, as with 'ordinary' patients, there ought to be a presumption of competence to make treatment decisions for the mentally ill, especially the 'marginally competent'. If one accepts this presumption, then it becomes necessary to be more aware of the effectiveness of each aspect of treatment. If patients are to have more say about the treatment which is to be given to them, then the mental health professional will need to know what the treatment will do for the particular illness, what the possible side-effects are in order to be in a position to advise the patient. Melded into this concern about effectiveness of treatment is an awareness of a need for greater preciseness of psychiatric diagnosis. Effectiveness of treatment concerns will be written about briefly in the conclusions referring to the comments of E.M.Coles, Barabara Wootten and the text of C.D.Webster, R.J.Menzies and M.A.Jackson.

CHAPTER II

HISTORICAL ASPECTS

Introduction

Part I

It is hoped by tracing the legislative antecedents of present day legislation relating to mental health, that some insights will be gained about the treatment and protection of the madmen of the past and the mentally disordered of today. Legislation can be said to reflect public attitudes about, and the degree of social control of, various aspects of human activity. There was, however, no legislated concern about madmen during feudal times until 1342 because people rarely left the lands of their feudal lord who had the responsibility for these people within his domain. The evolvment of the Commercial Period and the growth of cities saw the beginning of legislative provisions concerning these people. Later in the Victorian period, it will be noted that some of the provisions bear a marked resemblance to some of today's enactments, e.g. requiring two certificates by two doctors for a committal. This chapter will show the beginning of public concern about the mentally ill, and the development of medical pre-eminence in the field of mental health. Then, there is the legalistic model which became prominent from 1890 to about 1930 as this model gradually gave way to the medical model with virtually unrestricted psychiatric discretion in the 1950's, culminating in the United Kingdom in

1959 with the passage of the *Mental Health (England and Wales) Act*. In 1982, there was a legislated move from this model to a type which incorporates some aspects of both the legal and medical models. It has been called 'new legalism'. 'New legalism' appears to be an attempt to insure that persons needing help from mental health professionals get that help with a minimal loss of liberty and in the least intrusive manner. It is hoped that this brief overview will assist in understanding present and proposed legislation in chapters two, three and four. With some knowledge of the past and present means of attending to the problems of the mentally ill, some philosophical thoughts about their rights and the issue of incompetence will be expressed in chapter VI. Finally, in chapter VII, the approach of the courts to the problems in this area will be examined. The approach of some courts will be seen to have developed in advance of legislation, recognizing competence as a variable concept rather than a global one which affected all aspects of an individual's life.

Early Period

Legislative intervention in the affairs of the mentally ill dates back to the 14th century when the *Statute of Prerogatives* was passed by Edward II (17 Edw. 11, c. 9) in 1342. H.M.R. Pope says that it is uncertain whether the statute was declaratory of existing law or was new law but it is certain that it is the

first statute to deal with 'idiots and lunatics'¹. Thomas Maddox cites cases during the reign of Edward I (1272-1307), in which the Crown attended to the property "of all natural fools" and the land was preserved for the benefit of heirs². The Statute of Edward II provided with respect to lunatics:

The king shall provide when any shall happen to fail his wit as there are many lucid intervals that their lord's lands and tenements shall be safely kept without waste or destruction and they and their household shall live and be maintained completely from the issue of same; and residue beyond their reasonable sustenance shall be kept to their use, to be delivered unto them when they recover their right mind; so that such lands and tenements shall in no wise within the time aforesaid be aliened; nor shall the king take anything for his use. And if the party shall die in such state, then the residue shall be distributed for heirs upon the advice of the Ordinary.

It was said by Lord Erskine that it was up to the Crown to look after those who cannot look after themselves - as a matter of Royal conscience.³

It is interesting to note the similarities between this old provision and some of the present legislation dealing with the mentally ill. There was a recognition that there were lucid periods, that families were entitled to maintenance, that the estate was to be protected and that the Crown was not to benefit from the estate. Since the times of William I & II and Henry I

¹H.M.R.Pope, M.A., *A Treatise on the Law and Practice of Lunacy*, Sweet & Maxwell Limited, London, 1892, p.25

²Thomas Maddox, *The History and Antiquities of the Exchequer of the Kings of England* 2nd ed., 1769, reprinted 1969, Augustus M. Kelly, Publishers, N.Y. p.323

³*Ex parte Cranmer* (1608) 12 Ves.449

(1066-1135) it was the Lord Chancellor to whom a petition was directed by persons seeking an appointment of guardianship of a lunatic.⁴ Kathleen Jones says that such applications were for those of considerable means and were rarely made⁵. This was due to the fact that madhouses had come into existence and it was easy to confine relatives there. In England, these places started to emerge in the 1700's. They were unlicensed and unsupervised. They came to be certified when legislation was passed "to diminish the inconvenience and expense of commissions in the nature of *writs de lunato inquirendo* [applications to the Chancellor] and to provide for the better care and treatment of idiots, lunatics and persons of unsound mind found by such inquisitions"((1833) 3 & 4 William IV,c.36). Jones says that she believes this "was the first attempt to put on a statutory basis, a procedure that had grown up piece-meal".⁶

The first legislation to provide for the maintenance of such people was passed in 1744, according to Hunter and Macalpine⁷. The Act, entitled *An Act for the Reducing the Laws Relating to Rogues, Vagabonds, Sturdy Beggars and Vagrants into One Act of Parliament*, provided that two justices of the peace may order at the expense of the patient, or failing that, of the parish,

⁴ Chapter in the *History of the Insane in the British Isles*, DANIEL HACK TUKE, Kegan, Paul, Trench & Co., London, 1882

⁵ note 10

⁶ note 7, p.222

⁷ 1968. Introduction to *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, John Connolly, M.D., J. Churchill, London, 1847.

persons of little or no estate who by lunacy or otherwise are furiously mad and dangerous to be abroad ... be apprehended and kept safely locked up in such secure places ... as justices may direct and appoint (if such justices find it necessary) to be chained ... during the time only as such lunacy or madness shall continue".⁸ Despite all the advances made during 20th century, present day mental health statutes still suffer from terms that are too broadly defined and rely upon individual judgements in their application and interpretation. The 1744 legislation said that custody was temporary, to be maintained while lunacy and madness continues. Lest it be thought that altruism and concern for these persons was the reason for making these provisions, it should be pointed out that Vagrancy Laws were amended during the reign of George II to include idiots and lunatics as a means of "mitigating a common nuisance".⁹ The *Vagrancy Laws* and the *Black Act* of George I (9 Geo.,c.22) were a means of social control as the feudal system was disintegrating and cities were developing in an era of commercial growth. Such laws could be seen as a means to keep people working and not wandering about aimlessly. With the growth of cities, such wanderers were more noticeable. For appearances' sake, something had to be done to remove the growing number of beggars and lunatics from within the cities, primarily London.

⁸ ibid p.8

⁹ 17 Geo.11,c.5.

While the amendments to the *Vagrancy Act* in 1744 spoke of 'curing', there was no mechanism for declaring a person cured. Following George III's insanity becoming public knowledge, it was advocated by the medical practitioners of the day, that treatment should be sought without "shame or secrecy" and such terms as 'patient' and 'hospital' came into use with respect to the insane.¹⁰ Thus far, legislation was more in the nature of social control than protection of those who could not look after themselves. The mad had been thought of as witches, but during the latter half of the 18th century, people's attitudes were changing to the extent that witchcraft trials were rare.¹¹ It is to be noted that legislative changes still related to Chancery insane persons. Such persons were those who had estates which could afford the cost of Chancery proceedings. Jurisdiction for declaring persons insane rested with the Chancellor who was personally delegated authority by the king. This role of the Chancellor had nothing to do with his being the Chief Justice of the Court of Chancery. "The Court of Chancery is not the curator of either the person or the estate of a person non compos mentis, whom it does not and cannot make its ward."¹² Persons with little or no estate had no legislative protection. The 1744 *Act* did not provide for a court hearing. The licensing of private mad-homes, where people could quietly hide their

¹⁰Kathleen Jones, Ph.D., *Law, Lunacy and Conscience 1744-1845: The Social History of the Care of the Insane*, Routledge & Kegan Paul Limited, London, 1955, p.56.

¹¹ibid, p.46.

¹² Sir William Holdsworth *A History of English Law*, vol.1, p.476.

'embarrassing relatives', was so loose that there were no provisions to impose a penalty for failure to comply with terms of a license and no authority for its revocation.

Middle Period

In the Early Period, the care of the poor insane was a family and community responsibility, where the quality of such care as was given, varied from family to family and community to community. With urbanization came the creation of institutions for various classes of dependents and deviants. Grob says :

The movement to establish public hospitals...was an expression of growing concern with the problems arising out of poverty, pauperism, disease and crime which in turn stimulated the emergence of distinct social policies and institutional structures intended to deal with these issues in the early decades of the 19th century".¹³

Grob, of course, is talking about American developments, as English institutions began earlier, but for much the same reasons. This public concern grew as urban areas grew, having, during the Commercial Period of English history when the feudal system was passing from the scene, been gradually replaced by an entrepreneurial system. 'Moral treatment' had begun in England with the belief that such treatment could restore the insane to health and instill 'correct' habits and values. The belief at the time was that buildings and isolation were in themselves cures, and Andrew Scull notes "There is evidence...that the

¹³Charles N. Grob, *Mental Institutions in America: Social Policy to 1875*, New York Free Press, 1973, p.85.

public viewed any slackening of the rigid segregation of the mad with more than passing trepidation, reasoning that lunatics would scarcely have been locked up in the first place unless it was not safe to leave them at large".¹⁴ Peter McCandless in Scull's book says that he believes the frequency and likelihood of conspiracies to place sane persons in asylums were rare and that "[T]he the greatest threat to civil liberty arose ...from ignorance, arrogance and narrow mindedness".¹⁵ The Victorian moral code tended "to equate the respectable with the reasonable, the unrespectable with the irrational".¹⁶ Early psychiatrists (alienists) by giving "an air of scientific authority" to hearings of insanity and "ascribing unconventional ideas and actions to insanity"¹⁷ set themselves up as guardians of this respectable code. "...[I]nsanity and immorality at times became all but indistinguishable"¹⁸

After a number of Bills had been passed by the House of Commons and defeated by the House of Lords, a Bill introduced by Lord Shaftsbury and supported by the government of Sir Robert Peel, was passed in 1845. This Bill unified the law with respect

¹⁴ *Madhouses, Mad-Doctors and Madmen* ANDREW SCULL ed., University of Pennsylvania Press, Philadelphia, 1981, *The Social History of Psychiatry in the Victorian Era* ANDREW SCULL, 5-32, p.13.

¹⁵ PETER McCANDLESS, *Liberty and Lunacy: The Victorians and Wrongfull Confinement*, 339-362, p.347. in *Madhouses, Mad-Doctors and Madmen*, ANDREW SCULL, ed., University of Pennsylvania Press, Philadelphia, 1981.

¹⁶ *ibid*, p.351.

¹⁷ *ibid*, p.352

¹⁸ Scull, p.25.

to the insane, their care and custody. The new *Act* and subsequent amendments through to 1890 required, among other things, that no one could be admitted to a licensed house without a medical certificate from two medical men at the request of the "nearest male relative"¹⁹, inspection of licensed houses by a Visitor²⁰ and a requirement that every county and borough provide an asylum for lunatics.

To The Present

Hunter and Macalpine note from the U.K.'s Standing Committee's Report (1815-16) that "the care and treatment of the insane could only be brought into line with other branches of medical practice if it were separated from the profit motive of the private mad-house system; from the indolence of magistrates who failed to provide accommodation and from the parsimony of parish offices who herded them into workhouses".²¹ Fortunately, we cannot have indolent magistrates today. With the collapse of the reform movement in the House of Commons, following the defeat of the above mentioned three Bills, it fell to philanthropists and publicity to convince the public of the need for reform. Bethlem and York Retreat are but two examples of institutions that contributed to the reform movement outside the

¹⁹ Sir Roland Knyvet Wilson, *History of Modern English Law*, 1875, p.264

²⁰This provision exists still in some Australian jurisdictions and bears a resemblance to Albert's Official Representative.

²¹Note 4, p.132.

government. Writings in periodicals, medical works by persons such as Sir Andrew Halliday, George Burrows and William Ellis added impetus to a new direction in looking at insanity - "...An interest in insanity not merely from a clinical point of view, but as a social problem"²².

The *Lunatic Act* of 1845 brought a unified approach to the care and custody of the insane and exemplified the slow evolution of the public concern which changed the 'lunatic' or 'mad-person' of 1744 to the 'person of unsound mind' of 1845.²³ By this enactment "... the system was...placed on a more permanent footing"²⁴ In 1853, a new provision was passed "as regards the private care of a lunatic not so found"²⁵ which provided that "no person could be received into a licensed house without a written order of the nearest male relative who is accessible and a certificate in the prescribed form from two medical men"²⁶ (16 & 17 Vict., c.96). Licensed premises for the insane, granted by Commissioners in Lunacy in London and by Magistrates of the county in other areas, were to be visited frequently and unexpectedly. Other legislation, passed in 1853 (16 & 17 Vict., c.70 & 69), permitted enquiries to be made with or without a jury and conducted by one or both Masters in Lunacy

²² *ibid*, p.195.

²³ *id*

²⁴ Note 20, p.264.

²⁵ *id*

²⁶ *id*

instead of a special commission for each case. Chapter 97 required every county and borough to provide an asylum for pauper lunatics. In 1874, lunatics for the first time were maintained by the State having previously been the responsibility of county and local authorities.

The *Lunacy Act* of 1890 exemplifies procedural protection in the legalistic model of mental health legislation. It incorporated within it the requirement that there be certification by a medical practitioner prior to confinement in an asylum as a private patient rather than the previous system of an application by a relative and two medical certificates. The 1890 statute marks the end of a century of reform to give the insane protection from wrongful detention. The campaign by the legal profession and a number of Lord Chancellors brought about the new law despite strenuous arguments by Lord Shaftsbury, chairman of the Lunacy Commission, and the medical profession which had argued that legal intervention had gone far enough. Their opinion was that judicial participation in the administrative process would deter families from seeking aid while the illness was "at an early curable stage".²⁷

The *Mental Health Treatment Act (U.K.) 1930* introduced voluntary admissions to public mental hospitals and authorized compulsory hospitalization of involuntary patients for set

²⁷CLIVE UNSWORTH, *The Balance of Medicine, Law and Medicine*, p.105, in *Social Work, Welfare and the State*, NOEL PARRY, MICHAEL RUSTINAND, CAROLE SATYAMURTI, eds., London, England, Edward Arnold (Publishers) Ltd., 1979.

maximum periods based upon medical certification and no judicial certification was required. Unsworth says the 1930 legislation brought about a large increase in the number of voluntary patients but little change so far as compulsory admissions were concerned. Unjustified detentions were guarded against by the introduction of mental health tribunals. The history of mental health legislation has been said to be due to "the rise of social and medical professions, advances in psychiatric treatment and the growth of humanitarian concerns for the disadvantaged"²⁸. Unsworth sees the developments as arising from "broad movements of social change"²⁹ and that there should be a re-evaluation of the roles played by each of these professions.

While it can be said that legalistic controls over the insane date back to the 1700's, the legalistic approach to insanity began with the *Act* of 1845. The legislation in the latter half of the 19th century set out in detail the legal formalities as to how, where and under what circumstances an individual was to be declared insane and what was to happen after the pronouncement. According to Larry Gostin, the *British Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, which presented its report in 1957 after three years work, saw existing relevant legislation as being "devised in the social ostracism of the late Victorian era, as attaching moral blame to deviant individuals by judicially

²⁸note 27, p.104

²⁹id

certifying them as insane."³⁰ The approach taken by the Commission was to regard disorders of the mind as being similar to diseases of the body in that patients had no control over them and were not responsible for such impairments - legally or morally. The resulting legislation³¹ saw to it that "psychiatric care would be available when it was medically prescribed ... without legal process and sanction"³². Thus began, in legislation, the medical model of attending to the needs of the insane. In the years between 1890 and 1957, there had developed a large body of psychiatric knowledge and a growing public concern which demanded treatment of such persons. The 1959 Act reflected a recognition of medical pre-eminence in the mental health field. The "wide discretionary authority delegated to the medical profession was made at a time of general optimism about the capacity of mankind to solve its age-long problems of disease and deviance"³³. Pharmacological advances were seen to presage a scientific breakthrough to cure schizophrenia. Medicine was seen as humane and the law appeared to subordinate individual welfare for a collective good³⁴. The legal formalism embodied in the Lunacy Laws of 1890 - 1930 limited use of

³⁰Larry Gostin, *The Merger of Incompetence and Certification: The Illustration of Unauthorized Medical Contact in the Psychiatric Context*, Int.J. of Law and Psychiatry, 2:127-167, 1979, p. 167

³¹*The Mental Health (England & Wales) Act 1959*

³²Gostin, *supra*, note 30

³³*ibid*, p. 128

³⁴*id*

compulsory powers in the mental health field and "often the term is used to signify the importance of judicial determination of the need for compulsory admission"³⁵.

Legal formalism was rejected in the 1959 Act which emphasized professional discretion. The U.K. *Mental Health (amendment) Act, 1982* has been seen as a move away from the unlimited professional discretion of the 1959 Act towards a model that is more legalistic in its nature, which, for various reasons, Gostin calls the 'new legalism'. Professor Kathleen Jones is of the opinion that legal intervention is only remedial and that "Legal enactments have been tried repeatedly and contributed little to genuine psychiatric programs"³⁶. Gostin is critical of this opinion stating that "Professor Jones' argument is directed against a legal formalism that few would support"³⁷. Contemporary legal thought does not support the attitudes found in the Victorian lunacy laws and supports the belief that law and humanism are not mutually exclusive. Gostin argues that health and social services should be based on enforceable rights and not dependent on charity or the discretion of mental health professionals. While there is no immutable obligation to provide such services, they cannot arbitrarily be withdrawn from specific groups or individuals once given. As equity and

³⁵ Larry Gostin, *Contemporary Social Historical Perspective on Mental Health Reform*, *Journal of Law and Society*, 10:47-70, 1983, p.47

³⁶ Kathleen Jones, *The Limitations of the Legal Approach to Mental Health*, *Int.J. of Law and Psychiatry*, 3:1-15, 1980, p.14

³⁷ *id*

fairness are the cornerstones of law, it must be apparent that unjust denial of services must be remedied by the law. Such right to services is not based upon moral philosophy but upon statutes. In this manner, the law as expressed in statutes, serves the mentally ill. It is in this sense that the 'new legalism' differs from the Victorian legalism. The law may be regarded as being individualistic and too narrow. However, in an activist role, it should be seen by the public and the practitioners of the law as a protector of personal dignity and status, prepared to assist to meet an individual's needs. It is those 'needs' which are in dispute between lawyers and psychiatrists. With memories of the legalistic tangle between Victorian times and the '50's, can there be any wonder about concerns as to how far the 'new legalism' will go to restrict the discretion of the mental health professional? Similarly, given the unfettered discretion given to psychiatrists during the '50's and '60's, can there be any doubt about the need to give statutory support to the dignity and rights of the mentally ill individual?

Gostin says that the essence of the 'new legalism' is to "insure a full and fair hearing of the case"³⁸ that is being considered without unnecessary formality. Previously, under the old lunacy laws, reviews by magistrates tended to be "routinized confirmation of medical authority" and failed to be a safeguard

³⁸note 35, p.54

against "unwarranted use of compulsory powers"³⁹. Verdun-Jones in his commentary on new mental health legislation in New South Wales, quotes Gostin's affirmation of the idealized and anticipated role of 'new legalism':

The new legal approach to psychiatry does not usurp the function of the caring professions. It seeks only to alter public perceptions of the mental health services, which should place an emphasis on the person distressed and not on the concerns of Society or the profession. Once this principle is accepted, it follows services should be provided as of right, according to the needs of the person and not at the discretion of the professional; a person's consent should be the operative factor and not what others feel would be in the individual's best interest; and the receipt of services should be for the benefit of the person and not to provide an automatic rationale for society to diminish the civil and social status of the individual. ⁴⁰

Verdun-Jones examines the new legislation and finds a number of innovative thrusts at the previously impervious shield around the medical model. He points to the rare use of a preamble to the Bill to set out the philosophical perspective of the government with respect to mental health.⁴¹ He suggests that this is to divert criticism that the detailed, explicit legal requirements are a return to the Victorian legalism, and are but one more step towards de-institutionalization and budget cuts. An Inquiry, called the Richmond Report, besides recommending de-institutionalization of the mentally ill and mentally

³⁹id

⁴⁰Simon Verdun-Jones, *The Dawn of 'New Legalism' in Australia? New South Wales Mental Health Act, 1983 and Related Legislation*, INTERNATIONAL JOURNAL OF LAW AND PSYCHIATRY, 1983, 8:95-118, p.97.

⁴¹ See the N.W.T.mental health legislation as another example in Appendix A.

disabled, suggested that a portion of the funds from the sale of institutional facilities be specifically committed to the creation and maintenance of community facilities for such persons.

It is in the area of community services and budget controls that much new legislation flounders. Plaut ⁴² illustrates that a legislated program is not necessarily an implemented program. Verdun-Jones points out in the last portion of his commentary that without provision for "specialized legal services for mental health patients" ⁴³, it is questionable that patients will be able to make use of the reforms. Without advocates with specialized knowledge "... the spirit of the new legalism will remain in the realm of aspiration rather than reality". ⁴⁴

Part II

As mental health legislation is placed within provincial jurisdiction, we move now to examine the evolvement of relevant legislation in one of the provinces, British Columbia.

In 1873, the first legislation of this sort was passed⁴⁵. This statute set out the management of insane asylums and how

⁴²Vicki L. Plaut, *Punishment Versus Treatment of the Guilty But Mentally Ill*, JOURNAL OF CRIMINAL LAW AND CRIMINOLOGY, 1983, 74:428-456

⁴³Note 40, p.116

⁴⁴id, p.117.

⁴⁵ *An Act Respecting Asylums for the Insane*, 36 Vict., c.28

persons were to be received into them. Section 6 said that no persons were to be received as a lunatic without a certificate from two qualified medical practitioners, verified by a stipendiary magistrate. The medical certificate shall state that the two doctors examined the patient "at the same time and in the presence of each other" (section 7) and that they had made due inquiry into the necessary facts and found the patient to be a lunatic. There was no provision for the discharge of a lunatic but the patient was to be detained "so long as he continues to be insane" (section 8). The *Act* sets out in detail how the cost of maintenance of the lunatic in the asylum was the responsibility of parents or spouse. There was a Medical Superintendent and a Superintendent of the Asylum. The former was "to direct and control the medical and moral treatment of the patients" (section 4). To be noted is the continuation of the English approach - moral treatment. The other Superintendent was responsible for the financial management of the asylum and was to perform his duties "in accordance with the direction of the Medical Superintendent" (section 5). Lunatic was defined as "any insane person, whether so found by inquisition or not" (section 23). In this *Act*, there is no definition of "insane person".

By amendment in 1893 (56 Vict., c. 18), the certificate, mentioned above, now requires that the two doctors examine the patient separate and apart from one another. By section 4, a person could lay an information if it was believed that the person was "insane and dangerous to be at large and exhibited a

purpose of committing some crime for which if committed he would be liable to be indicted." No person apprehended on a warrant could be detained for longer than three days. Within such period, a justice shall hear evidence from the family and friends about the habits of the suspect (section 7). If the person was found to be insane and dangerous to be at large, the justice shall commit that person "to the common goal...there to remain until the pleasure of the Lieutenant-Governor is known or until the prisoner is discharged (section 9). If, however, the person was shown to be a resident for at least six months, such committal was made pending admission to an asylum or, in appropriate circumstances, committed to a friend or relative until removal to an asylum, receipt of an order of the Lieutenant-Governor or otherwise discharged by law. There were two requirements for committal - insanity and dangerousness. Discharge under section 24 came about when the person was no longer insane and dangerous and not a fit person to be confined in an asylum. Criminals and lunatics were not to be kept in the same room. Native indians were not to be kept in asylums unless the federal government guaranteed to pay their costs. The committing doctors were now required to separate observed knowledge from hearsay evidence.

The first *Lunacy Act* in B.C. was passed in 1897 ⁴⁶ along with the *Hospital for the Insane Act* which repealed the previous *Insane Asylums Act*. The *Lunacy Act* dealt with the care and

⁴⁶61 Vict., c.126

commitment of lunatics which borrows extensively from the relevant 1890 Act in England. The enactment provided that an inquisition hearing could not hear evidence of the person's behavior which was more than two years old unless the justice directed otherwise. It was also provided that a person could be released on probation. The *Hospitals for the Insane Act* was amended several times, becoming the *Mental Hospitals Act* in 1912 and then the *Mental Health Act* in 1964. The *Patients' Estate Act*⁴⁷ succeeded the *Lunacy Act*

With this brief history of mental health legislation, the next chapter will examine present legislation. It is not intended to say in a definitive way why changes have been made but to merely point out that changes have been made. Today there appears to be a recognition that the stern model of the Victorian era and the broad discretionary powers incorporated in the medical model failed to meet adequately the needs of the mentally ill and the expectations and concerns of society. Revisions of some of the Canadian legislation seem to reflect concern for the needs and rights of these people in a model characterized by Gostin as the 'new legalism'.

⁴⁷S.B.C.1962, c.44

CHAPTER III

CURRENT LEGISLATION

The purpose of this chapter is to describe the provisions of the various mental health enactments in Canada with some comparisons and comments about them. In the appendices are relevant sections of each jurisdiction for easier reference.

Current legislation in each of the Canadian jurisdictions show the various historical developments referred to previously. As will be shown, Canadian statutes are varied in their approach to the rights of the mentally ill whether they are incarcerated in mental institutions or in correctional facilities. Some reflect concern for the mentally ill as individuals with rights and variable degrees of competence (Saskatchewan, New Brunswick). Others appear to rely solely on the medical model with individual rights being a secondary concern despite the use of Review Boards and shorter periods of commitment (B.C. and Newfoundland). In this chapter, it is intended to examine Canadian mental health legislation with respect to the right to receive, and the right to refuse, treatment and the requirement (or lack thereof) for a determination of competence to make an informed decision before treatment may be imposed. These issues will be discussed in the context of involuntary patients in psychiatric facilities, prisoners serving jail sentences and persons held under terms of a warrant of a Lieutenant-Governor. There is one basic assumption. Everyone has a right to "decide

what (if anything) should be done to his body".¹ This remains true except as may be varied by legislation, emergencies and incompetence.

In British Columbia, admission to a mental health facility is governed by the *Mental Health Act*.² There are informal admissions (sec.19) and formal admissions (sec.20).³ An informal or voluntary patient who seeks to leave the facility is required to give 72 hours notice of such intention to the director (section 19(4)). Discharge of the patient must be given if during that period the requirements for detention set out in section 20 cannot be met. For a person to be admitted as a formal or involuntary patient, the person must be in need of medical treatment and requiring care, supervision and control in a mental health facility for his protection or welfare or for the protection of others (sec.20). All patients are subject to the discipline and direction of the director and staff (sec.26). There appears to be no real distinction between an informal patient and a formal patient. Because of the restriction on leaving and imposed discipline, it is pointless to maintain the distinction.

There is no requirement in the *Act* to determine competence of patients. Treatment of whatever sort can be imposed upon any

¹*Hopp v. Lepp*[1980] 112 DLR(3d)67 p.70 per Laskin C.J.C.

²R.S.B.C. 1979, c.256 as amended.

³Sections of the *Act* referred to herein are in the Appendix A.

involuntary patient regardless of competence or refusal to accept treatment. The Director is required to provide "each patient...with professional service, care and treatment appropriate to his condition...and for those purposes may sign consent to treatment forms" (sec.8(1)(a)). A formal patient has a qualified right to treatment. The only guidance as to quality and nature of treatment is found in the above phrase - "appropriate to his condition". No minimum standards are set out in the *Act*. The authority of the Director to impose treatment is emphasized by an amendment in 1981, wherein it was stated that "treatment authorized by the director shall be deemed to be given with the consent of the person"(sec.25.2). It is possible that the provision to impose treatment without a determination of competence would not withstand a challenge under the *Charter of Rights and Freedoms*⁴

Prisoners held in B.C. provincial correctional centres or youth containment centres under the *Corrections Act*⁵ may be transferred to a provincial health facility under order of the Lieutenant-Governor -in-Council (section 25(1)) or under the authority of the person in charge of jails (section 25(2)) upon receipt of two medical certificates (section 20). The director of a mental health facility may accept those prisoners upon receipt of an application and copies of two medical certificates (section 20). The director "may authorize that the person

⁴ Canada Act, 1982 (U.K.) c.11.

⁵ R.S.B.C. 1979 c.70.

receive care and psychiatric treatment appropriate to his condition" (section 25(4)). Section 25.1 provides for the admission to provincial mental health facilities of persons found to be unfit to stand trial or not guilty by reason of insanity. It would appear that prisoners affected by the various provisions of section 25 have the right to treatment once the certificates prescribed in section 20 are given to the person in charge of the jail. The treatment to be given is that which is deemed appropriate to the prisoner/patient's condition. The question arises as to how doctors get to see mentally disordered prisoners to complete the required certificates. Who commences the procedure?⁶

In Alberta⁷, Nova Scotia⁸ and Newfoundland⁹, two medical certificates are required for an involuntary admission of a mentally ill person to an appropriate facility. Manitoba¹⁰ and Prince Edward Island¹¹ require a certificate from only one physician to admit an involuntary patient. Ontario also requires only one certificate but requires that the attending physician at the admitting facility examine the patient as well and then

⁶this will be discussed later

⁷R.S.A. 1980 *Mental Health Act* c.M-13, section 19.

⁸R.S.N.S. 1967 *Hospitals Act* c.249 as am. section 28.

⁹S.N. 1971 *Mental Health Act* No. 80 as am. section 6.

¹⁰S.M. 1965 *Mental Health Act* c.M-110 section 9.

¹¹R.S.P.E.I. 1974 c.M-9 as am. section 10.

certify to the director that the admission is appropriate¹². Quebec¹³ provides specifically for a psychiatric examination to be followed within 96 hours by an examination conducted by another psychiatrist for involuntary patients. The legislation, as cited above, permits treatment to be imposed upon a patient in Alberta (sections 15, 19 & 20), Manitoba (section 4) and Newfoundland (section 7(3)). In P.E.I., a patient is defined as "a person who is under observation, care or treatment of a psychiatric facility" (section 2(m) and to be admitted to a psychiatric facility, a physician must complete an application stating the patient is suffering from a mental disorder requiring hospitalization for the safety of self or others (section 10). Section 9 says "anyone in need of treatment...may be admitted." Treatment is implied.

So too, with Quebec, treatment is arguably implied by definition. Involuntary patients are subject to 'close treatment' (section 11 & 12) and committed persons are sent to hospital centres which are defined as places "equipped to admit and treat persons suffering from mental disorders". In Quebec, where a patient is suffering from mental illness, in order for a certificate of incompetency to manage one's affairs to be issued, a psychiatric assessment must be made by a registered

¹²R.S.O. 1980 *Mental Health Act* c.262 section 9 & 14.

¹³R.S.Q. 1977 *Mental Patients Protection Act* c.P-41 sections 3, 7, 12

psychiatrist¹⁴. Where such a patient refuses treatment, the curator will seek additional information and recommendations from consultants who are not physicians. This statute does not distinguish between competency to administer one's affairs and competency to consent to treatment¹⁵ Morrison says that many patients in Quebec who are capable of managing their estates, are placed under curatorship in order that they can be treated, even against their will¹⁶. He notes that the slowness and adversarial nature of the judicial procedure "may be appropriate in terms of choosing between rights of two opposing individuals but not between opposing rights in the same individual"¹⁷.

Legislation¹⁸, in Quebec in 1984, distinguishes between competency to manage one's estate and competency to consent to treatment and the Public Curator is no longer curator of the person unless the Court so orders. There is a provision for a substitute consent by a parent, spouse or close friend. At the time of Morrison's article, this legislation had not been proclaimed. Morrison notes in Quebec that some psychiatrists continue to use public curatorship to treat patients involuntarily and others use the *cure ferme* - the civil

¹⁴Public Curatorship Act, *S.Q. cap. C80, 1982*

¹⁵ Informed Consent, Competency, and Psychiatry: A Quebec Perspective, *DENIS MORRISON, Health Law in Canada 6:106-108, 1986*

¹⁶ *ibid*, p.107

¹⁷ *id*

¹⁸ Bill 20, 5th Session, 32nd Legislature, to amend Civil Code

commitment article 46- which is opposed by Morrison because this article authorizes only custody and not treatment. He supports those psychiatrists who broadly interpret the emergency principle and use persuasion to get patients to take their medication. Within the various provincial jurisdictions, there is no requirement to assess the competence of a patient to consent to, or to refuse, treatment except in Nova Scotia.

In Ontario and Nova Scotia, there is a mechanism which permits a substituted consent to be used when a patient is unable or unwilling to consent to treatment. Treatment cannot be imposed without the consent of an involuntary patient in Ontario (section 35(2)). Ontario's Act provides that, when an involuntary patient or nearest relative refuses consent, the attending physician may apply to a regional board for authorization of a treatment or course of treatment. Such treatment is that which is concurred in by two psychiatrists, (one a member and the other not a member of the facility in the patient is detained) each of whom state, after examining the patient, that the treatment will likely improve the patient's condition and that there will likely be no improvement without the treatment (section 35(4)). The Board, after hearing the evidence from the patient, nearest relative and/or Official Guardian and any others as the Board may deem appropriate, may recommend treatment. It may not authorize psychosurgery (section 35(5)). There is no specific direction as to when or by whom a patient shall be found incompetent. There is no presumption of

competence in the Act. There is however, a definition of competence: "having the ability to understand the subject matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent".¹⁹ The incongruous nature of this enactment is apparent when it is realized that within two subsections of the same section what is given in one subsection, is taken away in another subsection - that no involuntary patient shall be given treatment without his/her consent and provides a procedure by which that refusal can be overridden.²⁰ In one case, a competent involuntary patient and her family refused to consent to ECT treatment and the Board of Review gave its substituted consent. The issue was tested in court on the grounds that ECT was a form of psychosurgery as defined in the statute. The court held that it was not a form of psychosurgery and the Board had acted within its jurisdiction.²¹

In Nova Scotia, the *Hospital Act* (section 46(1)) provides that no patient in a hospital shall receive treatment without his/her consent. Section 34 provides that every patient admitted to a psychiatric facility shall be examined within three days of admission to determine if psychiatric services are needed. Section 43 says capacity to consent to treatment is to be determined by a psychiatrist of the facility within three days

¹⁹section 1(g).

²⁰section 35(2) and (4).

²¹*Re. T and Board of Review for the Western Region et al* (1983), 3 D.L.R.(4th) 442.

of admission to the facility. Section 44(2) sets out the guidelines for the examining psychiatrist:

Does the patient:

(a) understand the condition for which the treatment is proposed?

(b) understand the nature and purpose of the treatment?

(c) understand the risks involved in undergoing the treatment?

(d) understand the risks in not undergoing the treatment?

The psychiatrist shall assess whether or not the ability to consent has been affected by the patient's condition.

This last proviso is subjecting the patient to unlimited psychiatric discretion. As will be noted in the comments about the studies in Oregon by Bloom (1984) and Godard (1986) in chapter V, this amounts to saying that any refusal to accept treatment is a product of mental disorder. Where a person is found to be incapable of consenting to treatment, the person may be treated upon receiving the consent of his/her guardian (if there is one) or the spouse or next of kin or, if consent is "unable to be obtained, upon the obtaining of the consent of the Public Trustee"(section 46(2)). Capacity to consent is to be re-examined periodically (section 47) and, unless the re-examination is done within the time limits, there is a presumption of capacity to consent(section 48). The Act is

silent about whether a patient and/or spouse or kin may dispute a determination of incapacity. While the provision of section 47 expresses concern for the rights of patients and a belief in the autonomy of the individual there is little value in the section because the refusal of a competent patient can be overridden by relatively unfettered psychiatric discretion.

New Legislation

In 1985, three jurisdictions replaced or amended mental health legislation - Saskatchewan²²; Northwest Territories²³ and New Brunswick²⁴. The amendments to the New Brunswick *Act* have yet to be proclaimed.

From the name of the new Saskatchewan *Act* onward, it is apparent that there are major changes in the province's mental health law. The title which includes the word 'services' denotes an emphasis found in greater detail in section 3. The wording points to the need for services to people in need of psychiatric assistance rather than the creation and maintenance of institutions as set out in the equivalent section of the repealed *Act* (section 4). The new section 3 says, in part, that "the minister may do anything...consider[ed] advisable for preventing circumstances that lead to mental disorder and

²²1985 *Mental Health Services Act* c.M-13.1.

²³*Mental Health Act* c.6 (2nd 1985).

²⁴1985 *Mental Health Act* c.59.

distress and for promoting and restoring mental health and well-being...". To a greater extent, the new *Act* appears people-oriented.

There is a serious effort to meet possible challenges under the *Charter of Rights and Freedoms*. Section 14 of the *Saskatchewan Act* says that no one who receives mental health services shall be deprived of any right or privilege solely by reason of receiving mental health services except as may be excepted by this *Act*. Persons detained or apprehended under the *Act* have a right to be informed promptly of the reasons for such action (section 16(1)(a)) and a copy of the documentation which authorized the detention or apprehension shall be given to that person (section 16(1)(b)). This conforms with section 10 of the *Charter*. To meet a possible challenge under section 7 of the *Charter*, and recognizing that the terms 'voluntary' and 'detention' may be incompatible with the principles of fundamental justice, section 17 says, in part, that "a person may on his own request...receive assessment and treatment services as an outpatient...[or] with advice and on the arrangements of a physician with admitting privileges to an in-patient facility, may be admitted...as an in-patient." Section 25(1) provides that "no diagnostic or treatment services or procedures are to be carried out...except with...consent" of the patient or if incompetent, with the consent of the nearest relative. With respect to an involuntary patient, diagnostic procedures and treatment which are "consistent with good medical

practice" and "necessary" may be given without that patient's consent, provided, that the attending physician has explained "the purpose, nature and effect" of diagnosis and/or treatment and considered "the views [of] the patient" about choice of therapist, diagnosis and/or treatment and alternatives (section 25(3)).

There are three criteria which must be met in order for a person to be lawfully admitted to an in-patient facility as an involuntary patient. Those criteria are:

1. the person is suffering from a mental disorder for which treatment or care and supervision is needed and can only be supplied in an in-patient facility, and

2. the person is unable to fully understand and make a decision about his need for services because of the disorder, and

3. the person, due to the disorder, is likely to cause harm to self or others or suffer substantial mental or physical deterioration unless detained in an in-patient facility (section 24(2)).

All three criteria must be present "within the past 72 hours" of the examination conducted by two physicians (one of whom must be a psychiatrist). Upon the certificates being issued, the person may be detained "until the end of the 21st day following the day" of admission (section 24). It is for the physician with admitting privileges to an in-patient facility to assess the two

medical and the one legal criterion.

One of the unique features of this new legislation, is the provision of a mechanism whereby a person admitted to an in-patient facility has access to someone to advise him/her about rights under the *Act*. Section 10 says

The minister shall appoint one or more official representatives for each region to assist patients in understanding their rights and obligations pursuant to this Act.²⁵

The duties of the Official Representative are to be found in section 16(2) of the *Act* and Regulation 1, section 13. The duties include that upon receipt of notice of persons detained under the *Act* (sections 18, 19, 21, 22), the Official Representative is to visit the patient within 24 hours of detention. The Official Representative shall disclose the information received from a patient to no one except as required by law. This includes the director of the facility unless the means of identifying the patient are removed. While it is, perhaps, uncommon for a physician to err in making a judgement concerning a patient's ability "to fully understand and make an informed decision" concerning the need for treatment, it is arguable that a second opinion by the Official Representative concerning the competence of the patient would be appropriate.²⁶ The Official Representative is appointed by the minister upon the recommendation of the Legal Aid Commission

²⁵In many ways this is similar to the inspector under New Brunswick legislation to be discussed later.

²⁶See later comments on competence.

which receives a grant from the government for payment of these services. The inclusion of the Official Representative in assisting to determine the competence of the patient may preclude the possibility that the judgement of the physician was clouded by the medical needs and the wishes of the patient were given little weight. It is to be remembered that all three criteria set out in section 24(2)(a) must be present for a valid certificate to be issued.

The *Mental Health Act* of the North West Territories has a number of innovative provisions as well as provisos which update the mental health laws of the Territories. Initially, there is a preamble which sets out two guiding principles which are intended to aid the administrators to meet the intentions of the legislature. The first is a recognition of the multi-cultural nature of that jurisdiction's population and a direction that the culture be considered when there is to be a determination of whether a person is suffering from a mental disorder. Secondly, the *Act* should be applied in the least restrictive manner.

One novel feature in the legislation is the recognition of the scarcity of mental health professionals in the remote sparsely populated areas of the Territories. There is a provision to make use of lay people to provide emergency first aid. Section 2 defines 'lay dispenser' as "a person who is authorized by a Medical Health Officer, appointed pursuant to the *Public Health Act*, to administer emergency first aid in a community which is without a resident nurse." Section 21(2) sets

out that a lay dispenser can give emergency medical or psychiatric treatment where a registered nurse is not available and the patient cannot be placed immediately under the care of a medical practitioner. Such treatment must be necessary to preserve the health of the patient and a reasonable attempt must be made to communicate with a doctor before administering treatment.

Recognition of the cultural mosaic of the North West Territories is also found in section 8 which requires that a doctor making a psychiatric assessment of an aboriginal person who is not fluent in English or French but speaks an aboriginal language, consult with an elder from the same community of the person being assessed and secure from the elder an opinion as to whether the person in question is suffering from mental disorder.²⁷ It is interesting to note that section 2 defines mental disorder to include an inability "to meet the ordinary demands of life". This permits a recognition that the 'ordinary demands of life' in remote areas of the North may be very different from the demands in urban areas. The *Act* does not define 'aboriginal people'; that is defined in the *Charter* (section 35(2)).

The criteria by which any person in the NWT is to be measured in assessing the need for psychiatric treatment in a NWT hospital are found in section 9 and are the same as in

²⁷Under the *Official Languages Act* NWT 1984 (2nd) c.2 there are six Indian and one Eskimo aboriginal languages.

Ontario's *Mental Health Act*, namely the mental disorder is of such a nature that the likely result of not being hospitalized is serious bodily harm to that person or imminent and serious physical impairment of that person. The doctor must also have a reasonable cause to believe that the person has threatened or attempted to cause bodily harm to self or others or has shown a lack of competence to care for self.

Sections 10, 11, 12 & 13 set out similar criteria to those set out in section 9 and deal with the authority of other persons to order people to be examined. Section 10 authorizes an application to a justice or Territorial judge for an order that the person named in the application be psychiatrically examined by a medical practitioner. Sections 11, 12 and 13 deal with the authority of a psychologist, peace officer or "any person", who becomes aware of an individual within the guidelines of section 9, to take such a person into custody to a medical practitioner or territorial hospital when "circumstances are such that to proceed under section 10 would be unreasonable or would result in a delay that would likely result in serious bodily harm to that person or serious and imminent physical impairment to that person."

This new legislation permits the imposition of treatment upon an involuntary patient regardless of competence to consent. Section 21(1)(b) permits a medical practitioner to "administer emergency medical or psychiatric treatment [to a person who] has attained the age of majority and is mentally competent to give a

valid consent [and] refuses to consent." A medical practitioner, treating an involuntary patient in a hospital, may administer any treatment regardless of competence and/or rejection of the treatment if the patient's nearest relative consents (section 22). There are two restrictions on the type of treatment:

(a) "psychosurgery or lobotomy or other irreversible forms of treatment without the consent of the patient if the patient has reached the age of majority and is competent to give a valid consent"; or

(b) ECT without the consent of the patient who has reached the age of majority and is competent to give a valid consent or the patient's nearest relative gives consent when the patient is not of age or is not competent.

It would appear that treatment cannot be imposed upon a voluntary patient. A voluntary patient is one who is admitted to a hospital suffering from a mental disorder and upon the written recommendation of a medical practitioner and with a valid written consent of the patient (section 7). Except for emergencies, the treatment sections deal with involuntary patients (section 21 to 23). There is no provision for a voluntary patient to discharge himself/herself from a hospital. Discharges (sections 44 & 45) are effected by the hospital when the involuntary patient is "no longer suffering from a mental disorder..." to the degree necessary for committal, upon the order of the Supreme Court or Court of Appeal, or upon the expiry of the detention period. The

harshness of the treatment provisions is somewhat lessened by section 36 which requires the medical practitioner to inform the patient and nearest relative orally, "in language which the patient and his nearest relative can understand" of the reason for admission and the need for care and treatment prior to admission to the hospital. However, this does not alter the fact of imposed treatment upon a competent person who refuses treatment. An involuntary patient is entitled to receive an independent medical opinion as to his mental disorder and treatment (section 39) but there is no indication to whom such an application should be made or who selects the independent doctor, if one is available. By not making provision for a mechanism for determination of capacity or for implementation of section 39, the NWT legislature has failed to do what it sought to do - protect the mentally disordered adequately. The innovative principles set out in the preamble and the recognition of multi-culturalism in section 8 are diminished by the failure to put into practice the second principle of the preamble - use of the least restrictive manner of treatment.

Sections 32 to 35 are concerned with persons who appear in court charged or convicted of a territorial or federal offence and appear to be suffering from a mental disorder. Where it appears to a court, by evidence or by a report of at least one medical practitioner and the prosecutor and accused consent, that the accused suffers from a mental disorder, the court may remand the accused to a hospital for observation for a period of

less than 30 days. Except for emergencies as described in section 21, there is no provision for treatment. Within the period set by the court, the medical practitioner shall prepare a written report on the mental condition of the accused. There is no provision within the enactment as to what is to be done with the report if the accused is not considered to be unfit to stand trial or is unlikely to be found not guilty by reason of insanity but is mentally disordered. Hospital Orders as considered in the proposed amendments to the *Criminal Code* will be discussed when those amendments are examined.

New Brunswick's *Mental Health Act*, amended by S.N.B. c.59 and assented to on June 27, 1985 has yet to be proclaimed. In the present statute, mental disorder is defined as "any disease or disability of the mind", a definition similar to the definition found in the definition section in the proposed amendments to the C.C. . The new *Act* has a definition similar to that found in the new NWT statute - "a substantial disorder of thought, mood, perception, orientation or memory which grossly impairs a person's (a) behaviour (b) judgement (c) capacity to recognize reality or (d) ability to meet the ordinary demands of life, but does not include the disorder known as mental retardation;". This more detailed definition should bring more explicit criteria to mind when an individual is being examined. The definition of an involuntary patient is now included in the definition section - "a person who is detained in a psychiatric facility pursuant to an order by a tribunal under subsection

A tribunal, a court or administrative tribunal designated by the Lieutenant-Governor-in-Council, hears applications by attending physicians to admit persons to a psychiatric facility as involuntary patients. The attending physician must be of the opinion that the person suffers from a mental disorder, that recent behaviour of the person presents "substantial risk of imminent physical or psychological harm to himself or others" and should not be admitted as a voluntary patient and that there are no less restrictive appropriate alternatives (section 8(1)). This new provision is different from the former one in that the application is made to a tribunal rather than the psychiatric facility. A new section 7.1 speaks of an examination certificate to be used when a person is not suitable for admission as a voluntary patient. Such a certificate is authority for conveyance to a psychiatric facility where the person may be detained for observation and examination for 72 hours. The attending psychiatrist at the psychiatric facility has authority to restrain and administer "routine medical treatment" (section 7.1(4)(c)) which is defined as "generally recognized and acceptable medical treatment". At this stage, psychiatric treatment is not authorized. A person so detained has the right to be informed of the reasons for detention and to retain and instruct counsel. In the present Act, section 7 provided for the admission of a voluntary patient who was believed to be in need of "observation, care or treatment" in a psychiatric facility

upon the recommendation of a physician. The present section 8 provides for the assessment and treatment of involuntary patients for a period of not more than one month. The new section 8 calls upon the attending physician, after observation and examination of the patient to either:

1. release the person as one not needing "observation, care or treatment", or

2. admit the person as a voluntary patient if suitable and in need of observation, care or treatment, or

3. apply to a tribunal for admission as an involuntary patient.

The application shall be made to a tribunal within 72 hours of detention and an examination report completed by the attending physician shall accompany the application. The present section 13 provides for extension of the detention period. Renewal certificates are authority for treatment. The amending provisions repeal section 13 and provide, that on the first renewal for one month, examination by the attending psychiatrist is sufficient if the necessary criteria are present. On second renewal for a period of not more than three months, two psychiatrists (one being the attending psychiatrist) upon personal examination, must complete the appropriate form stating that the required criteria have been met. Any subsequent renewals (for six months) must be approved by the review board. The use of the review board in this context is new. The new

provisions call for a certificate of detention which is authority for the detention and treatment of involuntary patients.

Under the present statute, the presiding judge may find that a person who appears before him appears to suffer from a mental disorder, and direct him/her to attend at a psychiatric facility for examination (section 14(1)). The new provision directs the judge in these circumstances to order an examination. By subsequent subsections, that order is authority for a peace officer to take such person to a medical facility, psychiatric facility or a physician's office for examination.

The present section 29 remains unchanged and provides that a patient shall be discharged when he is no longer in need of observation, care or treatment as is provided in the psychiatric facility.

Concerning persons held under a warrant of the Lieutenant-Governor, the review board shall review each case at least once a year (section 34) and the procedure to be followed is as set out in section 32. There are only minor changes in the amendments except for the addition of subsection 5 which would permit a review board to engage independent medical, psychiatric or other professional persons to give evidence and make submissions.

The amendments alter the *Corrections Act*²⁸ by adding section

²⁸ R.S.N.B. 1973 c.26

16.1 which permits the minister to order a person in a correctional institution to be moved to a psychiatric facility upon receipt of an examination certificate completed by a medical practitioner.

There is nothing within the present *Act* or in the amendments which requires an assessment of competence to make decisions about the individual's need for treatment. Treatment can be imposed on a competent patient whether voluntary or involuntary. Section 36 deals with competence to manage his/her estate and that assessment is to be made upon the submission of a psychiatrist.

While not much comment has been made about many of the provisions within the various statutes, it is submitted that it is obvious the approach of the different legislative bodies in Canada is as diverse as the jurisdictions. There are some similarities as to basic provisions (review boards, shorter duration of initial commitment periods), but by omission, there is a virtual denial of the necessity of specific assessments of competence in 11 of the 12 jurisdictions. Changes in other jurisdictions in relation to other matters may be forthcoming. The new laws of the N.W.T., Saskatchewan, and New Brunswick may be forerunners of wider recognition of rights and protection of the mentally ill such as the Official Representative in Saskatchewan and the emphasis upon cultural matters in the N.W.T. However, it is submitted, there is a distinction to be considered between passing new legislation and implementing any

new approach or philosophy that may be espoused in the new legislation. Is there a readiness to fund the changes appropriately or is the new legislation merely political posturing? Undoubtedly, it is true the attitude of the persons involved in the treatment processes for these people is very important for the different approach to be allowed to function (as will be noted in Chapter VI), but without funds, there is no chance to assess the effectiveness of the new approach.

As indicated in Chapter II, Plaut has made a comparison between the states of Michigan and Illinois comparing the manner in which they introduced new legislation relating to the trials of the criminally insane. It illustrates the need for a budget commitment at the time of implementing a new approach to a problem in mental health services. Michigan, in 1976, passed legislation which permitted juries to find accused persons guilty but mentally ill, if the accused raised the defence of insanity which was not proved to the satisfaction of the jury. Upon the jury making a finding of guilty but mentally ill, the court had authority to impose a sentence and direct that the accused undergo assessment and treatment. Michigan's Supreme Court has ruled that there was, as a result of this legislation, a statutory right to treatment²⁹.

The Michigan statute provides that the treatment to be provided is as "psychiatricly indicated". Other states (Illinois and New Mexico) have passed legislation similar in nature but

²⁹ *People v. McLeod*, 407 Mich. 632, 637 [1980]

provide that treatment be given as is deemed necessary by the State's Department of Corrections. In Illinois, the change in the law was not accompanied by an additional appropriation of funds to allow for the additional examination and treatment. Plaut points out that persons found to be guilty but mentally ill in Illinois, received no different treatment than persons otherwise sentenced.

It is not intended to discuss the merit, or lack thereof, of such a determination but merely to illustrate that more than a change in the law is required when a change in policy is made. Indeed, governments' commitment to a policy change once the rhetoric has been cast aside, can be discerned by the extent to which they fund the policy change. The same could be said when considering the policy of de-institutionization and privatization of the after-care homes for the mentally ill.³⁰

³⁰see comments of Gordon and Verdun-Jones in Chapter VII.

CHAPTER IV

PRESENT CRIMINAL PROVISIONS

If it is accepted that the criminal process is intended to protect members of a society, then it should treat individuals as responsible beings, able to choose between breaking the law or not. Following from this, general sanctions imposed, set by legislatures and imposed by the courts, should be in proportion to the seriousness of the offence. Culprits should be treated individually and humanely. Restraint and humaneness, coupled with this presumption of responsibility should therefore, be foremost when examining the criminal process' interaction with the mentally disordered offender. One's responsibility for individual acts connotes control over acts and being accountable for the consequences of those acts. An inability to control one's acts as a consequence of mental disorder, logically requires that the criminal process attend to the matter humanely and justly.

The current law requires that persons who are found to be unfit to stand trial or not guilty by reason of insanity are to be held indefinitely pending the 'pleasure' of the Lieutenant-Governor. In each of the provinces there is a review board which has been created under the provisions of the *Criminal Code* (section 547) or by Order-in-Council. These boards make recommendations to the Lieutenant-Governor about whether to release a person held under a Lieutenant-Governor's warrant and

whether the release is to be absolute or conditional. The pleasure of the Lieutenant-Governor is a reflection of the demands of the provincial government. Those recommendations may or may not be the same as the review board's recommendations. This manner of dealing with such people is a reflection of society's attitude towards the mentally disordered. The attitude, judging from the absence of provisions in legislation to protect mentally disordered persons, appears to be one of wilfull blindness as to what happens to these people once the court no longer has jurisdiction over them. Also, there is an innate fear of 'crazy' people. There are, it is suggested, two basic reasons for this fear and why this colors society's attitude toward these people. First, loss of mind equates to loss of self. Second, the crimes which garner most headlines are those which are violent and may involve loss of life, and are committed by persons who may be mentally ill. It is that fear of violence which dominates these attitudes because violence, in the public's mind seems to be associated with the mentally disordered'

Presently, the criminal law provides two possible scenarios for the mentally disordered accused. The *Criminal Code* provides for those who are unfit to stand trial (section 534) and those who are found not guilty by reason of insanity (section 545). The *Code* ignores those who are mentally disordered but adjudged

'see Schiffer, chapter 1, note 11; Vernon L. Quinsey, Barry A. Boyd, *Assessment of the Characteristics of Dangerousness of Offenders Held Under Warrant of Lieutenant-Governor*, Crime and/et Justice, 4: 268-274, 1977.

fit and sane and are sentenced to a definite term of imprisonment. All three groups should be entitled to effective psychiatric treatment. There are no stated goals such as treatment and recovery set out in criminal legislation. "...[T]he law retains an unwholesome ambiguity as to what the disordered accused may face once he leaves the court room"²

The relevant provisions (sections 542, 545, 546, 547) are complex, being closely bound to the interfacing of a number of disciplines - medicine, psychiatry, psychology, social work, hospital administration, law and the criminal justice system. To this are added the moral and ethical points of view of the proponents of each discipline concerning the nature and quality of treatment; the appropriate time of discharge and the political conflicts over whether or not to release. The Canadian separation of powers between federal and provincial authorities further complicates the scene. The federal powers encompass the passage of criminal law and appointment of judges. With the provincial governments rests the authority to administer the law and to operate the courts and responsibility for mental health legislation.

One of the requirements of the criminal law of any sovereign state must be that it is uniform in all parts of the state. So too must be the manner in which persons are treated by the law. The concern here is with the treatment of those who, owing to

²MARC E. SCHIFFER, *Mental Disorder and the Criminal Process*, Butterworths, Toronto, 1978, p.289

their mental condition, cannot be said to be responsible for their criminal infractions. The *Criminal Code* makes no comment about what happens to such persons once the court no longer has jurisdiction over them. As Schiffer described it above - "an unwholesome ambiguity" is the plight of these people. To make all those who are not guilty by reason of insanity subject to provincial mental health legislation would be inappropriate. It has been noted previously that the terms of mental health legislation vary from province to province. The criteria for committal varies. Imposition of treatment is not consistent nor is the basis of release. Such divergence would mean that those people who have become involved in the criminal process would not be treated equally. Perhaps a person found not guilty by reason of insanity would be subject to involuntary commitment in one province and not in another and thus create an infringement of section 15(1) of the *Charter*:

Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular without discrimination based on...mental...disability.

Initial Order by Court and Initial Disposition by Lieutenant-Governor

Two of the most readily observable aspects of the *Criminal Code* provisions are that, where there has been a finding of insanity at the time of the offence, the court has no alternative but to "order that he be kept in strict custody in the place and in the manner that the court...directs until the pleasure of

the Lieutenant-Governor is known",³, and secondly, such a disposition is an indeterminate one. Such an order must be made regardless of the nature of the offence or the dangerousness (or absence thereof) of the individual. There is no opportunity for a hearing before the court as to the appropriateness of such an order by either the Crown or the defence. Without entering into a discussion about the mental health professionals' ability to assess mental illness or to treat such an illness as Donald Mazer does, it cannot be denied that

Canada's laws are based upon a libertarian tradition, a tradition which holds that the individual is entitled to due process of law before he can be deprived of his freedom. ...Even the safeguards protecting an inmate in a penitentiary exceed those of the mental patient. No citizen is more deprived of his fundamental liberties not because of what he has done but because of who he is.⁴

While it is true that up to the point when the court must make its order, the individual has likely received the benefit of due process of the law. But what is the situation at that point? The court has heard evidence upon which the finding of insanity is based. However, such evidence need not necessarily relate to dangerousness, continued mental illness and current condition. If the court has no alternative, is it possible to say that the individual continues to be subject to the due process of law? It is well recognized that mental illness is not static but is "a fragmented irrational combination of intact and destroyed

³section 542(2)

⁴*Mental Illness and the Law*, DONALD MAZER, 94-105, p.103, in *Law and Social Control in Canada*, WILLIAM K. GREENAWAY, STEPHEN L. BRICKEY, eds., Prentice-Hall of Canada Ltd., Ontario.

faculties"⁵. There may be considerable variation in the mental condition of the individual since the date of the offence.

It is obvious, from reading sections 542 and 543, that only the custody of the accused is dealt with and there is no legislated right to treatment. The Lieutenant-Governor is in control of the entire process with no legislated guidelines. This official has the discretion as to the place and manner of detention which can range from a jail commitment⁶ to confinement in a psychiatric facility. The latter is the usual direction. However, it should be realized that the Lieutenant-Governor represents the Queen and, as representative of the Sovereign, "acts as parens patriae to persons of unsound mind [who] are in need of special care"⁷. A Lieutenant-Governor has authority to create an Advisory Board of Review in section 547 to assist in determining whether or not a release and discharge should be given to these individuals. Without an Advisory Board of Review, the Lieutenant-Governor's guardianship is unfettered by any legislative directions. Once such a board has been created, the *Criminal Code* requires that it:

1. review the case of every person within six months of the order for safe custody has been made, and thereafter, every 12 months; and

⁵*Competence, Marginal and Otherwise: Concepts and Ethics*, BENJAMIN FREEDMAN, *Int. J. Law & Psych.*, 1981, 4: 53-72, p.55

⁶*R v. Coleman*, (1927) 47 C.C.C.148

⁷*Watching for the Hellebore: The Role of the Advisory Board of Review*, S.WHITELY, *Manitoba Law Journal*, 1981, 14: 259-280, p.261

2. report to the Lieutenant-Governor whether recovery is sufficient to enable a trial to be held or, if being held as not guilty by reason of insanity, recovery has been such as to allow the person to be discharged conditionally or absolutely, having regard to the interests of the public and the individual.

There is nothing within the *Code*, which requires that the recommendations of the Advisory Review Board be accepted. In practice, acceptance of the recommendation is usual. But as Whitely notes, in Ontario the Minister of Health "on occasion...[provides] different advice to the cabinet from that contained in the recommendations by the Ontario Board"⁸.

Mr. Justice McQuaid, discussing the mentally disordered and noting that the uniqueness of these people "has long been recognized in law"⁹ says:

They are persons who require and are entitled to, the special concern of the Crown and through the Crown, of those special institutions established for their care, treatment and where possible, their cure.

B.C., Saskatchewan and Manitoba created review boards by Order-in Council and are able to avoid the requirements set out in the *Code* if they so desire. There is nothing the court can do to require the Lieutenant-Governor to act once "the conditions precedent to the exercise of power be met and that there be compliance with the rules of natural justice"¹⁰ There is no

⁸ *ibid*

⁹ *Reference re. Procedures and the Mental Health Act* (1984) 5 D.L.R.(4th) 577, p.591, (P.E.I.S.C. in banco)

¹⁰ Note 7, p.262; also cases dealing with having to act fairly

mention of therapy or treatment in any of the sections. The relevant section speaks of recovery and, in view of the guardianship role of the Lieutenant-Governor, it is presumed that treatment will be provided. If treatment is dependent upon the discretion of provincial correctional authorities, that presumption may be ill-founded.

It is the duty of a Lieutenant-Governor to make known his 'pleasure' under section 545. Such 'pleasure', as indicated earlier, is virtually unfettered except for the duty to act fairly. Prisoners in federal correctional facilities fare little better than those who are subject to the Lieutenant-Governor. There exists within the federal scheme, Commissioner's Directives and Penitentiary Service Regulations. The effect of these rules has been considered by the courts.¹¹ The result is that Commissioners' Directives are merely administrative directions between employer and employee and give nothing to inmates that is legally binding. Commissioners' Directives are orders issued pursuant to the *Penitentiary Act*, section 29(3). Section 29(1) permits the Governor-in-Council to make regulations for treatment. Commissioners' Directive 207 sets out the provisions for such treatment but confers no legal rights upon the inmates. Vandervort¹² and

¹⁰(cont'd) will be discussed in chapter VII.

¹¹ *R v. Institution Head of Beaver Correctional Camp, ex parte MacCaud*(1969) 1 O.R.373, Ont.H.C.J.

¹²LUCINDA VANDERVORT, *Legal Aspects of Medical Treatment of Penitentiary Inmates*, Queen's Law Journal, 3:368-423, 1976-77, p.369

Schiffer¹³ note that section 2.06 (now section 16 C.R.C. 1978 c.1251) uses the words "in accordance with directives" and thereby confers upon the inmate a right to medical treatment in line with whatever directives may be in force. Psychiatric treatment is specifically directed in section 20(2) of the regulations which requires that "so far as practicable" psychiatric, psychological and social counseling be made available to inmates as they are "capable of benefiting therefrom". Prior to 1978, the Regulation said an inmate suffering from mental disease was to be segregated and provided with psychiatric treatment "appropriate for his case"(section 3.05). There is no discussion as to what is meant by 'practicable' or how and by whom it is determined that an inmate might be capable of benefitting. While it is permissible to transfer such inmates to provincial psychiatric facilities, the Law Reform Commission of Canada says "such transfers are rare"¹⁴ and that persons who are in need of treatment "are detained without the prospect of treatment".¹⁵

Schiffer notes that there is a lack of diagnostic facilities in Canadian prisons¹⁶. There are four Regional Psychiatric Centres. Federal authorities operate one in Matsqui, B.C. and

¹³MARC E. SCHIFFER, *Psychiatry Behind Bars: A Legal Perspective*, Butterworths, Toronto, 1982, p.166

¹⁴Law Reform Commission, Working Paper #14 *The Criminal Process and Mental Disorder*, 1975, p.46

¹⁵*id.*

¹⁶note 1, p.291

one in Kingston, Ontario. A Centre in Saskatoon, Saskatchewan is operated jointly by the Canadian government and the Saskatchewan government. The Pinel Institute in Quebec is operated by that province. The Centres look after psychotic prisoners, violent and sexual offenders and provide assessments as to fitness to stand trial. Some programs are operated with the purpose of controlling the symptoms of mental illness and, where possible, they attempt to effect cures. Schiffer argues that, by virtue of *Penitentiary Service Regulations*, inmates have a right to treatment. The Minister of Justice has authority with approval of the Governor-in-Council, to enter an agreement with any province to make use of provincial psychiatric facilities for treatment of federal inmates found to be mentally ill during their incarceration (Regulations, section 19(1)). Once admitted to a provincial facility, the prisoner becomes subject to that province's mental health act to the extent of determining the right to receive and the right to reject treatment and whether or not capacity to consent to treatment is relevant.

Responsibility for authorizing treatment appears to rest with non-medical authorities as indicated in the Correctional legislation set out in Appendices B and C. Administration of treatment is within the power of medical personnel hired by the prison administration which can overrule medical personnel's recommendations. As indicated earlier, the need for psychiatric treatment is within the discretion of prison authorities. Ten years ago, Vandervort argued for health services to be delivered

independently of the prison authorities. She said that health services should not be restricted by prison budgets; hiring and firing of health personnel should not be under the jurisdiction of prison authorities and primary allegiance of health personnel should not be with prison services¹⁷. While prison authorities are responsible for the custody, discipline and security arrangements for inmates, physicians should have as their chief concern the medical well-being of the inmates. The conflict between these needs is a policy and political headache. However regardless of the size of the headache, an inmate "has at the very least, a human right to have his unique interests fairly represented when decisions are made that affect him as a person"¹⁸. The conflict between prison authority and medical opinion is only briefly commented on here to illustrate the difficulties that can arise when discretionary power rest wholly with the prison administration for treatment of mentally disordered inmates.

The cases of *McCann*¹⁹ and *Martineau*²⁰ can be seen as reflecting a growing judicial and social awareness of the problems faced by prisoners. Within Canada this social consciousness should expand the scope of "the principles of

¹⁷note 11

¹⁸*ibid*, p.383

¹⁹[1982] C.C.C.(2d) 180 (F.C.T.D.)

²⁰[1979] 50 C.C.C.(2d) 353 (S.C.C.)

fundamental justice"²¹. It is appropriate to recall the words of Haines J.:

A man sentenced for a crime does not lose his rights at the prison door. The correction authorities have become custodian of his rights as well as his person and upon them devolve a serious obligation.²²

It is suggested that this 'serious obligation' rests also with those to whom custody of persons found unfit to stand trial and not guilty by reason of insanity are given. The growing social consciousness of the judiciary and the recognition of being the custodian of prisoners' rights is to be found in the proposed amendments to the *Criminal Code* which will be discussed later.

Review Process

When the Lieutenant-Governor does appoint a board of review pursuant to section 547(1), the Advisory Review Board is required to review every case within six months of the initial disposition and thereafter at least once every 12 months. The Advisory Review Board must report fully the results of each review to the Lieutenant-Governor as to whether the person has recovered and whether "it is in the interest of the public or that person to be discharged"²³. If the person is to be discharged, the Board is required to advise whether it is to be absolute or conditional. The Advisory Review Board is required to make recommendations considered desirable in the interests of

²¹section 7, *Charter*

²²*R. v Williams* 1976 L.Med.Q., 144, p. 159

²³section 547(5)

recovery and not contrary to the public interest. The ultimate decision rests with the Lieutenant-Governor who responds to the direction of the government. In B.C., no Advisory Review Board has been created under the *Code* provisions. An Order-in-Council Advisory Review Board was set up in B.C. in 1969 for the purpose of making recommendations with respect to those who are not guilty by reason of insanity and those who are unfit to stand trial. When the *Criminal Code* was amended in 1970 to permit the creation of such boards, B.C. did not make use of the amendments. The current B.C. Advisory Review Board was set up by a letter from the Attorney General. The Advisory Review Board conforms to the standards set out in the *Code* so far as can be determined. The recommendations of the Advisory Review Board are made to the Social Services Committee of cabinet which then indicates the wishes of the Lieutenant-Governor. All persons in B.C., who become subject to these warrants, are kept at the Forensic Psychiatric Institute in Coquitlam, B.C.

The *Criminal Code* does not make provision for the treatment of those found not guilty by reason of insanity or for interim release. In B.C., the Forensic Psychiatric Institute makes recommendations to the Advisory Review Board to permit interim releases under a broad definition of 'close custody'. Recently a legal opinion was given by the Attorney General's office to the effect that the phrase meant being locked up in a secure building and subject to restricted movement areas. Safe custody (the next stage to strict custody) was said to require actual

supervision. Prior to this ruling, selected persons were able to attend educational facilities outside Forensic Psychiatric Institute and return each day, with the approval of the Review Board. Since that opinion, two levels of conditional discharge became the mechanism by which the programs were continued. The Advisory Review Board through reports from the Forensic Psychiatric Institute, makes use of pre-release residences on Institute grounds that are separate from the confinement building. The two levels of conditional discharge are:

1. the patient lives off the Forensic Psychiatric Institute premises unescorted and returns each day.

2. the patient lives off the premises and subject to specific terms which are set out in a written contract signed by him or her.

The B.C. Advisory Review Board rarely grants absolute discharges and persons who are released on the second level are constrained in their movements and activities for the rest of their lives. They are required to report at least once a month in Vancouver or Victoria, the areas where all these people reside. They are also aware that a conditional discharge can be revoked at any time for breach of the contract. The follow-up in the community is supervised by the Forensic Psychiatric Services Commission, established in 1974.

In 1981, Dr. J. P. Duffy, the then chairman of the above commission, told the Ninth Annual Conference of

Lieutenant-Governors' Advisory Review Boards, concerning recidivism, "Most of this patient group had major mental illnesses before committing the offence which led to their coming under an O.I.C. Their behavior is, as predicted in the literature, exactly the same as any other group of mentally ill patients in the same age group."²⁴ He said that the greatest danger these patients "pose on discharge is to themselves"²⁵, noting that one woman and ten men committed suicide in the period of 1972-1981. During that time there were about 60 patients on modified O.I.C.'s at any one time.

Before considering the indeterminate sentence aspect of these provisions, there are some negative comments concerning the appropriateness of the policy regarding Lieutenant-Governor's warrants. The Report of the Law Reform Commission of Canada, 1976, says "...our position [is] that the dispositions should be made openly according to known criteria, be reviewable and of determinate length. The present Lieutenant-Governor's Warrants offend all three counts." During the above conference, Professor B. Barker from the University of Alberta describes "the psychiatrically labeled...as incomplete persons and [are] consequently not accorded those considerations generally accepted as appropriate for the protection of human dignity."²⁶ Further, he says

²⁴ Ninth Conference Report, 1981, p. 4

²⁵ *id*

²⁶ *ibid*, chap. IV, p. 1

The individual freedom from arbitrary actions is a pre-condition of a moral society. ...The continuation of arbitrary restrictions upon individual freedom found in the Lieutenant-Governor's Warrant is an affront to the notion of a moral society. ...Support for these Warrants is found in public ignorance and the enthusiasms of those who are responsible for the daily operation of the present system of arbitrary incarceration. The public is unaware of the nature of what is done to the psychiatric patient or the reasons.²⁷

He calls upon the administrators of the criminal justice system to view skeptically the claims of psychiatrists concerning the purpose and efficacy of their treatments.

With these thoughts in mind, the following is a brief consideration of the indeterminate sentence aspect of Lieutenant-Governor's warrants. I suggest that it is now generally accepted that psychiatric expertise when related to predicting dangerousness is unreliable and been found to be so by the courts.²⁸ While Part XXI of the *Code* is concerned with dangerous offenders it is not illogical to relate the comments concerning indeterminate sentences in that regard to the matter at hand. Webster & Dickens say in their report "...from an ethical standpoint, it is questionable if the harshness of indeterminate sentencing can be justified,..."²⁹ Speaking from the perspective of Part XXI, indeterminate sentences are inappropriate in that they attempt to ensure some sort of future

²⁷ *ibid*, p.3

²⁸ *Frye v. U.S.* 293 F. 1013 (DCCA), 1923; *R v. K* (1919), 10 C.R. 235

²⁹ *Deciding Dangerousness: Policy Alternatives For Dangerous Offenders*, CHRISTOPHER WEBSTER & BERNARD DICKENS, Centre of Criminology, University of Toronto, 1983, p.8

non-violent behavior based on non-existent predictive expertise. However, given the ambiguous and floating nature of mental illness, it is well to remember that in the case of those who are not guilty by reason of insanity and subject to a Lieutenant-Governor's Warrant, they have gone through the trial process to the extent that the facts alleged have been proved and the special verdict rendered. The question arises as to whether there are different considerations on this issue from the perspective of section 547 of the *Criminal Code*

Much conflicting material has been written about the effect of long term imprisonment and whether such imprisonment has a negative effect upon psychiatric rehabilitation. In Mark Schiffer's book³⁰ a number of studies are cited which indicate conflicting opinions. ³¹ A major distinction between those sentenced as dangerous offenders and the committal of those who are not guilty by reason of insanity is that the latter group enter facilities with known mental disorders and such is not the case for the former group. On the issue of whether imprisonment of itself is capable of producing a specific mental illness, Schiffer cites the work of D.J. West³² and questions whether any real evidence exists to show a causal relationship between

³⁰*Psychiatry Behind Bars*, Butterworth, 1982

³¹*Psychological Survivor*, S. COHEN & L. TAYLOR, Harmondsworth; Penguin, 1972, 86-111;
Observations of Physio-Psychological Changes in Persons Sentenced to Life Imprisonment, W. Rasch, unpublished paper, 1978, p. 9;
Psychological Correlates of Long Term Imprisonment: Cognitive Variables, P.A. BANNISTER, et al, 1973, 13 *Brit. J. Crim.*, 312, p. 320.

³²*The Habitual Prisoner*, London, McMillan, 1963

imprisonment psychosis or any other recognized mental disorders.³³ Schiffer says it can "be argued that for certain offenders with a pre-existing disorder, the prison environment is counter-productive"³⁴ and cites a number of cases where the courts have recognized this. The role of the psychiatrist with persons institutionalized under Part XXI is a dual one - to provide the best treatment possible for the patient and to protect the community from dangerously disordered persons. As a treater and a protector, the psychiatrist is likely to be seen by the patient/prisoner as a jailer and as Schiffer notes "no true doctor/patient or nurse/patient relationship can develop so long as one party is a prisoner of the other..."³⁵. It is also debatable that a "therapeutic relationship is necessarily destroyed by coercion"³⁶. Schiffer makes a brief mention of Ganser Syndrome and notes numerous commentaries as to its existence. He says "the syndrome was said to be characterized by a clouding of consciousness, the giving of approximate answers to questions asked, somatic symptoms, subsequent amnesia for the above answers"³⁷. Schiffer says there seems to be general agreement as to the existence of such a disorder but considerable confusion as to its nature and etiology.

³³note 13, p.233.

³⁴*ibid*

³⁵*ibid* p.230

³⁶*ibid*, p.231

³⁷*ibid*, p.232

Concern for the mental health of the prisoner/patient and protection of citizens is a terrible dilemma for both the psychiatrist and the Review Board operating under section 547.

Schiffer notes the comments of Boslow et al:

if he releases, as rehabilitated, a man who shortly resumes his old pattern of crime, it reflects poorly on the entire profession and arouses public scepticism and indignation, especially since such cases are apt to be widely publicized and sensationalized. If he detains a man excessively long, he may have to deal with his own conscience and he may undo his own rehabilitative efforts by encouraging feelings of hopelessness and betrayal in the inmate. ³⁸

Perhaps because of these conflicting roles and "in the light of extreme fallibility of [psychiatrists' and psychologists'] present predictive abilities"³⁹, great care needs to be taken to avoid false positives. Review Boards should be required to have a global picture of each case that they review. It should be the exception that any information in the Institute's files would be kept from the patient. Perhaps only concern for third parties' safety should be the reason for keeping information secret. The *Abel* case⁴⁰ held that the Advisory Review Board must act fairly but could in its discretion, withhold some specific facts and impose terms when the facts are released. Indeterminate sentences have been held not to be 'cruel and unusual treatment or punishment' under the *Bill of Rights* ⁴¹. It could be a

³⁸note 12, p.282

³⁹*ibid*, p.291

⁴⁰1980, 31 O.R.(2nd) 520

⁴¹*R v. Buckley* [1970] 2 C.C.C. - 4, P.C. of Middlesex (Cr. Div.) Ont.; *R v. Roestad* [1971] 19 CRNS 190 (Ont.C.C.); *R v. Hatchwell* (1974) 1 WWR 307 (B.C.C.A.).

different matter when the phrase is considered under the *Charter* because it is included in the *Constitution Act* (1982 U.K. c.11). The Bill of Rights is an ordinary bill of Parliament which is amendable and repealable at the whim of Parliament. The *Charter* as part of the Constitution is amendable only in a specified manner and is not subject to the whim of a parliamentary majority. It is conceivable that American court decisions will be useful in interpreting this common phrase despite a previous reluctance of Canadian courts to adopt American case law. It should be noted that the Canadian phrase includes the word 'treatment' and the American phrase does not.

The study of Quinsey & Boyd² "indicated that there are no data which indicate that patients found to be not guilty by reason of insanity are neither more nor less dangerous than persons who have committed similar crimes and served fixed sentences in correctional institutions."³ He adds "A special review policy for these patients which involves the institution, review board, cabinet and Lieutenant-Governor and which removes the power of release from the hospital cannot therefore, be justified on the grounds that the patients are more dangerous than those serving fixed sentences."⁴

²The Assessments of the Characteristics and Dangerousness of Patients Held Under Warrants of the Lieutenant-Governor, Crime and/et Justice, February 1977

³ *ibid* 274

⁴ *ibid*

"The fact that so few of the patients got into trouble upon release is the most important finding of this study"⁴⁵. Low recidivism of persons held under a Lieutenant-Governor's warrant seems to be further confirmed in 1981⁴⁶. Quinsey indicates there are three reasons for low recidivism among this group: (a) patients are relatively old when released; (b) few patients are released directly to the street, and (c) most patients were non-criminals when the violent act was committed. I would suggest that close monitoring upon release is another factor to be considered.

⁴⁵ *A Follow-up of Patients Found "Unfit to Stand Trial" or "Not Guilty Because of Insanity"* VERNON L. QUINSEY, MANFRED PREUSSE, ROBERT FERNLEY, *Can. Psychiatric Assoc.*, 20:461-466, p.466, 1975

⁴⁶ *Mental Disorder and Criminal Responsibility*, STEPHEN J. HUCKER, CHRISTOPHER D. WEBSTER, MARK H. BEN-ARON; Chap. 8: *Long-term Management of the Mental Disordered Offender*, VERNON L. QUINSEY, Butterworth, Toronto, 1981

PROPOSED AMENDMENTS TO MEET CHARTER CHALLENGES

There is a major shift in policy in the proposed amendments to the *Criminal Code*¹ with respect to those persons who are found to be unfit to stand trial and those who were formerly found not guilty by reason of insanity. As will be noted in the conclusion, there are areas which may lead to difficulties. However, the changes appear to be a valid step towards making the public aware of what happens to persons who, due to a mental condition, are not to be held responsible for criminal actions or are unable to stand trial.

The proposed definition section of the C.C. has two new definitions:

'*mental disorder*' means a disease of the mind and includes a disability of the mind.

'*unfit to stand trial*' means, in respect of an accused, the inability of the accused on account of mental disorder to conduct a defense at any stage of the proceedings in respect of an offence charged against the accused or to instruct counsel to do so and in particular, the inability of the accused to : (a) understand the nature and the object of the proceedings; (b) Understand the possible consequences of the proceedings ;

(c) communicate with counsel.

Section 16 is to be repealed and the following inserted :

No person shall be convicted or discharged under section 662.1 of an offence in respect of an act or omission on the part of that person that occurred while that person suffered from a mental disorder that rendered him incapable of appreciating the nature and quality of the act or omission or of knowing that the act or omission

¹ Minister of Justice, Proposed Amendments to the *Criminal Code*, (Mental Disorder) (Ottawa: Queen's Printer, 23-2-86)

is wrong.

The term insanity has been deleted. The new section has maintained the meaning of that term as defined by various court decisions, emphasizing 'appreciation' and 'knowing'. The definition has made no distinction between a legal wrong and a moral wrong. It is likely that the courts will maintain the present interpretation of 'wrong' as there is no clear legislative intention to the contrary. The definition of 'mental disorder' is broad enough to include any definition that may become acceptable by the medical profession and thus allow for new knowledge.²

Sections 542 to 547 would be repealed and replaced by 542 to 547.36. The proposed new section 542 is concerned with definitions. The definition which could have the greatest impact on this part of the Code is the definition of a party to proceedings which determine a disposition, which includes:

(d) Any other person having a substantial interest in the proceedings designated by the court or Review Board as a party to the proceedings.

Such a definition could include victims of an accused and could permit their contribution towards determining the disposition of such a person. The Review Board is set up under section 547.21. A new verdict replaces the verdict of 'not guilty by reason of insanity'. Section 547.19 provides that when it has been

²Number of mental disorders recognized by the American Psychiatric Association in 1952 - 110; in 1986 - 210; Harper's Index, December, 1986.

determined that an accused comes within the meaning of section 16, the court and/or jury shall declare that the accused committed the act or omission and render a verdict of not criminally responsible on account of mental disorder . This will be discussed more in the portion dealing with mental disorder procedure but, suffice for the moment, the accused is to be deemed not to have been acquitted or convicted.

Section 544 says that a court may make, on its own motion or on application of the accused or prosecutor, an order for an assessment of the mental condition of the accused where there are reasonable grounds to believe that evidence of the mental condition may be necessary. Such an order may be made to determine fitness or mental disorder as per section 16 as well as determination of the appropriate disposition when an accused has been found unfit to stand trial or not criminally responsible. Evidence of statements made by an accused "to the person specified in the order or to a person acting under the direction of the person..." is not admissible in the proceedings without the consent of the accused (section 543(1)) except in certain circumstances (section 543(2) to (4)).

Unfit To Stand Trial

Under these new proposed amendments, the courts have been given specific directions as to what they may do with respect to accused persons where the courts have reasonable grounds to believe that it may be necessary to have evidence of the

accused's mental condition. An order made under the proposed section 544(1) shall specify by whom or where the assessment is to be made; whether the accused is to be remanded in custody for the period of the assessment and the period (not exceeding 30 days) during which the assessment is to be made. If there are "compelling circumstances" that period may be extended to 60 days by the court (section 545(2)). Extensions of remand periods for purposes of section 544(1) are governed by section 544(3) to (7). There is a presumption against custodial remand in section 546(1). An order to remand in custody shall not be made unless:

1. the accused consents;
2. accused is required to be detained in respect of another matter;
3. court is satisfied that detention is required in order to assess the mental condition of the accused; or
4. the prosecutor shows why detention is justified within the meaning of the provisions concerning bail applications.

Where an accused is charged with certain offences, section 546(2) says that the court is governed by sections 457(5.1) and 457(2) which sections also relate to bail applications. No person who is subject to an order under section 544(1) may be given psychiatric or other treatment without the consent of the accused, or such other person as may be authorized to consent in provincial statutes. However, a court or Review Board may order treatment so as to render the accused fit to stand trial

Disposition reports, which are reports on the mental condition of the accused to be prepared by the person named in the order under section 544(1) are to be filed with the ordering court and the Review Board Copies are to be given to the Crown and the defence (section 547.1(1) to (4)). The contents of such reports, which are given to the accused and other parties, may have portions deleted for a variety of reasons (section 547.27(2) to (5)), the main ones being the likelihood of endangering a third party or hampering the treatment of the accused.

There is a presumption of fitness to stand trial. To off-set this presumption, a court must be satisfied on a balance of probabilities. The court may direct a trial of the issue of fitness at any step of of the proceedings. This may be done by the court on its own motion or on application by the Crown or defence. The burden of satisfying the presumption rests upon the applicant. The trial of the issue may be delayed by the court until the accused is required to answer the charge at a preliminary hearing or the opening of the case for the defence at a trial (section 547.11 to 547.13). If the accused is found to be fit, the matter shall proceed as if no such issue had been tried (section 547.14(1)). If found unfit, any plea of the accused shall be set aside and the jury (if any)

³For comments in this situation, see Margaret A. Sommerville, *Refusal of Medical Treatment in "Captive" Circumstances*, 63 C.B.R. 59, 1985.

discharged(section 547.14(2). If the trial of the issue has been postponed and the accused is discharged or acquitted at the conclusion of the Crown's case, the issue shall not be tried (setion 514.14(3).

The authorization of treatment upon an accused by a court or Review Board for the purpose of rendering the accused fit, shall be given only if a qualified medical practitioner gives evidence that he has assessed the accused and believes "that a specific psychiatric or other treatment will likely render the accused fit to stand trial" and that without the treatment, the accused will remain unfit (section 547.15(2) & (2)). An accused may challenge the motion and tender evidence (section 547.15(3)). No treatment shall be given pursuant to section 547.15(1) without notice being given to the accused and without the consent of the hospital where the accused is to be detained for the treatment. No court or Review Board shall authorize ECT or psychosurgery (section 547.15(4) & (5)). By section 547.16 an accused may be detained in the hospital until completion of the trial where the Review Board has reason to believe that the accused may become unfit if released from the hospital. The burden of proving that an unfit accused has become fit, rests with the applicant who must satisfy the court on a balance of probabilities.

There is a presumption that the accused was not suffering from a mental disorder at the time of the offence and, in order to rebut that presumption, the court must be satisfied to the contrary on a balance of probabilities. The court, the crown or the defence may raise the issue. There are restrictions upon the Crown tendering evidence to prove the accused suffered from a mental disorder at the time of the offence. The court may allow the Crown to submit such evidence where the offence is an indictable one and :

- (a) the evidence previously tendered (other than evidence of mental disorder) would warrant a judge and/or jury being satisfied beyond a reasonable doubt that the accused committed the offence and
- (b) the admission of evidence of mental disorder would not prejudice the accused in his defence and
- (c) the interest of justice requires evidence of mental disorder be admitted, given the nature and seriousness of the offence, the extent to which the accused may be a danger to the public and the substantial nature of the evidence indicates the accused lacked the required intent to commit the offence.

Whoever alleges the mental disorder bears the burden of proof.

(section 547.18)

As indicated earlier, there is a new verdict (section 547.19). For the new verdict to be rendered, the court and/or jury must be satisfied that the accused committed the offence and that, due to mental disorder, the accused lacked the criminal intent and, therefore, is not criminally responsible for the act or omission. The accused shall be deemed not to have been acquitted nor found guilty of the offence. While "the accused

may plead *autrefois acquit* to any subsequent charge relating to that offence" (section 547.2(1)), any court may consider the verdict when considering interim release or disposition or sentence to impose for any other offence. The National Parole Board may also consider the verdict when considering parole or pardon for any other offence.

Dispositions and Continuing Review

The proposed amendments do away with Lieutenant-Governor's Warrant, The Review Board takes over the responsibilities formerly held by the Lieutenant-Governor and the role of the Review Board is broader than that of the Lieutenant-Governor. A Review Board "shall be established or designated for each province" (section 547.21) and be composed of at least five persons. One of the persons must be a psychiatrist and the chairman, a judge of the Federal Court, a superior, district or county court or a person retired therefrom. Where only one psychiatrist is on the Board, one other member must be a "qualified mental health professional". There is no definition of this term.

When a verdict of unfit to stand trial or not criminally responsible has been rendered, the court hearing the matter shall determine when the Review Board will likely hold a dispositional hearing with respect to the accused. If the court is of the opinion that the Review Board will not hold such a hearing within a reasonable time; the court can readily make a

disposition and if it is of the opinion a disposition should be made forthwith, the court may on its own motion or on the application of either the Crown or defence, hold a hearing as directed in section 547.24. Any disposition by the court other than an absolute discharge, shall be in force for no longer than three months (section 547.22). The court shall hold a hearing as soon as practicable after the verdict. If the court does make an interim order, the board's hearing shall be held prior to the expiry date of the interim order. The Review Board has all the powers conferred on commissioners by the *Inquiries Act*, Part I, sections 4 & 5.

The rules and regulations governing Review Boards are set out in sections 547.26 and .27. They are extensive and seek uniformity across the country. In each province, the Lieutenant-Governor-in-Council is permitted to make rules dealing with practice and procedure so long as they are not inconsistent with those in the C.C. or any other Act of Parliament. The Governor-in-Council may make regulations to secure uniformity in rules of the Review Boards and they prevail over rules made by a province. Review Board rules for dispositional hearings are set out in section 547.27. The Review Board may withhold the whole or any part of a dispositional report or other information from the accused if the Review Board is satisfied that disclosure would endanger a third party or if treatment or recovery of the accused would be seriously impaired. Information may be kept from other parties if, in the

opinion of the Review Board, that information is not necessary for the proceedings and might be prejudicial to the accused. There are restrictions on disclosure and publishing of dispositional reports (section 547.27(6) to (11)).

Dispositions Available to Review Boards and Duration of Dispositions

By the proposed sections 547.28 to 547.3, the Review Board must consider any disposition report, representations and submissions and other relevant information before it, as well as the protection of the public from dangerous persons, re-integration into society and other needs of the accused before making its decision. The proposed Act sets out four options available to the Review Board :

1. direct that the accused be detained in a hospital or other appropriate place provided the consent of the person in charge of the detaining facility is obtained and the accused is subject to such conditions as the Review Board deems fit in the circumstances, including delegation of authority to a person in charge of the accused to vary liberty restrictions within limits. Notice of a variation which increases the restrictions on the liberty of the accused shall be sent to the Review Board forthwith.

2. where the verdict is unfit to stand trial and subject to section 547.15, authorization to treat may permit treatment of the accused.

3. direct accused be discharged subject to conditions deemed

appropriate by the Review Board having regard to re-integration into society and safety of the public.

4. direct accused be discharged absolutely where it is in the interest of the re-integration of the accused into society and the accused is not a significant risk to society.

The proposed amendments to the C.C. provide for the maximum length of time any accused shall be subject to disposition orders. Where an accused was charged with an offence listed in section 547.29(3) (generally charges of endangering public safety) the accused may be detained for a maximum of ten years or the maximum sentence in respect of the offence, whichever is shorter. Where an accused is charged with any other offence, the maximum period of detention is two years or the maximum sentence of imprisonment for that offence, whichever is shorter. Subsection 4 provides that, for a charge of first degree murder, the maximum time for which the accused can be held is life. When a person has been found unfit to stand trial, the prosecutor shall show at least every two years or on application of the accused, to the satisfaction of the court "that sufficient admissible evidence can be adduced at that time to put the accused on trial."(s.s.5). Where a *prime facie* case is not made, the court shall discharge the accused absolutely. The hearing shall be in the nature of a preliminary hearing as per Part XV of the C.C.

Reasons for disposition shall form part of the record of the Review Board and copies of the reasons shall be provided to the

parties as well as, on request, a transcript of the proceedings. The transcript shall have deleted any portion for which a party was excluded from the hearing.

Any party can appeal to the relevant Court of Appeal against any disposition (547.31) but shall do so within ten days of the date of disposition. The Court of Appeal may exercise all the powers of the Review Board and substitute its opinion for that of the Review Board or may refer the matter back to the Review Board in whole or in part.

The Review Board shall review each disposition at least once a year for so long as the disposition remains in force and at any other time at the request of a party may hold a review in accordance with section 547.27.

Hospital Orders section 662.2(1) to (10)

Where a court imposes a sentence and finds on the basis of a disposition report that the accused is suffering from a serious mental disorder that is not likely to improve in prison, the court may order, with the consent of the accused and hospital, that the accused be detained and treated for a period not exceeding 60 days. The period in the hospital shall be considered as time served on the sentence. No Hospital Order shall be made with respect to an accused sentenced for an offence for which there is a minimum sentence or mental disorder due to drug or alcohol addiction or when the sentence is less than 60 days or the accused has been found to be a dangerous

offender. The legislation permitting Hospital Orders in England and Wales⁴ is far different from what is proposed in this Canadian legislation. The above statute provides that, before a court can make a Hospital Order, the court must have evidence that the accused is suffering from mental illness. One of the consequences of such an Order is that there is no time limit on the Order and release can only be made by the Mental Health Tribunal or the Home Secretary. There is, however, a mandatory review by the Tribunal at least once a year. The difficulty faced by Canadian courts is that they do not have this option (even under the proposed legislation) to institutionalize a sex offender. Further, other than for short term relief, there is no authority in the courts to direct or order psychiatric treatment. It is to be noted that correctional institutions are not likely to provide an appropriate environment for psychiatric programs as inmate motivation to use such programs is low⁵.

Comments

Doing away with this particular role of the Lieutenant-Governor and related mechanisms in favor of a Review Board with full hearings, uniform procedure and criteria across Canada will meet the requirements of the *Charter*. There are a number of major benefits accruing from the amendments:

⁴*Mental Health Act* (U.K.), 1983, c.20

⁵J.S.Wormith, *A Survey of Incarcerated Sexual Offenders*, 25 Can. J. Crim. 379, 1983

1. by using the new verdict, it should become apparent to the public that the accused is not 'getting off' by successfully claiming insanity. The public will be aware that a period of detention will follow such a verdict. The present verdict of not guilty by reason of insanity is seen as an acquittal. It has been indicated that the public worries about the release of these people "because they committed serious crimes and have not been dealt with through the correctional system" ⁶.

2. the new verdict brings home to the accused that he did the act for which he was tried. The accused will be unable to rationalize that he was acquitted.

3. The end of indeterminate sentences will prevent major injustices due to the imposition of years of custody for what may have been minor offences. This benefit is enhanced by required reviews with counsel. Uniform rules of procedure should insure fairness across the country.

4. the adoption of the concept of Hospital Orders should be seen as a welcome trend as the judges will have another option to deal with sick accuseds even if only for a very limited period. The present proposal might be seen as the beginning. There appears to be no basis for the maximum 60 day period with no provision for an extension. Perhaps it is anticipated that, if additional time for treatment is required, the provincial

⁶Vernon L. Quinsey, Manfred Preusse, Robert Fernley, *A Follow-Up of Patients Found to be Unfit to Stand Trial or Not Guilty by Reason of Insanity*, Can. Psychiatric Association Journal 20:461-467, 1975

mental health acts will be used. From past experience this is not likely. It is possible that the division of powers between the provinces and the federal government is a large obstacle to a program similar to the one in England and Wales. In some instances, concurrence by jail authorities will be needed. Schiffer notes in his 1978 text that there are studies which indicate that mental illness is exacerbated by the prison environment. It is possible that, if there was adequate and complete treatment recidivism would be reduced. Quinsey's studies indicate that when compared with prisoners who have been sentenced to definite prison terms, the recidivism amongst those released after being held under a Lieutenant-Governor's Warrant is low⁷. True this may depend on age, prior background or intense supervision but if a return to crime is reduced, in the long run there would be reduced costs to government and the public.

There are several areas, which if left as is, could lead to warehousing again, and/or conflict between the two levels of government. While there is provision for treatment without consent of an accused who is likely unfit to stand trial there is no provision within the act for treatment of a person found not criminally responsible. Nor is there any provision for the determination of mental competence to make treatment decisions of such persons. One would expect that an order for detention in a hospital would be for the purpose of treatment but what would

⁷ *ibid*

be the situation for a person ordered detained in an "other appropriate place"?(section 547.28). For clarification purposes at least, the right to treatment ought to be set out.

CHAPTER VI

COMPETENCE AND RIGHTS

"A society that is sensitive to rights, is, for that reason sensitive to persons".¹

Mental illness is "a fragmented irrational combination of intact and destroyed faculties".²

"The policy of the law is that the liberty of no man should be interfered with if he has sufficient understanding..."³

Introduction

Historically, the professions of law and medicine have been entwined. With respect to the mentally ill, the two professions diverge in that the lawyers emphasize rights and autonomy and doctors concentrate on patients' "needs" or conferring benefits. Their perspectives do converge, however, in the larger area of goals in that both seek to relieve suffering. When there is

¹Competence, Marginal or Otherwise : Concepts and Ethics, BENJAMIN FREEDMAN, International Journal of Law & Psychiatry, 4:53-72, 1981.

²*id.*, p.55.

³ *Peel v. Peel* [1912] 21 O.W.R.945, Ont.Pr.Div.

unresolved conflict in relation to the means of achieving this goal, the patient will have neither their rights nor their needs attended to fully. The practitioners of each profession should be willing to examine new ideas and be prepared to continue the learning process. By being aware of ethical dilemmas faced by each other, the approach to patients could be co-operative rather than adversarial. Doctors by training tend to be paternalistic and protective and an enforcer of the means to make a patient 'well'. Lawyers by their training are questioners and more inclined to libertarian ideals. Professional relationships between patient and doctors have disappeared to a large extent with increased bureaucratization and technocratization of medical treatment, the enhanced education of patients and less readiness on the part of patients to accept authority. The present tendency to a more egalitarian doctor-patient relationship is reflected in the doctrine of informed consent.

To recognize that informed consent is to be sought is to acknowledge that a patient may override a physician's recommended treatment. As pointed out in chapter 2 dealing with legislation, where a patient refuses treatment, there are procedures which, if followed, permit the imposition of treatment in certain circumstances. In B.C., treatment can be imposed without having to follow any legislated procedure. Justice should demand that a person's autonomy be respected. Justice, which has its origins in abstract principles, should

assist in shaping laws but it must be apparent that such principles alone will not create justice. It is in the administration of the laws with an appropriate degree of flexibility that justice is likely to be attained.

Acceptance of the principle of personal autonomy implies the right of self-determination. "Once a person is capable of making a free and informed decision he has the right, without interference and within the limits imposed by his living in society" to make a decision affecting himself".⁴ The rule of self-determination safeguards "a personal sphere of integrity and guarantees the individual a measure of control over his life."⁵ This principle means a right to refuse treatment or to have treatment stopped even if death is likely to be a consequence, provided the decision is made while the patient is lucid. For example, the accepted approach to Jehovah's Witnesses and blood transfusions and Doukhobor hunger strikes⁶ clearly indicates respect for this principle. "The individual's personal reasons, whether or not shared by others or society, should be respected, whatever one's opinion of their logic, relevance or validity."⁷

⁴ Law Reform Commission of Canada Report #28 p.12 SOME ASPECTS OF MEDICAL TREATMENT AND CRIMINAL LAW, Law Reform Commission of Canada, Ottawa, 1986.

⁵ *id* p.12

⁶ *Attorney-General of B.C. v. Astasforoff*, (1983) 6 C.C.C. (3d) 498(B.C.C.A.)

⁷ note 1, p.12

Moral Imperative of Competence

In 1980, Stephen Wear said "The moral status and circumstances of the mentally ill have lately become topics of pressing concern and controversy on levels of both theory and practice." ⁸ In the seven years since that article, there have been some major changes in some provincial legislation but many anachronisms still remain and only one province explicitly requires that there be an assessment of competence - Nova Scotia. Others do so only by implication.

However, despite this apparent lack of concern for requiring an assessment of competence, it has been said "One of the notable developments of medical ethics, both in theory and in practice, has been the attempt to extend the protection of basic rights to patients". ⁹ Protection has been extended by various legislative amendments, such as shorter periods of confinement and easier access to review boards. The theory of rights and protection of rights, however, appear to run counter to the "facts of power"¹⁰ controlled by medical practitioners. It has been seen that, historically, physicians have been exerting control over 'madmen' and the mentally ill since the 19th century. They have defined mental illness and treated that which they defined. They have defined when mental illness ceases to

⁸Mental Illness and Moral Status, Journal of Medicine and Philosophy, 5:292-311, 1980

⁹Rights and Responsibilities, SARA ANN KETCHUM and CHRISTINE PIERCE, Journal of Medicine and Philosophy, 6:271-280, p. 271.

¹⁰*id*

exist. They have been society's arbiters of what is normal. They have sought to ease suffering with their specialized knowledge through this power, which until lately overrode the wishes or demands of their patients. Publicity, and court cases about patients being kept for extended periods of time in institutions with little or no treatment, coupled with a growth of public awareness of rights in general, I suggest has brought a greater consciousness that individual rights apply to everyone regardless of their confinement in a mental institution or their being mentally ill. The power of physicians combined with the power of politicians had previously tended to bury the problems of the mentally ill. Budget priorities have placed the care and treatment of these people towards the bottom of the scale of priorities. Without adequate facilities and staff, physicians cannot adequately treat them, even within their power structure.

American courts have said that it is morally and legally wrong to hold an involuntarily committed person without treatment and recognized the right to treatment.¹ As these rights came to be recognized, there developed a greater awareness, vis-a-vis the mentally ill, of the doctrine of informed consent and the concept of competence. "The importance of

¹Wyatt v. Stickney 325 F. Supp.781,782(M.D.Ala.1971) per Johnson J. "[T]he purpose of involuntary hospitalization for treatment purposes, is treatment and not mere custodial care or punishment. This is the only justification from a constitutional standpoint that allows civil commitment to mental institutions. ... To deprive any citizen of his or her liberty upon the altruistic theory that confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process."

defining competence to consent...is underscored by the highly intrusive nature of many treatments..."¹²

Before examining the theory of competence, it may be appropriate to discuss the different perspectives of the legal and medical professions and the autonomy of the individual with respect to one's body and mind. The Law Reform Commission of Canada¹³ asserts that the principle of autonomy over one's body means "that every competent person should have the right to refuse medical treatment even when such refusal may lead to his death or a continuation of his illness."¹⁴ Within the ambit of this principle is the right to choose between different types of treatment, the right to decide not to be treated and the right to refuse treatment imposed by others for which there is no voluntary consent. However, some legislatures, for reasons of public policy and the related rights of others, have limited these rights in varying degrees. The LRC is speaking from a legal perspective but does recognize that there are societal limits upon self-determination. It notes that freedom of choice and freedom of refusal in psychiatric matters are "fluid and contingent notions"¹⁵. There are, it says, degrees of autonomy which are dependent upon an individual's condition and

¹²Evaluating Assessments : Forensic Assessments and Instruments, THOMAS GRISSO, Plenum Press, New York, 1986, Chapter 10, p.312

¹³Behaviour Alteration and The Criminal Law, Working Paper #43

¹⁴*id* p.16

¹⁵*id*

circumstances. It is said by the Law Reform Commission that a mentally well person has a greater degree of autonomy than a mentally ill person just as a person placed in a situation or environment outside his/her usual milieu, will have less practical autonomy than when in his/her usual surroundings. It is not certain that this is so since the degree of autonomy will be the same but the person may not be able exercise his autonomy to the same extent, feeling unsure or uncomfortable in the new situation. Similarly in relation to the mentally ill, the autonomy remains the same but the ability to exercise it is diminished.

However much the intermingling of personal factors such as environment, education and location within society may affect how a person responds to the issues of personal freedom (which cannot be objectively measured), there are basic values which ought to be protected. The doctrine of informed consent is implied by a freedom of choice, one of the basic values. Once freedom of choice is limited or lost due to incompetence, a person's decisions are given little credence because the decision-making process is deemed to be malfunctioning. Upon this assumption, the mental health professional likely ignores the obligation to inform the patient of the specifics of the treatment program. As will be discussed later, information ought to be given in order to enable the therapist to assess the manner in which the patient uses the information to arrive at a decision. It is not the decision which is to be examined, but

the process by which the decision is reached. The fact of a refusal to accept treatment should not be the basis for a presumption of incapacity or as the only evidence of incapacity to give a valid consent. By being consciously aware that there is a distinction between global competence and the narrower issue of competence to consent to treatment, it should be apparent that, in this regard, psychiatric patients do not differ from other medical patients. Some of the differences in obtaining consent between psychiatric patients and patients receiving medical treatment are :

1.mental disorders suppress or diminish capacity to consent while this is not necessarily so with medical patients without mental disorders;

2.use of psychiatric techniques may restrain or eradicate an ability to make an informed choice.

3.medical patients have the right to receive opinions from different specialists, right to answers to questions asked and wishes are usually acceded to - not so with mental patients.

The lack of clarity between the roles of medicine and law is referred to by H.Tristram Englehardt Jr¹⁶and he notes that one will subvert the other to its purposes. Law becomes an instrument of medicine in order to obtain a right to treat without consent. Law uses medicine as an instrument of social control and places mental health professionals into the roles of

¹⁶Introduction to Mental Illness: Law and Public Policy, eds.: BARUCH A. BRODY & H. TRISTRUM ENGLEHARDT Jr.; D. Reidel Publishing Company, London, England, 1980

policemen. The unclear norms in the mental health area further confuses the respective roles of legal and mental health professionals. Their spheres of expertise collide as a consequence of different perspectives despite a similar goal - to assist or benefit the client.

One of the difficulties of a concept such as mental illness is its variable nature. The great variety of forms that mental illness can take precludes a precise definition. There are definitions of specific forms of mental illness such as paranoid schizophrenia and manic depression. Psychiatrists define as well as diagnose and treat the various illnesses. To that extent, psychiatrists tell us what is real and how unreality ought to be treated. That diagnosis places persons in sick roles, endowing them with responsibilities and rights - "excused from work or criminal responsibilities ... obliged to seek treatment"¹⁷. The distinction between the role of being mentally ill and the role of being physically ill is a sharp one. It is one which goes to the "very roots of our personhood"¹⁸. It is to be noted that by common usage a person 'has' pneumonia, a cold or cancer but it is said colloquially that a person 'is' schizophrenic, a manic depressive or a neurotic. While DSM3 lists symptoms for illnesses, the general awareness of symptomology by the public is slight. Lay appreciation, it is suggested, does not extend much beyond describing a person with schizophrenic symptoms as being

¹⁷ *id*

¹⁸ *id* p.x

'a' schizophrenic.

Being mentally ill may lead to more dramatic social changes than being physically ill such as loss of employment, family or friends, who are hostile because they fear or do not understand the situation. People comprehend physical ailments more readily even though there may be great fear of them. Mental illness "visits us with uncontrollable fears, obsessions, compulsions and anxieties. [It] gets inside us".¹⁹ With a physical ailment, one is able to stand outside oneself to examine it. Since mental illness affects how we perceive ourselves, others and our surroundings, it is more intrusive and more controlling. Thus mental illness more clearly delineates the boundaries of an individual's world than does physical illness. Medicine defines mental illness and uses the law to impose controls upon those who come within the various definitions in order to treat and/or protect.

The definition of mental illness is susceptible to many meanings and nuances and society's attitude is ambiguous and varied because the nature of mental illness is so diverse. This variegated nature of mental illness poses problems related to the fundamental principle of respect for the autonomy of the individual. Physical autonomy has long been recognized and accepted and, in Canada, is protected by the Criminal Code. Mental autonomy in the sense of protecting psychological integrity is less certain. Some of the provisions of the Charter

¹⁹ *id.*

may be of some assistance (sections 7 & 12). In civil law, there are actions for damages for alienation of affection, pain and suffering and authority to remove children from a home where there is a threat to their psychological well-being. Such actions will give after-the-fact compensation for breach of psychological integrity. Wear notes that, with respect to status and competence, judicial findings in civil law have tended to regard mentally ill persons according to their level of competence rather than their status "as a result of diagnostic inclusion in a given abstract category"²⁰.

Before examining the doctrine of informed consent, a question to be discussed is whether everyone is entitled to have their sphere of individuality protected. Are all persons entitled to have their physical and psychological autonomy protected? To narrow the field of contemplation, that question will be examined in the context of the mentally ill. All persons have rights and responsibilities. Are those rights and responsibilities altered by mental illness? Benjamin Freedman and Stephen Wear have each examined the position of the mentally ill and their rights. Both consider the issues from a moral perspective and emphasize the centrality of competence. Wear looks at moral agency in relation to what is normal and what is abnormal. Wear says "To be a moral agent, one must be capable of understanding the nature of one's situation, the actions one performs and to some extent, the consequences of these

²⁰note 8, p.296

actions"²¹. Further, individuals as moral agents must be responsible and free in order to be eligible for praise or blame, in a moral sense. For moral agency to exist there must be freedom and rationality. What is normal and abnormal is dependent upon the context in which the phenomenon occurs. Mental wellness like mental illness is identified by description and assessment in a specific context. Wear says that mental illness is a varying continuum. Mental wellness can be said to be part of the same continuum which ranges from various degrees of well-being to the different stages of being ill. "The point is that mental health is one thing and the capacity to function within the broader range of mental competence is another. Many people can be coherently seen as mentally unhealthy and still be considered competent"²². If it is accepted that mental illness exists and that rationality and freedom concomitantly exist with rights and freedoms, a mentally ill person is diminished in moral status and suffers a corresponding reduction of rights and responsibilities. The assessment of the degree of diminishment is a determination of the degree of incompetence.

Benjamin Freedman²³ says that rights protect personality and define the limits of that protection. It is through rights that individuals are able to claim possession of anything - legal or moral. Without rights, a person can possess nothing. As Freedman

²¹note 8, p.297

²²note 8, p.306

²³Competence : Marginal and Otherwise ,International Journal of Law and Psychiatry, 4:53-72, 1981

says "rights serve the function of protecting interests of the personality"²⁴

Stephen Wear says that certain rights and responsibilities or privileges and duties have constant values that fluctuate only in terms of status and competence. They are not dependent upon the context within which they operate. These rights and responsibilities are said to be inalienable. Wear says that one cannot be said to be wholly sane or insane because that approach has no regard for the variable nature of mental illness which, as indicated earlier, is a graded continuum. As capacities for rationality and freedom are necessary ingredients of moral agency and status, mental illness diminishes a person's moral status because of a lessened capacity to make rational decisions, or to possess fully freedom of choice. "...[I]t is the degree of incapacitation that is morally relevant and determining, not any abstract designation [of a form of mental illness]. More specifically ... the diminishment of the capacities of rationality and freedom in the mentally ill is the basic and morally significant fact about them and their rights and responsibilities which must be designated in direct proportion to such diminishment"²⁵. When institutional care of the mentally ill is examined, it becomes apparent that the privileges and duties of the inmates vary with the degree of illness, according to Wear. Staff in the institution will

²⁴ *id*, p.53

²⁵ note 8 ,p.294

attempt to correlate such variations with the competence of the inmates. ("By fulfilling dormitory and program responsibilities, patients retain and may increase their privileges, while failure to do so or inappropriate behavior can lead to reduction or loss of such rights"²⁶).

Interests and desires can be protected through rights if they can be expressed. For those who are competent, their interests and desires are usually heeded by mere expression i.e. a competent person's right to seek medical care is expressed, in a decision to seek care for whatever condition he/she desires and whatever form of care he/she chooses. Where there is no expression of interest or desire, it is necessary to look elsewhere to find an expression of rights which may be described as being in an incompetent's 'best interests'²⁷ Freedman is concerned about those who are of dubious competence whom he calls the 'marginally competent'. Those who are incompetent due to mental illness, for the most part, are not wholly incompetent. It is the status of these people that is of urgent concern. How are the persons who are competent only in some respects to be dealt with? The difficulties of dealing with such persons arises from the failure to recognize the existence of

²⁶ *id*, p.295

²⁷ It is not intended to discuss the merits and demerits of 'best interests' and 'substituted judgement'. Suffice to note that the former appears to support a paternalistic approach and the latter has an autonomous orientation, as noted by Margaret Sommerville in her article *Changes in Mental Health Legislation as indicators of Changing Values and Policies in Psychiatry, Human rights and The Law*, MARTIN ROTH and ROBERT BLUGLASS, eds., Cambridge University Press, 1985, p.156-214.

this third group alongside the clearly competent and the clearly incompetent.

Freedman says that only by understanding the concept of competence can we begin to meet the needs of the marginally competent and deal with the issue of informed consent. What is involved in this concept? Does it involve empirical and/or moral qualities? Trained observers such as psychiatrists and psychologists can describe the facts they have seen as experts in court. The court determines what ought to be done. Similarly, with competence, there is an evaluation of facts and a determination of what ought to be done - the response- which is based upon a moral theory. The moral theory interprets the facts and guides the action. Thus both empirical and moral qualities are involved. It is suggested that only by realizing that what we ought to do should be based upon a moral theory, will we know how to interpret or act upon the facts observed. Ethical considerations and a moral theory are involved when determining competence because they will guide conscientious actions for the betterment of the patient.

However, when one says there is to be a consideration of observed particulars and consequent actions are to be based upon a moral theory, one is not much further ahead because there is no standard by which competence is measured. Freedman says that to have a standard of competence is to maintain a balance between freedom and protection. In order to do that, competence needs to be understood at a conceptual level and at a policy

level. Some way must be developed to determine whose choices are to be respected and who needs to be protected.

Freedman uses consent to medical treatment as the situation in which to discuss competence. At the conceptual level, Freedman says the focus should be upon the characteristic possessed by the individual which sets him apart as being the one whose right of self-determination is to be restricted. This level is then person-centered. At the policy level, it is sought to balance freedom and protection but the issue to be met is who is to have freedom and who is to be protected? To do this it is necessary to look at the criteria of competence listed by Freedman²⁸ who accepts the criteria listed by Roth, Meisel and Ridz²⁹. Those criteria are:

1. One is competent to consent to treatment if, in consenting, one achieves a *reasonable result* or is seeking a reasonable outcome.
2. One is competent to consent to treatment if one has followed a rational process in making up one's mind, if one can give, or has given, *rational reasons* for the choice made.
3. One is competent to consent to treatment if one is *able to express consent to, or refusal of,* that treatment for whatever reason and despite the seeming unreasonableness of the outcome.
4. One is competent to consent to treatment if one has the *ability to understand* and knowingly act upon the information which the doctor supplies in the course of "obtaining a consent".
5. One is competent to consent to treatment if one *actually understands* and acts upon the information which

²⁸note 23, p. 59

²⁹*Test of Competency to Consent to Treatment*, 139 American Journal of Psychiatry, 279, 1979

is provided by the physician³⁰.

In the result, Freedman says that competence is not just an ability to make a decision or that the decision lead to a reasonable outcome. Acceptance of either or both of the first two criteria is not appropriate because it ignores the value of freedom and stresses results rather than the process of making a choice or decision. The fact that a decision is made, need not equate to competence. For example, a refusal to consent to an appendectomy because a haircut is needed is a decision, but not a rational one. Also, understanding given information and knowingly acting upon that information is not an adequate test for competence because these two tests depend on the kind and amount of information that is given. The doctrine of informed consent has three components. It must be an informed consent. The person giving consent must do it voluntarily and must be competent. To say that competence is dependent upon information is to repeat what is already required as one of the consent components.

The fifth criterion listed by Roth *et al* describes a situation where a decision is made on the basis of assimilation of information given by the doctor for a specific occasion, i.e. a rational use of information. The difficulty with this criterion is that 'rational' is then equated with 'acceptable' and is paternalistic in approach. Freedman suggests that 'rational reasons' should be replaced by 'recognizable reasons'.

³⁰note 23, p.59

He says that, if there is an acceptable premise, it must be followed by a conclusion related to the premise in order to be a recognizable reason. The idea of recognizable reasons should be broad enough to accept an individual's value system (even when not the same as the assessor's) if the reasons have premises strong enough to justify the conclusion reached by the patient. Recognizable reasons cannot result from false premises. Also, the reasons given must support the conclusion (a patient refuses an operation because the bank is closed). Freedman says "that which allows us to grant freedom of action in our society is the warranted belief that, by and large, one person's choices will be recognizable by others"³¹. Although the search for 'recognizable reasons' can be said to be a subjective process, this type of search has the merit of being directed towards the patient's perspective and the searcher being cognizant of the patient's cultural background.

It is important to attempt to determine competence because in doing so there is a recognition of personal worth. Even if the assessment shows incompetence, the patient can be assured of his/her own significance. Incompetence does not relate to intelligence but, in the sense used here, relates to a specific decision. Freedman has said that sufficient information should be given to a person so that a decision can be made. The process or the manner in which the information is used is relevant to the issue of competence. The decision-making process is the key

³¹ *Id.*, p.64

rather than the decision itself. "Information is prior to competence, in that a competent decision includes, but extends beyond, the requirement that the person involved be able to allow the informing process to enter his decision-making in a substantial way. He must be capable of utilizing the information provided in formulating his reasons"³². The patient's value system should be considered.

In summary, each individual as a moral agent is capable of comprehending his/her situation and environment and is free and rational. A mentally ill person by virtue of loss of capacity for freedom and rationality is diminished with respect to rights and responsibilities. For example, the patient maybe unable to change his/her mind in recognition of received new facts. Having regard to western society's high esteem for personal freedom and respect for physical and psychological spheres of integrity, a marginally competent person should not be impeded in his other activities any more than is necessary. To accomplish this, there should be a presumption of competence (as there is the presumption of sanity in the *Criminal Code*. Competence should be assessed after giving the information necessary for an informed decision to be made. Given the particular premise, it should be considered whether the resulting response is a recognizable one.

³²note 19, p.65

SOME COMMENTARIES ON RIGHTS AND DECISION MAKING PROCESSES

It is suggested that, if one accepts that each individual is a moral agent with the attributes set out by Wear and Freedman, the rights of each individual must be protected along with the freedom to exercise those rights. Larry Gostin, speaking of human rights and noting that the moral choice is not always clear as to which individual interest is to be protected (health and well-being or self-determination and liberty), says that a person's choice as to where his/her own interests lies, should be protected. He said "Where society is to withdraw that basic human prerogative [right of choice] because it claims the individual is incapable of rationally exercising choice, it must give the person the opportunity to refute that proposition before an impartial tribunal"³³. Freedman, as noted previously, does not speak of the choice being made rationally, but calls for the response to be a recognizable one. He says it is important to determine how a patient uses information - the process by which decisions are made and not the decision itself - when determining competence. Gostin notes that the use of an impartial, multi-disciplinary tribunal, before whom the individual presents such evidence as he/she desires in an attempt to answer the reasons for deprivation of autonomy, is made for the purpose of fairness rather than to get a 'correct' or 'right' decision. Freedman and Gostin are pointing out that

³³Psychology, Human Rights and the Law, eds.: MARTIN ROTH & ROBERT BLUGLASS, Cambridge University Press, 1985, Human Rights in Mental Health, LARRY GOSTIN, 148-155, p.149

it is the individual who matters and not that which may appear to be bureaucratically appropriate. The proper use of such tribunals could do much to insure that there is an examination of thought-processes rather than just the examination of a choice and that a major emphasis will be placed upon protection of autonomy. Tribunals emphasizing these matters would cause them to be seen as practical and valuable goals. Informality of procedures before the tribunals could dampen the adversarial positions of the medical and legal professions and such reviews should not impede the access to treatment.

Psychiatric reluctance to commit persons needing treatment may stem, according to Sommerville, less from a reluctance to commit them than an aversion to the legal process involved. There may also be a certain reticence to accept that a mentally ill person is competent to question a prescribed treatment or a failure to recognize that competence in that area varies with time, context and treatment. Gostin said "The foundation of the common law right to impose treatment rests upon the presumed incompetency of the patient to consent"³⁴. The initial question is not the medical issue of whether treatment is beneficial but whether treatment should be imposed. That question is not exclusively a clinical one. Given the variability of human conditions, there can be no single answer but surely there can be no more fundamental right than to have access to a process by which it is determined whether and what treatment is to be

³⁴ *id*, p. 151

given? For the appearance of justice, and certainly from the patient's perspective, the decision-maker must be independent.

A further reason for independent tribunals is set out by Margaret Sommerville in her article in the Roth & Bluglass collection. She notes³⁵ that the more a decision deviates from a doctor's preconception and the more serious the nature of the decision, the more likely the patient is to be judged incompetent. Also there is little point in asking for a decision if the patient cannot refuse. To have any meaning, the request for a consent must carry with it the option of refusal. The writer is aware of a patient who, upon being transferred from an institution to a psychiatric ward in a hospital, was asked to sign a consent to treatment which had already been given. Upon admission to the Institute, she had refused to sign a consent to treatment and refused again after the treatment. Surely such action must further antagonize and confuse the patient.

In mental health care there are no all-good or all-bad decisions because there are rarely any absolutes. There are competing benefits and competing harms. Decision-making concerning the formulation of laws and regulations for institutions or issues concerning patients ought to be undertaken with a sense of balance. That process should be re-examined continuously to assess precisely what principles are being applied and what the real intent and effect of those decisions are. What has the highest priority - individual claims

³⁵note 27, p.168

to autonomy or society's claim to protection? It is apparent, that if there is to be a balance of priorities, the procedures which reflect that balance must be flexible. Decision-makers need to be aware that stated or apparent reasons may not be the ultimate reason. For example, suppose it is said that the mentally ill will be relieved of many problems by being deinstitutionalized. They will become more independent, freer to do what they wish and better able to function 'normally'. The purpose of de-institutionalization may be said to be supportive of autonomy. However, unless some of the support which the individuals had in the institutions is given in the community, their new-found autonomy may be lost without ever being able to use it. Such 'liberation' can mean an absence of being told what and when to do things, not having regular meals planned and given, absence of regularity in receiving medication and the necessity of having to earn a living to sustain oneself if financial assistance is not sufficient. De-institutionalization can also mean reducing government expenses. If those who are marginally competent are allowed to drift without adequate casework supervision or support within the community, can they be said to be autonomous? It is said, in Working Paper #43 of the Law Reform of Canada, that autonomy implies having a choice. If a person is not able to find accommodation, supplement financial assistance or to self-control medication or food routines, there is no choice but to drift. With drifting, these people are not protected nor is society protected. By appearing to be protective of autonomy, a decision to de-institutionalize

mental patients with nothing or very little more, has not given the patients protection or autonomy and has not given society protection. Hence, a continuing re-assessment of the basis for decisions is necessary. Questions to be answered are whether policy and legislation have the same goals and whether there is budget support for legislative innovations.

Margaret Sommerville has said that most decisions are made by the medical profession and this reflects a trust that decisions will be made in a manner that reflects medical expertise³⁶. She says that the fact that some aspects of decision making have been taken out of the medical context should not be interpreted as a distrust of the medical profession but rather as a recognition of the need for a broader perspective in some areas. The law as part of that broader perspective, operates at two different levels which serve as protective mechanisms. The levels are substantive and procedural. Even though they function in a different fashion, they have the same aim or purpose. When there is uncertainty about the substantive law to be followed, the governance of decision-making will be limited or protected by procedural rules. The safeguards provided by procedural devices are used when the issue of which substantive legal principle to be applied is uncertain or circumstances are so varied that the appropriate principle cannot be predicted. It is in the area of reviews by tribunals that the law can be most protective of the

³⁶note 27

individual. The tribunal, in reviewing a matter before it, has to decide on a balance between individual and integrative values. Are the patient's values to outweigh the integrative values of the patient's social sphere - family and community concerns? The tribunal must keep both sets of values in mind, taking care that emphasis on one set does not act detrimentally upon the other. The law seeks to be certain that, with our present sense of the importance of individual rights, they are not unjustifiably curtailed. Margaret Sommerville says that it is one thing to promote the interest of the family because it is best for the individual and another because it is best for the family ³⁷. The balance to be achieved obviously depends upon the composition of the tribunal, its authority and the procedures it follows.

The law is not interested in a return to the legal straight-jacket which existed as a result of the 1890 Lunacy Act in England and was adopted by Canadian jurisdictions. As Larry Gostin indicated, the 'new legalism' recognizes that autonomy in commitment and treatment matters are not absolute. England and Canadian provinces have legislated provisions which permit refusals to be overridden. It is apparent that the requirement of explicit procedures to override a refusal amounts to a recognition that a person's autonomy is to be respected. It is not illogical to seek consent even though a refusal may ultimately be cast aside. By seeking consent, information is

³⁷ *id.*, p. 166

given to the patient. Access to information is a right and the use of information provided should be the basis upon which a decision is made to accept or reject treatment. Further, the process of giving information as a matter of right is supported by the belief that an individual ought not to be deprived of any more rights than is necessary. When considering the value of autonomy as opposed to the value of the benefits of treatment, the composition of the tribunal becomes critical for often it is under the guise of providing a benefit that individual rights are restricted. In making decisions, the tribunal faces the complex matter of competence and the assessment thereof. As indicated earlier, competence is no longer considered an all or nothing matter. The tribunal should be considering functional competence and decide whether decisions are to be based upon the 'best interest' or 'substituted judgement' standards. In England, the determination to be made is whether the patient is "capable of understanding the nature, purpose and effects of the treatment"³⁸ in question. Ontario defines competence as "having the ability to understand the subject matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent"³⁹. Both statutes are silent as to who makes the assessment but Sommerville suggests that it is implied that the doctor or tribunal will make the judgement. Finally, there is one other concern that the tribunal should be

³⁸Mental Health (Amendment) Act, 1982, sections 43(2)(a) & 44(3)(a)&(b)

³⁹Mental Health Act, R.S.O. 1980, c. 262

aware of and that is the phenomenon of institutionalization. Sommerville indicates that patients can become accustomed to hospital routine or seek to conform or are manipulated by staff to 'go along' with the treatment program.

In an article by Roth, Lidz, Meisel et al⁴⁰ it is noted that many studies are compromised because it is not known whether absence of understanding is due to patients being "poorly informed by professionals about the nature of decisions which lay before them" or because testing is done some time after procedure and it is not known if patients really did not understand or simply forgot.

A study cited by the above authors (Cassileth, 1980) found a relationship between poor patient understanding and demographic features such as low patient education, severity of illness, age and occupational status. Both general and specific competency need to be considered because, while general competency likely indicates specific competency, general incompetency rules out a patient being specifically competent. In such situations, the determination of competency with respect to specific treatment should be done orally (rather than written forms) and in a language the patient understands. Roth et al believe that reliance upon signed consent forms, as evidence of patients being informed and understanding what is to happen, is a

⁴⁰Competency to Decide About Treatment or Research, LOREN H. ROTH, CHARLES W. LIDZ, ALAN MEISEL, PAUL H. SOLOFF, KENNETH KAUMAN, DUANE G. SPIKER and F. GORDON FOSTER, International Journal of Law and Psychiatry 1982, 5:29-50

mistake. Information should be given orally in conjunction with information sheets which can be kept. The sheets should be prepared by educators and should be appropriate to the educational and vocational level of the patients.

In the next part, the results of a study published in 1984 will be examined to consider the degree and manner of application of the doctrine of informed consent⁴¹ along with a study of the right to refuse treatment conducted in Oregon in 1984⁴².

INFORMED CONSENT : A RIGHT OR A RITE

Bloom *et al* briefly examine the current American legal position and other empirical studies (of which there are few) with respect to the right to refuse treatment, one of the facets of the doctrine of informed consent. This study is concerned with the characteristics and refusal patterns of 82 state hospital patients in 1983 who had been handled by new procedures set out in Oregon's laws governing informed consent. Each of the patients had refused treatment.

The right to refuse treatment court cases focus in the main, according to these authors, upon *Rogers v. Okin* (1979) in

⁴¹ *Informed Consent : A Study of Decisionmaking in Psychiatry*, CHARLES W. DIDZ, ALAN MEISEL, EVIATUR ZERUBAVEL, MARY CARTER, REGINA M. SESTAK, LOREN H. ROTH, The Guilford Press, 1984

⁴² *An Empirical View of Patients Exercising Their Right to Refuse Treatment*, JOSEPH D. BLOOM, LARRY R. FAULKNER, VICTOR M. HOLME, RICHARD A. RAWLINSON: 1984 *Int.J. of Law & Psychiatry* 7:315-328

Massachusetts and *Rennie v. Klein* (1978) in New Jersey. Both cases were referred to the U.S. Supreme Court but each were referred back to the court of original jurisdiction for further review. Rogers was sent back in light of another decision of that state (In the Matter of Richard Roe III, 1981). This latter case requires a judge to determine competence and make a substituted judgement. Rennie was returned because of the decision in *Youngberg v. Romeo* (1982) which returned decision making to the clinical and hospital level. *Rennie* (1983) decided that due process could be met through the use of an internal hospital review process.

Summarizing American thought from these decisions ⁴³ and relevant literature, these authors say:

1. the right to refuse treatment exists for involuntary patients on a qualified basis. This right exists through resolution of constitutional issues (right to privacy, due process, free thought) plus separation of competency from decisions relating to commitment.
2. the right to refuse treatment is right to refuse psychotropic medication which now has been placed in the same treatment category previously reserved for E.C.T. and psychosurgery.
3. there is no consensus of opinion how the State should protect due process or specific procedures to be followed in order to override a refusal of such drugs in a non-emergency

⁴³More recent decisions will be discussed in the next chapter.

situation.

The above cases set out two models:

1. The *Rogers* case (1979) called for a judicial determination to override a patient's refusal regardless of competence of the patient.
2. The *Rennie* (1978) said due process did not have to entail a judicial hearing but could use a psychiatric hearing officer, not in the employ of the Mental Health Division of the State and *Rennie* (1983) returned decision making to the level of an internal hospital review process.

A third procedure is set out in Utah's civil commitment legislation which permits a judge to make a determination of competence at the civil commitment hearing. The authors do not indicate whether a court decision of incompetence continues throughout a patient's stay in hospital or whether it is to be reviewed after a certain period of time. In Minnesota, there is a 30 day time limit during which treatment may be imposed. In Nova Scotia, competence is to be assessed by a psychiatrist within three days of admission and such admission is to be reviewed "at any time as the need arises [but] at least once every three months" during the first year as a patient and thereafter, every 12 months⁴⁴. In none of the Canadian jurisdictions is the determination of competence, vis-a-vis capacity to refuse treatment, made by the courts. There is no explicit presumption of competence in any Canadian mental health

⁴⁴R.S.N.S., c.248 as am., sections 43 & 47

legislation. In Saskatchewan, incompetence is one of the basis for admission to a psychiatric unit.

Bloom *et al* refer to a study by Zito, Lentz, Rouff and Olson (in press at time of this publication, 1984) in which new procedures were set out to handle medication refusal in Minnesota. An internal peer review process was created in the form of a Treatment Review Panel, composed of a physician, psychologist, social worker and patient advocate. None of these person could be part of the patient's treatment team. This panel was to decide:

1. if the patient "cannot engage in a rational decision-making process"
2. "whether the patient is suffering from a 'major' mental illness with severe functional incapacity"
3. whether there was any previous benefit from use of drugs or known benefits clearly outweigh the risks involved in treatment.

If these criteria are met, the decision to override can be made for a period of 30 days. The criteria are clearly paternalistic. Possibly the inclusion of a patient advocate and a social worker on the panel will lessen the emphasis upon 'rational' criteria. There is no indication that the decision shall be by consensus or majority. Zito *et al* (1985) found that "there were no significant differences between consenters and refusers in assaultive or threatening behavior, suicide attempts or

non-compliance with other activities"⁴⁵. Godard *et al* note from Zito et al (1985) that persistent refusals likely to be schizophrenic, to be placed more frequently in seclusion, were more self-abusive and required larger doses of medication.

In Oregon, a new administrative rule (1983) came into force which placed psychotropic medication in the same category as E.C.T. and were called 'significant procedures'. These procedures may be used for 'good cause' without consent. Good cause is determined by the treating physician (after consultation with the treatment team on the basis of four factors, called 'good cause factors':

(a) The person's rejection of the procedure ... is a product of the person's mental illness...; and (b) The proposed procedure will restore or prevent deterioration of the person's mental or physical health; alleviate suffering; or save or extend the person's life; and

(c) The proposed procedure is the most appropriate treatment according to current clinical practice and all other less intrusive procedures have been considered; and

(d) The treating physician...has made a conscientious effort to obtain informed consent by attempting to explain the procedure more than one time and at different times. (Oregon Administration Rule 1983)

It is conceivable that, in determining whether rejection of treatment or lack of capacity to consent "is a product of the the person's mental illness", consideration will be given to examining the reasons to see if they are 'recognizable reasons' as outlined by Freedman. There is no indication in the Oregon

⁴⁵Godard et al, 1986, p.296

rule how it is to be determined that a refusal to give consent is a product of the patient's mental illness. Is it determined to be such a product if the given reason is only contrary to the doctor's value system or must the reason be 'unrecognizable' in that it is not supported by the premise?

When the treating physician finds these factors, the hospital supervisor appoints an examining physician (not an employee of the Mental Health Division) who shall interview and examine the patient. The procedure cannot be authorized if one or more of the factors are absent. In the retrospective study done by the authors of 82 refusers (84 refusals) during the year 1983, there were nine independent examiners. These examiners recommended overriding 95% of the refusal episodes (80 of the 84). 72% of the refusals were made at the time of admission. The authors cite extreme ward behaviors and disorganization of patients who were threatening and aggressive as indicators of reasons for refusals. The authors state that "their symptoms...provide the best explanation for their medication refusal"⁴⁶. They say in support of their conclusion that 82% were discharged during the study and that 96% were improved during their hospital stay. It would be interesting to know how many of the group that initially refused to give their consent had been patients previously and had refused on other occasions. Perhaps their current refusal resulted from concerns about the effects of earlier treatment? There is some support for their

⁴⁶ibid,p.325

contention. The authors cite Rodenhauser (1984), an Ohio study involving 14 symptomatic refusers. The authors note that "He perceived denial of illness and grandiosity as the leading causes of treatment refusal"⁴⁷.

The authors are unable to discern from their data or the literature why there was "the high degree of consensus...between the treating physicians, independent examining physicians and the hospital supervisor"⁴⁸. They indicate "the seriousness of our subjects' illness suggests that the overrides were appropriate"⁴⁹. The clear implication is that because the illness was serious, the override is appropriate and not whether the patient is incompetent. Freedman speaks of seriousness of condition and complexity of situation⁵⁰. Seriousness of the result, if the decision is made erroneously, is relevant only in-so-far as requiring a thorough examination of competence. Complexity requires more careful scrutiny because "reasons of policy, of utility, of the exercise of social judgement"⁵¹ demand it and not because the choices are "more difficult to make in a competent fashion"⁵². Bloom *et al*, noting the extra

⁴⁷*The Right to Refuse Treatment in Oregon: A Two Year State-wide Experience*, GOODARD, BLOOM, WILLAIMS & FALKNER, Behavioral Sciences and the Law, 4:293-304, 1986, p.295

⁴⁸ Bloom, note 41, p.325

⁴⁹ *id*

⁵⁰ note 1, p.67

⁵¹ *id*

⁵² *id*

costs to health care services created by the right to refuse treatment, say that such costs are not worthwhile to preserve patient dignity. They state that patients do not refuse medication because they want to preserve their dignity and that refusals are made "because they are seriously mentally ill"⁵³. There does not appear to be any relevant literature which says that patients refuse treatment in order to preserve their dignity. Preservation of dignity may be a by-product of other matters such as ascertaining competence but not as a subjective reason to refuse. Godard *et al* note that one of the difficulties of the study (a retrospective record review) was to secure from patients accurate reasons for refusing, pointing out that refusal reasons for some patients were not clear. Some reasons were "blatantly psychotic"⁵⁴. The study reveals four out of 73 patients refused because of side-effects and 12 refused saying they had a legal right to refuse.

Simon Verdun-Jones notes that little is known about the attitude of patients following the imposition of compulsory treatment ⁵⁵. He points to an Australian study (Shannon, 1980) which suggests that patients are angry at the lack of control of their lives which can be harmful to a therapeutic relationship, if such a relationship can evolve in present day institutions. As noted earlier, Canadian legislatures permit treatment to be

⁵³Bloom p.326~

⁵⁴Godard, 1986, p.301

⁵⁵*Right to Refuse Treatment - The Other Side of The Coin*, unpublished article, May, 1987

imposed without consent upon involuntarily committed patients whether competent or not. Some provinces require procedures to be followed prior to imposition of treatment (Ontario and Nova Scotia) and others do not (B.C.). In 30 of the American states there are provisions to override a patient's refusal of treatment⁵⁶.

It is submitted that seriousness of mental illness is not the *sine qua non* of a refusal. The degree of seriousness of mental illness, if one accepts Freedman's rationale, is related to the degree of care taken to determine competence. To accept the hypothesis of Bloom *et al* would mean that seriousness of mental illness equates to an inability to decide yea or nay about treatment. While the four factors listed in the Oregon rule must be considered in conjunction with one another, it appears that the greatest emphasis is placed upon the first one, namely, "rejection of procedure...is a product of the person's mental illness..."⁵⁷. Finally, it is possible to examine this report and be left with the impression that the primary concern of the authors is not to effect the 'best' procedure in order to give credibility to a valid informed consent process, but to show that it incurs higher costs and a decrease in funds available for community services. They say it is necessary "to strike a realistic balance"⁵⁸ between the

⁵⁶Godard et al, 1986, p.294

⁵⁷Bloom, p. 319

⁵⁸ id, p.327

perspectives of lawyers and doctors in order to maintain a responsible approach for "the care, treatment and rights of the mentally ill"⁵⁹. Such concerns are policy level considerations which will define a 'realistic' balance, but it is at the conceptual level, that concerns for individuals ought to be formulated. Budgetary concerns are a fact of everyday political life but, in our Western society, which espouses individuality and freedom, those concerns ought to be held at least parallel to, if not subservient to those ideals.

As one examines the extensive study of Lidz, Meisel et al some words of Sir John Wood and Alan A. Stone come to mind. Sir John Wood: "...that the strengthening of the legal framework protecting the patient will be relatively ineffective unless it is matched by parallel administrative changes"⁶⁰. Alan A. Stone drawing upon his many years of experience including a term as president of the American Psychiatric Association, lists eight major failings of psychiatry, two of which are:

(2) The greatest failing of the modern health system, causing suffering to patients, has been the failure of continuity of care. Legal reform has intensified this problem at every turn. (3) The greatest professional, ethical failing of modern psychiatry, and indeed of all medicine, has been the abandonment of the responsibility that runs to the patient as a person. Instead the doctor defines his role in some narrower technical sense. Legal reform has made it easier for psychiatrists to justify

⁵⁹ *id*

⁶⁰ MARTIN ROTH & ROBERT BLUGLASS, eds., *Psychiatry, Human Rights and The Law*, SIR JOHN WOOD, *Detention of Patients: Administrative Problems Facing Mental Health Tribunals*, 114-122, p. 115

and rationalize this failure of responsibility.⁶¹

Lidz and Meisel *et al* examine three sections of a Pennsylvania hospital shortly after the passage of informed consent legislation in that state. The three sections were the Outpatient Clinic, Research Ward and Evaluation Centre. The study is made by trained observers watching hospital personnel as they deal with patients in each of these sections, noting how the staff deals with informed consent. The study shows the problems a busy psychiatric centre faces administratively trying to deal with patients as individuals, how procedures can frustrate any rights program and how personnel through disinclination or miscomprehension can negate the thrust of a policy. The narrow subjective focus of the staff can, and did, divert attention from the needs of patients to the goals of the staff. There was a failure to answer questions and, when answered, the fulness of the answer seemed to vary with the staff's perception of the degree of illness. Frequently it appeared as if the patient expected the staff to make the decisions and staff accepted this. There was a failure to talk about the nature of the treatment which was to be given and the possible side-effects. This failure appeared in part to result from others being expected to make treatment decisions. This was true especially in the Evaluation Centre. There appeared to be no clear authority as to who did the informing. There was a

⁶¹ALAN A. STONE, *Psychiatric Abuse & Legal Reform: Two Ways to Make A Bad Situation Worse*, *International Journal of Law and Psychiatry*, 1982 5:9-28, p.11

diffusion of responsibility.

The model of informed consent used by Lidz and Meisel et al consisted of five components - disclosure, competence, understanding, voluntariness and decision. They noted that understanding and competence are overlapping concepts. A major problem in this area of study, they say, is to understand what is meant by 'understanding'. Recall is only one aspect of that term and the authors says those few studies which do exist are flawed by failure to note this or to define 'understanding' in terms of the particular study. They note that timing and language used are important factors in this regard as well the manner in which the information is given. Understanding is related to the information received and should include the purpose of the proposed treatment. It was noted by the authors that patients who believed there was something wrong with them, were the most co-operative of all the patients. This co-operation led staff to be more open about the information given.

When information is given, patients appear to follow the lead of staff, asking few questions. This appears to be the same for written or oral information. The authors note that written information has the benefit of consistency but fails to meet individual educational and vocational circumstances. The observers noted that staff spoke of the bureaucratization of their role by the requirement of having to give out information to the patients in order to attempt to secure an informed

consent. To them it was a rite rather than a right. Frequently, staff were more interested in getting information than giving it. An example quoted by the authors illustrates this. A patient in the Evaluation Center asked the psychiatrist "Do I need help?" to which the reply was "That is a good question." and proceeded to gather more information from the patient. It appeared to the authors that information was given primarily to secure compliance rather than as an aid for the patients.

In summary, the authors note that "Informed consent in the pristine form envisioned by law and by ethicists was only, if ever, found in the hospital. ...The fact we did not find informed consent in its pristine form does not mean we did not find, from time to time some constituent parts.⁶² They say that there is no evidence in their study that informed consent law has substantial positive effects as presently implemented. There was no sign that disclosure and securing of patients' consent increased patients' participation in treatment, decision making or improved staff - patient communication or increased patient co-operation and autonomy. There was no large increase in the number of refusals. Lidz, Meisel *et al* suggest that the failure to find strong indications of positive or negative consequences may be due to the minimal efforts by staff to comply with the legal doctrine. Another factor which interferes with informed consent doctrine is institutional practice where a patient is seen and treated by a number of professionals. Informed consent

⁶² *id*, p. 315

envisages a one-on-one relationship between the doctor and the patient. Such is not the case in large centres where care is in the hands of a team in a day to day sense, with the physician or director being legally responsible. With floating responsibility as to who should tell what to the patient, the doctrine is in limbo. It is apparent from this study that institutional psychiatry, the socialization of mental health professionals and the structure of the delivery system for care services works against decision-making as hoped for by the proponents of this doctrine. "Decision-making is not typically a mutual process but one undertaken predominately by health professionals with information given to patients after decisions are made in order to obtain compliance with treatment regimens⁶³.

⁶³ *id*, p. 326

CHAPTER VII

COURT DECISIONS AND THE MENTALLY ILL

Introduction

It was indicated earlier that the courts, in advance of legislative action, recognized the variability of competence among the mentally disordered. Indeed it can be said that the courts were more concerned with the protecting the rights of the mentally disordered than were the public and their politicians. The virtue of the law's involvement with the rights of the mentally ill is its ability to deal with individuals rather than with a class of people. As early as 1869, Canadian courts have sought to put the individual first. In *Re. Mein*¹, the court was concerned about a conflict of interest between the roles of a medical officer who had charge of a patient and who also was seeking an order for payment of maintenance on behalf of the asylum. In an application for a declaration of incompetency, an Ontario court in the above cited case said:

Personal service upon the alleged lunatic of a copy of the petition is not essential, but as the object in serving him is that he may have an opportunity of appearing on it and showing the court that he is not a lunatic, it would scarcely be safe for the court to dispense with service, upon the unsupported testimony of the medical officer in whose charge the patient is, and who, if he is wrongfully confined, has an interest in preventing access to him. I propose, therefore, to direct that in this case a medical man, named by the court shall visit the alleged lunatic and report upon his condition before any order is made. I am more inclined to adopt this course because in this case the

¹[1869] 2 Chy. Chrs.429

asylum authorities are, by their bursar, petitioners, and seek to have the estate of the lunatic paid over to them .

Also, the courts have stressed the paramountcy of the interest of the person over the interests of his/her estate ². In an application for a declaration of incompetency, an Ontario court said:

"It is not the policy of the courts to discourage applications of this character where good grounds exist even for serious suspicion of the unsoundness of mind - and on the other hand, the courts are very careful not to make an order declaring anyone a lunatic without practically conclusive evidence" ³.

It was indicated earlier as well that the nineteenth century legalistic model of dealing with this group of people was cumbersome and delayed access to treatment procedures. With changes in legislation, of necessity there were new interpretations of the law during the transition from the legalistic model to the medical model and now, (since about 1980), to a model called 'new legalism' . Since 1982, Canadian courts have had the *Constitution* with the included *Charter of Rights and Freedoms* ⁴ by which to measure and protect individual rights and freedoms. Section 15 of the *Charter* relating to equality rights came into force in 1985. By section 52, the *Constitution*, rather than Parliament (or provincial legislatures in matters of provincial jurisdiction), is the supreme law of

²*Re. Clark*, [1892] 14 P.R. 370; *Re. Thomas* [1918] 15 O.W.N. 185; *Re. Howell*, [1919] 17 O.W.N. 47

³*Re. Peel*, [1910] 19 O.W.R. 511

⁴Canada Act, 1982, (U.K.) c.11

Canada. The courts are now in a position to protect the constitutional rights of all persons in Canada; to insure, through the 'due process of law' concept and the prohibition against discrimination, that the mentally ill receive treatment and, when they are competent, that they enjoy the right to refuse treatment. It is suggested that such provisions as those in B.C.'s *Mental Health Act* that permit treatment upon the consent of the Director, of a patient without a determination of competence, could be set aside by the courts. Whether the courts will grapple with this issue from a 'rights' or 'needs' perspective will depend to large extent upon the social awareness of the courts. Roth and associates contend "that judgements of competency go beyond semantics or straight forward applications of legal rules; such judgements reflect social considerations and societal biases as much as they reflect matters of law and medicine"⁵. It may be that the failure of mental health legislation to require active consideration of a patient's competence will render the legislation voidable as a violation of the *Charter*. Regardless of the provisions of any such legislation, the failure of mental health professionals to make an actual determination of competence of a patient may be declared a violation of the patient's right to privacy and /or security as well as an infringement of the patient's autonomy.

⁵ L.H.ROTH, A. MEISEL, C.W.LIDZ, *Test of Competency to Consent to Treatment*, American Journal of Psychiatry, 1977, 134:279-284

Legal Standards for Competence Assessment

The doctrine of informed consent from a legal perspective has three elements:

1. knowledge of relevant treatment information;
2. voluntariness;
3. competence of the person giving consent.

Knowledge involves giving to the patient information about the risks, benefits, alternatives and side-effects of the proposed treatment. The key word is 'proposed', which means information is to be given before consent, in line with Freedman's premise that information should precede decision. The scope of disclosure in medical (as opposed to psychiatric) cases has been set out, within the Canadian context, in the case of *Hopp v. Lepp*⁶. This case requires the doctor to answer specific questions posed by the patient, and even in the absence of questions, the patient shall be told the nature of the proposed treatment, its gravity, material risks and any unusual risks attendant upon the performance of the treatment⁷. Whether or not disclosure has been adequate is to be determined in the circumstances of each case. Grisso⁸ notes that American law recognizes two legal standards and that a third has been

⁶[1980] 2 S.C.R. 192

⁷*ibid*, p.210

⁸Thomas Grisso, *Evaluating Assessments: Forensic Assessments and Instruments*, Plenum Press, New York, 1986, Chapter 10

suggested by the President's Commission for Ethical Practices (1982):

1. disclosure shall be what the average, reasonable practitioner would provide in similar circumstances (*Natanson v. Kline* [1960]) or

2. disclosure shall be adequate to inform the average, reasonable patient (*Cobbs v. Grant* [1972]) or

3. disclosure of any information that the specific patient would likely consider relevant when making a treatment decision. The last point is in line with the Canadian case of *Reibl v. Hughes*,⁹ wherein the headnote says:

Merely because the medical evidence established the reasonableness of a recommended operation, did not mean that a reasonable person in the patient's position would necessarily agree to it if proper disclosure had been made of the risks attendant upon it, balanced against those against it. The patient's particular situation and the degree to which surgery or no surgery were balanced, would reduce the force, on objective appraisal of the surgeon's recommendation. In deciding what decision a reasonable person in the patient's position would have made, the patient's particular position should be considered objectively and not subjectively.¹⁰

For an informed consent to be voluntary, there must be an absence of coercion, unfair persuasions and inducements. As indicated in the last chapter, institutionalization may inhibit a truly voluntary consent because of the patient's desire 'to get along' with staff who control much of a patient's life. It

⁹[1980] 2 S.C.R. 880

¹⁰*ibid*, p.882

is suggested just because a patient is an involuntary resident in an institution, that does not mean that consents secured therein are necessarily involuntary. However it does suggest that the issue ought to be examined more closely than would be the case in relation to the consent of a person who is an out-patient or a non-psychiatric patient. The common law has long recognized that competence is not an all or nothing concept. Despite court recognition in advance of legislative provisions, the law has yet to formulate "a widely accepted definition of the types of functions or capacities relevant for a legal construct of competence to consent"¹¹.

Grisso observes a conflict between the approach between Applebaum & Roth (1982) and Shim & Sales (1985) with respect to the competence element of informed consent. The latter's analysis contends that competence refers only to capacity for reasoning and capacity for understanding. Shim and Sales state that actual understanding is part of the knowledge element. Applebaum and Roth in their summary of the judicial approach to competence, set out four potential tests:

1. if there is no evidence of a preference or a choice of treatment, either for or against, the patient is incompetent.

2. the patient is incompetent if there is no actual understanding of the given information or if there is no capacity to understand the information.

¹¹Grisso, supra, note 8, p.314

3. competence is not present if there is no ability to use the information in the decision-making process.

4. The patient is incompetent if there is no affective or cognitive appreciation of the consequences of the decision. There needs to be an appreciation of the whole situation that is faced by the patient.

Concerning the use of information, reference should be made to earlier comments by Freedman in relation to his moral theory. With respect to the last point by Applebaum and Roth, assistance as to the meaning of 'appreciate' can be gained by examining the interpretations given by the Canadian courts to the present section 16(2) of the *Criminal Code*: "For the purpose of this section a person is insane when he...has a disease of the mind to an extent that renders him incapable of appreciating the nature and quality of an act or omission...". To appreciate, is to have the capacity not only to know what is being done, but also to be able to comprehend the consequences flowing from the act¹². To know the physical quality of an act is not the same as appreciating the nature and quality of an act¹³.

While competence is the main concern here, it may be appropriate to suggest that, in the net result, it makes little difference whether actual understanding is part of the knowledge element or the capacity element of informed consent because both must be considered when determining when a consent is an

¹²R. v. *Kjeldsen*, [1982] 1 W.W.R. 577 (S.C.C.)

¹³R. v. *Cooper*, [1980] 51 C.C.C.(2d) 129 (S.C.C.)

informed one. One of the findings of the Lidz et al (1984) study indicated that the clinical staff, in the psychiatric hospital where the study was conducted, did not extend themselves to secure informed consents and the findings in general, do not indicate the existence of any specific concern about competence on the part of the staff. Grisso notes that when decision-making capacities are questionable, "usually it is decided to forego or delay proposed treatment or to seek consent from relatives or authorized non-judicial review boards"¹⁴. Lidz et al (1984) suggest that evaluations of competence occur during doctor-patient interviews as a result of the doctor's impression of the patient's capacity to give consent. It appears to Grisso from the data of Kaufman, Roth, Lidz and Meisel (in print, 1986), that "treating professionals are more likely to base judgements about competency to consent on global evaluations of mental status, rather than on an evaluation of abilities specific to understanding and weighing treatment options"¹⁵. It is indicated by Grisso that the U.S. court decision in *Rogers v. Okin* (1982) has led to the development of lists of specific questions to be considered when assessing competence¹⁶. However as indicated by Lidz et al (1984), there are infrequent efforts by the mental health professionals to make assessments of competency in practice because, as Grisso suggests, there is infrequent judicial scrutiny of their assessments and because

¹⁴Note 8, p.318

¹⁵*id*

¹⁶Binney & Veliz, 1984

they tend to misperceive incompetence to consent as being a "global incapacity defined by the degree of psychopathology or developmental status"¹⁷ and hence, do not address the need to make such an assessment outside the usual diagnostic procedures.

Despite such professional reluctance and because of the trends in law and theory, Grisso sees a need for "a specific construct of competence to consent"¹⁸ which would be considered entirely separately from the diagnosis of mental illness. Such a construct would involve defining the abilities and functions that are to be examined to assess competence. Grisso draws upon five analyses¹⁹ to show that:

1. The various factors which may influence treatment decisions, are not conceptually relevant when examining the competence element;

2. reasoning abilities (weighing, deliberating options and use of treatment information) are involved in the competence element and are related to the specific task of decision-making rather than global abilities;

3. The patients' understanding of the information and the context within which the information is given (regardless of whether this is considered part of the knowledge or competence

¹⁷note 8, p.31-9

¹⁸*id*

¹⁹Shin & Sales (1985); Tepper & Elwork (1984); Applebaum & Roth (1982); Grisso & Vierling (1978); President's Commission for Ethical Practices (1984)

element) are critical factors to be considered when setting up a construct. Other considerations in this regard are:

1. an awareness of whether or not a deficit of understanding is due to a permanent condition of the patient (irreversible brain damage); or temporary deficit due to misuse of drugs;

2. an awareness of the manner in which information was disclosed including clarity of presentation and whether it is within the patients' intellectual and vocational abilities;

3. whether information has been forgotten or not comprehended.

There are at least two reasons to search for such a valid construct. Use of such a construct to secure relevant data about the patient's competence is to be considered an aid to, rather than a means of making the judgement. By standardizing information, there will be a consistent quality of information to enable the professional mental health worker to exercise his discretion responsibly and morally.

After detailed examination of three experimental instruments developed for measuring functional abilities, Grisso says that these instruments attempt to assess capacity to reason about treatment-related situations; capacity to understand treatment related information and actual understanding. If actual understanding is to be part of the competence element, then the structure of informed consent is wrong because the knowledge element would be without purpose or definition. This was pointed

out by Freedman ²⁰ in his discussion. If the legal construct of informed consent (three elements) continues to be the accepted premise, then it is logical that the disclosure of essential information and its reception to produce knowledge (actual knowledge), should relate to the knowledge element. Appreciation of the context in which the knowledge is to be applied (capacity to understand), is at the heart of competence. However, as indicated earlier, both elements need to be considered (along with voluntariness) in order for there to be informed consent. Thus any instrument which is to measure functional abilities ought to include portions which can measure actual knowledge and capacity to understand.

Grisso states that one of the problems of standardizing assessment instruments is "the necessity to develop many different instruments for different treatment proposals"²¹ which arise in hospital settings. However, as he points out, the instruments do not have to be content specific to a particular patient since the treatment-related items can be made to generalize over a prospective population. The essence is to be able to measure understanding, including appreciation. Generalization can be attempted if the treatment information is broad enough to cover the patient population. It is difficult to visualize such an instrument being both general and specific enough to measure a particular patient's ability. It is supposed

²⁰Chapter 5, note 1

²¹ note 8, p.341

that the instruments are to be considered merely as an aid to decision-making and not as a substitute decision-maker. Once the instruments have been shown to be valid by their consistency and objectivity, the problem will be to convince practitioners to use them meaningfully. Having regard to the study of Lidz *et al* (1984), one suspects that only if those who are to use them can be convinced of the importance of the doctrine of informed consent and the merit of actively assessing competence, will the instruments be used in a manner which shows that the right of autonomy is not a mere rite.

Decisions and the Charter

It is suggested that court decisions of the past must be construed now in the context of the *Constitution*²² generally, and, in particular, the *Charter of Rights and Freedoms*. Constitutions are to be interpreted broadly and liberally²³ but regard must be had to the plain meaning of words and there is a need to resist the temptation to be over-expansive²⁴. The *Charter* being part of the *Constitution* is not an ordinary statute like the *Bill of Rights*, and as such is to be generously rather than legalistically interpreted so that individuals will

²²*Canada Act, 1982 (U.K.)*, c.11

²³*Southam Press Inc. v. Hunter et al*, [1982] 68 C.C.C.(2nd) 356 (Alta. Q.B.)

²⁴*Dolphin Delivery Ltd. v. Retail, Wholesale and Department Store Union local 580 et al*, [1984] 10 D.L.R.(4th) 198 (B.C.C.A., aff. S.C.C.)

have a full measure of the rights and freedoms it guarantees²⁵. When the *Charter* uses the term 'rights', it guarantees State intervention to protect the individual in the activity referred to. When it speaks of 'freedom', the *Charter* guarantees non-interference by the State in the activity embraced by the freedom²⁶. The various Interpretation Acts in the Canadian jurisdictions do not apply to the interpretation of the *Charter*²⁷. Section 7 of the *Charter* (right to life, liberty and security) has an independent substantive effect with a meaning not limited in context by the rights inferred by sections 8-14. The 'principles of fundamental justice' ought not to be interpreted as limiting courts to a review of procedural matters, rather it permits a review of the substance of legislation that interferes with the person's right to life, liberty and security.²⁸ Also, there is a need for compelling factors to justify placing the collective interests of society ahead of the rights of the individual²⁹.

²⁵*Quebec Association of Protestant School Boards et al v. Attorney-General of Quebec et al*, (1982) 140 D.L.R.(3d) 33 (Que.S.C., aff. C.A. and S.C.C.)

²⁶*Re Alleman et al and Commissioner of the NWT*, (1983) 144 D.L.R.(3d) 467 (N.W.T.S.C.) and aff. N.W.T.C.A.(1985) 8 D.L.R.(4th) 230

²⁷*Law Society of Upper Canada v. Skapinker*, (1984) 11 C.C.C.(3d) 481 (S.C.C.)

²⁸*Re R.L.Crain Inc. et al v. Couture et al*, [1983] 6 D.L.R.(4th) 478 (Sask.Q.B.); *Reference Re: Section 94(2) Motor Vehicle Act*, (1985) 23 C.C.C.(3d) 289 (S.C.C.)

²⁹*ibid*

It has been noted that *Charter* provisions were preceded, in a number of provinces, by the altering of criteria for civil commitment in a manner which embraces the 'new legalism' advocated by Gostin and Verdun-Jones. Gordon and Verdun-Jones have discussed these matters and have observed as well, that the timing of the implementation of the *Charter* provisions is co-incidental with the sociological developments of "de-institutionalization, non-institutionalization and privatization"³⁰. They point out the paradox of civil rights activists praising the efforts of legislators in enacting provisions for the greater protection of mental health patients and the failure of these same legislators to provide adequate facilities for the patients upon their release. It is pointed out by Gordon and Verdun-Jones that, under the guise of "enlightenment and humanitarianism"³¹, patients have been removed from institutions and placed in private accommodation for the profit of entrepreneurs. They cite E.S.Lightman³² for the observation that these people "are housed...often under conditions that should be utterly unacceptable in any civilized society"³³.

³⁰ROBERT M. GORDON, M.A.(Crim) and SIMON VERDUNJONES J.S.D., *The Impact of the Canadian Charter of Rights and Freedoms Upon Canadian Mental Health Law: The Dawn of a New Era or Business as Usual?*, *Law, Medicine and Health Care*, 1986, 14:190-197, p.194

³¹*ibid*, p.195

³²*The Impact of Government Economic Restraint on Mental Health Services in Canada*, *Canada's Mental Health*, 34:24-28

³³*id*

Noting Gostin's 'new legalism', the authors state that the law's central role is to be certain that mental patients receive effective treatment within clearly defined guidelines that have been set out to protect them. They look for the law to avoid Victorian legalism and to foster "the evolution of a new form legalism, active in creating new social policy"³⁴.

Alberta, B.C. and Saskatchewan through their mental health acts³⁵ are provinces which provide a statutory right to treatment. None of the other provinces do so. In those three provinces, that right is limited "to the resources currently available"³⁶. Gordon and Verdun-Jones observe that, in Canada, "it seems that a broadly conceived right to effective mental health treatment is likely to be established only by generous interpretation of the *Charter*"³⁷.

Concerning criminal matters, sections 7, 9, and 12 have been used to challenge the provisions of the *Criminal Code* with respect to Part 21 (dangerous offenders) and section 542 (Lieutenant-Governors' Warrants) in a number of cases but to no avail³⁸. The *Swain* case looks at section 542(2) as part of a

³⁴note 30, p.195; note earlier comments in Chapter 1, p.12-16

³⁵Chapter 2, notes 7, 5, 17 respectively and in appendix A

³⁶note 30, p.195

³⁷note 30, p.196

³⁸*Re. Moore and the Queen*, (1984), 10 C.C.C.(3d)306 (Ont.H.C.J.); *Re. Rebic*, (1986), 20 C.C.C.(3d) 196 (B.C.S.C.) and (1986) 4 W.W.R. 401 (B.C.C.A.); *Regina v. Swain*, (1986) 24 C.C.C.(3d) 385 (Ont. C.A.)

larger legislative scheme. Where there has been procedural fairness with due process protections in other parts of the same scheme with regards to an individual, the provisions of section 7 will not apply. The initial detention, upon a finding of not guilty by reason of insanity was made without an inquiry within the due process requirements. However, these requirements are said in the majority judgement of the court, to be met by section 545. In the same manner persons held under a warrant of a Lieutenant-Governor are protected, according to the court, by section 547 which requires that the Lieutenant-Governor consider certain factors when deciding what to do with such a person. In dissenting, Brook J.A. noted that while there may be a presumption of continued mental illness or dangerousness, that presumption is not irrebuttable. He said that the standard applied by the review board and the Lieutenant-Governor was vague and very discretionary. To be fair, within the meaning of section 7, a person whose liberty is at stake, must be entitled to put his case and call evidence.

The B.C.C.A. case of *Re Reblac*³⁹ followed the judgement of the majority in *Swain*. The court, composed of Justices Esson, Cheffins and Macfarlane agreed, in the net result, that there was no discrimination with respect to section 542. Mr. Justice Esson, with whom Cheffins J.A. concurred, accepted the Crown's position that 'discrimination' in section 15(1) of the *Charter*, must be interpreted narrowly so as to apply to unjustifiable

³⁹ (1987) 28 C.C.C. (3d) 154

distinctions. Citing the arguments of Mc Intyre J.⁴⁰, Esson J.A. held that it is necessary to determine if inequality was created "rationally and not arbitrarily or capriciously" and whether the departure from universal application was necessary to attain a desirable social objective. The appellant/defendant had argued that this section should be given "a broad and neutral meaning"⁴¹ but Esson J.A. says that the words cannot be interpreted in a neutral sense because some discrimination is "laudatory"⁴² and that "[m]ost laws discriminate in some way"⁴³ The major error in the appellant's case was in considering the differentiation between a person who has been found not guilty by reason of insanity and one found not guilty. As the person who has been found not guilty by reason of insanity has been found to have committed the offence in question but is not criminally responsible, the comparison should be made with a person who has been found guilty. In other words, the issue of discrimination is to be determined among groups of similarly situated persons and if there is a distinction in treatment amongst them, there may be discrimination within the meaning of the *Charter*.

Macfarlane J.A., who arrives at the same conclusion via a different route, says the words 'without discrimination' refer,

⁴⁰ *Mc Kay v. R*, (1980) 54 C.C.C. 129, p.159

⁴¹ *Rebic*, p.383

⁴² *ibid*, 384

⁴³ *id*

at one end of the spectrum to differences which could be described as unreasonable or unjustified and, at the other end, to differences which are seen to be acceptable- e.g. laws which protect children and the aged. He cites Dickson C.J. "...the interests of true equality may well require differentiation"⁴⁴. To Macfarlane J.A., the distinction in section 542(2) C.C. is unfair and unreasonable and therefore, section 1 of the *Charter* needs to be considered. It is apparent that as part of the legislative scheme relating to "insane criminals, the learned justice says that the restrictions are a limitation "justified in a free and democratic society" ⁴⁵. He accepts that the objective of section 542(2) is desirable in a social sense, noting that "[s]ociety has a legitimate social interest in persons"⁴⁶ who have committed a criminal offence and have been found to be not criminally responsible. This being so, it is appropriate to override a constitutionally protected right or freedom. These *Criminal Code* provisions are intended to protect society and the the accused until health is restored. His Lordship appears to believe that the periodic reviews required by the *Criminal Code* provide protection against arbitrary conduct by the authorities. The question that may need to be answered is the case of a prisoner who receives inadequate or no treatment while held on a warrant of a Lieutenant-Governor.

⁴⁴ *R. v. Big M Drug Mart Ltd.*, [1985], 1 S.C.R.295, p.347

⁴⁵ *Charter of Rights and Freedoms*, section 1

⁴⁶ *R. v. Saxell*, (1980) 59 C.C.C. (2d)176, p.167 per Weatherston J.A. (Ont.C.A.)

Would such lack of treatment be considered "cruel and unusual treatment or punishment" under section 12 of the *Charter*? The possibility of such an action can be seen from the judgements in the cases of *Re. Moore*⁴⁷ and *Re Mitchell and the Queen*⁴⁸. While section 542 of the *Code* will not be impugned under this provision of the *Charter*, individual case circumstances may warrant the application of section 12.

The majority judgement does not consider the fact that the *ad hoc* committee in B.C. which allegedly operates under the same terms as a Review Board set up under section 547(1) C.C., is not subject to those restrictions. All it need do is act in accordance with procedural fairness. Macfarlane J.A. says that there is no difference between the two types of bodies. It will be recalled from Chapter 4 that there are proposed amendments in this regard in the *Criminal Code*. The B.C. committee is able to set its own rules and procedure and there is no indication in any of the judgements how this committee operates.

Informed consent and the non-psychiatric patient

There are two Supreme Court of Canada decisions which set out the requirements of informed consent for 'ordinary' patients⁴⁹ outside the mental health system. In the first case,

⁴⁷(1984) 10 C.C.C.(3d) 306 (Ont.H.C.J.)

⁴⁸(1983) 6 C.C.C.(3d) 193 (Ont.H.C.J.)

⁴⁹*Hopp v. Lepp* [1980] 2 S.C.R. 192; *Reibl v. Hughes* [1980] 2 S.C.R. 880

a patient suffered a permanent disability following a back operation. He sued the first doctor, alleging negligence and battery. At trial, the negligence aspect was dismissed and not appealed at the subsequent hearings. The battery allegation was dismissed at trial, allowed in the Court of Appeal of Alberta and denied in the Supreme Court of Canada. The Alberta Court of Appeal in a majority judgement, ruled that, as there was not an informed consent, there was an unlawful invasion of the patient's body (battery) and awarded him \$15,000.00 damages. The main issue in the Supreme Court of Canada was whether there was disclosure and if there was, what was the extent of disclosure?

Generally speaking, as the headnote observes:

"If no specific questions are put as to possible risks, the surgeon is under no obligation to tell the patient that there are possible risks since there are such risks in any operation. The decided cases appear to indicate that a surgeon, generally, should answer any specific questions posed by the patient as to the risk involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation"⁵⁰.

The scope of disclosure and whether it has been breached, is dependent upon the circumstances of each case. Chief Justice Laskin, rendering the judgement for the Court, notes that prior consent "does not immunize a surgeon or physician from liability for battery or negligence if he has failed in a duty to disclose risks of surgery or treatment, known or which should have been known to him and which were unknown to the patient"⁵¹. He cites

⁵⁰note 48, p.193

⁵¹note 48, 196

the *Parmely* case⁵² for the principle that a patient has the right to decide what, if anything, should be done with his body. For present purposes, it is interesting to note that the Chief Justice includes the word 'therapy' along with surgery when he says that the patient must be sufficiently informed to make a choice as to whether or not to proceed with the proposed treatment⁵³. It would appear that psychotherapy, without the patient being informed sufficiently to make a choice of therapy or no therapy, would render the therapist liable for performing non-consensual therapy.

Laskin C.J.C. cites *Kenny v. Lockwood*⁵⁴ and says that case

"...is important as much for what it portended as for what it actually decided. It indicated that a surgeon who recommends an operation which involves known risks or special or unknown risks, is under an obligation to his patient to disclose those risks and if he fails to do so, and injury results from one of the undisclosed risks or not fully disclosed risks, the patient's consent to the operation will be held not to be an informed consent, although the operation itself was competently performed"⁵⁵.

Having regard to the Court's use of 'therapy', it would be appropriate to substitute in the above quotation, 'therapy' for 'operation' and 'injury' could be said to include 'side-effects'. With respect to the latter matter, reference is made by the Court to the case of *Male v. Hopmans*⁵⁶ which dealt

⁵²[1945] S.C.R. 635. p.645-46

⁵³*id*

⁵⁴ [1932] O.R. 141

⁵⁵Hopp, 204

⁵⁶[1967] 64 D.L.R.(2d) 105

with the situation where a patient became deaf as a result of using a drug with known side-effects. The doctor did not order or make any tests of the drug when it was known from the literature that there was a risk of side-effects. If tardive dyskinesia is a known side-effect of some drugs, what would be the position of the physician in the situation where that injury occurred to a mental patient who was competent (or the doctor did not specifically assess competence) and the treatment was given without an informed consent? Chief Justice Laskin says

"I am far from persuaded that the surgeon [psychiatrist ?] should decide on his own not to warn of the probable risk of hearing or other impairment if the course of treatment contemplated is administered. A surgeon [psychiatrist ?] is better advised to give the warning which may be coupled with the likely consequences if the treatment is rejected.⁵⁷ (emphasis added)

The Court quotes from *Canterbury v. Spence*⁵⁸ for a standard of materiality "...[a] risk is...when a reasonable person, and what the physician knows or should know to be the patient's position, would likely attach significance to the risk or cluster of risks in deciding whether or not to undergo the proposed therapy"⁵⁹. The Court summarizes the variety of risks:

1. probable risks which must be disclosed, as contrasted with mere possibilities, those which are involved in any operation.

⁵⁷note 30, p.208

⁵⁸[1972] 464 F.(2d) 772 (U.S.C.A.)

⁵⁹Hopp, p.208

2. whether or not a risk is remote, if that risk should materialize and there would be grave consequences, the risk must be disclosed.

3. Those special or unusual risks that relate to the particular case and serious consequences that could be the result in the specific case, the risk must be disclosed, even if it is a mere possibility.

The Court concurred with the findings of the trial judge, reversing the Court of Appeal saying there was no evidence to support the interpretation given by Morrow J.A.

In a decision after *Hopp*, Chief Justice Laskin for the Court in the *Reibl* case (supra), again discusses the standard of disclosure of risks. *Reibl*, the plaintiff/appellant, age 44, formally consented to an operation to increase the rate of flow through the left carotid artery. He suffered a stroke which left him paralysed and impotent. The operation had been competently performed. The issue was lack of informed consent because of non-disclosure of risks, having regard to the particulars of the patient.

The Court reaffirmed the dicta of the *Hopp* case when it said,

"...that even if a certain risk is a mere possibility which ordinarily need not be disclosed, yet if its occurrence carries serious consequences, as for example, paralysis or even death, it should be regarded as a material risk requiring disclosure"⁶⁰.

⁶⁰Reibl, 884

It was known that there was a risk of a stroke, of paralysis or death with the operation and also even without the operation, there was a risk of a stroke or death. The trial court accepted the testimony of Reibl, who had one and a half years to work before his pension vested, when he said that if he had been "properly informed of the magnitude of the risk"⁶¹, he would have waited until after the pension had vested as immediate surgery was not imperative. Also, he said he would rather live a "shorter normal life than a longer one as a cripple because of surgery"⁶².

So the question which arises, is how specific must the information be in order to decide between surgery or no surgery, treatment or no treatment? The fiduciary relationship between a doctor and a patient means that the patient is entitled to rely on the doctor's statements in order for the patient to arrive at a decision. The scope of the duty to disclose "is defined by the evaluation of a variety of inter-related factors"⁶³ which have specific reference to the case in question. Laskin C.J.C. says that failure of disclosure, regardless of seriousness, unless there is misrepresentation or fraud, goes not to the validity of consent, but rather necessitates the framing of the cause of action in terms of negligence. He says this, despite the fact that such failure relates to an informed consent. His judgement,

⁶¹ *ibid* 885

⁶² *id*

⁶³ *ibid* 887

with the concurrence of the other judges, is that it was a "breach of an anterior duty of due care, comparable to the duty of due care in carrying out the particular treatment to which the patient has consented"⁶⁴. The English courts have also held that the doctrine of informed consent is part of the law of negligence, quoting with favor the words of Laskin C.J.C. in the *Reibl* case⁶⁵. "The materiality of non-disclosure"⁶⁶ is not dependent solely upon expert medical evidence. Such evidence is to be considered along with evidence from other sources - e.g. the patient and the patient's family. In assessing all the evidence, consideration is to be taken of the patient's particular concerns coupled with an objective assessment in terms of reasonableness⁶⁷.

In summary non-psychiatric patients have the right to decide what may or may not be done with/to their bodies. Doctors treating them are in a fiduciary relationship with them, requiring sufficient information be given to them so as to enable them (the patients) to make an informed choice for or against the proposed treatment. In addition to answering any questions asked, the Supreme Court of Canada has said that doctors must take into account the particular position of patients whereby a consequence, which may only be a possible

⁶⁴Reibl 892

⁶⁵ *Freeman v. Home Office* [1983] 3 All E.R. 589

⁶⁶Reibl 895

⁶⁷Reibl 900

risk, but nevertheless because of the nature of the patient's position, becomes a material risk. Is there a distinction between a competent, non-psychiatric patient and a competent, psychiatric patient in this regard? Except for the provisions within the certain provincial mental health statutes which permit treatment to be imposed regardless of competence, it is submitted that there ought to be no distinction. Chief Justice Laskin in the *Reibl* case cites the words of Cardozo J., "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages"⁶⁸. An Ontario case which will be discussed later (p.161), permitted the imposition of ECT upon a competent involuntary patient despite the objections of the patient and the patient's family⁶⁹. Can the *Charter* overcome such an infringement of personal autonomy? Ought the *Charter* through the courts protect the individual in such circumstances?

Treatment and operations without consent

It was indicated in Chapter 2, that Nova Scotia is the only provincial jurisdiction to require in its mental health legislation that an assessment of competence be made for all involuntarily committed patients and, if a patient is found to

⁶⁸ *Schloendorff v. Society of New York Hospital* [1914], 211 N.Y. 125, 105 N.E. 92, p.93 (emphasis added)

⁶⁹ *Re T and Board of Review of Western Region et al* [1983] 3 D.L.R.(4th) 442

be incompetent, to empower a psychiatrist to make a declaration of incapacity (section 45). In Saskatchewan, under the new *Mental Health Services Act*, one of three conditions to be met for admission is that "as a result of the mental disorder the person is unable to fully understand and to make an informed decision regarding his need for treatment or care and supervision"(section 24(2)(a)(ii). Section 37(1) says that a patient shall be discharged when he no longer meets the criteria of section 24(2)(a). There is no provision for an involuntary admission of a person who may need treatment and may cause harm to himself and/or others but is competent, except in emergencies. It is possible that the two physicians may believe that such a person does not 'fully understand' and is not able 'to make an informed decision'. Such a criterion appears to be a paternalistic approach. A 'recognizable reason' for disagreement with the physicians' diagnosis may not coincide with the perspective of the physicians. It may be that a specific requirement to assess competence with respect to treatment decisions will better meet needs and protect rights than requiring all three criteria to be met.

In July, 1983, Mr. Justice Durand of the Quebec Superior Court rendered a decision which discussed the position of a person being held on a Lieutenant-Governor's Warrant and upon whom the staff of a psychiatric institution wanted to impose treatment without the prisoner's consent⁷⁰. The prisoner

⁷⁰*Institute Philippe Pinel de Montreal, v. Dion*, [1983] 2 D.L.R.(4th) 234

suffered from paranoid schizophrenia. Treatment to prevent deterioration of his mental state was necessary but was refused. An application, on behalf of the Institute, was made for a declaration that the Institute had authority and power to force such a person to undergo psychiatric treatment. The prisoner refused to recognize that he was ill.

The Court refers to provisions in various statutes⁷¹ setting out the right of individuals to be free from anything being done to their bodies without their consent. The learned Justice notes exceptions such as minors and the obligation to look after those who cannot look after themselves. He refers to an old English case⁷² and the doctrine of *parens patriae*: "...[it] is founded on the obvious necessity that the law should place somewhere the care of individuals who cannot take care of themselves, particularly in cases where it is clear that some care should be thrown around them." (emphasis added by Durand J.) The court says that, with respect to children, the courts seek to determine what is "best" for the children. With respect to incompetent adults, the courts seek to make the decision which "the incapacitated person would have made if he had been competent to decide"⁷³ but recognize that, subject to exceptions, "An individual right to inviolability of his person

⁷¹Canadian Bill of Rights, 1960 (Can.), c.44 (as am.); Quebec Charter of Human Rights and Freedoms R.S.Q.1977, c.C-12, section 1; Canadian Charter of Rights and Freedoms (supra) section 7

⁷²*Wellesley v. Duke of Beaufort*, [1827] 38 E.R. 237 and on appeal 4 E.R. 1078

⁷³note 70, p.238

necessarily includes inviolability of his thoughts, his right of dissent and even to make wrong decisions"⁷⁴. The prisoner's illness was such that it would not cure itself; that a part of the psychotic delusion is the inability to recognize the illness and the delusion of persecution by the government is reinforced by the fact of detention and prospect of a trial. The Court quotes from the Canada Law Reform Commission Report: *Mental Disorder and the Criminal Process*, 1976 at page 76 wherein it speaks of refusal of treatment by an incapacitated person:

The question is not whether the refusal is reasonable but rather whether the individual is sufficiently aware to make a decision, even if we do not agree with it⁷⁵.

Besides affirming that the doctrine of *parens patriae* requires that the State make a decision for an incompetent citizen, the court decided each individual case ought to be examined by a court so that this right was not decided by medical opinion only. He cites an American case⁷⁶ which disagrees with the *Quinlan* ratio⁷⁷ of creating an ad hoc or permanent committee to take over duties which are within the jurisdiction of established courts. Durand J. adopts the Massachusetts decision in *Saikowicz* when he describes the role of the courts in this area. He sees it not as an encroachment on the domain of medical expertise but "Rather...to require the process of detached but

⁷⁴ *id*

⁷⁵ note 70, p 241

⁷⁶ *Superintendent of Belchertown State School et al v. Saikowicz*, [1977], 370 N.E.(2n) 417

⁷⁷ *Re. Quinlan* [1976], 355 A.(2n) 647

passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility...and is not to be entrusted to any other group, purporting to represent the morality and conscience of our society,...⁷⁸. The Court has expressed concern for its responsibility to make difficult decisions; for the rights and needs of individuals and for the need to be certain that the individual in cases such as this, is incompetent.

Concerning the latter point about incompetence, the court found that Dion was capable of managing his affairs but that without treatment he would be condemned "to detention in perpetuity and eventual loss of all contact with reality"⁷⁹. Dion was suffering from paranoid schizophrenia "with megalomania and persecution complex"⁸⁰. The evidence before the court was to the effect that as of August 10, 1982 "the prolongation of his stay without pharmacotherapeutic treatment further aggravates his condition"⁸¹ and further as of January 31, 1983 "the delusion continues to entrench itself..."⁸². Mr Justice Durand, after noting the above loss of contact with reality says "this is clear evidence of the respondent's [Dion's] incapacity and, using *a contrario* the terms of the last paragraph of article 986

⁷⁸note 70, p.242

⁷⁹note 70, p.241

⁸⁰*ibid*, p.235

⁸¹*ibid* p.240

⁸²*id*

of the *Civil Code* the finds the respondent is 'unable to give a valid consent'⁸³. While Mr. Justice Durand did not say specifically that Dion was incompetent, the above quotation, including the phrase from article 986 '*a contrario*' "unable to give a valid consent", means he was decided that Dion was not competent to give a valid consent at that time. However it is submitted that the most notable aspect of the Dion case is that it may presage direct court supervision of its judgements. Durand J. accepted the offer of the Director-General of Pinel to set up a special medical committee to review Dion's situation regularly.

It is to be noted that despite the evidence before the court that Dion would deteriorate if not forcibly treated, Dion, prior to an appeal being heard, was found fit to stand trial, pleaded guilty and was subsequently released from Pinel. Durand J. had made no comment about the possibility of improvement as all the evidence was to the contrary. Sommerville observes that courts should make an express finding in this regard "because the chance of spontaneous improvement is clearly most important in assessing the risk/benefit ratio of various courses of action and in determining the overall justification of ordering treatment despite a person's refusal of it"⁸⁴.

⁸³ *ibid*, p.241

⁸⁴ Margaret A. Sommerville, *Refusal of Medical Treatment in "Captive" Circumstances*, 1985, 63 C.B.R.59, p.61, note 7.

Morrison in his comments about the Dion case⁸⁵ notes that Dion did not fit the criteria under the *The Public Curator Act* or the *Mental Patient Protection Act of Quebec*. He says "The court itself provided the substitute consent"⁸⁶. He says that the *Mental Patients Protection Act*⁸⁷ uses dangerousness as the basis of commitment, not treatment, and the *Public Health Act*⁸⁸ authorizes treatment in cases of emergency. The legislation does not contemplate the idea of emergency in relation to situations where the patient's condition will deteriorate without treatment. Generally speaking, it is apparent that the principles of paternalism are to be considered alongside the principles of autonomy as well as the interests of health and State against patients' best interests. In the particular case of Dion, Morrison believes the trial's decision fused paternalism with autonomy, and that the two interests (State and patient) were almost identical, because to end detention, it was necessary to treat⁸⁹. It was recognized by Morrison that the areas of competence to refuse or to consent to treatment and competence to manage one's affairs are distinct and ought not be mixed. He say

The overruling of patient's treatment refusal rests on the assessment and and determination of incompetency of

⁸⁵ Denis Morrison, *The Right to Refuse Treatment in Quebec Health Law in Canada*, 5:65-68

⁸⁶ *ibid* p.65

⁸⁷ L.R.Q. c.P41

⁸⁸ L.R.Q. c.P41

⁸⁹ note 85, p.68

such a patient in very well defined circumstances and only in the case of firmly expressed, long-sustained refusal... after having exhausted the mechanisms resulting from the principles of sound clinical practice and judgement.⁹⁰.

In an Ontario High Court of Justice case mentioned earlier⁹¹, Mr Justice Van Camp was called upon to rule on the issue of whether or not to impose ECT treatment on a competent involuntary patient. This was prior to the effective date of section 15 of the *Charter*. The manner in which the issue came before the court was such that the only issue was whether ECT was a form of psychosurgery. Psychosurgery is prohibited by the Ontario *Mental Health Act* (section 35(5)). The court notes that there is a basic right to remain untouched by others and that statutes should not be interpreted in a fashion which is contrary to that right unless that intent is clearly expressed. If there is more than one reasonable interpretation, the court should adopt the meaning which least disturbs that right. Also, to be noted is that the onus is upon the applicant to prove that ECT is a form of psychosurgery. Section 35(1) defines psychosurgery for the purposes of this statute. For the purposes of this case the relevant portion is: "psychosurgery means any procedure that...interrupts the continuity of histologically normal brain tissue,...".

Van Camp J. accepts the evidence that ECT causes "no

⁹⁰ *ibid*, p.67

⁹¹ note 69

interruption of continuity of tissue"⁹². Therefore, as ECT was not a form of psychosurgery, the Board of Review had jurisdiction to authorize the treatment.

In Ontario, it appears as if the policy makers are uncertain as to the direction in which they intend to go. As noted in Chapter 3, the legislature passed Bill 7 (not proclaimed) which withdrew from the Board of Review the jurisdiction to override an involuntary competent patient's refusal to consent and by Bill 190, (first reading in the legislature) it is proposed to return that authority to the Board as well as extending the compulsory treatment provisions to those who are held under a warrant of the Lieutenant-Governor and those who are remanded by a court for observation and assesment. It would appear that these last two provisions would apply even if the persons concerned do not meet the criteria for civil commitment. It is submitted that this about-face is a regressive move which is not in keeping with the spirit and letter of the *Charter*. It is further suggested that, if it is accepted that competent mentally ill patients have a moral right to refuse treatment, that right should be recognized legislatively rather than being required to proceed through the web of various court levels in order to enforce that right. It would appear that the psychiatrists in Ontario were successful in urging the provincial government to alter course because of the expressed fear that recalcitrant patients with the right to refuse

⁹²note 69, p.451

treatment would turn psychiatric facilities into warehouses rather than hospitals⁹³. There can be no doubt that the conflict of needs versus rights is still continuing.

The question remains as to why such a narrow argument was raised. The report does not indicate why the patient and her family were refusing this treatment. Were alternate forms of treatment attempted without success? The patient was present and was represented by counsel before the Board of Review. This Board was composed of two psychiatrists, one lawyer and two persons who were neither psychiatrists nor lawyers. The Board was unanimous in its decision to authorize the treatment. Would the decision of the Board or the court be any different now that section 15 of the *Charter* is in effect? If the law is that treatment cannot be imposed without consent upon a competent patient, then, do statutory provisions which authorize the imposition of treatment upon competent involuntary patients contravene section 15? That section says, in part, that every person "has the right to equal protection...without discrimination...based on ... mental...disability."? As the issue of informed consent was not argued before Van Camp J., this case decides nothing more the proposition that ECT is not a form of psychosurgery under this definition. It is unfortunate that the issue of competence was not raised before the court.

⁹³C. McKague, *Civil Rights Endangered in Mental Health Bill*, THE GLOBE & MAIL, April 20, 1987, A7, as cited by S. N. Verdun-Jones in unpublished article dated May, 1987 *The Right to Refuse Treatment: The Other Side of the Coin*

On October 23, 1986, Mr. Justice La Forest delivered a judgement on behalf of nine justices of the Supreme Court of Canada, in the name of *Re. Eve*⁹⁴. Eve at the time of the original hearing was a 24-year-old female person who suffered from extreme, expressive aphasia and was considered to be mildly to moderately retarded. Evidence before the court was to the effect that, physically, she was an adult; attracted to and attractive to men; might be capable, under supervision, of performing the mechanical duties of a mother but no more; incapable of comprehending the concept of marriage; of understanding the relationship between intercourse, pregnancy and birth. Her mother, a widow, sought an appointment as Eve's committee with authority to consent to the sterilization of Eve. There was no question that this was to be a non-therapeutic operation. Mr. Justice McQuaid of the Prince Edward Island Supreme Court denied the application. On appeal, the P.E.I.S.C. (in banco) reversed the decision. The Supreme Court of Canada restored the original decision. Following an examination of this case will be a review of a B.C. Court of Appeal decision entitled *Re. K.*⁹⁵ where the operation concerned involved a minor and the court was able to classify the operation as therapeutic and arrive at a different decision than Mr Justice La Forest.

Essentially, the judgement of La Forest J. says that sterilization "should never be authorized for non-therapeutic

⁹⁴ [1986] 31 D.L.R. (4th) 1

⁹⁵ [1985] 63 B.C.L.R. 145

purposes under the *parens patriae* jurisdiction⁹⁶ of the court. In fact, he says that "[t]he grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilization without consent, when compared with 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 that person"⁹⁷ (emphasis added). It would appear that the basis for a non-consensual operation is whether or not the operation is therapeutic or non-therapeutic. The Supreme Court of Canada, speaking of hysterectomies as a form of sterilization, appears to be saying that such an operation can never be therapeutic. While not being openly critical of the B.C. court of Appeal, La Forest J. said that the decision in the *Re. K.* case "is at best dangerously close to the limits of the permissible"⁹⁸. La Forest J. said that "sterilization may, on occasion, be necessary as an adjunct to treatment of a serious malady but I would underline that this, of course, does not allow for subterfuge or for treatment of some marginal problem"⁹⁹. It is within this context, I suggest, that 'permissible' is defined.

In the course of arriving at the Court's decision, La Forest J. made some very interesting comments, and coming as they do as

⁹⁶note 94, p.32

⁹⁷*id*

⁹⁸*ibid*, p.34

⁹⁹*id*

part of a Supreme Court of Canada decision, bear much weight regardless of whether some of them may be *obiter dicta*. After noting the historical evolution of *parens patriae*, the learned justice cites Theobald¹⁰⁰ for the observation that this doctrine has never been limited by definition¹⁰¹ but that does not mean "that the discretion to exercise it is unlimited"¹⁰². As the jurisdiction of the court is based upon the necessity of acting "for the protection of those who cannot care for themselves"¹⁰³, the principle to be followed is that "the discretion is to do what is necessary for the protection of the person for whose benefit it is to be exercised"¹⁰⁴. The learned Justice reminds us that the discretion is not for the benefit of others and it is important for the courts to bear this in mind when "tempted to act because failure to do so would risk imposing an obviously heavy burden on some other individual"¹⁰⁵. He also recalls the words of Lord Eldon: "it has always been the principle of this court, not to risk incurring damage to children...which it cannot repair, but rather to prevent the damage being done"¹⁰⁶. La Forest J. says, to emphasize the point, "...a court...must exercise great caution to avoid being misled by this all too

¹⁰⁰*The Law Relating to Lunacy*, H. THEOBALD, 1924

¹⁰¹note 94, p.16

¹⁰²*ibid*, p.29

¹⁰³*ibid*, p.28

¹⁰⁴*ibid*, p.29

¹⁰⁵*id*

¹⁰⁶*Wellesley v. Wellesley* (1828) 38 E.R. 242; p.30 Eve judgement

human mixture of emotions and motives"¹⁰⁷.

Mr. Justice La Forest points out the fallacy of attempting to classify 'substituted judgement' as being in effect the person's own judgement. While the issue of whether a court may authorize a sterilization operation (or any other operation) upon an incompetent person may be debatable, there can be no question that any such decision by any person, other than the subject of the operation, is not a decision of the subject, whether it be classified as a 'substitute' decision or one made in the 'best interests' of the subject. The Justice quotes from American cases¹⁰⁸ and adopts for himself the words: "It clearly is not a personal choice, no amount of legal legerdemain can make it so."

The court concludes with a brief comment on the burden of proof, noting that as a surgical procedure in normal circumstances requires consent, the burden of proof rests with the applicant who seeks to have it performed. The burden of proof is a civil one but "must be commensurate with the seriousness of the measure proposed"¹⁰⁹. Thus rejected again is the degree of proof set out by Chief Justice Burger of the United States Supreme Court who stated that clear and convincing evidence was the standard of proof required when benefits and

¹⁰⁷note 94, p.31

¹⁰⁸*Re. Guardianship of Eberhardy* [1981] 307 N.W.2d 881, p.893 (Wis.S.C.); *Re. Grady* [1981] 426 A.2d 467 (N.J.S.C.)

¹⁰⁹note 94, p.37

personal rights conflict in matters involving competent persons¹¹⁰. This standard of proof was adopted by Wood J. in the original hearing of *Re. K.* This matter had previously been discussed in B.C. courts¹¹¹ and rejected.

These two B.C. cases relate to applications under section 27 of the B.C. *Mental Health Act* by mental patients who argued that they were no longer within the definition of being mentally ill and ought to be released. Mr Justice Locke, in the last noted case, quotes extensively from the judgement of Chief Justice Burger including the following:

"...we must be mindful that the function of the legal process is to minimize the risk of erroneous decisions..."¹¹²

"At one time or another every person exhibits some abnormal behavior which might be perceived by some as symptomatic of a mental or emotional disorder, but which is in fact within a range of conduct that is generally acceptable...Loss of liberty calls for a showing that the individual suffers from something more serious than is demonstrated by idiosyncratic behavior"¹¹³.

"...the individual's interest in the outcome of a civil commitment procedure is of such weight and gravity that due

¹¹⁰*Addington v. Texas*, [1979] 441 U.S. 418

¹¹¹*Hoskins v. Hislop*, [1981] 26 B.C.L.R. 165 (Wallace J., in chambers); *Robinson v. Hislop*, [1980] 24 B.C.L.R. 80 (Locke J.)

¹¹² *Robinson*, p.87

¹¹³ *Robinson*, p.88

process requires the state to justify confinement by proof more substantial than a mere preponderance of the evidence" ¹¹⁴.

Locke J. further notes Burger C.J.'s comments that the criminal standard of proof is too high, bearing in mind that "Given the lack of certainty and the fallibility of psychiatric diagnosis, there is a serious question as to whether a state could ever prove beyond a reasonable doubt that an individual is both mentally ill and likely to be dangerous..."

Locke J., seeking to minimize the possibility of making a wrong decision and being cognizant that eccentric behavior may not be abnormal or due to mental illness, cites the above *Addington* comments and notes that he "is not at liberty to follow the ultimate wordings suggested by *Addington v. Texas* as I consider the path to be marked by Canadian authorities" ¹¹⁵. The standard is set out in the Supreme Court of Canada judgement of Cartwright J. ¹¹⁶ wherein he (Cartwright J.) discusses the civil preponderance of evidence test and says

I wish however to emphasize that in any civil action before the tribunal can safely find the affirmative of an issue of fact required to be proved, it must be reasonably satisfied, and that whether or not it will be so satisfied must depend on the totality of the circumstances on which its judgement is formed *including the gravity of the consequences of the finding* ¹¹⁷. (emphasis added by Locke J.)

This judgement had been adopted by an earlier Court of Appeal of

¹¹⁴ *id*

¹¹⁵ *ibid*, p.91

¹¹⁶ *Smith v. Smith* [1952] 2 S.C.R. 312

¹¹⁷ *ibid*, p.90

British Columbia¹¹⁸. It may be surmised that Locke J. is reluctant not to be able to follow the standard enunciated by Burger C.J. However, it is suggested that that by emphasizing 'the gravity of the consequences' the learned justice has found an implicit means of increasing the burden of proof when civil loss of liberty is at stake, the quality of proof being commensurate with the consequences.

In view of the comment by Mr Justice La Forest about the Court of Appeal decision regarding *Re. A*, it will be appropriate to examine the original hearing before Wood J. as well as the Court of Appeal decision. In January, 1985 Mr Justice Wood rendered his decision in this matter¹¹⁹ which involves an application by the mother of a severely handicapped female child (10 years old) for an hysterectomy. The evidence indicated that the onset of the child's menstrual periods was thought to be imminent and the child had a phobic fear of the sight of blood. She was not capable of recognizable speech and cannot communicate her feelings in great detail but can display basic emotions of love, hate and fear. She could respond appropriately to simple questions and directions and it was believed that she understood more than she could communicate. The court found that the parents wanted the operation to save their daughter from potential problems and not for the contraceptive effect.

¹¹⁸*Adolph v. Adolph* (1964) 51 W.W.R. 42

¹¹⁹[1985] 19 D.L.R. (4th) 255

For Mr Justice Wood there were two issues before the court:

(a) Who can legally consent to the sterilization when the patient is incapable of consent through age or disability?

(b) What standards are to met before a substituted consent can be given?

Wood J., referring to old case law and Blackstone's Commentaries, noted that the rights of parents cannot be discussed without recognizing that the role of parenthood is one of obligations rather than rights. He said parental rights are "subject to the power of the court to intervene for the benefit of the child"¹²⁰. There is legislative support for this proposition¹²¹. Once it is seen that the court can intervene, the question to be answered is whether the jurisdiction should be exercised in the instant case. The test is the benefit of the child. Such power, argued by the Attorney-General of B.C. and agreed to by Wood J., should be exercised "sparingly and cautiously"¹²². What are the legal rights of K? Without a valid consent, the court notes that there are two sets of consequences:

1. The liability of doctors who operate and

2. violation of the personal security of K.

This legal right to personal security is recognized in our *Constitution* and there is equal protection to infants and the

¹²⁰ *ibid*, p.258

¹²¹ *Family and Child Service Act*, S.B.C. 1980, c.11, section 21

¹²² note 119, p.265

mentally disabled'¹²³. A further right - the power and privilege to bear children - is affected by this decision. Mr Justice Wood accepts the comment of Madame Justice Heilborn:

The type of operation proposed is one which involves the deprivation of a basic human right, namely the right of a woman to reproduce and therefore it would, if performed on a woman for non-therapeutic reasons and without her consent, be a violation of such right'¹²⁴.

Even if it is unlikely '¹²⁵ that K will ever have children, Wood J. says the right is no less important to her. He says that the power to reproduce, part of the identity of a woman, is no less integral to K's womanhood than a normal woman. To deny this, would mean that a person such as K is not entitled to equal protection as guaranteed by section 15 of the *Charter*. If K was competent, she could at some time consent to this as it is a legal operation.

After examining various definitions of 'therapeutic' and considering medical opinions, the Justice decided that the proposed operation could not be classified as therapeutic and points out that it is uncertain how K would react to menstrual flow. While the courts are unlikely to intervene when the issue involves a therapeutic treatment or operation, when the risks and benefits are about equal or risks outweigh benefits, the court must invoke its inherent jurisdiction to see that the best interests of the child are met. The decision to be made is not

¹²³sections 7 & 15 of the *Charter of Rights and Freedoms*

¹²⁴*Re D. (a minor)*, [1976] 1 All E.R. 326, p.332

¹²⁵and disastrous, in the view of a pediatric neurologist

solely a medical one nor one which ought to be made subjectively¹²⁶. While parents have the right to give a substitute consent for a non-therapeutic procedure, the court has the duty and power to review that consent and to intervene, if in the court's opinion, to do so would be in the best interest of the child.

Having decided to review the matter, the court must consider who bears the onus to establish that such an operation is in the best interest of the child/adult; what factors are to be considered and what standard of proof is required to satisfy the onus. Wood J. stated that the person seeking the non-therapeutic operation must demonstrate the merit of the application by clear and convincing evidence. As has already been noted in the *Eve* case, this standard is not recognized by Canadian courts. In an appeal of this matter, the B.C. Court of Appeal also rejected this standard.

The Court of Appeal reversed Wood J's judgement in May, 1985¹²⁷, refused an application to delay judgement pending filing of an appeal; an application to the Supreme Court of Canada was denied because no one had status to appear¹²⁸. It is believed that the operation was performed before the matter of the application could be heard. The Court of Appeal held that

¹²⁶In *Re. Eve*, one medical witness said "...if this girl were your daughter, would you have her have a sterilization?"

¹²⁷[1985] 63 B.C.L.R. 145

¹²⁸[1985] 4 W.W.R. 757n

Wood J. had considered the problem of handicapped children in general rather than the issue of what was in the best interest of K¹²⁹. Also, Mr Justice Craig held that Wood J. erred in placing upon the parents of K the onus of establishing their case at too high a standard.

Mr Justice Anderson, who concurred with Craig J.A., added some additional comments. He disagrees with Wood J. at the outset when he stated that "the fact of sterilization was irrelevant" because

"It was conceded that for Infant K pregnancy would be a disaster. The loss of the right to reproduce was, *therefore*, not a matter for consideration. It could not be asserted that there was a reasonable possibility that Infant K would ever have the intellectual capacity to appreciate the loss of her uterus or menstrual function. It follows that the authorities involving sterilization of mentally disabled persons for purely contraceptive purposes, were inapplicable"¹³⁰. (emphasis added)

With respect, it is submitted that absence of "intellectual ability to appreciate" the consequences of sterilization, is not the only criterion by which a distinction can be made between therapeutic and non-therapeutic processes. There was before Wood J., evidence that K may not have related to her menstrual flow in the same manner as to bleeding from an injury or the taking of blood samples. There was no evidence of K's reaction to blood in general such as seeing blood from another person's wound. Also there was evidence before Wood J. that there is psychological damage resulting from such a non-consensual

¹²⁹note95, p.156

¹³⁰*ibid*, p.163-4

operation. Wood J. had described therapeutic procedures as the treatment of existing malfunctions rather than anticipated problems. Also, before Wood J., was the evidence of Dr. B. Tischler, that at an institution for severely or profoundly mentally handicapped persons, during a period of 35 years, there had not been a hysterectomy performed upon a patient. It was indicated that hygienic matters related to menstrual flow were handled in the same manner as other toileting functions. The Court of Appeal chose not to make comment on any of these matters in its judgement and rested its decision upon the questionable belief that the operation was therapeutic.

Summary

Grisso recommends the development of measuring instruments by which functional abilities can be assessed. Through the use of such instruments, there will be greater uniformity of assessment procedures and a greater awareness of the need to assess competence. Such instruments are to be guides in assessing competence to make treatment decisions.

Conscientious use of such instruments will necessitate the giving of information to the patient that is consistent with the patient's educational, vocational and social background. The instruments should be able to indicate how the patient has assimilated the information in the context of treatment needs.

To recognize the individuality of patients is but one of the difficulties to be met in preparing such an instrument. Others

involve the misperception of mental health professionals that that specific assessment of competence for making treatment decisions is unnecessary and convincing practitioners of the need to distinguish between functional competence and global competence.

It is anticipated that the courts will have opportunities through the application of *Charter* provisions to assist the mentally ill in enforcing their rights. Whether the courts will view these rights from a needs or a rights perspective, will depend upon the social awareness of the members of the various courts.

There is no question that 'ordinary' patients have the right to say what is to be done to them. The main distinction between 'ordinary' patients and mentally ill patients is not the fact of mental illness but the question of competence. Disclosure of appropriate information and assessment of the manner in which that information is used, should allow for assessment of the ability to make treatment decisions. It is submitted that the fiduciary relationship between the doctor and the patient requires this.

The *Hopp* and *Reibl* cases set the requirements and the scope of disclosure. Succinctly put, disclosure must place the patient in a position to make an informed decision and the information given must have regard for the peculiar position of the patient vis-a-vis life style, age, occupation etc. In other words the

physician ought to be aware of what is important to the patient and will likely influence the decision to proceed or not proceed with the prescribed treatment.

The *Dion* case accepted the Canadian Law Reform Commission's view (1976) that the issue involving the mentally ill in the criminal process is whether the individual is sufficiently aware to make a decision, regardless of approval of that decision. Justice Durand also insisted that because of the seriousness of treatment without consent, it was the duty of the courts to consider each application for such treatment and that such responsibility is not to be given to institutions.

The *Eve* and *K.* cases, discussing non-consensual operations, decided that the main criterion in such matters was whether or not the operations could be classified as therapeutic. As a result of *Eve*, non-therapeutic operations are unlikely to be permitted upon persons unable to give consent. Mr. Justice La Forest has placed a limited meaning upon the term 'therapeutic' to the extent that the situation of *Re. K.* would not be repeated.

The *Eve* case is important with respect to the mentally ill as well, due to the emphasis placed upon the issue of competence. It is submitted that to embark upon a course of treatment without specifically determining competence is a violation of the *Charter*. The *Hopp* case sets out the criteria to be met in the case of 'ordinary' patients. If it is necessary

that they be told the nature of the proposed treatment, its gravity, material risks and any unusual risks attendant upon the performance of the treatment, competence of the mentally ill should be specifically assessed to determine whether that information has been absorbed and appreciated, as is the situation in Saskatchewan.

As indicated in chapters 2 and 3, only in one Canadian jurisdiction is an assessment of competence required. Canadian authorities have been no more diligent than American jurisdictions were 13 years ago:

"Virtually all present involuntary commitment statutes however allow the commitment of mentally ill individuals who are dangerous to themselves without a finding that the individual lacks the ability to evaluate the desirability of such protection. Similarly over half the States which authorize compulsory hospitalization for the care and treatment of the mentally ill, do not require that the individual be unable to make his own treatment decision"¹³¹.

¹³¹*Civil Commitment of the Mentally Ill*, 1974, 87 Harvard Law Review 1190

CONCLUSION

"Witches" and "sinners", "fearsome" and "dangerous" - these words have described how the mentally ill have been perceived through the ages. Chains and locked windowless-rooms, shunned and isolated - these are examples of how society has treated the mentally ill in the past'. In the enlightened '80's of the 20th century, these unfortunates are no longer seen as witches and sinners but as persons suffering through no fault of their own. The physical restraints of chains and locks are no longer the standard form of treatment in Western society but may have been replaced by chemical bonds without the ascertainment of competence to accept or reject treatment.

It is apparent from the legislation that persons committed to mental health facilities, have gained some rights, limited periods of commitment and review boards to hear their complaints and to determine whether the commitment is justified. Some legislative provisions of the Victorian period continue in current legislation. The requirement that the patient be seen by two physicians, separate from each other, continues today in most Canadian jurisdictions as does the concept of a Visitor to inspect places of detention (commitment) in Saskatchewan. In Saskatchewan, there is the Official Representative whose duty it

¹Joel Hurstfield, *The Queen's Wards: Wardships and Marriage under Elizabeth I*, Frank Cass & Company Limited, London, 1973; Elliott T. Currie, *Crimes Without Criminals: Witchcraft and Its Control in Renaissance Europe*, *Law and Society Review*, 3:7-32, 1968

is to see and advise each committed person as to rights and procedures. In the Australian state of New South Wales, the position of the Visitor continues.

New legislation in Saskatchewan, the Northwest Territories and Ontario and unproclaimed legislation in New Brunswick indicate a further movement towards helping the mentally ill by making the determination of competence a requirement in Saskatchewan; by recognizing multi-culturalism in the Northwest Territories and in New Brunswick's unproclaimed legislation, there is recognition of the need to inform patients of the reasons for detention and their right to retain and instruct counsel. The majority of Canadian jurisdictions continue to impose treatment upon involuntary patients, whether competent or not, without the consent of the patients. As has been seen, Saskatchewan requires that for a patient to be involuntarily committed, his/her mental condition must be such that there is incompetency. If the person is competent, legally that person cannot be involuntarily committed in Saskatchewan. No treatment is to be imposed upon a competent person without the consent of that person. Further, the attending physician must discuss the purpose of the course of treatment with the patient along with alternatives and consider the comments of the patient prior to commencing the course of treatment.

In Nova Scotia the relevant legislation contains a strong statement in support of the concept of the right to refuse treatment. However, there is another criterion which diminishes

that statement and permits the discretion of a psychiatrist to be virtually unfettered. By section 44(2)(e) of the statute, the psychiatrist is empowered to determine whether or not the patient's ability to consent is affected by his condition. There is a saving provision in section 50(1)(2) which provides that a declaration of incompetency can be reviewed by a review board or a county court.

While some provinces have made changes concerning competence and rights, it would appear that Ontario, as indicated in Chapter 6 is not certain as to how to deal with the question of imposed treatment upon competent mental health patients. This inability to set a policy which will meet the needs and rights in this area, points to a dilemma which confronts policy makers. Part of the dilemma is to try to reconcile the demands of mentally ill persons, who are competent, that they be allowed to make treatment decisions with the aims of the mental health professionals who seek to help them with programs designed for that purpose. The battle over needs and rights continues in all Canada but, currently, is more visible in Ontario.

There are at least three groups of people by whom the mentally ill are affected - policy makers, policy implementors and mental health professionals. The policy makers include politicians and government employees. Persons in this group design strategies to meet public needs as they see them and determine what financial resources are to be allocated to the programs. It will be this group, for example, who will decide

the extent of de-institutionalization and what community facilities will be available for discharged persons.

The policy implementors are those who function within policy guidelines to put into effect the policies. Given the general policy and the extent of the financial commitment, the implementors put into effect the broad policy in a manner which may or may not have been intended by the policy makers. It is conceivable that, with many persons involved in the setting and implementation of policies there will be conflict between the different perspectives. Those who have the responsibility for setting the amount of funding available and of accounting for the funds used in each segment of the various programs, may attach more or less significance to some aspects of mental health policy than will the policy implementors and the mental health professionals. In such situations, it is apparent that such matters as funding, priorities *et cetera*, are likely to be determined by factors not wholly related to the needs of the mentally ill.

The mental health professionals, the only group with whom the mentally ill have any contact, are faced with the problems of providing treatment within certain constraints. Physical facilities for assessment and treatment are limited by funds available. Type of treatment is defined by policy considerations as well as the illness of the patient. For example, a patient may be adequately treated as an out-patient but because the patient cannot care for him/herself totally - meals, medication

or adequate accommodation - there is a committal due to inadequate community services to assist him/her. It would be remarkable if governments in Canadian jurisdictions which emphasize privatization and de-institutionalization, would follow the recommendations of the previously mentioned Richmond Report in New South Wales to set aside a portion of monies received from the sale of institutional property. For example, if fifty percent of monies received from the proposed sale of the Riverview complex in Coquitlam, B.C. could be allocated to community resource development to care for the discharged persons, then there would be some hope for the marginally competent. Not only would such a provision be remarkable, it would indicate a new, different and more realistic concern for the mentally ill and the problems to be met in the communities to which the discharged patients are directed.


The matter of equitable policies and laws, as contemplated in the title of this work, involves the distribution of equal justice or fairness². Involved in this, is the issue of the mentally ill and their rights as protected under the *Charter* and the rights of the rest of society which could be in conflict at times. As indicated earlier in the Plaut article³, legislative provisions are not sufficient, by themselves, to bring about policy changes. The study in a hospital by Lidz *et al*⁴ indicated

²John Rawls, *A Theory of Justice*, The Belknap Press of Harvard University, Cambridge, Massachusetts, 1971

³note 42, chapter 2

⁴note 40, chapter 6

that co-operation and commitment to change by mental health professionals are necessary to bring about changes. Acceptance of Freedman's belief that it is a moral necessity that competent mentally ill patients be allowed to make decisions about treatment, means that a specific effort must be made to assess competence.

It has become  apparent during the research and writing of this discourse, that the issues of rights and assessment of competence to make treatment decisions are more complex than a simple yea or nay. Because a mentally ill person does not receive treatment in a vacuum, psychotherapy should not be a unitary phenomenon. All patients, it is suggested, are social beings functioning within various contexts whether the illness be physical or mental. The nature and effectiveness of treatment will be affected by the environment of the patient which has controlled or directed, to a certain extent, their behavior and relationships. Recognition of this is to be found in the Northwest Territories legislation to which reference was made in Chapter 3. Coles makes reference to this social aspect of treatment and its effectiveness⁵. He refers to a study of McNair, Callahan and Lorr in 1982 which examined the relationship between the therapist's personality and the patient's response to therapy and found it "was dependent on the similarity of background and interest of patient and

⁵E.M.Coles, *Clinical Psychopathology: An Introduction*, Routledge and Kegan Paul, London, 1982

therapists"⁶. However, he notes that this may vary with the type of illness. It is accepted at the present, according to Coles, that an empathetic therapist is more successful with schizophrenic patients than the impersonal therapist who is better with neurotic patients. This is not to suggest that it is possible to be absolute about what is effective treatment or which facet of treatment is most effective. The complex equation by which treatment effectiveness is measured, requires a knowledge of what is being measured, how and by whom it is measured. Coles suggests that this is so because psychotherapy and mental illness are multifaceted and interactional. Any illness presents different faces to those involved. To the mentally ill, the distress, symptoms and/or complaint are subjective. The therapist sees the issue as one involving disease and/or conflict. The community sees mental illness as a potential source of violence. The State focuses principally upon the cost of treatment. Further, the criteria by which effectiveness of treatment is to be measured are to remain constant and conclusions are to be limited to those criteria when examining treatment effectiveness. Consideration is also to be had for adverse side-effects of the treatment. The selection of criteria presupposes a definition of successful treatment and a knowledge of the effect of each aspect of the treatment. In essence, while an evaluation of any treatment program is a steadily evolving process, there needs to be an awareness of the

⁶*ibid.*, p.382

patient's background, what type of illness is presented by the patient and how long the patient has been affected by the illness. Coles indicates that treatment is less effective if the illness is long standing. He also observes that "psychiatric diagnosis is a long way from being perfect"⁷ and "attempts to validate psychiatric diagnostic procedures have been severely limited by the absence of agreement regarding the definition of the disorders..."⁸. It is apparent, as mentioned earlier, that the value of a specific treatment is an evolving matter which is dependent upon additional knowledge which comes to the fore through experience and research. Clearly, as 'new' knowledge comes about, definitions of problems (illnesses) must be re-examined, refined or discarded. Recognition of biases and accepting of evidence contrary to biases are keys to defining problems and finding solutions (effective treatment).

Concerning the issue of competence to make treatment decisions, acceptance of the arguments of Grisso⁹ means that it is necessary to develop an instrument to assist mental health practitioners in determining competence. It is to be noted that, in assessing competence, subjective as well as objective factors are involved, the former being linked with the values and assumptions of the assessors¹⁰. A valid instrument is likely to

⁷ *ibid*, p.379

⁸ *ibid*, p.79

⁹ note 8, chapter 7

¹⁰ Caroline Kaufmann, Loren H. Roth, Charles W. Lidz, Alan Meisel, *Informed Consent and Patient Decision Making: The*

reduce the influence of subjective factors. Such an instrument, if used, will not end the difficulties in this area but would assist in the movement towards an equal distribution of justice for the mentally ill. Legislative recognition of the moral right to assessment of competence and the consequent financial needs arising from such recognition, will further assist in making the mental health system more equitable. Margaret A. Sommerville has said "that any decision regarding refusal of treatment by a patient, whether taken by a court or some other person or body, and whether to respect or to override the refusal, must be carefully structured and reached on a basis of precisely identified principles, applied in carefully delineated fact situations"¹¹.

It has been recognized that "in principle, clinical decision making is little different from many other kinds of decision-making and that it should be possible to improve the quality of clinical opinion simply by helping clinicians understand the basis upon which their recommendations rest"¹². The structure of the decision-making process and the principles upon which the structure rests, must allow for a review of the dispositions in order for clinicians to be aware of the nature

¹⁰(cont'd) *Reasoning of Law and Psychiatry*, International Journal of Law and Psychiatry 4:345, p.359

¹¹Margaret A. Sommerville, *Refusal of Medical Treatment in "Captivity" Circumstances*, 63 C.B.R. 59, p.89

¹²C.D.Webster, R.J.Menzies, M.A.Jackson, *Clinical Assessment Before Trial*, Butterworth & Co. (Canada) Ltd., Vancouver, B.C., 1982.

of variables which affect their decisions and the accuracy of their decisions. Webster *et al* call for equal emphasis upon the assessor and the assessee when studying the process, considering attitudes and definitions within the assessor's environment, relevant laws and the classifications of forms of mental illness¹³. Without a review of dispositions and an awareness of factors which affect decision-making of both the assessor and the assessee, the process will remain static and not improve, becoming mechanistic and likely unrealistic. It ought to be possible for equitable mental health laws and policies to exist in Canadian jurisdictions if the mental health professionals become aware of the relevant variables which affect their decision-making and that a competence assessment format used as a guide can assist in that process. This presumes a recognition of the need to make a competence assessment in the area of treatment decisions.

When treatment effectiveness was being discussed, the phrase 'recognition of biases' was used. As has been noted in Chapter 3 all Canadian jurisdictions make use of Review Boards to which the mentally ill can appeal their confinement and in some cases, their treatment. If there is acceptance of the principle that mentally ill persons have a right to have their competence to accept or reject treatment assessed, then it follows that there must be some body (an individual or a group) to whom the mentally ill patient and the mental health professional can

¹³For an examination of how psychiatric opinions are reached see Chapter 6 of Webster *et al*

refer the issue when there is disagreement. It is to be observed that biases cannot be completely set aside. As Barabara Wootten notes, commenting on peoples' attitudes to various crimes and related penalties, "[e]ven within the sphere precisely defined by the law, ..., subjective judgements cannot be shut out"¹⁴. While biases may not be able to be completely set aside, it is submitted that the recognition that biases exist, may limit their detrimental effect. Along with this recognition there must be cognizance of the multicultural nature of Canadian society. This would mean that Review Boards and mental health professionals ought to take into consideration the cultural background of patients when assessing this limited aspect of competence. There are a number of ways in which such Boards could accomplish this - varying the composition of the Board to meet specific backgrounds or having resource persons attached to the Boards to give evidence of the relevance of the cultural background to the particular case. Unquestionably, the initial implementation of such a process would be confusing, awkward and procedurally complicated, but should ease as the process evolves. It would be interesting to know whether the relevant sections of the Northwest Territories legislation have been used, the manner of application and how often.

Further consequences of requiring assessments of patients to make treatment decisions may include:

¹⁴Barbara Wootton, *Social Science and Social Pathology*, George Allen and Unwin Ltd., London, 1959

1. treatment may be delayed except in emergencies;
2. diagnosis may be delayed while assessment is being done;
3. paperwork and the non-treating bureaucracy will be increased.

These are negative prospects but there are some positive features:

1. if competent to make treatment decisions, the patient will likely recognize, through persuasion, the need for treatment and be more receptive and co-operative;
2. by having competence assessed, the patient may have an increased sense of self-worth;
3. by recognizing competence in this area, the mental health professional may be seen less as a forceful person of authority and more as a helpful consultant;
4. the mental health professionals may be more inclined to search for alternative forms of treatment and may become more precise in their diagnosis.

Having regard to all of the preceding, it must be apparent that the 'marginally competent' have a moral right to have their competence to make treatment decisions assessed and that right ought to be specifically recognized in legislation in each jurisdiction. Unquestionably there are many problems involved in such recognition, but that should not deter progress along the

road towards that goal. By moving step by step towards the goal of equitable mental health laws and policies, the right to autonomy for the 'marginally competent' will become more than a rite.

SOME PROVISIONS IN PROVINCIAL MENTAL HEALTH LEGISLATION

ALBERTA

Mental Health Act, R.S.A. 1980, c. M-13, as amended.

7.(1) The Minister shall establish one or more review panels for the purpose of hearing and considering applications from formal patients concerning the cancellation of admission certificates or renewal certificates.

(2) Each review panel shall be appointed by the Minister and composed of

- (a) a psychiatrist,
- (b) a physician,
- (c) a solicitor, who shall be chairman, and
- (d) a person representative of the general public.

(3) The Minister may designate a vice-chairman of the review panel and may appoint one or more alternate members in accordance with subsection (2) and if for any reason a member of a review panel cannot act he shall be replaced by an appropriate alternate member who shall act until the hearing is complete, and when so acting, an alternate member is a member for all purposes.

8.(1) A quorum for a review panel is the 4 members or alternate members appointed pursuant to section 7.

(2) Each member of the review panel is entitled to one vote, and in the event of a tie vote, the member acting as chairman has a 2nd vote.

(3) A decision of a majority of the members is the decision of the review panel.

(4) The Minister may periodically review the appointment of the members and alternate members to review panels and make any change he considers advisable.

9.(1) No person who is actively serving as a member of the staff of a facility is eligible to sit as a member or alternate member of a review panel when the panel is considering an application from a formal patient of the facility with which he is connected.

-- (2) A person who is

- (a) related by blood or marriage to a person applying to a review panel,

(b) a psychiatrist or physician who is treating or who has treated a person applying to a review panel, or

(c) a solicitor who is acting or who has acted for a person applying to a review panel,

is not eligible to be appointed as, or to sit as, a member or alternate member of a review panel for an application by that person.

10.(1) A review panel shall hear and consider applications in accordance with this Act and the regulations and for that purpose the members of the review panel have all the powers of a commissioner appointed under the *Public Inquiries Act*.

(2) The Minister shall provide secretarial, legal, consultative and other assistance to each review panel as may be required.

13.(1) On the admission of a patient to a facility a board is under a duty to provide the diagnostic and treatment services the patient is in need of and that the staff of the facility is capable and able to provide.

(2) The board of a facility in which a patient is detained shall determine what level of security is reasonably required for each patient in view of all the circumstances and thereafter is under a duty to provide it and to review the necessary level of security at intervals of not more than 6 months.

14. When a physician examines a person and is of the opinion that the person is

(a) suffering from mental disorder, and

(b) in a condition presenting a danger to himself or others,

he may, not later than 72 hours after the examination, issue a conveyance and examination certificate in the prescribed form with respect to the person.

15.(1) A conveyance and examination certificate is sufficient authority

(a) for any person to convey the person named in the certificate to a facility within 72 hours of the time it is issued and to detain that person while he is being so conveyed until the time he arrives at the facility, and

(b) for any physician to prescribe treatment for or to treat the person named in the certificate while he is being so conveyed and until the time he arrives at the facility.

(2) When a person is conveyed to a facility pursuant to a conveyance and examination certificate, the conveyance and examination certificate is sufficient authority,

(a) for one or more physicians who are members of the staff of the facility to observe and examine the person named in the certificate,

(b) to provide any treatment that in the opinion of the physician may be essential for the well-being of the person named in the certificate, and

(c) to care for, detain and control the person named in the certificate,
for a period of 24 hours from the time that person arrives at the facility.

16. A conveyance and examination certificate shall show

- (a) the name of the physician issuing it,
- (b) the date and time the personal examination was conducted,
- (c) the facts on which the physician formed his opinion that the person
 - (i) was suffering from mental disorder, and
 - (ii) was in a condition presenting a danger to himself or others, distinguishing the facts observed by him from the facts communicated to him by others, and
- (d) the date and time of issue.

17.(1) A person detained in a facility pursuant to a conveyance and examination certificate shall be examined as soon as possible.

(2) When a person is detained under

- (a) a conveyance and examination certificate, or
- (b) one admission certificate,

that person shall be released on the expiry of 24 hours from the time that the person arrived at the facility unless there are, within that time, 2 admission certificates in effect with respect to that person.

18.(1) When 2 physicians, after separate examinations by each of them, are of the opinion that a person is

- (a) suffering from mental disorder,
- (b) in a condition presenting a danger to himself or others, and
- (c) unsuitable for admission to a facility other than as a formal patient,

each shall issue an admission certificate in the prescribed form.

(2) In any case where at least one of the examinations conducted under subsection (1) does not take place at the facility to which the person examined is intended to be admitted as a formal patient, that person shall not be admitted as a formal patient at that facility unless at least one of the admission certificates is issued by a member of the staff of that facility.

(3) An admission certificate shall show

- (a) the name of the physician issuing it,
- (b) the date and time the personal examination was conducted,
- (c) the facts on which the physician formed his opinion that the person
 - (i) was suffering from mental disorder, and
 - (ii) was in a condition presenting a danger to himself or others, distinguishing the facts observed by him from the facts communicated to him by others, and
- (d) the date and time of issue.

19.(1) Two admission certificates are sufficient authority to observe, examine, care for, treat, control and detain the person named in them, in a facility, for a period of one month from the date the 2nd admission certificate is issued.

(2) One admission certificate has the same effect and provides the same authority as a conveyance and examination certificate issued under section 15.

20.(1) The period of detention of a formal patient may be extended when 2 physicians, after separate examinations by each of them, are of the opinion that the formal patient is

- (a) suffering from mental disorder,
- (b) in a condition presenting a danger to himself or others, and
- (c) unsuitable for continuation at the facility other than as a formal patient,

and each issues a renewal certificate in the prescribed form.

(2) At least one of the persons who issues a renewal certificate under this section shall be a member of the staff of the facility where the examination was made.

(3) Two renewal certificates are sufficient authority to observe, examine, care for, treat, control and detain the person named in them

- (a) in the first case where 2 renewal certificates are issued, for a period of not more than 2 additional months;
- (b) in the 2nd case and each subsequent case where 2 renewal certificates are issued, for a period of not more than 6 additional months.

(4) A formal patient whose period of detention under admission certificates or renewal certificates expires is thereupon a voluntary patient not subject to detention and shall be informed of that fact.

(5) A formal patient whose authorized period of detention under admission certificates or renewal certificates has not expired may be continued as a voluntary patient in accordance with the by-laws of the board and thereupon the admission certificates or renewal certificates, as the case may be, shall be deemed to be cancelled.

21. A renewal certificate shall show

- (a) the name of the physician issuing it,
- (b) the date that the personal examination was conducted,
- (c) the facts on which the physician formed his opinion that the person
 - (i) was suffering from mental disorder, and
 - (ii) was in a condition presenting a danger to himself or others, distinguishing the facts observed by him from the facts communicated to him by others, and
- (d) the date of issue.

22.(1) Anyone who has reasonable and probable grounds to believe that a person

- (a) may be suffering from mental disorder, and
 - (b) is in a condition presenting a danger to himself or others
- may bring an information under oath before a provincial judge.

(2) When an information is brought before a provincial judge under subsection (1) and the judge is satisfied that

(a) the person with respect to whom the information is brought should be examined in the interests of his own safety or the safety of others, and

(b) an examination can be arranged in no other way,

he may issue a warrant to apprehend that person for an examination.

(3) A warrant under this section may be directed to all or any peace officers and shall name or otherwise describe the person with respect to whom the warrant is issued.

(4) If a peace officer apprehends a person pursuant to a warrant under this section, the person shall be deemed to be a person in respect of whom a conveyance and examination certificate has been issued.

23.(1) When a peace officer observes a person

(a) apparently suffering from mental disorder,

(b) in a condition presenting a danger to himself or others, and

(c) acting in a manner that in a normal person would be disorderly,

the peace officer may, if he is satisfied that

(d) the person should be examined in the interests of his own safety or the safety of others, and

(e) the circumstances are such that to proceed under section 22 would be dangerous,

convey the person to a facility for an examination.

(2) A person conveyed to a facility pursuant to subsection (1) shall be deemed to be a person in respect of whom a conveyance and examination certificate has been issued.

24.(1) On a person becoming

(a) a formal patient, or

(b) the subject of renewal certificates,

the formal patient and his nearest relative shall

(c) be informed of the reason for his admission or the issuance of renewal certificates in simple language, and

(d) be given a written statement of

(i) the authority for his detention and the period thereof,

(ii) the function of the review panels,

(iii) the name and address of the chairman of the appropriate review panel, and

(iv) his right to apply to the review panel for cancellation of the admission certificates or renewal certificates.

(2) In the event of language difficulty, the board shall obtain a suitable interpreter and provide the explanation and written statement referred to in subsection (1) in the language spoken by the formal patient or his nearest relative.

(3) In addition to giving an explanation and written statement pursuant to this section, the board shall, having regard to the circumstances in each case in which the formal patient desires to exercise his right to apply for cancellation of admission certificates or renewal certificates, do any other

things the board considers expedient to facilitate the submission of one or more applications.

25.(1) A formal patient or a person on his behalf may apply to a review panel for cancellation of

- (a) admission certificates, or
- (b) renewal certificates,

by sending notice of application to the chairman of the appropriate review panel in the prescribed form.

(2) The Minister, the Director or a board may submit an application under subsection (1) on behalf of a formal patient, but when an application is so made, the word "applicant" wherever it occurs in this Part and section 47(1) includes the formal patient but not the Minister, the Director or the board.

(3) Only one application may be made to a review panel by a formal patient or a person on his behalf with respect to each 2 admission certificates or renewal certificates issued, but the Minister, the Director or a board may apply at any time.

26.(1) On receipt of an application under section 25, the chairman of a review [panel] shall give notice

- (a) to the applicant and any person acting on his behalf, and
- (b) to the nearest relative and any other person that the chairman considers may be affected by the application and should be notified,

of the date, time, place and purpose of the hearing.

(2) As soon as it is able to do so, the review panel shall carry out whatever investigation and hearing it considers necessary and may invite the applicant and any other person to testify or produce evidence at the hearing.

27.(1) All proceedings of a review panel shall be conducted in private and subject to subsection (2) no person has a right to be present without the prior consent of the chairman.

(2) The applicant and his representative have the right to be personally present during the presentation of any evidence to the review panel, but if in the opinion of the review panel there may be an adverse effect on the applicant's health by his presence, the applicant may be excluded, but in that event the review panel shall appoint a person to act on his behalf if he does not already have a representative.

(3) The applicant or person acting on his behalf has the right of cross-examination.

(4) Except as permitted by the chairman and except when the report is published by the applicant or his representative, no person shall publish a report of a hearing, investigation or deliberation by a review panel or the names of any persons concerned therewith.

(5) The chairman may adjourn a hearing for any period up to 21 days (and with consent of the Minister for a longer period) for any purpose he considers necessary.

28.(1) Within 28 days of the receipt of an application by the chairman

or any longer period the Minister allows, the review panel shall hear and consider an application.

(2) When the application is for the cancellation of admission certificates or renewal certificates, the review panel may

(a) cancel the admission certificates or renewal certificates, as the case may be, if it considers that the applicant is not in a condition presenting a danger to himself or others, or

(b) refuse to cancel the admission certificates or renewal certificates with or without conditions.

(3) The chairman of the review panel shall send a copy of the decision of the review panel in writing to the applicant, his nearest relative and to any person interested in the application, within 7 days of the date of its decision.

(4) When the review panel refuses to cancel admission certificates or renewal certificates, the written report of the decision of the review panel shall include a statement of the right of the applicant to appeal the decision of the review panel to the Court of Queen's Bench under section 32.

(5) When the application to the review panel was made by the Minister, the Director or a board, the chairman of the review panel shall send a copy of the report to the applicant and to the Minister, the Director or the board, as the case may be.

(6) The board of the facility in which the formal patient is detained shall take whatever action may be required to give effect to the decision of the review panel.

29.(1) When a person is convicted of a criminal offence and is sent to a facility for treatment, that person, whether or not admission certificates or renewal certificates have been issued with respect to him, may apply to the review panel in accordance with section 25 for an order transferring him back to a correctional institution.

(2) A review panel hearing an application under subsection (1) may

(a) make the order applied for, or

(b) cancel the admission certificates or renewal certificates.

(3) When a review panel makes an order transferring a person from a facility to a correctional institution or cancels admission certificates or renewal certificates, the board of the facility in which the person is detained shall

(a) comply with the order, or

(b) when admission certificates or renewal certificates are cancelled, arrange to have the person returned to a correctional institution.

30. No communication written by a patient in a facility or to a patient in a facility shall be opened, examined or withheld and its delivery shall not in any way be obstructed or delayed by the board or a member of the staff at a facility.

31.(1) A patient shall not be prevented from receiving visitors at hours

fixed by the board unless a physician considers that a visitor would be detrimental to the patient's health.

(2) Notwithstanding subsection (1), a solicitor acting for a patient may visit the patient at any time.

32.(1) Within 14 days of a decision of a review panel, the applicant may appeal to the Court of Queen's Bench.

(2) The application shall be made by originating notice.

(3) The notice shall be served on

(a) the Minister,

(b) the chairman of the board of the facility in which the applicant is a formal patient (if the applicant is a formal patient), and

(c) any other persons the Court directs,

not less than 15 days before the motion is returnable and the practice and procedure of the Court pertaining to applications by originating notice applies, so far as it is applicable, to an application under this section, except as otherwise provided by this section.

(4) The application shall be supported by an affidavit of the applicant setting forth fully all the facts in support of the application.

(5) An appeal under this section shall be a rehearing of the matter on the merits, and in addition to any further evidence adduced by the applicant, the Minister or the Public Trustee, the Court may direct that any transcript or minutes taken by the review panel at the original hearing of the evidence be put in evidence on the appeal and may direct that further evidence be given as it considers necessary.

(6) An order of the Court under this section is not subject to appeal.

(7) The Court may make whatever order as to the costs of the application that it considers fit.

(8) The Court may, with respect to an appeal from a decision of a review panel to refuse to cancel admission certificates or renewal certificates,

(a) quash the decision and order the cancellation of the admission certificates or renewal certificates, as the case may be,

(b) order that the review panel reconsider the applicant's application for cancellation, or

(c) make any other order it considers just.

33.(1) When a formal patient is discharged from a facility, the board shall, where possible, give notice of the discharge

(a) to the nearest relative, if the person discharged agrees, and

(b) to the referring source,

and when applicable shall state in the notice whether a certificate of incapacity issued under the *Dependent Adults Act* exists with respect to the person.

(2) When a formal patient has been discharged and refuses or is unwilling to leave the facility, the board or a representative of the board may require that the removal of the former patient be effected by

(a) any person who is liable for the payment of expenses incurred with respect to the former patient pursuant to section 45(1), or

(b) the Minister of Social Services and Community Health.

(3) The board may by registered mail notify the person responsible for the removal of the former patient to remove the former patient within 10 days from the receipt of the notice.

(4) If the notice is given under subsection (3), a copy of the notice shall be given by mail to the Director.

(5) When the notice under subsection (3) is given to a person referred to in subsection (2)(a) and that person fails to comply with the notice, that person is guilty of an offence and liable to a fine of not more than \$50 and in default of payment to imprisonment for a term not exceeding 10 days.

34.(1) A board shall comply with and take any necessary action to comply with a decision of a review panel concerning admission certificates or renewal certificates.

(2) An order of cancellation of admission certificates or renewal certificates does not require a board to cease treatment of a person if that person wishes to receive treatment on a voluntary basis and the board is willing and able to provide the treatment.

(3) When a formal patient is no longer a danger to himself or others, he may be discharged by the board and thereupon the admission certificates or renewal certificates, as the case may be, shall be deemed to be cancelled.

35.(1) When a judge has reason to believe that a person who appears before him charged with or convicted of an offence, suffers from mental disorder, the judge may order the person to attend a facility or service as an out-patient for examination.

(2) When an examination is made under this section, a report in writing shall be made to the judge as to the mental condition of the person.

(3) If the report indicates that the person examined needs treatment, the judge may order the person to attend a facility or service for treatment as an out-patient.

36.(1) A person who, pursuant to the *Criminal Code* (Canada), is remanded to custody for observation may be admitted to, examined and detained in and discharged from a facility in accordance with the law.

(2) A person who, pursuant to the *Criminal Code* (Canada), is detained under the authority of a warrant of the Lieutenant Governor may be admitted to, examined, treated and detained in and discharged from a facility in accordance with the law.

37.(1) In this section,

(a) "diagnostic and treatment centre" or "centre" means a place established by the Minister pursuant to section 3(1) and includes a facility that is not an approved hospital under the *Hospitals Act*;

(b) "legal representative" means an executor or administrator of the estate of a deceased person, the guardian or trustee of a

dependent adult under the *Dependent Adults Act* or the guardian of a person who is a minor.

(2) The Minister shall cause a record to be kept of the diagnostic and treatment services provided to every person in a diagnostic and treatment centre.

(3) For the purposes of assessing the standards of care furnished to persons in a diagnostic and treatment centre, improving mental health care facilities or procedures or for any other purpose considered by the Minister to be in the public interest, the Minister or any person authorized by the Minister may require that all or any of the following be sent to the Minister or any person designated by the Minister:

- (a) medical and other records in a centre;
- (b) extracts from and copies of those records;
- (c) diagnoses, charts or information available in respect of any person receiving diagnostic and treatment services in a centre.

(4) Information obtained from records maintained in a diagnostic and treatment centre or from persons having access thereto shall be treated as private and confidential information in respect of the person receiving diagnostic and treatment services in the centre and shall be used solely for the purposes described in subsection (3), and the information shall not be published, released or disclosed in any manner that would be detrimental to the personal interest, reputation or privacy of that person or that person's attending physician.

(5) Any person who knowingly and wilfully releases or discloses information described in subsection (4) to a person not authorized to receive it is guilty of an offence and is liable to a fine of not more than \$500.

(6) Notwithstanding subsection (4) or any other law, the Minister, a person authorized by the Minister or a physician may disclose any diagnosis, record or information relating to a person receiving diagnostic and treatment services in a centre

- (a) to the person to whom the diagnosis, record or information relates or his legal representative,
- (b) with the written consent of the person to whom the diagnosis, record or information relates, to any person, if in the opinion of the person making the disclosure it is in the best interests of the person to whom the diagnosis, record or information relates to disclose that information,
- (c) to a department or agency of the Government or a physician if that department, agency or physician is responsible for providing continued treatment to the person to whom the diagnosis, record or information relates,
- (d) to the Public Guardian, as defined in the *Dependent Adults Act*, if the diagnosis, record or information is, in the opinion of the person making the disclosure, relevant to the making of a guardianship order or a trusteeship order under the *Dependent Adults Act* in respect of the person to whom the diagnosis, record or information relates,
- (e) to a review panel established pursuant to section 7 that is to

hear or is hearing an application from the person to whom the diagnosis, record or information relates,

(f) to a department or agency of the Government when the disclosure is necessary in the administration of this Act or in the best interests of the person to whom the diagnosis, record or information relates,

(g) to a person conducting bona fide research or medical review if the disclosure is made in such manner as to ensure confidentiality of the diagnosis, record or information,

(h) to the Director of Medical Services under the *Occupational Health and Safety Act* when the diagnosis, record or information relates to an accident that occurred in respect of the person's occupation or one or more of his former occupations, or to a disease which is related to the person's occupation or one or more of his former occupations,

(i) to a Workers' Compensation Board, the Alberta Hospital Association or a provincial hospital insurance authority, if the information is required in order to establish its liability for payment,

(j) to the Department of National Health and Welfare for purposes in connection with the *Medical Care Act (Canada)* or the *Hospital Insurance and Diagnostic Services Act (Canada)*,

(k) to a medical records school for training purposes if the disclosure is made in such a manner that individual names of the person to whom the records relate are not revealed or made identifiable,

(l) to a board of review appointed pursuant to the *Criminal Code (Canada)* that is to review the case of the person to whom the diagnosis, record or information relates, or

(m) to the council of the College of Physicians and Surgeons of the Province of Alberta or an investigating committee under the *Medical Profession Act*, if

(i) an officer of the College makes a written request for the diagnosis, record or information and the disclosure is consented to by the person to whom the diagnosis, record or information relates or his legal representative, or

(ii) the disclosure is made in compliance with a notice under section 49 of the *Medical Profession Act*, to attend as a witness or to produce documents.

(7) Notwithstanding subsection (4) or any other law, a medical examiner appointed under the *Fatality Inquiries Act* is entitled to inspect and make copies of any diagnosis, record or information relating to a person receiving diagnostic and treatment services in a centre.

(8) Where a medical examiner obtains a copy of any diagnosis, record or information pursuant to subsection (7), the provincial judge who presides at a public inquiry under the *Fatality Inquiries Act* may admit the copy of the diagnosis, record or information in evidence at the public

inquiry but all proceedings related to the diagnosis, record or information shall be in private.

(9) Notwithstanding subsection (4) or any other law, when the Minister, a person authorized by the Minister or a physician

(a) is unable to disclose any diagnosis, record or information relating to a person by reason of subsection (4), or

(b) refuses to disclose any diagnosis, record or information relating to a person pursuant to subsection (6),

the person or his legal representative may apply to the court for an order directing the person having the diagnoses, records or information to release them or a copy of them to the person to whom the information relates or his legal representative or to some other person named in the order.

(10) An application under subsection (9) shall be made

(a) on motion in the course of any action or proceedings to which the person to whom the diagnosis, record or information relates or his legal representative is a party, to a judge of the court in which the action or proceedings is taken, or

(b) by way of originating notice to the Court of Queen's Bench, in any other case.

(11) An application under subsection (9) shall be heard in private and on the hearing of the motion the onus of showing why the order should not be made for the release of the diagnosis, record or information, or a copy of it, is on the respondent to the motion.

38.(1) Notwithstanding any admission certificates or renewal certificates issued with respect to a formal patient, the medical director of a facility may grant a formal patient leave of absence from a facility.

(2) Leave of absence may be granted on any terms and conditions prescribed by the medical director and without restricting the generality of the foregoing may include a condition that the formal patient remain under the supervision and subject to the treatment of any person or persons authorized by the medical director.

(3) When a formal patient is on a leave of absence granted under this section and it appears to the medical director that the patient's condition is presenting a renewed danger to himself or others, the board may by notice in writing given to

(a) the formal patient, or

(b) the person supervising the patient,

revoke the leave of absence and recall the formal patient to the facility.

(4) When a formal patient refuses to return to the facility or when the medical director is unable to serve a notice in writing pursuant to subsection (3), the medical director may declare the formal patient to be absent without leave and order any peace officer to return the person to the facility.

(5) Nothing in this section authorizes the granting of a leave of absence to a formal patient who is

(a) detained pursuant to a warrant of the Lieutenant Governor, or

(b) remanded to a facility pursuant to the *Criminal Code* (Canada).

39.(1) A board may, if otherwise permitted by law and subject to arrangements being made with another board, transfer a patient to the other facility on completing a memorandum of transfer in the prescribed form.

(2) When a patient is transferred under subsection (1), the authority to detain him continues in force in the facility to which he is transferred.

40.(1) When a patient requires hospital treatment that cannot be supplied in the facility, the board may, if otherwise permitted by law, transfer the patient to a hospital for treatment and return him to the facility on the conclusion of the treatment.

(2) When a patient is transferred under subsection (1), the board of the hospital or a person designated by it has, in addition to the powers conferred on it by any other Act, the powers under this Act of a board in respect of the custody, control and treatment of the patient.

41. When the Director has reason to believe that a person suffering from mental disorder may come or be brought into Alberta, the Director may issue a certificate in the prescribed form and a conveyance and examination certificate shall be deemed to have been issued at the time that person comes or is brought into Alberta.

42. When it appears to the Director

(a) that a formal patient has come or been brought into Alberta and his observation, care and treatment is the responsibility of another jurisdiction, or

(b) that it would be in the best interests of a formal patient to be cared for in another jurisdiction,

the Director may, on compliance in Alberta with the laws of the other jurisdiction, with all necessary modifications, issue a transfer in the prescribed form, to authorize his transfer to the other jurisdiction.

43.(1) When a formal patient leaves a facility and leave of absence has not been granted, the board may order any peace officer to return the person to the facility.

(2) On receipt of

(a) an order pursuant to subsection (1), or

(b) an order pursuant to section 38(4)

every peace officer is empowered to arrest, without warrant, the person named in the order and return that person to the facility.

(3) For the purposes of this Act, a formal patient who is returned to a facility under this section or section 38 may be detained for the remainder of the authorized period of detention to which he was subject when his absence was discovered.

44. A conveyance and examination certificate, an admission certificate, renewal certificate, warrant, certificate, order, transfer or other form issued under this Act or the regulations shall not be held to be insufficient or invalid by reason only of any irregularity, informality or insufficiency in it or in any proceedings in connection with it.

BRITISH COLUMBIA

Mental Health Act, R.S.B.C. 1979, c. 256, as amended.

8.(1) A director shall ensure that

(a) each patient in a Provincial mental health facility is provided with professional service, care and treatment appropriate to his condition and appropriate to the function of the Provincial mental health facility and, for those purposes, may sign consent to treatment forms for a person admitted under section 20, 23, 24, 25 or 25.1;

(b) standards appropriate to the function of the Provincial mental health facility are established and maintained; and

(c) the orders and directives of the minister are observed and performed.

(2) Subsection (1)(a) and (b) applies, with the necessary changes,

(a) to a person appointed under the regulations as an officer in charge of a psychiatric unit; and

(b) to a psychiatric unit.

17. . . .

(2) A person employed in a Provincial mental health facility or a private mental hospital or any other person having charge of a patient who ill treats, assaults or wilfully neglects a patient commits an offence punishable under the *Offence Act*.

18. Notwithstanding anything in this Act, a director or person having authority to admit persons to a Provincial mental health facility shall not admit a person to a Provincial mental health facility if

(a) suitable accommodation is not available within the Provincial mental health facility for the care, treatment and maintenance of the patient; or

(b) in his opinion, the person is not a mentally disordered person or is a person who, because of the nature of his mental disorder, could not be cared for or treated appropriately in the facility.

19.(1) The director of a Provincial mental health facility may admit any person to and detain him in the Provincial mental health facility where

(a) the person requests admission, if he has attained the age of 16 years; or

(b) on the request of a parent or guardian or, if a parent or appointed guardian is not available, of his nearest relative, if he is under the age of 16 years,

and the director is satisfied that the person has been examined by a physician who is of the opinion that the person is a mentally disordered person.

(2) A nurse in charge of a ward in a Provincial mental health facility shall

(a) ensure that each patient in the ward who was admitted under

2
this section is enabled to communicate without delay to the director of the facility any desire that he may form to leave the facility; and,

(b) on learning that a patient in the ward who was admitted under this section desires to leave the facility, promptly notify the director of the facility of that desire.

(3) Within 72 hours of the receipt of notification, in any way,

(a) of the desire to leave the facility of a patient over the age of 16 years who was admitted under subsection (1); or

(b) of a request for the discharge from the facility of a patient under the age of 16 years who was admitted under subsection (1), made by any person entitled to apply for the patient's admission,

the director shall discharge the patient from the facility.

(4) Subsections (2) and (3) do not apply if the requirements for detention of the patient under section 20 have been fulfilled.

(5) A person who has attained the age of 16 years and who has been admitted to a Provincial mental health facility on his own application under subsection (1)(a) is, notwithstanding any rule of law relating to minors, deemed to have the capacity to make the application and an agreement for payment for maintenance and treatment in the facility and to authorize his treatment in the facility.

20.(1) The director of a Provincial mental health facility may admit a person to and detain him in the Provincial mental health facility where he receives a written application that is accompanied by 2 medical certificates completed by 2 physicians in accordance with subsection (3) and is made

(a) by a near relative of the person;

(b) if there is no near relative of the person capable of acting and willing to act, anyone who has knowledge of the circumstances and the antecedents of the person or who has charge of the person at the time;

(c) a peace officer, or

(d) anyone who has reason to believe that the person is mentally disordered,

and signed not more than 14 days prior to the date of admission.

(2) An application under subsection (1) is not valid unless the applicant is 19 years of age or more and there is set forth in it

(a) the full name and address of the applicant;

(b) the relationship of the applicant, if any, to the person whose admission is applied for;

(c) the full name and address of the person whose admission is applied for; and

(d) the signature of the applicant and the date of the signature, together with whatever other information may be required by the text of the form of application, which shall be prescribed and may be altered by the Lieutenant Governor in Council.

(3) Each medical certificate shall be completed and signed by a physician who is not disqualified under subsection (4) and who has

examined the person whose admission is applied for not more than 14 days prior to the date of admission and shall set forth

(a) a statement by the physician that he has examined the person whose admission is applied for on the date or dates set forth and is of the opinion that the person is a mentally disordered person;

(b) in summary form the reasons on which his opinion is founded; and

(c) in addition to the statement required under paragraph (a), a separate statement by the physician that he is of the opinion that the person whose admission is applied for

(i) requires medical treatment in a Provincial mental health facility; and

(ii) requires care, supervision and control in a Provincial mental health facility for his own protection or welfare or for the protection of others.

(4) A physician is disqualified from giving a valid medical certificate under this section if he is

(a) the person whose admission is applied for;

(b) the applicant;

(c) a partner of the applicant;

(d) engaged in the practice of medicine in partnership or associated with the physician who completes the other certificate;

(e) a person employed as an assistant by the applicant or the physician who completes the other certificate; or

(f) except as provided in subsection (5), a person who receives or who has an interest in the receipt of payments made on account of the maintenance of the person whose admission is applied for.

(5) A physician on the staff of the Provincial mental health facility to which a person is to be admitted or a consultant or other physician employed there is not disqualified from giving a valid medical certificate by reason only of subsection (4)(f) unless the other certificate is given by such a physician or consultant.

(6) A medical certificate given under this section becomes invalid on the 15th clear day after the date on which the physician examined the person who is the subject of the certificate.

(7) The 2 certificates completed as required under this section are sufficient authority for a person to apprehend and convey the person named in the statement made under subsection (3)(a) to a Provincial mental health facility.

21.(1) A patient admitted under section 20 may be detained in a Provincial mental health facility until the anniversary of the date of his admission and he shall be discharged on that day unless the authority for his detention is renewed in accordance with this section.

(2) Authority for the detention of a patient may, unless the patient has previously been discharged, be renewed under this section

(a) from the expiration of the period referred to in subsection (1) of this section for a further period of one year; and

(b) from the expiration of any period of renewal under paragraph (a) for a further period of 2 years; and so on for periods of 2 years at a time.

(3) Within a period of 2 months ending on the day on which a patient who has been detained in a Provincial mental health facility would cease under this section to be liable to detention in default of renewal under subsection (2), the director of the Provincial mental health facility or a physician authorized by him shall examine the patient and either discharge the patient or record a written report of the examination and include in it his reasons for concluding that the detention of the patient should be renewed and the report is a renewal of the authority for the detention of the patient.

(4) A person admitted to a Provincial mental health facility under section 20 shall, at any time after the expiration of 30 days from the date that he was admitted, on his request or on the request of a person on his behalf, be entitled to receive a hearing, of which he shall have at least 2 days' written notice, to determine whether or not he should be detained.

(5) For the purposes of a hearing under subsection (4),

(a) the patient shall not be discharged until the results of the hearing are made known to him and then only if the results of the hearing indicate that he should be discharged; and

(b) the hearing shall be heard by

(i) a chairman who shall be appointed by the minister;

(ii) a physician who is appointed by and is on the medical staff of the Provincial mental health facility to which the patient is admitted; and

(iii) a person, other than the patient or a member of his family, who is appointed by the patient. Where the patient does not appoint a person, the director of the Provincial mental health facility to which the patient is admitted may appoint a person who, in his opinion, has knowledge of the circumstances of the patient.

(6) The minister may reimburse a person appointed under subsection (5) for reasonable travelling or out of pocket expenses necessarily incurred by him in discharging his duties under this section, and, in addition, may pay him the remuneration for his services the minister may prescribe.

22.(1) The provisions of section 20 apply, with the necessary changes and so far as they are applicable, to the admission of a person to and his detention in a psychiatric unit.

(2) Section 20(7) applies, with the necessary variations, to the apprehension and conveyance of a person to a psychiatric unit.

(3) Sections 19, 21, 26, 27, 28, 29, 30 and, so long as he may be detained therein, section 35 apply, with the necessary variations, to a patient in a psychiatric unit.

23. Where

(a) the form of application referred to in section 20 has been completed in accordance with that section for a person; and

(b) a medical certificate has been completed by a physician; but

(c) there is no other physician qualified to give a second medical certificate by whom the person can be examined practising in the vicinity or within a reasonable distance of the place where the person resides;

the completed certificate, endorsed by the physician who gave it with a statement in the terms of paragraph (c), is sufficient authority for a person to apprehend and convey the person to a Provincial mental health facility or a psychiatric unit, for the admittance of the person in the facility or unit and for his detention there for examination and for psychiatric treatment for a period which shall not, unless the detention becomes otherwise authorized, exceed 72 hours.

24.(1) Where a police officer or constable is satisfied from his own observations or from information received by him that a person

(a) is acting in a manner likely to endanger his own safety or that of others; and

(b) is apparently suffering from mental disorder;

he may take the person into custody and take him immediately to a physician; and if the physician is satisfied that that person is a mentally disordered person and in need of care, supervision or control for his own protection or welfare or for the protection of others, he may be taken, on the certificate of the physician, to a Provincial mental health facility, a psychiatric unit or an observation unit; otherwise he shall be released.

(2) Where an application is made to him by anyone who appears to have good reason to believe that a person is a mentally disordered person and dangerous to be at large, a Provincial Court judge or, if there is no judge then available, a justice may, if he is satisfied that the procedures for the admission of the person to a Provincial mental health facility or psychiatric unit or for conveying him there for examination, cannot be utilized without dangerous delay, issue a warrant in the form A in the schedule and that warrant shall be authority for the apprehension of the person concerned and for his conveyance and admission to, and psychiatric treatment in a Provincial mental health facility, a psychiatric unit or an observation unit.

(3) The director of a Provincial mental health facility or the officer in charge of a psychiatric unit or an observation unit may admit a person in respect of whom he is satisfied a certificate has been issued under subsection (1) or a warrant has been issued under subsection (2) and may detain him, examine and treat him for his condition in the facility or unit for a period which shall not, unless the detention becomes otherwise authorized, exceed 72 hours.

25.(1) The Lieutenant Governor in Council, on receiving 2 medical certificates completed in accordance with section 20 concerning the mental condition of a person imprisoned or detained in a correctional centre or youth containment centre under the *Correction Act* or a prison or lockup operated by a police force, may order the removal of the person to a Provincial mental health facility, on which

(a) the person in charge of the correctional centre, youth

containment centre, prison or lockup, shall, in accordance with the order, cause the person to be conveyed to the Provincial mental health facility named in the order and send to the director of the Provincial mental health facility an application for admission in the form prescribed by the Lieutenant Governor in Council by regulation, together with copies of the medical certificates, and

(b) the person shall be detained in that or any other Provincial mental health facility the Lieutenant Governor in Council may order until his complete or partial recovery or until other circumstances justifying his discharge from the Provincial mental health facility are certified to the satisfaction of the Lieutenant Governor in Council, who may then order him back to imprisonment or detention if then liable thereto or otherwise to be discharged.

(2) Notwithstanding that no order has been made under subsection (1), the person in charge of a correctional centre or youth containment centre under the *Correction Act*, or prison or lockup operated by a police force, on receiving 2 medical certificates in accordance with section 20 concerning the mental condition of a person imprisoned or detained in the correctional centre, youth containment centre, prison or lockup, may authorize the transfer of the person to a Provincial mental health facility and the director of the Provincial mental health facility may admit the person to the facility where he receives from the person in charge of the correctional centre, youth containment centre, prison or lockup an application for admission in the form prescribed under subsection (1)(a) together with copies of the 2 medical certificates.

(3) Where a person is authorized to be transferred and is admitted under subsection (2), he shall be detained in the Provincial mental health facility until his complete or partial recovery or until other circumstances justifying his discharge from the facility are certified to the satisfaction of the director who shall,

(a) where the person is not liable to further imprisonment or detention, discharge him, or

(b) where the person is liable to further imprisonment or detention, return him to the correctional centre, youth containment centre, prison or lockup from which he was transferred.

(4) Where a person is detained in a Provincial mental health facility under subsection (1) or (3), the director may authorize that the person receive care and psychiatric treatment appropriate to his condition.

25.1 Where, under the *Criminal Code*, a person is found to have been insane at the time that he committed an offence or is found unfit on account of insanity to stand his trial and the person is ordered to be detained in a Provincial mental health facility, he shall receive care and psychiatric treatment appropriate to his condition as authorized by the director.

25.2 Where a person is detained in a Provincial mental health facility

under section 20, 23, 24, 25 or 25.1, and notwithstanding that no order respecting the person has been made under the *Patients Property Act*, treatment authorized by the director shall be deemed to be given with the consent of the person.

27.(1) A person for whose admission to a Provincial mental health facility an application is made under section 20 or a patient or a near relative of the person or patient or anyone who believes that there is not sufficient reason for the admission or detention of the person or patient under this Act, may apply before admission of the person or after the date of admission of the patient to a Provincial mental health facility to the court for

- (a) an order prohibiting the admission of the person to a Provincial mental health facility pursuant to that application;
- (b) an order prohibiting the admission of the person to a Provincial mental health facility pursuant to that application or any other application for admission of the person to a Provincial mental health facility made prior to the date of the order; or
- (c) an order that the patient be discharged from the Provincial mental health facility.

(2) Nothing in this section affects the right of a person to apply for a writ of habeas corpus or other prerogative writ.

(3) On hearing an application under subsection (1), the court may review the evidence, including all papers relating to the admission applied for or the admission and detention of the patient and may hear further evidence it deems relevant.

(4) Where the court is satisfied that there is or was sufficient reason and authority for the admission of a person or patient to a Provincial mental health facility and for his detention in it, it shall order that the person or patient be detained in a Provincial mental health facility for care and treatment.

(5) Where the court is not satisfied that there is or was sufficient reason or authority for the admission of the person to a Provincial mental health facility or for the detention of the patient in it, it may make an order

- (a) prohibiting anyone from admitting the person to a Provincial mental health facility pursuant to the application for admission that gave rise to the application under this section;
- (b) prohibiting anyone from admitting the person to a Provincial mental health facility pursuant to an application for admission made prior to the date of the order;
- (c) that the patient be discharged from the Provincial mental health facility; or
- (d) that the director of a designated Provincial mental health facility obtain within 10 days a report from a physician who is recognized by the College of Physicians and Surgeons of British Columbia as being a specialist in psychiatry and who would not be disqualified from giving a valid medical certificate under section

20, stating whether or not in his opinion the person or patient is in fact mentally disordered and consequently requiring care and treatment in a Provincial mental health facility, and that the person, if he is not detained at the time of the making of the order in a Provincial mental health facility, attend before the physician for examination at a time and place appointed by the director.

(6) On receipt of the report made under an order under subsection (5), the court shall,

(a) if it is satisfied that the person or patient is mentally disordered and requiring care and treatment in a Provincial mental health facility, order that the person or patient be admitted to and detained in or detained in the Provincial mental health facility; or

(b) if it is not satisfied that the person or patient is mentally disordered and requiring care and treatment in a Provincial mental health facility, make an order under subsection (5)(a), (b) or (c).

(7) Where an order is made under this section for the discharge of a person or patient from a Provincial mental health facility, the director of the Provincial mental health facility shall immediately discharge the person or patient.

(8) In this section, "Provincial mental health facility" includes a psychiatric unit and a director of a Provincial mental health facility includes the officer in charge of a psychiatric unit. Where a person has, under section 22, been admitted to a psychiatric unit and removed to a Provincial mental health facility, an application made under this section prior to his removal shall be continued with the substitution of the appropriate parties and shall be deemed to include an application in relation to admission and detention in the Provincial mental health facility.

28.(1) Immediately after the admission of a patient to a Provincial mental health facility under section 20, the director of the facility shall send in writing to the next of kin of the patient a notice setting forth the rights of the patient under section 27.

(2) If the director has no information with regard to the identity of the next of kin of the patient, subsection (1) is sufficiently complied with if the notice is sent to the Public Trustee.

29.(1) When a transfer to another Provincial mental health facility is considered beneficial to the welfare of a patient, the director of the facility may, by agreement with the director of the other Provincial mental health facility, authorize the transfer and cause the patient to be transferred in accordance with his direction.

(2) Notwithstanding subsection (1), a person detained under section 25 may be transferred to another Provincial mental health facility only with the approval of the Lieutenant Governor in Council or, where the person is detained under section 25(2), with the authorization of the person in charge of the correctional centre, youth containment centre, prison or lockup from which he was transferred.

(3) A director of a Provincial mental health facility to whose facility a

patient has been transferred under this section has authority to detain the patient and the time limited by this Act for the doing of any thing shall run as if the patient's detention were continuous in one facility.

30.(1) The director of a Provincial mental health facility or the officer in charge of an observation unit may discharge a person from the facility or unit.

(2) An application or medical certificate made under this Act is not effective for use for the purposes of this Act after the discharge of the person with respect to whom the application or certificate is made.

(3) When a person is discharged from a Provincial mental health facility or observation unit other than by the operation of section 35(3), the director of the facility or officer in charge of the observation unit shall, on receiving an application by or on behalf of the person, furnish the person with a certificate of discharge, signed by the director, in the form prescribed by the Lieutenant Governor in Council.

31. Subject to section 34, the director of a Provincial mental health facility may release a patient detained in the Provincial mental health facility on leave for designated purposes for stipulated periods of time on the conditions the director may prescribe to the care of relatives of the patient or others capable of assuming responsibility for his care.

32. Subject to section 34, where the director of a Provincial mental health facility considers it beneficial to a patient he may cause the patient to be transferred from the Provincial mental health facility to an approved home on conditions the director may prescribe. The Lieutenant Governor in Council may make regulations for the selection and approval of approved homes and for the payment of the cost of the maintenance of the patients in them.

33.(1) For clarity, it is declared that the release of a patient on leave or his transfer to an approved home under section 31 or 32 does not, of itself, impair the authority for his detention and that authority may be continued, according to the same procedures and to the same extent, as if the patient were detained in a Provincial mental health facility.

(2) A patient who is on leave or has been transferred to an approved home shall, until discharged, be liable to recall either to the facility from which he was released or transferred or, if the transfer is authorized by the director pursuant to section 29, to some other facility, and the director of either facility may issue a warrant in the form B in the schedule for the apprehension of the patient and his conveyance to the facility to which he is recalled, provided that where a patient escapes from the custody of a person to whose care he has been released on leave or from an approved home, section 35(3) applies.

34. Except as provided by order of the Lieutenant Governor in Council, sections 31 and 32 do not apply to a patient

(a) who was admitted to a Provincial mental health facility under section 25 or under the *Criminal Code* (Canada) and remains

liable to imprisonment or detention in a jail, prison or training school; or
(b) who is detained in a Provincial mental health facility by reason of the *Criminal Code* (Canada).

36. On receipt of a written notification from the appropriate mental health authority of another province that a resident of the Province is in that other province and has been certified as being mentally disordered under legislation corresponding to this Act, the director of the Provincial mental health facility notified may agree that the person be returned to the Province for care and treatment and he may receive the person and detain him for 72 hours, during which time he shall either admit him to the Provincial mental health facility under this Act or release him at the end of that period.

British Columbia Regulation 118/80 under the *Mental Health Act*, as amended.

SCHEDULE

Division 8 — Conduct of Hearing Under Section [21] of the Act

8.01 In this division

“facility” means a Provincial mental health facility,

“panel” means the person appointed under section [21](5)(b) of the Act, and

“patient” means a person entitled to a hearing under section [21](4) of the Act.

8.02(1) A patient or a person on his behalf who requests a hearing under section [21] of the Act shall apply by completing Form M.H.A. 64/7 and serving it upon the Director of Mental Health Services who shall, on receiving it, notify the chairman of the panel.

(2) The chairman shall convene a hearing within 28 days of being notified under subsection (1).

8.03 The panel is entitled to all information and records located at any facility and which may be relevant to the hearing and, for that purpose, a staff member at a facility who is requested by the chairman or a member of the panel to give information or supply records shall comply with that request.

8.04 The hearing panel has power to summon witnesses to a hearing and for that purpose has the powers of a commissioner under sections 10 and 11 of the *Public Inquiries Act*.

8.05 The patient may be represented by counsel or agent who may call witnesses and make submissions on behalf of the patient.

8.06 Any person having a bona fide interest in or knowledge of matters

relevant to the hearings may give evidence or make submissions at the hearing.

8.07 All evidence presented at the hearing shall be treated as confidential.

8.08(1) After reviewing all evidence presented at the hearing, the panel shall, within 24 hours after the hearing has ended, determine, by simple majority, whether or not the patient's detention should continue.

(2) After making a determination under subsection (1), the chairman shall without delay serve a copy of it on the director of the facility where the patient is detained.

(3) The determination shall be in writing and shall give reasons.

8.09(1) If the panel determines that the patient's continued detention is justified, the director of the facility shall continue to detain the patient.

(2) If the panel determines that the patient should be discharged, the director shall immediately serve a copy of the determination on the patient and discharge him.

8.10(1) A patient or a person on his behalf may request another hearing at any time after six months from the time a determination has been made in a previous hearing.

(2) The chairman or the two members of the panel hearing the matter may abridge the time referred to in subsection (1) where

(a) it is considered in his or their opinion advisable, or

(b) new information relative to the patient's detention has become available.

8.11 The patient may at any time before it begins

(a) withdraw his request for a hearing, and

(b) reappoint another person as his representative under section [21](5)(b)(iii) of the Act.

8.12(1) A copy of section [21] of the Act and of these Regulations shall be posted in a conspicuous place that is accessible to patients in a facility.

(2) The director of the facility shall, within seven days of the admission of a patient pursuant to section [20], inform that patient of his right to a hearing under section [21](4) of the Act.

MANITOBA

The Mental Health Act, R.S.M. 1970, c. M110, as amended.

4.(1) The director may

(a) where he has reason to believe that a person is mentally disordered, order that the person be examined and treated as a patient in a psychiatric facility;

(2) The medical officer in charge of a hospital may

(a) subject to subsection (3), admit and detain for examination and treatment in the psychiatric facility of which he is in charge, such persons as are found to be mentally disordered;

7.(1) Any person in Manitoba who believes himself to be, or to be about to become, in need of treatment such as is provided in a psychiatric facility may apply for admission to a psychiatric facility; and the medical officer in charge of the psychiatric facility may receive and detain the person as a patient therein.

(2) No person shall be admitted or detained as a non-compulsory patient at a psychiatric facility unless in the opinion of the medical officer in charge of the psychiatric facility the person requires or is in need of psychiatric examination, care and treatment.

8.(1) Where any person in Manitoba is or is believed to be mentally disordered or in need of treatment such as is provided in a psychiatric facility, any relative or friend of the person or any clergyman, priest, physician, mayor, reeve, councillor, justice of the peace, or any kindly disposed person may, kindly and without violence, convey the person to a psychiatric facility and there make written application for the admission of the person as a patient therein, and the medical officer in charge of the psychiatric facility may admit the person.

(2) Within forty-eight hours after the admission of a person as a patient in a psychiatric facility under subsection (1) of section 7, or subsection (1), the medical officer in charge of the psychiatric facility in which the person is a patient, shall cause the patient to be medically examined and a written report made on the mental condition of the patient.

(3) A person admitted as a patient in a psychiatric facility under subsection 7(1) or subsection (1), may at any time after the expiration of 48 hours after he was admitted as a patient, give to the medical officer in charge of the psychiatric facility 24 hours notice in writing requesting his discharge from the facility and, except as is otherwise provided in this Act, the medical officer shall thereupon discharge the patient from the facility.

(4) Where a patient is a non-compulsory patient no treatment shall be given to the patient if the patient objects to the treatment.

9.(1) Where a duly qualified medical practitioner issues a medical certificate to the effect that he has examined the person named therein, and that the person should be confined as a patient at a psychiatric facility, the person may be admitted to a psychiatric facility as a compulsory patient.

(1.1) A medical certificate issued under subsection (1) is valid for a period not exceeding 14 days from the date of its issuance.

(2) Where a person with respect to whom a medical certificate is issued under subsection (1) refuses to go to a psychiatric facility, a justice of the peace, or a magistrate or a provincial judge may, upon the application of the medical officer who issued the certificate or upon the application of any person mentioned in subsection 8(1), issue a warrant directing that the

person be taken into custody and brought to a psychiatric facility for admission thereto as a compulsory patient.

(3) The warrant mentioned in subsection (2) may be directed to all or any constables or peace officers in Manitoba, shall name or otherwise describe the person to be apprehended, and shall state that the person is suspected or believed to be in need of examination or treatment at a psychiatric facility.

10.(1) Except as otherwise provided in this Part, a person admitted as a compulsory patient under section 9 shall not be detained at a psychiatric facility for more than twenty-one days.

(2) At any time within twenty-one days from the date of admission of a person under section 9, he may upon the certificate of his treating physician, or the certificate of a duly qualified medical practitioner on the staff of the psychiatric facility where the patient is confined, be detained as a non-compulsory patient.

11.(1) Notwithstanding section 10, where a person admitted to a psychiatric facility as a compulsory patient is, in the opinion of a psychiatrist on the staff of the psychiatric facility, in need of treatment that is likely to extend beyond 21 days, the medical officer in charge of the psychiatric facility may apply to a provincial judge for an order extending the time of detention of the person for such further period as may be necessary.

(2) Before making an order under subsection (1), the provincial judge shall consider such evidence as may be adduced before him with reference to the mental condition of the person; and if he is satisfied that the person is in need of treatment, as alleged, he shall grant the order.

12. Where a person admitted as a non-compulsory patient at a psychiatric facility is, in the opinion of a psychiatrist on the staff of the psychiatric facility, a person that is dangerous to himself or to others, or one who requires further treatment, he may be detained as a compulsory patient for a period not exceeding twenty-one days, but subsection (2) of section 10 and section 11 apply, mutatis mutandis, to that person.

13. The Lieutenant Governor in Council may, by order, direct that a person

- (a) who is a prisoner confined in a penal institution; or
- (b) who is convicted of an offence; or
- (c) who is acquitted of offence because of insanity;

be admitted to a psychiatric facility as a compulsory patient and such a patient shall not be discharged from the psychiatric facility except upon the order of the Lieutenant Governor in Council

14. Where, at any time during the detention of a person as a patient in a psychiatric facility, there occurs a change in his status as a patient, the medical officer in charge shall, where possible, notify the person's next-of-kin in writing as to the change.

15.(1) Where any person in Manitoba is or is suspected or believed to

be in need of examination and treatment in a psychiatric facility and the person refuses to be medically examined for the purpose of determining his mental condition, any person may apply to a magistrate or a provincial judge for an order compelling the person to be medically examined.

(2) Where an application is made under subsection (1), the magistrate before whom it is made shall consider such evidence as may be adduced before him and, if satisfied that the person is in need of examination, he shall order that the person be examined by a duly qualified medical practitioner.

(3) Where a medical practitioner under subsection (2) issues a certificate to the effect that he has examined the person named therein and that the person should be admitted as a patient at a psychiatric facility, sections 9, 10, 11, and 14 mutatis mutandis, apply to that person.

(4) Where a peace officer has reason to believe that a person

- (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;
- (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or
- (c) has shown or is showing a lack of competence to care for himself;

and in addition the officer is of the opinion that the person is apparently suffering from mental disorder of a nature that likely will result in

- (d) serious bodily harm to the person;
- (e) serious bodily harm to another person or;
- (f) imminent and serious physical impairment of the person;

and that it would not be reasonable to proceed as in subsection 15(1), he may apprehend the person and take him to an appropriate place for examination by a duly qualified medical practitioner.

(5) Where a peace officer takes a person into custody pursuant to a medical or judicial order, the person shall remain in the custody of the peace officer until he has been medically examined and brought to a psychiatric facility where admission to the facility is considered by the physician to be in the best interests of the safety of the person or other persons.

16. The director, where he deems it advisable, may place a patient under supervision or in the custody of a relative or friend who desires to keep and care for the patient and who is able to do so, with or without instructions for the patient to be presented, at stated intervals, for further examination or treatment; or he may discharge the patient.

17. The director may place under supervision as he may consider necessary any person whom he believes to be mentally disordered; but shall do so only upon the receipt of a certificate from a duly qualified medical practitioner, stating that he has examined the person and that the person is mentally disordered.

24.(1) Every person who is detained as a compulsory patient in a psychiatric facility under this Part may, as soon as he is, in the opinion of the director or medical officer in charge, recovered from his mental disorder and competent to act for himself, be discharged or allowed to leave the psychiatric facility on probation for a period of time not exceeding six months.

(2) Where a patient is placed on probation under subsection (1) the director or medical officer in charge may order the patient to report from time to time at a psychiatric facility or clinic for further medical examination; and at the end of the probationary period the director or medical officer in charge may discharge the patient or, where considered necessary, place the patient on probation for a further period of six months after which period he may be discharged or, if necessary, detained at a psychiatric facility for further treatment.

(3) Except for the purpose of returning the patient to his place of imprisonment, nothing in this section authorizes the discharge of a patient who is imprisoned for an offence and whose sentence has not expired.

(4) Where a discharged patient or patient placed on probation is in indigent circumstances, he shall be furnished with necessary clothing and funds sufficient for sustenance and travel to his home or place of residence.

25.(1) The medical officer in charge of a psychiatric facility may admit to the facility, or transfer; a person who has been committed to a psychiatric facility in another province or territory of Canada or in another country, or to a psychiatric facility under the jurisdiction of the Government of Canada; and may detain the person for such time as may be required for diagnosis, care and treatment of the person.

(2) Where a person is admitted to a psychiatric facility under subsection (1), the provisions of this Part respecting a compulsory patient apply mutatis mutandis.

26.(1) The Lieutenant Governor in Council shall appoint a board to be known as The Mental Health Review Board (hereinafter referred to as the "board") consisting of 6 regular members made up as follows:

(a) 2 psychiatrists:

(b) 4 other persons who shall not be psychiatrists.

(2) The Lieutenant Governor in Council shall also appoint 3 alternate members, one of whom is a psychiatrist and 2 who are not psychiatrists and, where for any reason a regular member cannot act, an alternate member appropriate to comply with subsection (1) shall act in his stead.

(3) The Lieutenant Governor in Council shall fix the term of office of the members and alternate members of the board who shall serve for the term so fixed and thereafter until their successors are appointed.

(4) The regular members and alternate members of the board may be paid such remuneration and such out-of-pocket expenses as may be authorised.

(5) A psychiatrist and 2 other members who are not psychiatrists constitute a quorum, and a decision of the majority is the decision of the board.

(6) Any 3 members of the board, one of whom shall be a psychiatrist may sit as a panel of the board and when so constituted the panel may carry out all the duties and functions of the board under this Act; and 2 panels of the board may sit at the same time; and a decision of a panel is deemed to be a decision of the board.

(7) The board shall review the status of every patient in a psychiatric facility within 12 months after his admission thereto and at least annually thereafter and for a review under this subsection where the board considers it necessary it may hold hearings to determine whether the patient should continue to remain as a patient in the facility or whether he should be discharged.

(8) Where the board receives an application from

- (a) a patient or his legal representative; or
- (b) a relative of the patient; or
- (c) the patient's physician or psychiatrist, or any kindly disposed person known to the patient; or
- (d) the medical officer in charge of the psychiatric facility to which the patient is admitted; or
- (e) the ombudsman appointed under The Ombudsman Act;

to review the status or treatment of the patient, the board shall not later than 30 days after the receipt of the application or such longer period as the minister may allow hold a hearing thereof and shall give written notice to the parties concerned not less than 7 days prior to the date of the hearing.

(9) Hearings of the board pursuant to subsection (7) and (8) shall be in camera except that where the hearing is held pursuant to subsection (8)

- (a) the applicant and his legal representative;
- (b) the patient, where he is not the applicant and his legal representative or his physician or psychiatrist;
- (c) the medical officer in charge of the psychiatric facility; and
- (d) any other person with the consent of the board;

has a right to attend, to adduce evidence and to examine and cross-examine witnesses.

(10) Notwithstanding subsection (9) in any hearing of the board the board may exclude the patient or any other person therefrom where the board is of the opinion that the attendance of the patient or the person would be detrimental to the health of the patient or the person.

(11) For the purpose of any hearing or review by the board, the board shall have access to and may make copies of or take extracts of all clinical records of the patient and documents pertaining to the admission and treatment of the patient kept at the psychiatric facility.

(12) The board may in its discretion provide the persons present at any of its hearings with copies of any or all of the documents and records mentioned in subsection (11).

(13) The documents and records that the board obtains under subsection (11) and the copies thereof furnished to persons under subsection (12) shall be returned by the board to the psychiatric facility after the conclusion of the hearing.

(14) A member of the board

- (a) who is related or known to the patient; or
- (b) who has or has had any relationship with the patient as a member of the staff of the psychiatric facility in question; or
- (c) who has or has had a patient or client relationship with the patient;

is excluded from sitting as a member of the board in any hearing at which the patient is the subject of the hearing.

(15) The board shall endeavour to complete any of its hearings not later than 28 days after the date of the hearing and shall within that time, in writing, notify all the parties concerned of its decision.

[This section not yet in force.]

26.1(1) Where pursuant to a hearing held under subsection 26(7) or (8) the board makes a decision, order or ruling, any person affected by the decision, order or ruling may appeal the decision, order or ruling to a judge of the county court having jurisdiction in the matter; and the appeal shall be a hearing de novo.

(2) Where a person launches an appeal under subsection (1), unless the appeal court otherwise orders, he shall not be required

- (a) to deposit any money as security for the costs of the appeal, or
- (b) to furnish a transcript of the evidence upon which the order, decision, or ruling, as the case may be, was made;

but where the appeal court orders the person to deposit money as security for costs, the amount to be so deposited shall be in the discretion of the appeal court.

(3) The decision of the county court under subsection (1) is final and not subject to any further appeal.

[This section not yet in force.]

26.2(1) In section 26 and this section, "clinical record" means the clinical record or any part thereof compiled in a psychiatric facility with respect to a patient.

(2) Except as may be otherwise provided in this Act, no person shall disclose, transmit or examine a clinical record.

(3) The medical officer in charge of a psychiatric facility in which a clinical record is prepared and maintained, may disclose or transmit the record to, or permit the examination thereof by

- (a) any person with the consent of the patient, where the patient has attained the age of majority and is mentally competent; or
- (b) any person, where the patient has not attained the age of majority, or is not mentally competent

(i) with the consent of the Public Trustee where the patient is the ward of the Public Trustee, or

(ii) with the consent of the nearest relative, where the patient is not the ward of the Public Trustee; or

(c) any person employed in or on the staff of the psychiatric facility, for the purpose of assessing or treating the patient; or

(d) the medical officer in charge of a health facility or a psychiatric facility currently involved in the direct care of the

patient, upon the written request of the medical officer; or
(e) a physician engaged in the direct care of the patient, where the delay in obtaining the consent mentioned in clause (a) or (b) is likely to endanger the mental or physical health of the patient; or
(f) any person for the purpose of research, academic pursuit or the compilation of statistical data where the name and other means of identification of the patient are removed from the records.

(4) Subject to subsections (5) and (6), the medical officer in charge of a psychiatric facility shall disclose, transmit or permit the examination of the clinical record of a patient pursuant to a subpoena, order or direction of a court with respect to a matter in issue before the court under this Act or any other Act of the Legislature.

(5) Where the disclosure, transmittal or examination of a clinical record is required by a subpoena or order under subsection (4) in respect of a matter in issue or that may be in issue in the court and the attending physician of the patient states in writing that he is of the opinion that the disclosure, transmittal or examination of the clinical record or of a specified part of the clinical record

(a) is likely to result in harm to the treatment or recovery of the patient; or

(b) is likely to result in

(i) injury to the mental condition of a third person; or

(ii) bodily harm to a third person;

the medical officer in charge shall comply with the opinion with respect to the clinical record or the part of the clinical record specified by the attending physician except under an order of the court before which the matter is or may be in issue made after a hearing from which the public is excluded and that is held on notice to the attending physician.

(6) On a hearing under subsection (5), the court or body shall consider whether or not the disclosure, transmittal or examination of the clinical record or the part of the clinical record specified by the attending physician

(a) is likely to result in harm to the treatment or recovery of the patient; or

(b) is likely to result in,

(i) injury to the mental condition of a third person, or

(ii) bodily harm to a third person;

and for the purpose the court may examine the clinical record, and, if satisfied that such a result is likely, the court shall not order the disclosure, transmittal or examination unless satisfied that to do so is essential in the interests of justice.

(7) Where a clinical record is required pursuant to subsection (4), (5) or (6), the clerk of the court in which the clinical record is admitted in evidence or, if not so admitted, the person to whom the clinical record is transmitted shall return the clinical record to the medical officer in charge forthwith after the determination of the matter in issue in respect of which the clinical record was required.

(8) Except as provided in subsections (4) and (5), no person shall

disclose in an action or proceeding in any court or before any body any knowledge or information in respect of a patient obtained in the course of assessing or treating or assisting in assessing or treating the patient in a psychiatric facility or in the course of his employment in the psychiatric facility except,

- (a) where the patient has attained the age of majority and is mentally competent, with the consent of the patient;
- (b) where the patient has not attained the age of majority or is not mentally competent, with the consent of the Public Trustee where the patient is a ward of the Public Trustee or the consent of the nearest relative of the patient where the patient is not a ward of the Public Trustee.

26.3 The medical officer in charge of a psychiatric facility shall shortly after the admission of a patient to the facility

- (a) provide or cause to be provided to the patient a written communication outlining the functions of the board and the manner in which a matter could be referred to the board;
- (b) advise the patient of his right to send and receive mail in accordance with section 97; and
- (c) cause to be conspicuously displayed in writing in the psychiatric facility, those matters referred to in clauses (a) and (b).

36. The director, upon evidence satisfactory to him that a person imprisoned for an offence in any prison or place of detention, other than a penitentiary, or held in safe custody and charged with an offence against any law that is in force in the province, is a mental retardate, may order the removal of the person to an institution; and the person so removed shall remain there until he is fit to be returned to prison, if he is then liable to be returned thereto, or, if otherwise, that he be discharged.

37.(1) A judicial order that a mental retardate be sent to an institution authorizes the conveyance of that person to, and his reception in, the institution mentioned in the order within a time to be mentioned in the order; and the person shall be detained in the institution until otherwise ordered by a magistrate or until removed or discharged therefrom under this Part.

38.(1) Where a mental retardate has been placed in an institution for mental retardates or under custodianship by order of a magistrate, on the application of the original applicant, a parent or guardian of the mental retardate, the director, the medical officer in charge of the institution, or the person appointed custodian, or of a person appointed by any of them for the purpose, a magistrate, on being satisfied that the interests of the mental retardate and of the public require it, may, in his discretion, by order,

- (a) discharge the retardate from the institution or from

custodianship, either conditionally or unconditionally; or

(b) direct that the retardate be granted leave on parole for such period of time as it considers reasonable; or

(c) otherwise deal with the retardate as he sees fit.

(2) An order made by a magistrate under subsection (1) may, upon application by a person mentioned in that subsection, be rescinded by a magistrate; and a magistrate may order that the mental retardate be retaken and again placed in an institution or under custodianship.

(3) The magistrate may require notice of the application under subsection (1) or (2) to be given to the director, the medical officer in charge of the institution, the person appointed custodian, the parent or guardian of the mental retardate, if known, or to such of them or such other person as he deems advisable, and the persons so notified shall be entitled to be heard on the application.

39.(1) Where a mental retardate is placed in an institution or under supervision by the director, he may, at any time, where he considers it to be in the interests of the mental retardate or the public,

(a) direct that the mental retardate be discharged from the institution, either conditionally or unconditionally; or

(b) direct that the mental retardate be granted temporary leave for such period of time as he considers reasonable; or

(c) otherwise deal with the mental retardate as he sees fit.

(2) An order made by the director under subsection (1) may be rescinded by him; and he may, by further order, direct that the mental retardate be retaken and again placed in an institution or under supervision.

(3) No order shall be made by the director under this section unless he gives written notice to the parent or guardian of the mental retardate, if known, or to such other person as he deems advisable of his intended action; and the persons so notified are entitled to be heard by the director.

40.(1) Notwithstanding section 39, the parent or guardian of a mental retardate who has been placed in an institution or under supervision by the director may apply to the director requesting that the mental retardate be discharged from the institution or from supervision; and the director may grant the application under such terms and conditions as he may prescribe.

(2) Where the director refuses an application under subsection (1), the applicant may appeal the decision to the board; and the board may conduct such investigations, make such inquiries and hear such persons as it sees fit and make such order as under the circumstances seems reasonable.

(3) Where an application under subsection (2) is disallowed by the board, no further application shall be made by the applicant to the director or the board until after the expiration of six months from the date of the order under subsection (2).

(4) Notwithstanding section 39, the director may require the parent or guardian of a mental retardate who has been placed in an institution or under supervision by the director to remove the mental retardate from the institution or from supervision under such terms as he may prescribe.

(5) Where a parent or guardian is not satisfied with an order of the

director made under subsection (4), he may appeal the order to the board, and the board may conduct such investigations, make such inquiries and hear such persons as it sees fit and make such orders as under the circumstances seem reasonable to the board.

...

43.(1) Where the director has, under this Part, determined that a person is a mental retardate, if he also finds that it is not necessary for the safety or welfare of the mental retardate or of the public that the mental retardate be placed in an institution or under supervision, the director may give a certificate in writing to that effect.

(2) Where a magistrate has, under this Part, determined that a person is a mental retardate, if he also finds that it is not necessary for the safety or welfare of the mental retardate or of the public that the mental retardate be placed in an institution or under a custodian, he may make a declaration in writing to that effect signed by him and release the mental retardate.

...

94.(1) No responsibility for the detention or custody of a person in a psychiatric facility or institution or for placing a person under supervision rests on the officers or staff or employees of the psychiatric facility or institution, if the person has been detained or is held in custody or is placed under supervision in accordance with this Act of the Legislature relating to mentally disordered persons.

(2) No action lies, or shall be instituted, against any person, whether in his public or private capacity, where that person is acting under the authority of this Act, for any loss or damage suffered by any person by reason of anything done by him in good faith, or omitted to be done by him in the exercise of powers given to him by this Act.

(3) The act or omission of a person who is not employed in, or in connection with a psychiatric facility or institution, or who is not an agent or employee of the director or of the medical officer in charge of the psychiatric facility or institution or under the direction or control of the director or medical officer in charge of the psychiatric facility or institution, at the time of the act or omission, does not bind, or create any liability upon, and is not admissible in evidence in any civil proceedings against, the director or medical officer in charge of a psychiatric facility or institution, or any person employed in, or in connection with the psychiatric facility or institution.

95. No person who brings in a patient or a person to a psychiatric facility or institution, or who lays an information under this Act, or who, acting as a magistrate or court, places a person under custody, supervision, or commits him to a psychiatric facility or institution under the provisions of the Act, or who signs or carries out, or does any act with a view to signing or carrying out, an order purporting to be an order for the removal of a person to a psychiatric facility or institution, or any report or medical certificate under this Act, is liable to any civil proceedings in respect

thereof, whether on the ground of want of jurisdiction or any other ground, if that person has acted in good faith and with reasonable care.

96. Where proceedings are taken against any person for bringing or committing a person to a psychiatric facility or institution or for laying an information or signing or carrying out any such order, report, or medical certificate as in section 95 mentioned, or doing anything in pursuance of this Act the proceedings may, upon summary application to a judge of the Court of Queen's Bench, be stayed upon such terms as to costs and otherwise as the judge may think fit, if the judge is satisfied that there is no reasonable ground for alleging want of good faith or of reasonable care.

103. Any officer, nurse, attendant, servant, or person employed in a psychiatric facility or institution, or any person having charge, care, control, or supervision of a mentally disordered person, by reason of any contract or tie of relationship of marriage or otherwise, who ill-treats or wilfully neglects the mentally disordered person is guilty of an offence.

105.(1) A person who violates any provision of this Act is guilty of an offence.

(2) Any person who is guilty of an offence under this Act is liable, on summary conviction, to a fine not exceeding five hundred dollars or to imprisonment for a term not exceeding one year, or to both such a fine and such an imprisonment.

NEW BRUNSWICK

Mental Health Act, R.S.N.B. 1973, c. M-10, as amended.

6.(1) Notwithstanding this or any other Act, admission to a psychiatric facility may be refused by the authorities thereat where the immediate needs in the case of the proposed patient are such that hospitalization is not urgent or necessary.

(2) Where admission to a psychiatric facility is refused under subsection (1), the reasons for the refusal shall be communicated forthwith to the physician who made application for or recommended the admission of the proposed patient.

7. Any person who is believed to be in need of the observation, care or treatment provided in a psychiatric facility may, upon the recommendation of a physician, be admitted thereto as an informal patient.

8.(1) Any person who

(a) suffers from mental disorder of a nature or degree so as to require hospitalization in the interests of his own safety or the safety of others, and

(b) is not suitable for admission as an informal patient,

may be admitted as an involuntary patient to a psychiatric facility upon application therefor in the prescribed form signed by a physician.

(2) The physician signing the application shall state and show clearly therein that he has personally examined the person who is the subject of the application and has made due inquiry into all of the facts necessary for him to form a satisfactory opinion.

(3) The physician signing the application shall also in the application state the facts on which he formed his opinion of the mental disorder, distinguishing the facts observed by him from the facts communicated to him by others, and shall note the date upon which the examination was made.

(4) Every such application shall be completed no later than seven days after the examination referred to therein, and no person shall be admitted to a psychiatric facility upon an application except within fourteen days of the date on which the application was completed.

(5) Such an application is sufficient authority

(a) to any person to convey the person who is the subject of the application to a psychiatric facility, and

(b) to the authorities thereof to admit and detain him for assessment or treatment therein for a period of not more than one month.

9.(1) A person who believes that another person

(a) is suffering from mental disorder, and

(b) should be examined in the interests of his own safety or the safety of others,

may give information on oath to a judge of the Provincial Court, and if upon inquiry the judge is satisfied that

(c) such examination is necessary, and

(d) such other person refuses to submit to a medical examination, the judge may issue his order for examination in the prescribed form.

(2) In every order under this section it shall be stated and shown clearly that the judge issuing the order made due inquiry into all of the facts necessary for him to form a satisfactory opinion.

(3) An order under this section may be directed to all or any constables or other peace officers and shall name or otherwise describe the person with respect to whom the order has been made.

(4) Notwithstanding subsection (3) the order may be directed to a relative or friend of the person subject to the order where that relative or friend so requests.

(5) An order under this section shall direct, and is sufficient authority for, any person to whom it is addressed to take the person named or described therein to an appropriate place where he may be detained for medical examination.

10. Where a constable or other peace officer observes a person

(a) apparently suffering from mental disorder, and

(b) acting in a manner that in a normal person would be disorderly,

the officer may, if he is satisfied that

(c) the person should be examined in the interests of his own safety or the safety of others, and

(d) the circumstances are such that to proceed under section 9 would be dangerous,

take the person to an appropriate place where he may be detained for medical examination.

11. An examination referred to in section 9 or 10 shall be conducted forthwith and, wherever practicable, the place of examination shall be a psychiatric or other medical facility.

12. An informal patient may, upon completion of the prescribed form, be continued as an involuntary patient, and in any such case section 8 applies *mutatis mutandis*.

13.(1) The period of detention of an involuntary patient may be extended upon the completion of a certificate of renewal in the prescribed form by the attending physician upon personal examination.

(2) The attending physician shall not complete a certificate of renewal unless in his opinion the patient

(a) suffers from mental disorder of a nature or degree so as to require further hospitalization in the interests of his own safety or the safety of others, and

(b) is not suitable to be continued as an informal patient.

(3) A certificate of renewal is authority to detain the patient for treatment as follows:

(a) a first certificate is valid for not more than two additional months from the date of expiration of time specified under subsection 8(5);

(b) a second certificate is valid for not more than three additional months from the date of expiration of the first certificate;

(c) a third certificate is valid for not more than six additional months from the date of expiration of the second certificate;

(d) a fourth certificate is valid for not more than twelve additional months from the date of expiration of the third certificate;

(e) each subsequent certificate is valid for not more than twelve additional months from the date of expiration of the last certificate issued.

(4) An involuntary patient whose authorized period of detention has expired shall be deemed to be an informal patient.

(5) An involuntary patient whose authorized period of detention has not expired may be continued as an informal patient upon completion of the prescribed form by the attending physician.

14.(1) Where the presiding judge has reason to believe that a person who appears before him charged with or convicted of an offence suffers from mental disorder, he may order that person to attend a psychiatric facility for examination.

(2) Where an examination is made under this section, a report on the

mental condition of the person shall be communicated in writing to the judge by the medical director.

(3) If the medical director reports that the person examined needs treatment, the judge may order the person to attend a psychiatric facility for treatment.

15.(1) Where the presiding judge has reason to believe that a person in custody who appears before him charged with an offence suffers from mental disorder, the judge may, by order, remand that person for admission as a patient to a psychiatric facility for a period of not more than two months.

(2) Before the expiration of the time mentioned in such order, the medical director shall report in writing to the judge as to the mental condition of the person.

16. A judge shall not make an order under section 14 or 15 until he ascertains from the officer-in-charge of a psychiatric facility that the services of the psychiatric facility are available to the person to be named in the order.

17. Notwithstanding this or any Act or any regulation made under any other Act, the medical director may report all or any part of the information compiled by the psychiatric facility to any person where, in the opinion of the medical director, it is in the best interests of the person who is the subject of an order made under section 14 or 15.

18. Any person who, pursuant to the *Criminal Code*, chapter C-34 of the Revised Statutes of Canada, 1970, is

(a) remanded to custody for observation, or

(b) detained under the authority of a Warrant of the Lieutenant-Governor,

may be admitted to, detained in, and discharged from a psychiatric facility in accordance with the law.

25.(1) Upon the advice of the attending physician, the officer-in-charge of the psychiatric facility may, if otherwise permitted by law and subject to arrangements being made with the officer-in-charge of another psychiatric facility, transfer a patient to that other psychiatric facility upon completing a memorandum of transfer in the prescribed form.

(2) Where a patient is transferred under subsection (1), the authority to detain him continues in force in the psychiatric facility to which he is so transferred.

26.(1) Upon the advice of the attending physician that a patient requires care or treatment that cannot be supplied in the psychiatric facility, the officer-in-charge may, if otherwise permitted by law, transfer the patient for that purpose to a facility where such care or treatment is available and return him to the psychiatric facility upon the conclusion thereof.

(2) Where a patient is transferred under subsection (1), authorities of that facility have, in addition to the powers conferred upon them by any other Act, the powers under this Act of an officer-in-charge of a psychiatric facility in respect of the custody and control of the patient.

27. Where the Director has reason to believe that it would be in the best interests of an involuntary patient in a psychiatric facility in New Brunswick to be hospitalized in a psychiatric facility in another jurisdiction, the Director, with the approval of the Minister and upon compliance with the laws respecting hospitalization in that jurisdiction, may by order in the prescribed form authorize the patient's transfer thereto and detention therein.

28.(1) Where the Director has reason to believe that an involuntary patient of a psychiatric facility in another jurisdiction may be hospitalized in a psychiatric facility in New Brunswick, the Director, with the approval of the Minister, may by order in the prescribed form authorize the patient's transfer thereto and admission therein.

(2) A patient transferred to a psychiatric facility under subsection (1) shall be admitted as an involuntary patient under section 8.

29.(1) A patient shall be discharged from a psychiatric facility when he is no longer in need of the observation, care and treatment provided therein.

(2) Subsection (1) does not authorize the discharge into the community of a patient who is subject to detention otherwise than under this Act.

30.(1) There shall be one or more review boards appointed by the Lieutenant-Governor in Council.

(2) Each review board shall consist of three persons, one of whom is a judge of The Court of Queen's Bench of New Brunswick who shall act as chairman, one of whom is a psychiatrist, and one of whom is not a barrister and solicitor or a physician.

(3) The Lieutenant-Governor in Council may appoint alternate members for each review board, and, where for any reason a member of the review board cannot act as a member, an alternate member appropriate to comply with subsection (2) shall act in his stead.

(4) An officer or servant of a psychiatric facility shall not act as a member of a review board when the case of a patient of that facility is being reviewed.

(5) A member shall hold office for the period not to exceed three years, as is specified in his appointment, but is eligible for reappointment at the expiration of his term of office.

(6) The three members of a review board constitute a quorum, and the decision of a majority is the decision of the review board.

(7) For the purposes of any hearing or inquiry conducted under this Act the members of the review board have all the powers conferred upon commissioners under the *Inquiries Act*.

31.(1) An involuntary patient, or any person on his behalf, may apply in the prescribed form to the chairman of the review board having jurisdiction to inquire into whether the patient suffers from mental disorder

of a nature or degree so as to require hospitalization in the interests of his own safety or the safety of others.

(2) An application under subsection (1) may be made

(a) when any certificate of renewal respecting the patient comes into force, or

(b) when the patient, after having been admitted to a psychiatric facility, is subsequently continued as an involuntary patient.

(3) An application under subsection (1) may be made at any time by the Minister, the Director, or the officer-in-charge in respect of any involuntary patient.

32.(1) Upon receipt by the chairman of a review board of an application in writing the review board shall conduct such inquiry as it considers necessary to reach a decision and may hold a hearing, which in the discretion of the review board may be *in camera*, for the purpose of receiving oral testimony.

(2) Where a hearing is held, the patient has the right to be personally present, unless the review board is of the opinion that this would be detrimental to his health, in which case he has the right to be represented.

(3) Where a hearing is held, the patient or his representative may call witnesses, cross-examine witnesses, and make submissions.

(4) The review board or any member thereof may interview a patient or other person in private.

33.(1) Upon the conclusion of an inquiry, the chairman shall prepare a written report of the decision of the review board and within the time prescribed in the regulations transmit a copy thereof to the applicant and to the officer-in-charge where he is not the applicant.

(2) Upon receipt of a copy of the decision, the officer-in-charge shall take any action required to give effect thereto.

(3) Nothing in this section shall permit the discharge into the community of a person who is subject to detention otherwise than under this Act.

34.(1) The case of every patient in a psychiatric facility who is detained under the authority of a Warrant of the Lieutenant-Governor under the *Criminal Code*, chapter C-34 of the Revised Statutes of Canada, 1970 shall be considered by a review board once in every year, commencing with the year next after the year in which the Warrant was issued.

(2) Notwithstanding subsection (1), a review board shall consider the case of any patient to which that subsection applies at any time upon the written request of the Minister.

(3) Section 32 applies *mutatis mutandis* to cases under this section.

(4) Upon the conclusion of an inquiry, the chairman shall prepare a written report of the recommendations of the review board and, within the time prescribed by the regulations, shall transmit a copy thereof to the Lieutenant-Governor in Council, and may in his discretion transmit a copy thereof to any other person.

[This section not in force.]

66.(1) No action, prosecution or other proceedings shall be brought or be instituted against any officer, nurse, clerk, attendant or other employee of a psychiatric facility, or against any other person, for an act done in pursuance of execution or intended execution of any duty or authority under this Act or the regulations, or in respect of any alleged neglect or default in the execution of any such duty or authority, without the consent of the Attorney General.

(2) All actions and prosecutions against any person, for anything done or omitted to be done in pursuance of this Act, shall be commenced within six months after the act or omission complained of has been committed or occurred, and not afterwards.

(3) No action shall lie against any psychiatric facility or any officer, employee or servant thereof for a tort by any patient.

67. Every person who contravenes or is a party to the contravention, directly or indirectly, of any provision of this Act or the regulations is guilty of an offence and upon summary conviction, is liable to a fine of not less than twenty-five dollars and not exceeding one hundred dollars and, in default of payment is liable to imprisonment in accordance with subsection 31(3) of the *Summary Convictions Act*.

68. . . .

(2) Where, in the opinion of the Minister,

(a) it is impractical for a psychiatric facility for the time being to comply with all provisions of the regulations made under paragraph (1)(b), and

(b) it is in the best interests of the population served by such psychiatric facility,

he may by his authorization in writing, relieve such psychiatric facility from the application of the relevant provision or provisions for such period and upon such conditions as he specifies in the authorization.

Regulation 70-16 under the *Mental Health Act*, as amended.

3.(1) The observation, care and treatment of patients in a psychiatric facility shall be under the supervision of a psychiatrist.

(2) Notwithstanding subsection (1), it shall not be necessary for psychiatric facilities listed in schedule 3 of section 1 to be under the supervision of a psychiatrist.

10.(1) An Application for Review under section 31 of the Act may be made where the attending physician or the officer-in-charge has received a request for the discharge of a patient and such request has been denied.

(2) An Application for Review under section 42 of the Act may be made where the attending physician or the officer-in-charge has received a request for cancellation of the Certificate of Incompetence or Notice of Continuance from the patient or former patient and such request has been denied.

(3) An Application for Review shall be endorsed by the attending physician or officer-in-charge with the particulars prescribed therein.

11. Where a request for the discharge of a patient has been denied, the patient or other person to whom the denial is made shall be advised of any rights he may have to make application to a review board.

12. Every psychiatric facility in respect of which a review board has jurisdiction, shall provide Applications for Review and envelopes pre-addressed to the chairman of the review board having jurisdiction, and an Application and envelope shall be furnished forthwith to any person who requests them.

13. When an Application for Review is completed by or on behalf of a patient and presented to his attending physician or the officer-in-charge for endorsement of particulars, such physician or the officer-in-charge shall so endorse the Application as soon as possible and return it to the applicant.

14. The written report of the decision of a review board referred to in section 33 of the Act shall be transmitted to the persons described therein within seven days after the decision is reached, and not later than one month from the date of receipt of the Application for Review by the chairman.

NEWFOUNDLAND

The Mental Health Act, 1971, S.N. 1971, No. 80, as amended.

6.(1) Subject to subsection (2), any person, who in the opinion of a physician is suffering from mental disorder to such a degree that the person requires hospitalization in the interests of his own safety, safety to others or safety to property, may without his consent be admitted to, detained within and treated at a treatment facility.

(2) Subject to this Act, no person shall be admitted to and detained within a treatment facility without his consent unless two physicians, whose opinions it is that the person is suffering from mental disorder to the degree specified in subsection (1) of this section, subscribe to a certificate of authorization in accordance with the following provisions of this Act.

(3) A certificate bearing the subscription of one physician shall be sufficient authority for any person to convey the person in respect of whom the certificate is subscribed to a safe and comfortable place and detain him there until he is medically examined by another physician.

(4) A certificate shall not be subscribed to by either physician

(a) until he has personally examined the person named in the certificate as being the person who is suffering from mental disorder to the degree specified in subsection (1) of this section and has made enquiry from such records or sources as may be reasonably necessary to enable him to reach his opinion;

(b) unless it is made and dated within seven days of the personal examination required under paragraph (a);

(c) if the physician is the father, mother, son, daughter, husband or wife of the person or is closely related to or connected with the person by blood or marriage.

(5) The certificate shall be as near as circumstances permit to the form prescribed in the regulations, and shall state or specify

- (a) the name and address of the physicians making the certificate;
- (b) the times and places of, and circumstances relating to, the personal examinations of the person;
- (c) with clarity the facts on which the opinions of the physicians are based, distinguishing the facts observed by them and the facts communicated to them by others, and the reasons for the opinions;
- (d) that the person refuses to be admitted to a treatment facility recommended by the physicians; and
- (e) the treatment facility into which the physicians recommend that the person suffering from the mental disorder should be admitted.

7.(1) A certificate granted under this Act and remaining in force shall be sufficient authority for any person to convey the patient to the treatment facility specified in the certificate and, subject to this section, for the administrator or medical director of that treatment facility to admit and detain the patient therein.

(2) Upon admission of a patient pursuant to subsection (1) the patient shall be examined forthwith by the medical director or the attending physician, and the medical director or the attending physician as the case may be, shall, as soon as is medically possible, but in any event not later than fifteen days after admission either

- (a) confirm the certificate, or
- (b) revoke the certificate and discharge the patient forthwith.

(3) Confirmation of a certificate under subsection (2) shall be sufficient authority for the administrator or the medical director of the treatment facility to detain and treat the patient therein for a period of thirty days from the date of the patient's admission.

(4) In the event of the patient not reporting or being conveyed to the treatment facility within fourteen days after the date of the subscription of the certificate by either physician, the certificate shall cease to have effect.

8.(1) On the admission of a patient to a treatment facility the medical director may assign to the patient an attending physician, and there may be assigned to that patient during his period of treatment at a treatment facility different attending physicians.

(2) An attending physician may with the consent of the medical director, or the medical director may at any time revoke the certificate of a physician or a renewal of a certificate issued by him or by another attending physician under this Act.

9.(1) An attending physician may from time to time renew a certificate by granting a certificate of renewal in a form as near as circumstances

permit to the form prescribed in the regulations, but the certificate of renewal shall not be issued until the attending physician

(a) has made personal examination of the patient; and

(b) is satisfied that the patient continues to suffer from mental disorder to the degree specified in subsection (1) of Section 6.

(2) Certificates of renewal from time to time granted under subsection (1) shall be sufficient authority for the administrator or medical director to detain the patient in respect of whom the certificate of renewal is granted without his consent

(a) for a period of one month from the date of the first certificate of renewal;

(b) for a period of two months from the date of the second certificate of renewal;

(c) for a period of three months from the date of the third certificate of renewal;

(d) for a period of six months from the date of the fourth certificate of renewal; and

(e) for a period of one year from the date of every certificate of renewal after the fourth certificate of renewal.

(3) It is a condition of the validity of every certificate of renewal that it shall be granted

(a) in the case of a first certificate of renewal, prior to the expiry of the period specified in subsection (3) of Section 7; and

(b) in the case of every subsequent certificate of renewal, prior to the expiry of the period specified in subsection (2) of this section for the certificate of renewal which preceded it.

10.(1) Where an attending physician is of opinion that the health or interest of the patient would be better served by the transfer of the patient to another treatment facility named by him, whether or not such transfer should be temporary, he shall so notify the medical director, and the medical director may, after making the necessary arrangements with the administrator of the treatment facility named by the attending physician, authorize the transfer of the patient to that treatment facility.

(2) Upon receiving the authority from the medical director under subsection (1), the administrator shall make all necessary arrangements for the transfer of the patient to the treatment facility named in the authorization, and shall forward or cause to have forwarded to the administrator of that treatment facility the case papers and records of the patient or copies thereof.

(3) Upon the transfer of the patient under subsection (1) of this section, the administrator and medical director of the treatment facility to which the transfer is made shall, in addition to other powers conferred on them by law, have the same rights and powers respecting the patient as were held by the administrator and medical director of the treatment facility from which the transfer is made.

12.(1) Where an information on oath is laid before a magistrate that any person named and designated therein who is present within the district in which such magistrate exercises jurisdiction is believed by the informant to be suffering from mental disorder to the degree specified in subsection (1) of Section 6, the magistrate, after making due enquiry, may if he is satisfied

- (a) that the facts alleged in the information are well founded;
- (b) that it is reasonable and proper that the person should be examined by two physicians; and
- (c) that the person has refused or delayed or will refuse or delay to be so examined;

grant a warrant for his examination and such warrant shall be sufficient authority for a police officer or such other person as may be designated in the warrant to take the person named therein to both physicians and to detain the person until both physicians have carried out the examination.

(2) Every warrant granted under this section shall

- (a) contain a statement that the warrant is issued by the magistrate after making due enquiry into the facts and circumstances of the case;
- (b) be addressed to all or any police officers situated within the jurisdiction of the magistrate issuing the warrant, or if in the circumstances it would not be practicable or reasonable to so address the warrant, to such other person as the magistrate shall think fit;
- (c) describe the person in respect of whom the warrant is made; and
- (d) specify the place or places to which the person may be taken and detained for the purposes of examination by two physicians.

(3) The procedure in any hearing conducted pursuant to an enquiry under this section respecting the compelling of witnesses to attend, the taking and hearing of evidence and any other matter pertaining to such enquiry shall insofar as applicable be as near as circumstances permit to the procedure laid down in The Summary Jurisdiction Act.

13. Without prejudice to any right conferred on him by law, where a police officer observes a person acting in a disorderly or dangerous manner, the police officer may, if he has reasonable cause for believing that the person is suffering from mental disorder to the degree specified in subsection (1) of Section 6, and it is impracticable in the circumstances to obtain a warrant from a magistrate under Section 12, apprehend the person, take him to a treatment facility or other safe and comfortable place and detain him until he is medically examined by two physicians.

14.(1) Where a judge or magistrate has reason to believe that a person who appears before him charged with or convicted of an offence suffers from mental disorder, the judge or magistrate may order the person to be examined by a physician.

(2) The physician who carries out the examination under this section shall submit to the appropriate judge or magistrate a written report as to the mental condition of the person and if the report specifies that in the opinion

of the physician the person is or may be suffering from mental disorder and is in need of immediate treatment or observation, the judge or magistrate may

- (i) order the person to attend a treatment facility for treatment, or
- (ii) remand the person for observation to a treatment facility for any period not more than two months.

(3) The medical director of the treatment facility to which a person has been remanded for observation under subsection (2) shall, before the expiration of the period specified in the order or remand, report in writing to the judge or magistrate as to the mental condition of the person and as to whether a certificate has been issued under Section 6 of this Act.

(4) A certificate may be granted in the form and manner provided by this Act in respect of a person ordered to attend for treatment or remanded for observation under subsection (2) of this section, and upon the issuance of such a certificate

- (a) the provisions of this Act shall apply to that person as if he had been admitted following the issuance of that certificate; and
- (b) the period during which the person is detained within the treatment facility shall not be counted in computing the period of remand.

15.(1) Where a certificate is granted in respect of any person who has been convicted of an offence and is imprisoned under the authority of a statute of the province, or who, being charged with an offence under a statute of the province is in custody awaiting disposal of the charge, such person shall be transferred from the prison or other place of confinement to the treatment facility named in the certificate and, subject to this section, the provisions of this Act shall apply to such person during the period the certificate or renewal of the certificate is in force, so however that

- (a) the prior approval of the Minister of Justice shall be required to any treatment facility to which the person is admitted under this section or to which he is transferred under Section 10; and
- (b) the provisions of subsections (1) and (2) of Section 11 shall not be construed so as to limit or prejudice the right of any police officer to arrest and return the person to a prison or place of confinement at any time, if the person would, apart from the issuance of a certificate or renewal of a certificate, continue to be liable to imprisonment or custody.

(2) Upon the expiration or revocation of a certificate or renewal of a certificate granted in respect of a person to whom subsection (1) applies, the administrator of that treatment facility shall, after consultation with the Minister of Justice, either return the person to such prison or other place of confinement or release him as the Minister of Justice may direct.

16.(1) The Minister shall, with the approval of the Lieutenant-Governor in Council, appoint a Review Board, to be known as the Mental Health Review Board consisting of three persons, one of whom is a barrister, who shall act as chairman, one of whom is a physician, and one of whom is not a barrister or physician.

(2) No member of the Review Board shall be a physician, officer or servant of, or any person having a direct financial interest in, a treatment facility.

(3) The members of the Review Board shall

(a) hold office for a term of three years, and are eligible for reappointment on expiry of their term of office;

(b) carry out the functions and duties conferred on them by this Act and the regulations; and

(c) be entitled to such payments for remuneration, travel expenses and other outlays incurred by them in the performance of their duties as are prescribed in the regulations.

(4) Subject to subsection (5), if any member of the Review Board ceases to be a member, or refuses or is unable by reason of illness, disqualification or other cause to act as a member, the Minister shall, with the approval of the Lieutenant-Governor in Council, remove the member who refuses or is unable so to act, and shall forthwith fill the vacancy created by the cessation or removal.

(5) The Minister may, if he is of the opinion that a member of the Review Board is unable, by reason of temporary indisposition, to act as a member for a period not exceeding six months, appoint a member to act in his place for such period, not exceeding six months, as may be specified in the appointment.

17.(1) A patient within a treatment facility, or any person aggrieved and affected by the detention of a patient within a treatment facility, may at any time a certificate or renewal of a certificate is in force in respect of such patient, either personally or through a representative, apply for the discharge of the patient from the treatment facility by filing an application for review, in the form prescribed in the regulations, with the Review Board, and by serving a copy of such application for review

(a) on the medical director of that treatment facility;

(b) if the application is made by the patient or a person who is not the next of kin, on the next of kin; and

(c) on such other person as the Review Board may direct.

(2) The application for review shall, in addition to the matters prescribed in the regulations, set out in detail the facts on which the application is based, the reasons why the certificate or renewal of a certificate should be revoked, and, where it is made by a person other than the patient, the grounds of grievance and the extent to which the person is affected by the detention of the patient within the treatment facility.

(3) The medical director, the next of kin and such other person on whom service of a copy of the application for review has been made, may lodge with the Review Board answers to the application within seven days from the date of receipt by him or them of the copy of the application for review.

(4) An application for review under subsection (1) may be made at any time by the Deputy Minister in respect of a patient detained within any treatment facility under this Act, or by the medical director of a treatment facility in which a patient is so detained.

18.(1) The Review Board may, with the approval of the Minister, dismiss an appeal summarily if

(a) the appeal is vexatious or frivolous or is not made in good faith;

(b) the person appealing has not a sufficient personal interest in the subject matter of the appeal; or

(c) the application is made by or on behalf of a patient or person who has already appealed against his or the patient's continued detention within a treatment facility on grounds and for reasons which have already been determined by the Review board as being insufficient to order the discharge of the patient, and is made within six months of the earlier determination.

(2) Subject to subsection (1) of this section, the Review Board shall determine the application for review by conducting such enquiry as it considers necessary to reach a decision, and shall hold a hearing, which, in the discretion of the Review Board, may be in camera.

(3) When a hearing is held under this section, the patient or person applying for the review, the medical director, the next of kin and any other person on whom service of the application for review has been made, or their respective representatives, may call witnesses, produce documents and make submissions to the Review Board, and for the purposes of any hearing of the Review Board, each member thereof is vested with all the powers that are conferred on a commissioner by or under The Public Enquiries Act, and the Review Board is deemed to be an investigating body for the purposes of The Evidence (Public Investigations) Act, and there shall be full right to examine and cross-examine all witnesses called and to adduce evidence in reply, and without limitation of the generality of the foregoing, the provisions of Section 3 of The Public Enquiries Act shall apply to all such witnesses.

(4) The administrator or the medical director of the appropriate treatment facility shall, for the purposes of a review, furnish the Review Board with such information and reports respecting the patient affected by the review as the Review Board requests.

(5) Nothing in this section shall require the attendance of the patient at a hearing of the Review Board if the Review Board so directs, but the Review Board, or any member thereof may interview the patient in private for the purpose of assisting it in reaching a decision on the review.

19.(1) Upon the conclusion of an enquiry under Section 18, the Review Board shall prepare or cause to be prepared a written report on the proceedings of the review which report shall contain the decision of the Review Board and be signed by the chairman.

(2) Where the members of the Review Board are not unanimous, the decision of a majority is a decision of the Review Board.

(3) The Review Board shall have power to order the discharge of a patient from a treatment facility and, if such order is made, it shall be recorded in the decision of the Review Board.

(4) The report and decision of the Review Board shall be intimated to the applicant for the review, the Deputy Minister, the medical director, the

next of kin and any other person on whom service of the application for review has been made, and the medical director shall, if the decision contains an order of discharge, forthwith discharge or cause to have discharged the patient from the treatment facility.

(5) Subject to subsection (6), the findings of the Review Board on questions of fact are final and are not subject to appeal to a court of law.

(6) Nothing in this Act shall affect the right of any person aggrieved by a decision of the Review Board

(a) to appeal to the Supreme Court against such decision on a question of law, and for the purpose of such appeal the rules applicable to appeals made under The Judicature Act shall apply as if the decision of the Review Board was a decision of a judge of the District Court; or

(b) to apply to the Supreme Court for a review under writ of mandamus, certiorari or other prerogative writ.

20.(1) It shall be the duty of the physicians who grant a certificate to ensure that the medical director of the treatment facility named by them in the certificate has consented to the admission of such person to that treatment facility.

(2) Nothing in this Act shall require a medical director to admit any person to a treatment facility unless

(a) upon an order of a judge or magistrate, or

(b) in the case of a person in respect of whom a certificate has been issued, prior consent to the admission has been given by the medical director or a member of the staff of the treatment facility.

21. If the administrator, medical director, or any officer, servant or other person employed in a treatment facility maltreats, abuses or neglects any patient, or obstructs patients from communication with the Review Board, such administrator, medical director, officer, servant or other person shall be guilty of an offence and shall be liable on summary conviction to a penalty not exceeding five hundred dollars, or in default, to imprisonment for a period not exceeding six months.

CHAPTER 6

AN ACT RESPECTING MENTALLY DISORDERED PERSONS

(Assented to June 13, 1985)

Recognizing the many cultures of the peoples of the Territories, culture should be taken into account when assessing or examining a person to determine whether or not he is suffering from a mental disorder; and

Being committed to the principle that mental health services should be provided in the least restrictive manner;

The Commissioner of the Northwest Territories, by and with the advice and consent of the Legislative Assembly, enacts as follows:

Short Title

1. This Act may be cited as the *Mental Health Act*.

Short title

Interpretation

2. In this Act

Definitions

"appeal" means an appeal pursuant to section 30 of this Act;

"appeal"

"Commissioner" includes a person appointed by him pursuant to section 5 or 6;

"Commissioner"

"Minister" includes a person appointed by him pursuant to section 5 or 6;

"Minister"

"hospital" means a medical facility or other place designated by order of the Minister, whether located within or outside the Territories, for the observation, examination, care or treatment of a mentally disordered person;

"hospital"

"lay dispenser" means a person who is authorized by a Medical Health Officer, appointed pursuant to the *Public Health Act*, to administer emergency first aid in a community which is without a resident nurse;

"lay dispenser"

"medical practitioner" means a person who is entitled to practise medicine in the Territories pursuant to the *Medical Profession Act*;

"medical practitioner"

"mental disorder"	"mental disorder" means a substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life but mental retardation or a learning disability does not of itself constitute a mental disorder;
"mentally competent"	"mentally competent" means having the ability to understand the subject matter in respect of which consent is requested and the ability to appreciate the consequences of giving or withholding consent;
"nearest relative"	<p>"nearest relative" means</p> <ul style="list-style-type: none"> (i) a spouse who is mentally competent and of any age, including anyone who, although not legally married to a person, lives or cohabits with that person as a spouse of that person and is known as such in the community in which they live; or (ii) if there is no spouse or if the spouse is not available, any child who has attained the age of majority and is mentally competent; or (iii) if there are none of the above or if none are available, a parent who is mentally competent or a guardian; or (iv) if there are none of the above or if none are available, any brother or sister who has attained the age of majority and is mentally competent; or (v) if there are none of the above or if none are available, any other of the next of kin who has attained the age of majority and is mentally competent;
"prescribed"	"prescribed" means prescribed by the Commissioner by regulation;
"psychologist"	"psychologist" means a person who is entitled to practise psychology in the Territories pursuant to the <i>Psychologists Act</i> ;
"Public Trustee"	"Public Trustee" means the Public Trustee as defined in the <i>Public Trustee Act</i> ;
"restrain"	"restrain" means to keep under control by the minimal use of such force or mechanical or chemical means as is reasonable having regard to the physical and mental condition of the patient;
"review"	"review" means a review pursuant to section 27 of this Act.

Agreements

Agreements
with a
province

3. Subject to section 49 of the *Northwest Territories Act* (Canada), the Commissioner may, on behalf of the Government of

the Northwest Territories, enter into agreements with a provincial government for the admission of a person who is suffering from a mental disorder to a hospital in that province.

4. The Minister may, on behalf of the Government of the Northwest Territories, enter into agreements with the Government of Canada or a provincial government respecting this Act or the regulations and, in particular, but not so as to restrict the generality of the foregoing,

Agreements
with the
Government
of Canada or
a provincial
government

- (a) the conveyance of a voluntary or involuntary patient from the Territories to a hospital in a province;
- (b) the acceptance of a voluntary or involuntary patient by a hospital in a province;
- (c) the conveyance of an involuntary patient for a review or appeal hearing from a hospital in a province to the Territories;
- (d) the review by a review board of a province;
- (e) the patient's rights;
- (f) the periodical reports concerning a voluntary or involuntary patient;
- (g) the discharge of a voluntary or involuntary patient;
- (h) the discharge notices; and
- (i) the examination of persons on remand or under an order of the Commissioner pursuant to the *Criminal Code* (Canada).

Appointments

5. The Commissioner and the Minister may jointly appoint a person for the whole or a part of the Territories to act on their behalf for the purposes of sections 17, 18 and 20.

Joint
appointment

6. Notwithstanding section 5, where the Commissioner or the Minister do not agree on a joint appointment

Appointment by
Commissioner
or Minister

- (a) the Commissioner may appoint a person for the whole or part of the Territories to act on his behalf for the purposes of section 20; and
- (b) the Minister may appoint a person for the whole or a part of the Territories to act on his behalf for the purposes of sections 17 and 18.

Voluntary Patients

Voluntary
admission

7. A hospital may admit a person who is suffering from a mental disorder upon the written recommendation of a medical practitioner and with the written consent of the person being admitted where that person has attained the age of majority and is mentally competent to give a valid consent.

Involuntary Psychiatric Assessment

Application

8.(1) This section applies notwithstanding any other provision of this Act.

Consultation
with elder

(2) Where a medical practitioner is conducting a psychiatric assessment pursuant to section 9, 10, 11, 12 or 13 or an examination pursuant to section 14, of an aboriginal person who does not speak English or French fluently and who speaks an official aboriginal language fluently, he shall, if practicable, and with the consent of the aboriginal person where that person has attained the age of majority and is mentally competent to give a valid consent, consult with an elder who is from the same community and of the same cultural background as the aboriginal person and who knows the aboriginal person, and obtain the opinion of the elder as to whether the aboriginal person is suffering from a mental disorder of a nature or quality that will likely result in

- (a) serious bodily harm to that aboriginal person,
- (b) serious bodily harm to another person, or
- (c) imminent and serious physical impairment of that aboriginal person.

Authority to
detain during
consultation

(3) The length of time required to consult with an elder under subsection (2) shall be added to the length of time a medical practitioner is otherwise given under this Act to perform a psychiatric assessment of a person pursuant to section 9, 10, 11, 12 or 13 or an examination pursuant to section 14, and consultation pursuant to subsection (2) is sufficient authority for a medical practitioner to detain an aboriginal person in custody at a hospital within the Territories for the length of time required to complete the consultation.

Order for
psychiatric
assessment

9.(1) Where a medical practitioner examines a person and has reasonable cause to believe that the person

- (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;
- (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him, or
- (c) has shown or is showing a lack of competence to care for himself,

and the medical practitioner requires more time to gather information before forming an opinion as to whether that person is suffering from a mental disorder of a nature or quality that will likely result in

- (d) serious bodily harm to that person,
- (e) serious bodily harm to another person, or
- (f) imminent and serious physical impairment of that person,

the medical practitioner may order the detention of that person at a hospital within the Territories for psychiatric assessment by a medical practitioner where the person has not attained the age of majority or is not mentally competent to give a valid consent to undergo a psychiatric assessment or, if he has attained the age of majority and is mentally competent to give such consent, refuses to undergo a psychiatric assessment.

(2) An order made pursuant to subsection (1) is sufficient authority to detain the person who is the subject of the order in custody at a hospital within the Territories for a period of forty-eight hours beginning immediately after the examination referred to in subsection (1) is performed.

Authority of
the order

(3) A medical practitioner who orders the detention of a person pursuant to subsection (1) shall, within twenty-four hours of the examination which led to the issuing of the order pursuant to subsection (1), send a report respecting the order of detention under his signature to the Minister.

Report to
Minister

(4) A medical practitioner, in a report made pursuant to subsection (3), shall

Contents
of report

- (a) state that he personally examined the person who is detained and that he required more time beyond the examination under subsection (1) to observe the person in order to form his opinion as to whether that person is suffering from a mental disorder of a nature or quality that will likely result in serious bodily harm to that person or to another person;

- (b) set out the facts upon which he issued the order, distinguishing the facts observed by him from the facts communicated to him by others; and
- (c) state the date upon which the examination was made.

Application
for an order
of psychiatric
assessment

10.(1) A person may make an application, supported by an affidavit, to a justice or a territorial judge for an order to have the person named in the application undergo a psychiatric assessment by a medical practitioner.

Contents of
application

(2) The applicant shall state

- (a) the name of the person who is the subject of the application;
- (b) whether that person
 - (i) has threatened or attempted or is threatening or attempting to cause bodily harm to himself,
 - (ii) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him, or
 - (iii) has shown or is showing a lack of competence to care for himself,

and that he has reasonable and probable cause to believe that the person is apparently suffering from a mental disorder of a nature or quality that will likely result in

- (c) serious bodily harm to that person,
- (d) serious bodily harm to another person, or
- (e) imminent and serious physical impairment of that person.

Notice

(3) A justice or a territorial judge, as the case may be, shall give two days' notice of the hearing to the person who is the subject of the application unless the justice or territorial judge, as the case may be, is satisfied that no notice is necessary or that the delay caused by proceeding by notice might entail serious mischief.

Hearing

(4) The justice or territorial judge shall conduct a hearing on the application and hear evidence concerning

- (a) the alleged mental disorder, including
 - (i) medical or psychological evidence, wherever practicable,
 - (ii) testimony of the applicant, and
 - (iii) testimony of the subject of the application, wherever practicable; and

- (b) any other matter that the justice or territorial judge, as the case may be, deems relevant.

(5) Where the justice or territorial judge, as the case may be, based upon the information before him is of the opinion that the person who is the subject of the application is apparently suffering from a mental disorder of a nature or quality that will likely result in

Order for
psychiatric
assessment

- (a) serious bodily harm to that person,
(b) serious bodily harm to another person, or
(c) imminent and serious physical impairment of that person,

the justice or territorial judge, as the case may be, may issue an order in the prescribed form authorizing the psychiatric assessment of the person who is the subject of the application by a medical practitioner.

(6) A justice or a territorial judge, as the case may be, who issues an order pursuant to subsection (5) may direct that order to all peace officers within the Territories and shall name and describe the person with respect to whom the order has been made.

Order directed
to peace
officer

(7) An order made pursuant to subsection (5) is sufficient authority for any peace officer to whom it is directed, for a period not to exceed seven days from and including the day upon which the order is made, to take the person named and described in custody to a medical practitioner or hospital within the Territories without delay where that person may be detained at a hospital within the Territories for psychiatric assessment by a medical practitioner for a period not to exceed forty-eight hours from the time the person is transferred into the custody of the medical practitioner or hospital.

Authority
of the order

(8) Where a peace officer transfers the custody of a person named and described in an order made pursuant to subsection (5) to a medical practitioner or a hospital, a medical practitioner shall not issue an order referred to in subsection 9(1).

Order of
medical
practitioner
prohibited

(9) Where an application is made pursuant to subsection (1) to a justice for an order, the justice may exercise his jurisdiction pursuant to this Act or redirect that application to a territorial judge without delay.

Justice may
redirect
application

11.(1) Where a psychologist has reasonable and probable cause to believe that a person

Action by
psychologist

- (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself,

- (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him, or
- (c) has shown or is showing a lack of competence to care for himself,

and, if based upon the information before him, the psychologist is of the opinion that the person is apparently suffering from a mental disorder of a nature or quality that will likely result in

- (d) serious bodily harm to that person,
- (e) serious bodily harm to another person, or
- (f) imminent and serious physical impairment of that person,

and the circumstances are such that to proceed under section 10 would be unreasonable or would result in a delay that would likely result in serious bodily harm to that person or to another person or in imminent and serious physical impairment of that person, the psychologist may take that person in custody without delay to a medical practitioner or a hospital within the Territories for psychiatric assessment by a medical practitioner.

Written
statement

(2) Where a psychologist delivers a person apprehended pursuant to subsection (1) to a medical practitioner or a hospital, he shall provide the medical practitioner or hospital, as the case may be, with a written statement relating the circumstances which led him to act.

Action by
peace officer

12.(1) Where a peace officer has reasonable and probable cause to believe that a person

- (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself,
- (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him, or
- (c) has shown or is showing a lack of competence to care for himself,

and, if based upon the information before him, the peace officer is of the opinion that the person is apparently suffering from a mental disorder of a nature or quality that will likely result in

- (d) serious bodily harm to that person,
- (e) serious bodily harm to another person, or

- (f) imminent and serious physical impairment of that person,

and the circumstances are such that to proceed under section 10 would be unreasonable or would result in a delay that would likely result in serious bodily harm to that person or to another person or in imminent and serious physical impairment of that person, the peace officer may take that person in custody without delay to a medical practitioner or a hospital within the Territories for psychiatric assessment by a medical practitioner.

(2) Where a peace officer delivers a person apprehended pursuant to subsection (1) to a medical practitioner or a hospital, he shall provide the medical practitioner or hospital, as the case may be, with a written statement relating the circumstances which led him to act. Written statement

13.(1) Where a peace officer is not available and it would be unreasonable to wait for a peace officer to act pursuant to section 12, a person who has reasonable and probable cause to believe that another person Action by private person

- (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself,
- (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him, or
- (c) has shown or is showing a lack of competence to care for himself,

and, if based upon the information before him, the person is of the opinion that the other person is apparently suffering from a mental disorder of a nature or quality that will likely result in

- (d) serious bodily harm to that person,
- (e) serious bodily harm to another person, or
- (f) imminent and serious physical impairment of that person,

and the circumstances are such that to proceed under section 10 would be unreasonable or would result in a delay that would likely result in serious bodily harm to that person or to another person or in imminent and serious physical impairment of that person, the person may take the other person in custody without delay to a medical practitioner or a hospital within the Territories for psychiatric assessment by a medical practitioner.

Transfer to
peace officer

(2) A person who has apprehended a person pursuant to subsection (1) shall,

- (a) where a peace officer becomes available before he has taken the apprehended person to a medical practitioner or hospital for psychiatric assessment, transfer the custody of the apprehended person to a peace officer, and
- (b) where he delivers the apprehended person to a medical practitioner or hospital, provide the medical practitioner or hospital, as the case may be, with a written statement relating the circumstances which led him to act.

Certificate of Involuntary Admission

Examination

14. Where a medical practitioner examines a person and has reasonable cause to believe that the person

- (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself,
- (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him, or
- (c) has shown or is showing a lack of competence to care for himself,

and, if based upon the information before him, the medical practitioner is of the opinion that that person is apparently suffering from a mental disorder of a nature or quality that will likely result in

- (d) serious bodily harm to that person,
- (e) serious bodily harm to another person, or
- (f) imminent and serious bodily impairment of that person,

unless the person remains in the custody of a hospital, the medical practitioner shall

- (g) admit the person as a voluntary patient to a hospital if he is of the opinion that the person is suffering from a mental disorder of such a nature or quality that the person is in need of the care or treatment provided in a hospital, where the person has attained the age of majority and is mentally competent to give a valid consent and consents to being admitted as a voluntary patient; or

- (h) apply to admit the person as an involuntary patient to a hospital by completing and filing with the Minister an application for a certificate of involuntary admission as set out in section 16, where the person has not attained the age of majority or is not mentally competent to give a valid consent or, if he has attained the age of majority and is mentally competent to give such a consent, refuses to be hospitalized as a voluntary patient.

15. Where a medical practitioner performed a psychiatric assessment pursuant to section 9, 10, 11, 12 or 13, he shall

Involuntary
admission
pursuant to
psychiatric
assessment

- (a) where the person is detained pursuant to section 9 or 10 and the period of detention has not expired, release the person if he is of the opinion that the person is not suffering from a mental disorder of a nature or quality that will likely result in serious bodily harm to that person or to another person;
- (b) admit the person as a voluntary patient to a hospital if he is of the opinion that the person is suffering from a mental disorder of such a nature or quality that the person is in need of the care or treatment provided in a hospital, where the person has attained the age of majority and is mentally competent to give a valid consent and consents to being admitted as a voluntary patient; or
- (c) apply to admit the person as an involuntary patient to a hospital by completing and filing with the Minister an application for a certificate of involuntary admission, as set out in section 16, if he is of the opinion that the person is suffering from a mental disorder of a nature or quality that likely will result in
- (i) serious bodily harm to the person,
 - (ii) serious bodily harm to another person, or
 - (iii) imminent and serious physical impairment of that person,

unless the person remains in the custody of a hospital, and the person has not attained the age of majority or is not mentally competent to give a valid consent or, if he has attained the age of majority and is competent to give such a consent, refuses to be hospitalized as a voluntary patient.

16.(1) Where a medical practitioner applies to the Minister to admit a person as an involuntary patient, pursuant to paragraph 14(h) or 15(c), he shall, in the prescribed application,

Contents of
application

- (a) state that he has personally examined the person who is the subject of the application and has made a careful inquiry into all the facts necessary for him to form his opinion as to the nature and quality of the mental disorder of the person;
- (b) set out the facts upon which he formed his opinion as to the nature and quality of the mental disorder, distinguishing the facts observed by him from the facts communicated to him by others;
- (c) state the date upon which the examination referred to in section 14 was performed or the psychiatric assessment referred to in section 9, 10, 11, 12 or 13 was performed; and
- (d) indicate whether in his opinion the person ought to be transferred to a hospital outside the Territories.

Time to
complete the
application

(2) A medical practitioner shall complete the application made pursuant to paragraph 14(h) or 15(c) within twenty-four hours of the examination referred to in section 14 or psychiatric assessment referred to in section 9, 10, 11, 12 or 13.

Order of
medical
practitioner

(3) Where a medical practitioner decides to apply to admit a person as an involuntary patient pursuant to paragraph 14(h) or 15(c), he may order the detention of that person at a hospital within the Territories.

Authority of
application

(4) An order made pursuant to subsection (3) is sufficient authority to detain the person who is the subject of the order in custody at a hospital within the Territories for a period not to exceed forty-eight hours from the time the examination referred to in section 14 was performed or the psychiatric assessment referred to in section 9, 10, 11, 12 or 13 was performed.

Duties of
Minister

17.(1) The Minister, upon receipt of an application made pursuant to paragraph 14(h) or 15(c), shall examine the application to ascertain if the medical practitioner

- (a) has examined or performed a psychiatric assessment of the person who is the subject of the application; and
- (b) has completed the application as required by subsection 16(1) within the twenty-four hours referred to in subsection 16(2).

Decision of
Minister

(2) Once he has examined the application, the Minister may, within twenty-four hours of the receipt of the application referred to in subsection (1),

- (a) refuse the application and release from custody the person who is the subject of the application;
- (b) order that a psychiatric assessment be performed of the person who is the subject of the application, within forty-eight hours of that order, before refusing or approving the application; or
- (c) approve the application and issue a certificate of involuntary admission in the prescribed form.

(3) The medical practitioner who examines a person under an order made pursuant to paragraph (2)(b) shall report, in writing, to the Minister on the mental condition of that person before the expiration of the forty-eight hours stated in the order.

Written report

(4) The Minister may, within twenty-four hours of the receipt of the report referred to in subsection (3), refuse or approve the application made pursuant to paragraph 14(h) or 15(c).

Time for refusing or approving the application

(5) An order made pursuant to paragraph (2)(b) is sufficient authority for a medical practitioner to detain at a hospital within the Territories the person named in the order for a period not to exceed seventy-two hours from the time that the person is detained under the order.

Authority of order

(6) Where the medical practitioner has indicated on an application, made pursuant to paragraph 14(h) or 15(c), that the person who is the subject of the application ought to be transferred to a hospital outside the Territories because a hospital within the Territories is not equipped to restrain, observe, examine or treat that patient, the Minister shall, once he has issued a certificate of involuntary admission, without delay, forward the application to the Commissioner.

Transfer of application to Commissioner

18. Where the Minister, due to unusual circumstances, cannot approve and issue a certificate of involuntary admission within the time set out in subsection 17(2) or (4), he may order the extension of the period of detention set out in subsection 16(4) or 17(5) by one additional period which shall not exceed forty-eight hours.

Extension of time

19. A certificate of involuntary admission is sufficient authority, for a hospital within the Territories to admit and detain the person who is the subject of the certificate and to restrain, observe, examine or treat him for a period not to exceed seventy-two hours from the time the person is admitted to a hospital pursuant to the certificate.

Authority of certificate

Certificate
of transfer

20.(1) The Commissioner, upon receipt of an application which the Minister has forwarded pursuant to subsection 17(6) and having examined the application to ascertain that the provisions of this Act and the regulations have been complied with, may issue a certificate of transfer.

Authority of
certificate

(2) Subject to subsection (3), a certificate of transfer issued pursuant to subsection (1) is sufficient authority to arrange to transfer and to transfer the person named in the certificate to a hospital outside the Territories.

No transfer

(3) Notwithstanding subsection (2), an involuntary patient who is the subject of a certificate of transfer shall not be transferred to a hospital outside the Territories where that patient has filed an application for review or appeal until

- (a) the review is heard and decided and the time for an appeal has expired or the applicant withdraws his application or the Supreme Court dismisses the application, or
- (b) the appeal is heard and decided or the appellant abandons the appeal or the Court of Appeal dismisses the appeal

unless a medical practitioner is of the opinion that a hospital within the Territories is not equipped to restrain, observe, examine or treat that patient.

Treatment

Emergency
treatment
by a medical
practitioner

21.(1) A medical practitioner who examines a person pursuant to section 14 or assesses a person pursuant to section 9, 10, 11, 12 or 13 may administer emergency medical or psychiatric treatment to the person being examined or assessed where

- (a) the person has attained the age of majority and is mentally competent to give a valid consent, consents or, where the person has not attained the age of majority or is not mentally competent to give such a consent, the person's nearest relative consents; or
- (b) the person has attained the age of majority and is mentally competent to give a valid consent, refuses to consent or, where the person has not attained the age of majority or is not mentally competent to give such a consent, the person's nearest relative refuses to consent and
 - (i) the treatment is necessary to preserve the life or mental or physical health of that person,

- (ii) the failure to give the treatment or delay in giving the treatment would create a reasonably foreseeable risk of injury to that person or any other person, and
- (iii) the treatment cannot reasonably be delayed through alternative means of detention.

(2) A nurse duly registered pursuant to the *Nursing Profession Act* or a lay dispenser shall not administer ~~emergency~~ medical or psychiatric treatment to a person who is in custody pursuant to section 10, 11, 12 or 13 unless

Emergency treatment by a nurse or a lay dispenser

- (a) that person cannot be immediately placed under the care of a medical practitioner;
- (b) the treatment is necessary to preserve the life or mental or physical health of that person;
- (c) the failure to give the treatment or a delay in giving the treatment would create a reasonably foreseeable risk of injury to that person or any other person;
- (d) the treatment cannot be reasonably delayed through an alternative means of detention; and
- (e) the nurse or the lay dispenser communicates with a medical practitioner who authorizes the treatment or makes every reasonable attempt to communicate with a medical practitioner before administering the treatment.

22. Subject to section 23, a medical practitioner may administer medical or psychiatric treatment for the mental disorder to an involuntary patient who has been admitted to a hospital within the Territories under the authority of a certificate of involuntary admission where

Consent to treatment

- (a) the patient has attained the age of majority and is mentally competent to give a valid consent and consents to receiving treatment; or
- (b) the patient has not attained the age of majority or is not mentally competent to give a valid consent or, if he has attained the age of majority and is competent to give such a consent, refuses to consent to receiving treatment, the patient's nearest relative consents to the treatment.

23.(1) Treatment referred to in section 22 shall not include

Exceptional treatment

- (a) psychosurgery or lobotomy, or other irreversible forms of treatment without the consent of a patient who has attained the age of majority and is mentally competent to give a valid consent; or

- (b) electro-convulsive shock without the consent of
 - (i) a patient who has attained the age of majority and is mentally competent to give a valid consent, or
 - (ii) the patient's nearest relative where the patient has not attained the age of majority or is not mentally competent to give a valid consent.

Experimental treatment

(2) No experimental treatment involving any significant risk of physical or psychological harm shall be administered to a patient.

Extension of Detention

Extension of period of detention

24.(1) Subject to subsections (2) and (3),

- (a) where a certificate of involuntary admission has been issued pursuant to subsection 17(2) and a hospital within the Territories requires an extension to restrain, observe, examine or treat an involuntary patient; or
- (b) where a certificate of transfer has been issued pursuant to subsection 20(1) and a transfer of the involuntary patient to a hospital outside the Territories cannot be arranged within the period of detention referred to in section 19 due to extraordinary circumstances,

a territorial judge may extend the period of detention referred to in section 19 for one additional period not to exceed fourteen days, upon the application of a medical practitioner supported by an affidavit.

Time of application

(2) An application made pursuant to subsection (1) shall be made before the expiry of the period of detention referred to in section 19.

Application

(3) The medical practitioner shall give notice to the patient and his nearest relative of the hearing of the application made pursuant to subsection (1) and state in his application

- (a) that he has personally examined the person who is the subject of the application and he is of the opinion that
 - (i) the person is suffering from a mental disorder of a nature or quality that likely will result in
 - (A) serious bodily harm to that person,
 - (B) serious bodily harm to another person, or
 - (C) imminent and serious physical impairment of that person,
- unless the person remains in the custody of a hospital; and

- (ii) the person has not attained the age of majority or is not mentally competent to give a valid consent or, if he has attained the age of majority and is mentally competent to give such a consent, refuses to be hospitalized as a voluntary patient; and

(b) the reasons for requesting the extension.

(4) Prior to issuing an order to extend the period of detention pursuant to subsection (1), the territorial judge shall conduct a hearing on the application and hear evidence concerning

- (a) the alleged mental disorder, including
 - (i) medical evidence,
 - (ii) testimony of the applicant, and
 - (iii) testimony of the subject of the application, wherever practicable; and
- (b) any other matter he deems relevant.

Change From Involuntary to Voluntary Patient

25.(1) An involuntary patient whose authorized period of detention under this Act has not expired may be continued as a voluntary patient

- (a) where he has attained the age of majority and is mentally competent to give a valid consent and gives his written consent; and
- (b) upon the completion of the prescribed form by the medical practitioner and the filing of the form with the Minister.

(2) The medical practitioner shall notify, in writing, the involuntary patient's nearest relative of the change of status pursuant to subsection (1).

Escort

26.(1) An order by a justice pursuant to section 10, a certificate of involuntary admission or a certificate of transfer is sufficient authority to the person to whom it is addressed to take the person named in that order or certificate in custody and escort that person to a hospital named in that order or certificate.

Duty of
escort

(2) The escort shall retain the custody of the person so taken and remain at the hospital until the hospital accepts the custody of the person.

Review of Decision to Detain

Application
to Supreme
Court

27.(1) An involuntary patient, or any person on his behalf, may apply to the Supreme Court for a review of any decision which authorizes an involuntary patient's detention under this Act.

Affidavit

(2) The application shall be supported by an affidavit of the applicant setting forth fully all the facts in support of the application.

Authority of
review

(3) An application made pursuant to subsection (1) is sufficient authority for a medical practitioner to detain at a hospital the involuntary patient who is the subject of the review until the review is heard and decided and the time for an appeal has expired or the applicant withdraws his application or the Supreme Court dismisses the application.

Order of
examination

28.(1) Where the judge is of the opinion that an independent medical opinion is necessary, he may, prior to hearing the review, order the examination of an involuntary patient by a medical practitioner other than the one who has examined or assessed the patient.

Written
report

(2) The medical practitioner who examines an involuntary patient pursuant to an order made under subsection (1) shall report, in writing, to the judge on the mental condition of that patient before the expiration of the time stated in the order.

Hearing

29.(1) The judge may hear evidence concerning

- (a) the mental condition of the person named in the application including
 - (i) medical evidence,
 - (ii) testimony from the medical practitioner who has initially examined or assessed the person detained as an involuntary patient and the medical practitioner who has submitted a report pursuant to subsection 28(2), if any,
 - (iii) psychological evidence, and
 - (iv) testimony from a psychologist who has examined or assessed the involuntary patient; and
- (b) any other evidence the Court deems relevant.

(2) On an application for review pursuant to subsection (1), the judge shall, within fourteen days of the application, Decision

- (a) confirm the order or certificate authorizing the detention;
- (b) cancel the order or certificate authorizing the detention and order the discharge of the person; or
- (c) make any other order he considers appropriate.

Appeal

30.(1) Within thirty days of a decision of the Supreme Court under this Act, the involuntary patient, or any person on his behalf, may appeal to the Court of Appeal. Appeal

(2) The appeal made pursuant to subsection (1) is sufficient authority for a medical practitioner to detain at a hospital the involuntary patient who is the subject of an appeal until the appeal is heard and decided or the appellant abandons the appeal or the Court of Appeal dismisses the appeal. Authority of appeal

(3) An appeal made pursuant to subsection (1) shall be a rehearing of the matter on the merits, and, in addition to any further evidence adduced by the applicant, the Court may direct that any transcript taken by the Supreme Court at the review hearing be put in evidence on the appeal and may direct that further evidence be given as it considers necessary. Rehearing

(4) On an appeal pursuant to subsection (1), the Court shall, within fourteen days Appeal decision

- (a) confirm the decision of the Supreme Court;
- (b) quash the decision of the Supreme Court and order the discharge of the person; or
- (c) make any other order it considers appropriate.

Persons on Remand or Under an Order of the Commissioner

31.(1) Sections 32 to 35 only apply to a person who is charged with or convicted of an offence pursuant to an Act of the Parliament of Canada, an Act of the Territories or a regulation. Application

(2) Sections 32 to 35 do not apply to a young person as defined in the *Young Offenders Act* or *Young Offenders Act (Canada)*. Exemption

Examination
order

32.(1) Where in the opinion of a justice, territorial judge or judge, supported

(a) by the evidence, or

(b) by the report of at least one medical practitioner, in writing, where the prosecutor and the accused consent, ✓

there is reason to believe that a person who appears before him charged with or convicted of an offence, suffers from a mental disorder, the justice, territorial judge or judge, as the case may be, may order the person to attend a hospital as specified in the order and within the time stated in the order for observation for a period not to exceed thirty days.

Written
report

(2) The medical practitioner who examines a person pursuant to an order made under subsection (1), shall report, in writing, to the justice, territorial judge or judge, as the case may be, on the mental condition of that person before the expiration of the time stated in the order.

Emergency
treatment

(3) A person who is remanded to custody for observation may be given emergency treatment as specified in section 21.

Remand

33.(1) A person who, pursuant to the *Criminal Code* (Canada), is remanded to custody for observation may be admitted to, examined and detained in and discharged from a hospital in accordance with the law.

Idem

(2) Subsection 32(2) applies to a person who is remanded to custody for observation.

Order of the
Commissioner

34. A person who, pursuant to the *Criminal Code* (Canada), is detained under an order of the Commissioner because he was unfit to stand trial on account of insanity or insane at the time the offence was committed, may be admitted to, examined, treated and detained in and discharged from a hospital in accordance with the law.

No review
or appeal

35. No review or appeal lies pursuant to this Act from an order made pursuant to sections 32 to 34.

Rights of a Patient

Oral notice

36.(1) A medical practitioner shall inform a voluntary or involuntary patient and his nearest relative orally, in language which the

patient and his nearest relative can understand, of the reason for his admission to a hospital and the need for care and treatment before admitting the patient to a hospital.

(2) A medical practitioner shall give the involuntary patient and his nearest relative a written notice, within forty-eight hours of the examination or assessment pursuant to section 9, 10, 11, 12 or 13, stating

Written notice

- (a) the authority for the patient's detention, and the period of the detention; and
- (b) the patient's right to consult counsel, to apply to the Supreme Court for a review of the decision to detain him and to appeal the decision of the Supreme Court.

(3) Where the voluntary or involuntary patient does not speak or understand the same language as the medical practitioner, the hospital shall obtain a suitable interpreter and provide the explanation or written statement referred to in subsection (1) or (2) in the language spoken by the voluntary or involuntary patient and his nearest relative.

Language of notice

(4) Notwithstanding subsections (1) and (2), where an involuntary patient is not in a state to comprehend the explanation or the written statement, the hospital shall, having regard to the circumstances in each case, ensure that it is given at the first reasonable opportunity once the involuntary patient is able to comprehend the explanation or written statement.

Explanation or written notice repeated

(5) The rights of a patient set out in sections 36 to 42 shall be conspicuously posted in a hospital in places accessible to voluntary and involuntary patients.

Posting of rights

(6) Where a patient does not understand the language of the notice posted pursuant to subsection (5), the hospital shall ensure that the patient's rights are explained to him in a language the patient understands.

Explanation of notice

37. No communication written by a voluntary or involuntary patient in a hospital or to a voluntary or involuntary patient in a hospital shall be opened, examined or withheld and its delivery shall not in any way be obstructed or delayed by any member of the staff at the hospital unless

Communication by and to a patient

- (a) a medical practitioner considers that such communication would be detrimental to the patient's health or to

another person and orders that any communication to or from that patient may be opened, examined or withheld; and

(b) the patient is informed, in writing, of the order of the medical practitioner made under paragraph (a).

Visitors

38. A voluntary or involuntary patient may communicate by telephone or receive visitors at hours fixed by the hospital unless

(a) a medical practitioner considers that such communication or visitors would be detrimental to the patient's health or to another person and orders that the involuntary patient not be permitted to communicate by telephone or receive visitors, and

(b) the patient is informed, in writing, of the order of the medical practitioner made under paragraph (a),

but a patient may communicate by telephone with a lawyer at any time and a lawyer acting for the patient may visit the patient at any time.

Independent medical opinion

39. An involuntary patient has a right to an independent medical opinion regarding his mental disorder or the treatment he is receiving for his mental disorder from a medical practitioner.

Definition

40.(1) In this section, "abuse" includes any act which physically, mentally or emotionally injures, damages, causes undue discomfort or fear or takes unfair advantage of a patient.

Free from abuse

(2) An involuntary or voluntary patient has a right to security of the person and shall not be subject to any abuse at any time during observation, examination, care or treatment.

Offence

(3) Any person, other than a person who is suffering from a mental disorder, who contravenes subsection (2) is guilty of an offence.

Discrimination prohibited

41.(1) No person shall directly or indirectly refuse to employ or continue to employ a person on the basis that the person previously suffered from a mental disorder.

Services and facilities

(2) No person shall discriminate against a person by denial, restriction or otherwise with respect to any service, facility, goods, accommodation, rights, licence or privilege available or accessible to the public or a section of the public, on the basis that the person previously suffered from a mental disorder.

42.(1) A person who was an involuntary patient and has been discharged from a hospital may request that all court records pertaining to proceedings under this Act or the regulations with respect to him be destroyed.

Destruction of records

(2) Upon receipt of the request made pursuant to subsection (1), the court shall destroy the records.

Idem

Absence Without Leave

43.(1) Where an involuntary patient leaves a hospital without a leave of absence, the hospital may authorize a peace officer to return that patient to the hospital.

Absence without leave

(2) An authorization given under subsection (1) is sufficient authority for a peace officer to apprehend the involuntary patient referred to in subsection (1) and return that patient to the hospital.

Authority of order

Discharge

44.(1) Subject to subsection (3), a hospital shall discharge an involuntary patient

Discharge of involuntary patient

(a) when he is no longer suffering from a mental disorder of a nature or quality that will likely result in serious bodily harm to himself, serious bodily harm to another person or imminent and serious physical impairment to himself;

(b) when the Supreme Court or the Court of Appeal on review or appeal, as the case may be, cancels the detention authorized by this Act, a certificate of involuntary admission or an order to extend the period of detention and orders the discharge of that patient; or

(c) at the expiration of a period of detention unless an involuntary certificate of admission or an extension of the period of detention has been obtained.

(2) Where an involuntary patient is discharged pursuant to paragraph (1)(a), the certificate of involuntary admission shall be deemed to be cancelled.

Cancellation of certificate

(3) Subsection (1) does not authorize the discharge into the community of a patient who is subject to lawful detention otherwise than pursuant to this Act.

Exception

45. When an involuntary patient is discharged from a hospital, the hospital shall, where possible, give notice of the discharge

Notice

- (a) to the patient's nearest relative unless
 - (i) the patient being discharged requests that the nearest relative not be notified, and
 - (ii) the medical practitioner agrees that the request of the patient that the nearest relative not be notified is reasonable;
- (b) to the medical practitioner or hospital which referred the patient, if any; and
- (c) to the Minister.

Protection of Privacy

Not to be published

46. No person shall publish by any means any report of a hearing, decision, review or appeal held or made pursuant to this Act concerning a person who is alleged to be suffering from a mental disorder, in which the name of that person or any information serving to identify such a person is disclosed.

Private hearing

47.(1) Subject to subsection (2), no person other than an officer of the court, the parties and the nearest relative and their counsel and such other persons as the justice, territorial judge, judge or the presiding judge of the Court of Appeal, as the case may be, in his discretion expressly permits, shall be present at the hearing in all proceedings.

Exception

(2) A hearing shall be public where a person who is the subject of the proceedings requests a public hearing.

Confidentiality of Records

Interpretation

48.(1) In this section

"patient's health record"

"patient's health record" means the patient's health record compiled in a hospital or in the office of a medical practitioner or a psychologist in respect of a patient and includes any medical or psychological reports sent to the hospital by a medical practitioner or a psychologist;

"patient"

"patient" includes a voluntary and involuntary patient and a former patient.

Disclosure of patient's health record

(2) Subject to subsections (3) and (5), no person shall disclose, transmit or examine a patient's health record.

(3) A patient's health record may be examined by the medical practitioner and the person in charge of the hospital and the person in charge of the hospital may transmit the patient's health record to or permit the examination of the patient's health record,

Person who
may examine
the patient's
health record

- (a) where the patient has attained the age of majority and is mentally competent, by any person with the consent of the patient;
- (b) where the patient has not attained the age of majority or is not mentally competent, by any person with the consent of the patient's nearest relative;
- (c) by any person employed in or on the staff of the hospital for the purpose of assessing or treating or assisting in assessing or treating the patient;
- (d) by the person in charge of a hospital that is currently involved in the health care of the patient, who requests, in writing, to examine the record;
- (e) where the delay in obtaining the consent, as specified in paragraph (a) or (b), would endanger the life, a limb or a vital organ of the patient, without the consent of either the patient or his nearest relative, by a person currently involved in the health care of the patient in a hospital; or
- (f) by a person for the purpose of research, academic pursuits or the compilation of statistical data.

(4) Where a patient's health record is transmitted or copied for use outside the hospital for the purpose of research, academic pursuits or the compilation of statistical data, the person in charge of the hospital shall remove from the part of the patient's health record that is transmitted or from the copy, as the case may be, the name of and any means of identifying the patient.

Removal of
name or
means of
identifying
the patient

(5) Where the patient's health record is disclosed to or examined by a person for the purpose of research, academic pursuits or the compilation of statistical data, the person shall not disclose the name of or any means of identifying the patient and shall not use or communicate the information or material in the patient's health record for a purpose other than research, academic pursuits or the compilation of statistical data.

Disclosure
of name or
means of
identifying
the patient
prohibited

49.(1) Subject to subsections (2) and (3), the person in charge of a hospital or a person designated, in writing, by him shall disclose, transmit or permit the examination of a patient's health record

Disclosure
pursuant to
subpoena

- (a) pursuant to a subpoena, order, direction, notice or similar requirement in respect of a matter in issue or that may be in issue in a court of competent jurisdiction; or
- (b) where so required by an enactment.

Statement by medical practitioner or psychologist

(2) Where the disclosure, transmittal or examination of a patient's health record is required by a subpoena, order, direction, notice or similar requirement in respect of a matter in issue or that may be in issue in a court of competent jurisdiction, or by any enactment and a medical practitioner or a psychologist states, in writing, that he is of the opinion that the disclosure, transmittal or examination of the patient's health record or of a specified part of the patient's health record is likely to result in

- (a) harm to the treatment or recovery of the patient;
- (b) injury to the mental condition of another person; or
- (c) bodily harm to another person,

no person shall comply with the requirement with respect to the patient's health record or the part of the patient's health record specified by a medical practitioner or a psychologist except

- (d) under an order of the court before which the matter is or may be in issue; or
- (e) where the disclosure, transmittal or examination is not required by a court, under an order of the Supreme Court,

made after a hearing from which the public is excluded and that is held on reasonable notice to the medical practitioner.

Court may examine

(3) On a hearing under subsection (2), the court shall consider whether or not the disclosure, transmittal or examination of the patient's health record or the part of the patient's health record specified by a medical practitioner or a psychologist is likely to result in

- (a) harm to the treatment or recovery of the patient;
- (b) injury to the mental condition of another person; or
- (c) bodily harm to another person,

and for this purpose the court may examine the patient's health record and, if satisfied that such a result is likely, the court shall not order the disclosure, transmittal or examination unless satisfied that to do so is essential in the interests of justice.

Estates

Examination as to competency

51.(1) A medical practitioner who is examining or assessing a patient pursuant to section 9, 10, 11, 12, 13 or 14 shall examine the patient to determine whether or not he is mentally competent to manage his estate.

Certificate of mental incompetence

(2) Where a medical practitioner who performs an examination pursuant to subsection (1) is of the opinion that the patient is not mentally competent to manage his estate, he shall

- (a) issue a certificate of mental incompetence in the prescribed form; and
- (b) transmit the certificate to the Public Trustee.

Exceptional circumstances

(3) Where circumstances are such that the Public Trustee should immediately assume management of an estate, the medical practitioner shall notify the Public Trustee as soon as possible that a certificate of mental incompetence has been issued.

Exemption

(4) Subsections (1) to (3) do not apply to a patient whose estate is under committeeship pursuant to sections 12 and 12.1 of the *Public Trustee Act*.

Commencement of Committeeship

52. The Public Trustee shall be committee of the estate of a patient who is named in a certificate of mental incompetence issued pursuant to subsection 51(2) and shall assume management of that estate upon receipt of a certificate of mental incompetence if the patient has no other committee.

Powers and duties of Public Trustee

53. The Public Trustee who is committee of the estate of a patient shall have the same powers and duties as those conferred on him by the provisions of the *Public Trustee Act* concerning the estates of persons who are not mentally competent.

Cancellation of certificate of mental incompetence

54. The medical practitioner may, after examining a patient to determine whether or not that person is mentally competent to manage his estate, cancel the certificate of mental incompetence issued in respect of the patient and he shall forward a notice of cancellation in the prescribed form to the Public Trustee.

Notice of discharge

55. Where a certificate of mental incompetence has been issued, the person in charge of a hospital shall transmit to the Public Trustee a notice of the discharge from the hospital of an involuntary patient who was detained pursuant to this Act and the regulations and in respect of whom a certificate of mental incompetence is in force.

(4) Where a patient's health record is required pursuant to subsection (1) or (2), the clerk of the court in which the patient's health record is admitted in evidence or, if not so admitted, the person to whom the patient's health record is transmitted shall return the patient's health record to the person in charge of the hospital as soon as possible after the determination of the matter in issue in respect of which the patient's health record was required.

Return of
patient's
health record
to person in
charge

(5) No person shall disclose in an action or proceeding in any court or before any body any knowledge or information in respect of a patient obtained in the course of assessing or treating or assisting in assessing or treating the patient in a hospital in the course of his employment in the hospital except

Disclosure
in action or
proceeding

- (a) where the patient has attained the age of majority and is mentally competent, with the consent of the patient;
- (b) where the patient has not attained the age of majority or is not mentally competent to give a valid consent, with the consent of the patient's nearest relative; or
- (c) where the court or, in the case of a proceeding not before a court, the Supreme Court determines after a hearing
 - (i) from which the public is excluded, and
 - (ii) that is held on reasonable notice to the patient or, where the patient has not attained the age of majority or is not mentally competent to give a valid consent, to the patient's nearest relative,

that the disclosure is essential in the interests of justice.

Government Records

50.(1) A department or agency of the Government of the Northwest Territories may keep records containing information obtained by the department or agency for the purposes of administering this Act.

Government
records

(2) A record kept pursuant to subsection (1) may, at the discretion of the department or agency keeping the record, be made available for inspection to a medical practitioner, a hospital or any other person for the purpose of research, academic pursuits or the compilation of statistical data.

Records may be
made available
to specified
persons

(3) Where a record is made available, pursuant to subsection (2), for the purpose of research, academic pursuits or the compilation of statistical data, subsections 48(4) and (5) apply.

Research,
study or
statistics

Estates

Examination as to competency

51.(1) A medical practitioner who is examining or assessing a patient pursuant to section 9, 10, 11, 12, 13 or 14 shall examine the patient to determine whether or not he is mentally competent to manage his estate.

Certificate of mental incompetence

(2) Where a medical practitioner who performs an examination pursuant to subsection (1) is of the opinion that the patient is not mentally competent to manage his estate, he shall

(a) issue a certificate of mental incompetence in the prescribed form; and

(b) transmit the certificate to the Public Trustee

Exceptional circumstances

(3) Where circumstances are such that the Public Trustee should immediately assume management of an estate, the medical practitioner shall notify the Public Trustee as soon as possible that a certificate of mental incompetence has been issued.

Exemption

(4) Subsections (1) to (3) do not apply to a patient whose estate is under committeehip pursuant to sections 12 and 12.1 of the *Public Trustee Act*.

Commencement of Committeehip

52. The Public Trustee shall be committee of the estate of a patient who is named in a certificate of mental incompetence issued pursuant to subsection 51(2) and shall assume management of that estate upon receipt of a certificate of mental incompetence if the patient has no other committee.

Powers and duties of Public Trustee

53. The Public Trustee who is committee of the estate of a patient shall have the same powers and duties as those conferred on him by the provisions of the *Public Trustee Act* concerning the estates of persons who are not mentally competent.

Cancellation of certificate of mental incompetence

54. The medical practitioner may, after examining a patient to determine whether or not that person is mentally competent to manage his estate, cancel the certificate of mental incompetence issued in respect of the patient and he shall forward a notice of cancellation in the prescribed form to the Public Trustee.

Notice of discharge

55. Where a certificate of mental incompetence has been issued, the person in charge of a hospital shall transmit to the Public Trustee a notice of the discharge from the hospital of an involuntary patient who was detained pursuant to this Act and the regulations and in respect of whom a certificate of mental incompetence is in force.

56. No person, other than the Public Trustee, shall bring an action as next friend of a person of whose estate the Public Trustee is committee under this Act without the leave of a judge of the court in which the action is intended to be brought, and the Public Trustee shall be served with notice of the application for such leave.

Leave of
judge to
bring action

57. Where an action or proceeding is brought or taken against a person

Service of
documents

- (a) who is suffering from a mental disorder and has been admitted to a hospital; and
- (b) for whose estate a committee has not been appointed, and the action or proceeding is in connection with the estate of the person, the writ or other document by which the action or proceeding is commenced and any other document requiring personal service
- (c) shall be endorsed with the name of the hospital in or of which the person is a patient; and
- (d) shall be served
 - (i) on the Public Trustee, and
 - (ii) on that person or, where the medical practitioner is of the opinion that personal service on that person would cause or would be likely to cause serious harm to him by reason of his mental condition, on the person in charge of the hospital.

Miscellaneous

58.(1) Subject to subsection (2), all actions, prosecutions or other proceedings against any person or hospital for anything done or omitted to be done pursuant to this Act or the regulations shall be commenced within two years after the act or omission complained of occurred and not afterwards.

Limitation
of actions

(2) The time during which a mentally disordered person is confined to a hospital for a mental disorder shall not be computed against him for the purposes of subsection (1) and that person may bring an action any time within two years after he has been discharged from a hospital and no longer suffers from a mental disorder.

Computation
of time

59. Where a certificate of involuntary admission has been issued pursuant to this Act and a committee has not been appointed for the estate of the person named in the certificate,

Representative

- (a) that person may, where he has attained the age of majority and is mentally competent to do so, name a representative to commence an action or proceeding on his behalf; or
- (b) where the person named in the certificate has not attained the age of majority or is not mentally competent to name a person to commence an action or proceeding on his behalf, the Public Trustee may commence an action or proceeding.

Validity of documents

60. A certificate of involuntary admission, certificate of transfer or other order or form issued pursuant to this Act or the regulations shall not be held insufficient or invalid by reason only of any irregularity, informality or insufficiency in it or any proceedings in connection with it.

Exemption from liability

61. No person shall be liable for any loss or damage suffered by reason of anything done or omitted to be done by that person in good faith pursuant to or in the exercise of the powers conferred by this Act or the regulations.

Offence

62. Every person who contravenes any provision of this Act or the regulations is guilty of an offence and is liable on summary conviction to a fine not exceeding ten thousand dollars or to imprisonment for a term not exceeding six months or to both.

Regulations

63. The Commissioner, upon the recommendation of the Minister, may make regulations

- (a) respecting the examination or psychiatric assessment of persons;
- (b) governing the admission, detention, leave of absence, transfer, discharge and placement of patients admitted to a hospital pursuant to this Act;
- (c) respecting the duties of an escort referred to in section 26;
- (d) prescribing additional duties of a person appointed pursuant to section 5 or 6;
- (e) prescribing the forms required for the carrying out of the provisions of this Act and the regulations;
- (f) prescribing any matter or thing that by this Act may or is to be prescribed; and
- (g) respecting any other matter which the Commissioner deems necessary or advisable to carry out effectively the intent and purpose of this Act.

64. The *Mental Health Act*, R.S.N.W.T. 1974, c.M-11, is ~~Repeal~~
repealed.

65. This Act shall come into force on a day to be fixed by order ~~Coming into~~
of the Commissioner. ~~force~~

Printed by
Territorial Printer, Northwest Territories
Yellowknife, N.W.T./1985^(c)

NOVA SCOTIA

Hospitals Act, R.S.N.S. 1967, c. 249, as amended.

7A.(1) Where a person in a hospital requires medical or surgical treatment and is incapable of consenting to the required medical or surgical treatment for any reason and such person does not have a guardian or there is no one recognized in law who can give consent on his behalf to the required medical or surgical treatment, then the Trial Division of the Supreme Court or a Judge thereof may upon ex parte application by the Public Trustee authorize the required medical or surgical treatment.

15. The Governor in Council may make regulations . . .

(d) prescribing or relating to standards for buildings, equipment and physical facilities, staff requirements and qualifications, standards of care and treatment of patients, operating and administrative practices and other matters to be observed and performed in the establishment, maintenance and operation of hospitals;

(e) respecting admission, treatment, care, conduct, management, and discharge of patients or any class of patients;

(p) protecting the rights of persons under observation or of patients;

17D.(1) Where the responsible medical officer is of the opinion that a patient is not likely to improve with further stay in the psychiatric hospital, the psychiatric hospital may order that the patient be discharged or transferred to another institution.

26.(1) Subject to subsection (2) of Section 27, a person who is admitted to a facility shall be admitted as a person for observation.

(2) A person for observation is a person who is admitted to the facility for a period not exceeding seven days to determine whether or not that person requires the in-patient services provided by the facility.

(3) A person may remain in a facility as an informal patient or a formal patient subsequent to the observation period.

(4) An informal patient is a person who remains in a facility with his consent and upon the written recommendation of a qualified medical practitioner that such person requires the in-patient services provided by the facility.

(5) A formal patient is a person who remains in a facility as the result of the execution of a declaration of formal admission.

27.(1) A person may be admitted to a facility for observation:

(a) with his consent and upon the request of a qualified medical

practitioner that such patient requires the in-patient services provided by the facility;

(b) by medical certificates;

(c) by transfer from another facility within the Province;

(d) by transfer from a facility in another province or state or from a hospital under the jurisdiction of the Government of Canada.

(2) A person may be admitted to a psychiatric hospital pursuant to the provisions of the Criminal Code, the Penitentiaries Act, the Prisons and Reformatories Act or any other Act of the Government of Canada or of the Province.

(3) A person admitted to a psychiatric hospital pursuant to subsection (2) shall be admitted to the psychiatric hospital, detained therein and discharged therefrom in accordance with the provisions of the appropriate federal or provincial legislation governing that person or any regulations, orders in council, orders of a court or warrants made pursuant to such legislation.

28.(1) A person may be admitted to a facility by the execution of two medical certificates signed by two qualified medical practitioners.

(2) A medical certificate shall state that a qualified medical practitioner has reasonable and probable grounds to believe

(a) that the person suffers from a psychiatric disorder; and

(b) that the person should be admitted to the facility because

(i) he requires the in-patient services provided by that facility, and

(ii) he requires care that cannot be adequately provided outside the facility because he is a danger to his own safety or the safety of others.

(3) The two medical certificates shall be signed by two qualified medical practitioners each of whom has examined the person to be admitted for observation.

(4) A medical certificate must be signed by the qualified medical practitioner who examined the person within forty-eight hours of the examination and ceases to have any force and effect unless it is presented to the facility within seven days of the time of the signature of the qualified medical practitioner.

(5) Every medical certificate shall be in such form and contain such information as may be determined by the Governor in Council by regulation.

(6) Every medical certificate made and given under this Act shall be *prima facie* evidence of the facts therein appearing and that the judgement therein set out has been formed by the qualified medical practitioner on such facts as if the matters therein appearing have been verified on oath.

(7) Notwithstanding any other provisions of this Act, two medical certificates shall be sufficient authority for any person to convey the person named in the certificates to the facility and for the facility to detain him therein for observation.

(8) The certificates may be handed to a peace officer by a qualified medical practitioner and on receipt of the same such peace officer shall take

the person named therein into his care and convey him or cause him to be conveyed to the facility.

(9) Notwithstanding subsection (1), a person may be admitted to a facility by the execution of one medical certificate signed by one qualified medical practitioner where compelling circumstances exist for the admission of such person to a facility and where a second qualified medical practitioner is not readily available to examine the person and execute the second certificate.

(10) A person in respect of whom a certificate or certificates have been executed pursuant to this Section shall be admitted by the facility to which he is taken.

29.(1) A person who has reasonable and probable grounds to believe any person is suffering from a psychiatric disorder and that that person is a danger to his own safety or to the safety of others may give information thereof under oath to a magistrate.

(2) Where such information has been given under this Section the magistrate may

(a) direct and authorize any two qualified medical practitioners to visit and examine the person alleged to be suffering from a psychiatric disorder and to be in need of the in-patient services of a facility; or

(b) if the person cannot be examined pursuant to clause (a), issue a warrant for his apprehension and direct that he be taken to an appropriate place where he may be detained for medical examination.

30.(1) Where a peace officer has reasonable and probable grounds to believe that a person suffers from a psychiatric disorder and

(a) is a danger to his own safety or the safety of others; or

(b) is committing or about to commit an indictable offence, the peace officer may take the person to an appropriate place where he may be detained for medical examination.

(2) Every peace officer who apprehends a person and takes him to an appropriate place where he may be detained for a medical examination pursuant to subsection (1) shall file a full report with the Attorney General within twenty-four hours of such apprehension.

31.(1) For the purposes of Sections 29 and 30 an appropriate place where a person may be detained for medical examination shall mean a hospital, a medical facility, the office of a qualified medical practitioner or other place suitable for a medical examination but does not include a jail or lock-up unless no other suitable place is available.

(2) A person examined by a qualified medical practitioner pursuant to Section 29 or 30 shall be examined forthwith or as soon as practicable after he is first detained and in any event he shall not be detained for medical examination for a period exceeding twenty-four hours.

(3) A person examined pursuant to Section 29 or 30 shall be released immediately upon completion of the examination and returned to the place

where he was apprehended unless the physicians examining him admit him to a facility for observation or unless that person voluntarily admits himself to a facility for observation.

32.(1) A facility shall admit as a patient any person named in a warrant or order purporting to be made under the provisions of the Criminal Code, the Penitentiaries Act, the Prisons and Reformatories Act or any other Act of the Government of Canada or of the Province.

(2) The facility shall notify the Attorney General forthwith upon the admission of a person pursuant to this Section and shall report to the Attorney General immediately upon the recovery of such person and in any event shall report at intervals of not more than twelve months on the condition and progress of all persons detained in the facility including progress of all persons detained in the facility pursuant to this Section and the facility shall further make any report required by the terms of the committing order or warrant.

(3) The provisions of this Act respecting discharge or transfer of patients shall not apply to patients admitted pursuant to this Section where the terms of the committing warrant or order conflict with such provisions.

33. A facility may admit on transfer a patient who is in a facility in another province or state or in a hospital under the jurisdiction of the Government of Canada and may detain such person as a person for observation.

34.(1) Every person admitted to a facility for observation shall be examined by a psychiatrist and a decision made as soon as practicable after his admission as to whether or not that person requires the services provided by the facility and so as not to restrict the generality of the foregoing shall be examined by

(a) a qualified medical practitioner of the facility within twenty-four hours of the time of admission; and

(b) a psychiatrist of that facility within three days of his admission, excluding holidays;

and a decision made as to whether or not that person requires the services provided by that hospital within seven days after the date of admission.

(2) Prior to the eighth day after a person is admitted to a facility for observation a psychiatrist on the staff of the facility shall make a declaration stating whether the patient suffers from a psychiatric disorder and is a danger to his own safety or the safety of others.

(3) If the psychiatrist referred to in subsection (2) makes a declaration that the person suffers from a psychiatric disorder and is a danger to his own safety or the safety of others then the psychiatrist shall complete a form in the manner prescribed and that person shall become a formal patient.

(4) A declaration made pursuant to subsection (3) shall be known as a declaration of formal admission and shall be in such form and contain such information as may be determined by the Governor in Council by regulation.

(5) A person described by subsection (1) for whom no declaration of formal admission has been completed prior to the eighth day after he has been admitted to the facility shall be released from that facility unless he remains as an informal patient or unless he is transferred to another institution in the Province.

35.(1) An informal patient may become a formal patient after having been examined by a psychiatrist of the facility and upon the psychiatrist's completing the declaration of formal admission.

(2) A formal patient may become an informal patient.

36.(1) A declaration of formal admission is sufficient authority for the facility to detain a person as a formal patient.

(2) No person shall be detained in a facility as a formal patient for a period longer than one month as the result of a declaration of formal admission unless that declaration is renewed.

(3) A declaration of formal admission may be renewed for the following periods:

(a) the first period not to exceed three months subsequent to the period described in subsection (2);

(b) the second period not to exceed three months subsequent to the period described in clause (a); and

(c) subsequent periods to be not more than six months subsequent to the period described in clause (b).

(4) A person may be detained in a facility if he is detained therein either for observation or pursuant to a declaration of formal admission or pursuant to a renewal of the declaration of formal admission.

(5) A renewal of declaration of formal admission shall be in such form and contain such information as may be determined by the Governor in Council by regulation.

(6) Every person detained in a facility pursuant to a declaration of formal admission or a renewal of declaration of formal admission shall be examined by a psychiatrist on the staff of the facility within seven days prior to the expiry of the said declaration of formal admission or the renewal of declaration of formal admission.

(7) The examination conducted by the psychiatrist on the staff of the facility pursuant to subsection (6) shall be by a psychiatrist other than the psychiatrist who signed the declaration of formal admission or the renewal of declaration of formal admission unless no other psychiatrist is readily available.

37.(1) An informal patient may discharge himself from a psychiatric facility at any time.

(2) A formal patient may be discharged by a certificate of discharge of a psychiatrist of the facility.

(3) A certificate of discharge shall be in such form and contain such information as may be determined by the Governor in Council by regulation.

39.(1) A person in a facility or the guardian of that person or his spouse or next of kin or the Public Trustee may, on five clear days notice in writing to the administrator of the facility, apply to the judge of the county court for the district in which the facility is situate for the discharge of the person on the ground that he is not suffering from a psychiatric disorder or is not a danger to his own safety or the safety of others:

(2) Upon application the judge shall review the evidence and other papers related to the admission of the person to the facility and hear further evidence and may, if he considers it necessary to do so, cause the patient to be examined by one or more duly qualified medical practitioners and if the judge determines that the person should not be detained in the facility the judge shall grant an order for discharge.

(3) An order for discharge given under this Section is sufficient authority for the discharge of the person from the facility upon the filing of a certified copy of the order with the administrator of the facility.

(4) The judge may make such order as to the costs of the application as he considers proper.

(5) This Section does not apply in respect of a person detained in a facility under warrant of the Lieutenant Governor or under the provisions of the Penitentiaries Act or the Prisons and Reformatories Act or any other Act of the Government of Canada or of the Province.

40.(1) A facility shall admit a patient having settlement in the service area for which the facility is responsible where the patient has been transferred from a hospital.

(3) Notwithstanding the settlement of the patient, the service area of the facility, and the provisions of this Act, where the administrator of psychiatric mental health services believes that it is in the best interest of a patient to be treated in a facility other than the facility which would ordinarily be responsible for the patient, he may order that the patient be transferred to such other facility as he directs and the facility concerned shall put such order into effect.

(4) Prior to making an order under subsection (3), the administrator of psychiatric mental health services may seek the advice of the review board which shall review the case and advise the administrator of psychiatric mental health services accordingly.

41. Where a patient in a facility is transferred to another facility or hospital then the facility or hospital receiving the patient shall have the same authority to detain or treat a patient as the facility from which the patient was transferred had.

43.(1) Every person admitted to a facility shall be examined by a psychiatrist on the staff of that facility to determine that person's capacity to consent to treatment.

(2) The examination referred to in subsection (1) shall be made by the psychiatrist as soon as possible after the person is admitted to the facility but nevertheless within three days excluding holidays following his admission to the facility.

44.(1) A person in a hospital may be found after examination by a psychiatrist not to be capable of consenting to treatment or competent to administer his estate.

(2) In determining whether or not a person is capable of consenting to treatment the examining psychiatrist shall consider whether or not the person being examined

- (a) understands the condition for which the treatment is proposed;
- (b) understands the nature and purpose of the treatment;
- (c) understands the risks involved in undergoing the treatment;
- (d) understands the risks involved in not undergoing the treatment; and
- (e) whether or not his ability to consent is affected by his condition.

45.(1) A psychiatrist after having examined a person in a hospital to determine his capacity to consent to treatment shall complete a declaration of capacity in respect of that person.

(2) The declaration of capacity shall state whether or not in the opinion of the examining psychiatrist the person examined is capable of consenting to treatment or not.

(3) When a psychiatrist has completed the examination of a person in a hospital to determine that person's competency to administer his estate he shall complete a declaration of competency in respect of that person.

46.(1) No person admitted to a hospital shall receive treatment unless he consents to such treatment.

(2) If a person in a hospital is found by declaration of capacity to be incapable of consenting to treatment then that person may be treated either upon obtaining the consent of the guardian of that person, if he has one, or if he has not a guardian upon obtaining the consent of his spouse or next of kin and where the spouse or next of kin is not available or consent is unable to be obtained upon obtaining the consent of the Public Trustee.

47. The examination of a person in a hospital by a psychiatrist to determine whether or not that person is competent to administer his estate or capable of consenting to treatment may be performed at any time as the need arises, and notwithstanding this, such an examination in a facility shall be performed

- (a) at least once every three months for the first year during which the person is a patient; and
- (b) at least once every twelve months thereafter.

48. If an examination is not performed within the periods set out in Section 47, the person shall be presumed to be competent or capable of consenting until a psychiatrist determines that the person is not competent or capable of consenting.

49.(1) If a person in a hospital is examined by a psychiatrist and found incapable of consenting to medical treatment or incompetent to administer his estate and subsequent thereto has been re-examined and found to be capable of consenting to treatment or competent to administer his estate then the examining psychiatrist shall execute a revocation for the declaration of capacity or a revocation of the declaration of competency whichever is appropriate under the circumstances.

(2) The revocation of declaration of capacity shall be signed by the psychiatrist examining the person and shall state that the person described therein is capable of consenting to treatment.

(3) The revocation of declaration of competency shall be signed by the psychiatrist examining the person and shall state that the person described therein is competent to administer his estate.

(4) A revocation of declaration of capacity and a revocation of declaration of competency shall be in such form and contain such information as may be determined by the Governor in Council by regulation.

50.(1) A declaration of capacity or a declaration of competency concerning a person in a facility may be reviewed by a review board.

(2) A declaration of capacity or a declaration of competency may be reviewed by the county court.

(3) Such a review by a review board or a judge of the county court shall be made upon application by the person seeking the review who shall give five days notice to the administrator of the hospital.

(4) An application for a review pursuant to this Section shall be made by the person described in the declaration or by the guardian of the person if he has a guardian or by his spouse or if he has no spouse by the next of kin or if he has no next of kin by the Public Trustee.

(5) The judge of the county court or the review board, whichever is appropriate in the circumstances, may either confirm the declaration of capacity or the declaration of competency or determine that the same should be revoked.

(6) If the judge of the county court or the review board determines that the declaration of capacity or the declaration of competency should be revoked then he or it shall issue an order revoking the declaration of capacity or the declaration for competency whichever is appropriate under the circumstances.

52.(1) No psychosurgery shall be performed unless

(a) the patient to be treated consents;

(b) the patient to be treated has been assessed at a facility designated by the Governor in Council by regulation;

- (c) the treatment is recommended by the psychiatrist who is treating the patient at the facility;
- (d) the treatment is recommended by two psychiatrists who are not associated with the facility where the patient to be treated has been assessed;
- (e) the psychosurgery is performed in a hospital designated by the Governor in Council; and
- (f) the review board determines that there is compliance with the requirements in this subsection.

(2) If the patient whose consent is required pursuant to subsection (1) is incapable of consenting to treatment, consent shall be obtained from his guardian, and if he has no guardian his spouse, and if he has no spouse, his next of kin, and if there is no next of kin, the Public Trustee.

(3) The review board may require additional information or opinions before making a determination pursuant to subsection (1).

53.(1) The Governor in Council may appoint persons who shall constitute a review board for one or more facilities.

(2) The Governor in Council may determine the term during which a member of a review board shall hold office and may reappoint members of a review board for further succeeding terms.

(3) The Governor in Council may designate one of the members of a review board to be chairman and another to be vice-chairman.

(4) Nothing in this Act shall prevent members appointed to a review board pursuant to Section 547 of the Criminal Code (Canada) from being appointed to the review board pursuant to this Section.

54.(1) Three members of a review board shall constitute a quorum.

(2) The chairman shall designate which member of a review board shall sit on a review.

(3) No member of a review board shall sit on a review board when it is considering the review of

- (a) a patient of the member of a review board;
- (b) a client of the member of a review board; or
- (c) a relative of the member of a review board.

55. The functions of a review board shall be and it shall have authority to

- (a) determine whether a patient shall continue to be detained under a declaration of formal admission;
- (b) determine that the requirements of this Act have been complied with before psychosurgery is performed;
- (c) review a declaration of capacity;
- (d) review a declaration of competency;
- (e) make such recommendations as it sees fit respecting the treatment or care of a patient; and
- (f) advise the administrator of psychiatric mental health services where it believes it is in the best interests of the patient to be treated in a facility other than the facility where the person is a patient.

56. A review board may review the file of a patient at any time, and notwithstanding this, it shall review the file of each patient detained under a declaration of formal admission

- (a) at least once every six months for the first two years during which the person is a patient; and
- (b) at least once every twelve months thereafter.

57.(1) Subject to subsection (2), a review board shall review the file of a patient within one month of the request in the prescribed form by

- (a) the patient;
- (b) a person (other than another patient) authorized by the patient to act on his behalf;
- (c) the administrator of the facility where the person is a patient;
- (d) the medical director of the facility where the person is a patient;
- (e) the administrator of psychiatric mental health services; or
- (f) the Minister.

(2) A review board may refuse to review the file of a patient upon the request of the patient at any time during the six months following the date the file was previously reviewed.

58.(1) Subject to subsection (2), a review board may determine the procedure to be followed upon the review of a patient's file.

(2) A review board shall conduct a hearing for the review of a patient's file upon the request in the prescribed form by any person authorized to request a review pursuant to Section 57.

(3) Where a hearing is to be held under this Section, notice in writing of the hearing shall be given to the patient or a person authorized to act on his behalf, to the administrator of the facility in which the person is a patient, and to the person who requested the hearing where that person is not otherwise entitled to receive notice.

(4) The notices referred to in subsection (3) shall be served at least three clear days before the date of the hearing, and shall specify the time and place of the hearing as well as the name of the person who requested the hearing.

(5) Where a hearing is held, the patient unless otherwise ordered by a review board, and in any case his representative, shall have the right to attend and be heard.

(6) A review board may require the patient to appear at a hearing.

(7) A review board may, at any time, appoint a representative to act on behalf of a patient.

(8) Members of the public shall be excluded from a hearing unless otherwise requested by the patient or his representative.

(9) Members of a review board shall have the same powers and privileges as commissioners appointed under the Public Inquiries Act.

59.(1) Within the fourteen days after each review, a review board shall forward a written decision setting out fully the conclusion of the review board to

- (a) the person requesting the review;

- (b) the patient or his representative; and
 - (c) the administrator of the facility in which the person whose file was reviewed is a patient; and
 - (d) the administrator of psychiatric mental health services.
- (2) A review board shall maintain a record of each review including
- (a) the reason for the review;
 - (b) the written decision setting out fully its conclusions; and
 - (c) the names of persons to whom the decision was forwarded.

60. Where a review board determines that a patient should not continue to be detained under a declaration of formal admission,

- (a) the facility shall take such action as is required to give effect to such determination; or
- (b) the patient may remain in the facility as an informal patient.

63.(1) The records and particulars of a hospital concerning a person or patient in the hospital or a person or patient formerly in the hospital shall be confidential and shall not be made available to any person or agency except with the consent or authorization of the person or patient concerned.

(2) If a person or patient or former patient is not capable of giving consent in respect of his records and particulars then such consent may be given by the guardian of such person if there is a guardian and if there is no guardian by the spouse of such person and if there is no spouse by the next of kin of that person and if there is no next of kin with the consent of the Public Trustee.

(3) Notwithstanding subsections (1) and (2), a hospital or a qualified medical practitioner may refuse to make available information from the records or particulars of a person or patient if he has reasonable grounds to believe it would not be in the best interest of the patient to make available that information.

(4) If a hospital or a qualified medical practitioner refuses to make available the records and particulars of a person upon request by that person or upon authorization of that person or agency or upon authorization pursuant to subsection (2) then the person requesting the records and particulars or authorized to receive the same may make application to a county court judge and such judge shall in his discretion determine whether the records and particulars shall be made available and to what extent.

(5) Nothing in this Section prevents the records and particulars of a hospital concerning a person or patient in the hospital or a person or patient formerly in a hospital from being made available to

- (a) a person on the staff of the hospital for hospital or medical purposes;
- (b) the qualified medical practitioner of the person concerned designated by the person as his physician;
- (c) a person authorized by court order or subpoena;
- (d) a person or agency otherwise authorized by law;

(e) the Minister or any person or agency designated or authorized by the Minister.

(6) Nothing in this Section prevents

(a) the publication of reports or statistical information relating to research or study which do not identify individuals or sources of information; or

(b) the transfer of the records and particulars of a hospital from one hospital to another hospital; or

(c) the furnishing by a hospital of such information from the records and particulars of a person or patient in the hospital or formerly in the hospital to a municipal official as may be required for the purpose of establishing settlement.

(7) Nothing contained herein prevents a hospital or a qualified medical practitioner from disclosing general information on the condition of a person or patient unless that person or patient directs otherwise.

67. Any person who violates or fails to observe any provision of this Act or the regulations is liable on summary conviction to a penalty or not more than five hundred dollars and in default of payment to imprisonment for not more than ninety days.

ONTARIO

Mental Health Act, R.S.O. 1980, c. 262.

1. In this Act, . . .

(t) "restrain" means keep under control by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient; . . .

7. Notwithstanding this or any other Act, admission to a psychiatric facility may be refused where the immediate needs in the case of the proposed patient are such that hospitalization is not urgent or necessary.

8. Any person who is believed to be in need of the observation, care and treatment provided in a psychiatric facility may be admitted thereto as an informal patient upon the recommendation of a physician.

9.(1) Where a physician examines a person and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(b) has behaved or is behaving violently towards another person

or has caused or is causing another person to fear bodily harm from him; or

(c) has shown or is showing a lack of competence to care for himself,

and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) imminent and serious physical impairment of the person,

the physician may make application in the prescribed form for a psychiatric assessment of the person.

(2) An application under subsection (1) shall set out clearly that the physician who signs the application personally examined the person who is the subject of the application and made careful inquiry into all of the facts necessary for him to form his opinion as to the nature and quality of the mental disorder of the person.

(3) A physician who signs an application under subsection (1),

(a) shall set out in the application the facts upon which he formed his opinion as to the nature and quality of the mental disorder;

(b) shall distinguish in the application between the facts observed by him and the facts communicated to him by others; and

(c) shall note in the application the date on which he examined the person who is the subject of the application.

(4) An application under subsection (1) is not effective unless it is signed by the physician within seven days after he examined the person who is the subject of the examination.

(5) An application under subsection (1) is sufficient authority for seven days from and including the day on which it is signed by the physician,

(a) to any person to take the person who is the subject of the application in custody to a psychiatric facility forthwith; and

(b) to detain the person who is the subject of the application in a psychiatric facility and to restrain, observe and examine him in the facility for not more than 120 hours.

10.(1) Where information upon oath is brought before a justice of the peace that a person within the limits of the jurisdiction of the justice,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(c) has shown or is showing a lack of competence to care for himself,

and in addition based upon the information before him the justice of the peace has reasonable cause to believe that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or
(f) imminent and serious physical impairment of the person,
the justice of the peace may issue his order in the prescribed form for the assessment of the person by a physician.

(2) An order under this section may be directed to all or any constables or other peace officers of the locality within which the justice has jurisdiction and shall name or otherwise describe the person with respect to whom the order has been made.

(3) An order under this section shall direct, and, for a period not to exceed seven days from and including the day that it is made, is sufficient authority for any constable or other peace officer to whom it is addressed to take the person named or described therein in custody forthwith to an appropriate place where he may be detained for assessment by a physician.

11. Where a constable or other peace officer observes a person who acts in a manner that in a normal person would be disorderly and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(c) has shown or is showing a lack of competence to care for himself,

and in addition the constable or other officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) imminent and serious physical impairment of the person,

and that it would be dangerous to proceed under section 10, the constable or other peace officer may take the person in custody to an appropriate place for assessment by a physician.

12. An assessment under section 10 or 11 shall be conducted by a physician forthwith after receipt of the person at the place of assessment and where practicable the place shall be a psychiatric facility or other health facility.

13. Subject to subsection 14(5), the attending physician may change the status of an informal patient to that of an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission.

14.(1) The attending physician, after observing and examining a person who is the subject of an application for assessment under section 9 or who is the subject of an order under section 26,

(a) shall release the person from the psychiatric facility if the attending physician is of the opinion that the person is not in need of the treatment provided in a psychiatric facility;

(b) shall admit the person as an informal patient if the attending

physician is of the opinion that the person is suffering from mental disorder of such a nature or quality that the person is in need of the treatment provided in a psychiatric facility and is suitable for admission as an informal patient; or

(c) shall admit the person as an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission if the attending physician is of the opinion both that the person is suffering from mental disorder of a nature or quality that likely will result in,

(i) serious bodily harm to the person,

(ii) serious bodily harm to another person, or

(iii) imminent and serious physical impairment of the person,

unless the person remains in the custody of a psychiatric facility and that the person is not suitable for admission as an informal patient.

(2) The physician who completes a certificate of involuntary admission pursuant to clause (1)(c) shall not be the same physician who completed the application for psychiatric assessment pursuant to section 9.

(3) The officer in charge shall release a person who is the subject of an application for assessment under section 9 or who is the subject of an order under section 26 upon the completion of 120 hours of detention in the psychiatric facility unless the attending physician has released the person, has admitted the person as an informal patient or has admitted the person as an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission.

(4) An involuntary patient may be detained, restrained, observed and examined in a psychiatric facility,

(a) for not more than two weeks under a certificate of involuntary admission; and

(b) for not more than,

(i) one additional month under a first certificate of renewal,

(ii) two additional months under a second certificate of renewal, and

(iii) three additional months under a third or subsequent certificate of renewal,

that is completed and filed with the officer in charge by the attending physician.

(5) The attending physician shall not complete a certificate of involuntary admission or a certificate of renewal unless, after he has examined the patient, he is of the opinion both,

(a) that the patient is suffering from mental disorder of a nature or quality that likely will result in,

(i) serious bodily harm to the patient,

(ii) serious bodily harm to another person, or

(iii) imminent and serious physical impairment of the patient,

unless the patient remains in the custody of a psychiatric facility; and

(b) that the patient is not suitable for admission or continuation as an informal patient.

(6) An involuntary patient whose authorized period of detention has expired shall be deemed to be an informal patient.

(7) An involuntary patient whose authorized period of detention has not expired may be continued as an informal patient upon completion of the prescribed form by the attending physician.

(8) Forthwith following completion and filing of a certificate of involuntary admission or of a certificate of renewal, the officer in charge or his delegate shall review the certification documents to ascertain whether or not they have been completed in compliance with the criteria outlined in this Act and where, in his opinion, the documents are not properly completed, the officer in charge shall so inform the attending physician and, unless the person is re-examined and released or admitted in accordance with subsections (1) and (2), the officer in charge shall release the person.

15.(1) Where a judge has reason to believe that a person who appears before him charged with or convicted of an offence suffers from mental disorder, the judge may order the person to attend a psychiatric facility for examination.

(2) Where an examination is made under this section, the senior physician shall report in writing to the judge as to the mental condition of the person.

(3) If the senior physician reports that the person examined needs treatment, the judge may order the person to attend a psychiatric facility for treatment.

16.(1) Where a judge has reason to believe that a person in custody who appears before him charged with an offence suffers from mental disorder, the judge may, by order, remand that person for admission as a patient to a psychiatric facility for a period of not more than two months.

(2) Before the expiration of the time mentioned in such order, the senior physician shall report in writing to the judge as to the mental condition of the person.

17. A judge shall not make an order under section 15 or 16 until he ascertains from the senior physician of a psychiatric facility that the services of the psychiatric facility are available to the person to be named in the order.

18. Notwithstanding this or any other Act or any regulation made under any other Act, the senior physician may report all or any part of the information compiled by the psychiatric facility to any person where, in the opinion of the senior physician, it is in the best interests of the person who is the subject of an order made under section 15 or 16.

19. Any person who, pursuant to the *Criminal Code* (Canada) is,
(a) remanded to custody for observation; or
(b) detained under the authority of a warrant of the Lieutenant Governor,

may be admitted to, detained in, and discharged from a psychiatric facility in accordance with the law.

23.(1) Upon the advice of the attending physician, the officer in charge of a psychiatric facility may, if otherwise permitted by law and subject to arrangements being made with the officer in charge of another psychiatric facility, transfer a patient to such other psychiatric facility upon completing a memorandum of transfer in the prescribed form.

(2) Where a patient is transferred under subsection (1), the authority to detain him continues in force in the psychiatric facility to which he is so transferred.

24.(1) Upon the advice of the attending physician that a patient requires hospital treatment that cannot be supplied in the psychiatric facility, the officer in charge may, if otherwise permitted by law, transfer the patient to a public hospital for such treatment and return him to the psychiatric facility upon the conclusion thereof.

(2) Where a patient is transferred under subsection (1), the superintendent of the public hospital has, in addition to the powers conferred upon him by the Act under which the hospital operates, the powers under this Act of an officer in charge of a psychiatric facility in respect of the custody and control of the patient.

25. Where it appears to the Minister,

(a) that a patient in a psychiatric facility has come or been brought into Ontario from elsewhere and his hospitalization is the responsibility of another jurisdiction; or

(b) that it would be in the best interests of a patient in a psychiatric facility to be hospitalized in another jurisdiction,

the Minister may, upon compliance in Ontario with necessary modifications with the laws, respecting hospitalization in such other jurisdiction, by warrant in the prescribed form authorize his transfer thereto.

26. Where the Minister has reasonable cause to believe that there may come or be brought into Ontario a person suffering from mental disorder of a nature or quality that likely will result in,

(a) serious bodily harm to the person; or

(b) serious bodily harm to another person,

unless the person is placed in the custody of a psychiatric facility, the Minister by an order in the prescribed form may authorize any one to take the person in custody to a psychiatric facility and the order is authority to admit, detain, restrain, observe and examine the person in the psychiatric facility.

28.(1) A patient shall be discharged from a psychiatric facility when he is no longer in need of the observation, care and treatment provided therein.

(2) Subsection (1) does not authorize the discharge into the community of a patient who is subject to detention otherwise than under this Act.

29.(1) In this section,

(a) "clinical record" means the clinical record compiled in a psychiatric facility in respect of a patient and includes a part of a clinical record;

(b) "patient" includes former patient, out-patient, and former out-patient.

(2) Except as provided in subsections (3) and (5), no person shall disclose, transmit or examine a clinical record.

(3) The officer in charge and the attending physician in the psychiatric facility in which a clinical record was prepared may examine the clinical record and the officer in charge may disclose or transmit the clinical record to or permit the examination of the clinical record by,

(a) where the patient has attained the age of majority and is mentally competent, any person with the consent of the patient;

(b) where the patient has not attained the age of majority or is not mentally competent, any person with the consent of the nearest relative of the patient;

(c) any person employed in or on the staff of the psychiatric facility for the purpose of assessing or treating or assisting in assessing or treating the patient;

(d) the chief executive officer of a health facility that is currently involved in the direct health care of the patient upon the written request of the chief executive officer to the officer in charge;

(e) with the consent of the patient or, where the patient has not attained the age of majority or is not mentally competent, with the consent of the nearest relative of the patient or, where delay in obtaining the consent of either of them would endanger the life, a limb or a vital organ of the patient, without the consent of either of them, a person currently involved in the direct health care of the patient in a health facility;

(f) a person for the purpose of research, academic pursuits or the compilation of statistical data.

(4) Where a clinical record,

(a) is transmitted or copied for use outside the psychiatric facility for the purpose of research, academic pursuits or the compilation of statistical data, the officer in charge shall remove from the part of the clinical record that is transmitted or from the copy, as the case may be, the name of and any means of identifying the patient; and

(b) is disclosed to or examined by a person for the purpose of research, academic pursuits or the compilation of statistical data, the person shall not disclose the name of or any means of identifying the patient and shall not use or communicate the information or material in the clinical record for a purpose other than research, academic pursuits or the compilation of statistical data.

(5) Subject to subsections (6) and (7), the officer in charge or a person designated in writing by the officer in charge shall disclose, transmit or permit the examination of a clinical record pursuant to a subpoena, order, direction, notice or similar requirement in respect of a matter in issue or that may be in issue in a court of competent jurisdiction or under any Act.

(6) Where the disclosure, transmittal or examination of a clinical record is required by a subpoena, order, direction, notice or similar requirement in respect of a matter in issue or that may be in issue in a court of competent jurisdiction or under any Act and the attending physician states in writing that he is of the opinion that the disclosure, transmittal or examination of the clinical record or of a specified part of the clinical record,

(a) is likely to result in harm to the treatment or recovery of the patient; or

(b) is likely to result in,

(i) injury to the mental condition of a third person, or

(ii) bodily harm to a third person,

no person shall comply with the requirement with respect to the clinical record or the part of the clinical record specified by the attending physician except under an order of,

(c) the court before which the matter is or may be in issue; or

(d) where the disclosure, transmittal or examination is not required by a court, under an order of the Divisional Court,

made after a hearing from which the public is excluded and that is held on notice to the attending physician.

(7) On a hearing under subsection (6), the court or body shall consider whether or not the disclosure, transmittal or examination of the clinical record or the part of the clinical record specified by the attending physician

(a) is likely to result in harm to the treatment or recovery of the patient; or

(b) is likely to result in,

(i) injury to the mental condition of a third person, or

(ii) bodily harm to a third person

and for the purpose the court or body may examine the clinical record, and, if satisfied that such a result is likely, the court or body shall not order the disclosure, transmittal or examination unless satisfied that to do so is essential in the interests of justice.

(8) Where a clinical record is required pursuant to subsection (5) or (6), the clerk of the court or body in which the clinical record is admitted in evidence or, if not so admitted, the person to whom the clinical record is transmitted shall return the clinical record to the officer in charge forthwith after the determination of the matter in issue in respect of which the clinical record was required.

(9) No person shall disclose in an action or proceeding in any court or before any body any knowledge or information in respect of a patient obtained in the course of assessing or treating or assisting in assessing or treating the patient in a psychiatric facility or in the course of his employment in the psychiatric facility except,

- (a) where the patient has attained the age of majority and is mentally competent, with the consent of the patient;
- (b) where the patient has not attained the age of majority or is not mentally competent, with the consent of the nearest relative of the patient; or
- (c) where the court or, in the case of a proceeding not before a court, the Divisional Court determines, after a hearing from which the public is excluded and that is held on notice to the patient or (where the patient has not attained the age of majority or is not mentally competent) the nearest relative of the patient, that the disclosure is essential in the interests of justice.

30.(1) The Lieutenant Governor in Council may appoint a review board for any one or more psychiatric facilities.

(2) A review board shall be composed of three or five members, at least one and not more than two of whom are psychiatrists and at least one and not more than two of whom are barristers and solicitors and at least one of whom is not a psychiatrist or a barrister and solicitor.

(3) The Lieutenant Governor in Council may designate one of the members of a review board as chairman.

(4) The Lieutenant Governor in Council may appoint alternate members to a review board, and, where for any reason a member cannot act, the alternate member appropriate to comply with subsection 2 shall act in his stead.

(5) An officer or servant of, or a person with a direct financial interest in, a psychiatric facility shall not act as a member of a review board when the case of a patient of that facility is being reviewed.

(6) A member shall hold office for the period, not to exceed three years, specified in his appointment, but is eligible for reappointment at the expiration of his term of office.

(7) A psychiatrist and a barrister and solicitor and another member who is not a psychiatrist or a barrister and solicitor constitute a quorum, and the decision of a majority is the decision of the review board.

31.(1) An involuntary patient, or any person on his behalf, may apply in the prescribed form to the chairman of the regional review board having jurisdiction to inquire into whether the patient is suffering from mental disorder of a nature or quality that likely will result in,

- (a) serious bodily harm to the patient;
- (b) serious bodily harm to another person; or
- (c) imminent and serious physical impairment of the patient,

unless the patient remains an involuntary patient in the custody of a psychiatric facility.

(2) An application under subsection 1 may be made,

- (a) when a certificate of involuntary admission respecting the patient comes into force;
- (b) when any certificate of renewal respecting the patient comes into force; or

(c) when the patient, after having been admitted to a psychiatric facility, is subsequently continued as an involuntary patient.

(3) An application under subsection (1) may be made at any time by the Minister, the Deputy Minister or the officer in charge in respect of any involuntary patient.

(4) On the completion of a fourth certificate of renewal and on the completion of every fourth certificate of renewal thereafter, the patient shall be deemed to have applied in the prescribed form pursuant to subsection (1) to the chairman of the regional review board having jurisdiction.

32.(a) Upon receipt of an application by the chairman, the review board shall conduct such inquiry as it considers necessary to reach a decision and may hold a hearing, which in the discretion of the review board may be *in camera*, for the purpose of receiving oral testimony.

(2) Where a hearing is held, the patient may attend the hearing unless otherwise directed by the chairman and, where he does not attend, he may have a person appear as his representative.

(3) Where a hearing is held, the patient or his representative may call witnesses and make submissions and, with the permission of the chairman, may cross-examine witnesses.

(4) The officer in charge shall, for the purpose of an inquiry, furnish the chairman with such information and reports as the chairman requests.

(5) The review board or any member thereof may interview a patient or other person in private.

33.(1) Upon the conclusion of an inquiry, the chairman shall prepare a written report of the decision of the review board and within the time prescribed by the regulations transmit a copy thereof to the applicant and to the officer in charge where he is not the applicant.

(2) Upon receipt of a copy of the decision, the officer in charge shall take any action required to give effect thereto.

34.(1) The Lieutenant Governor in Council may appoint an advisory review board for any one or more psychiatric facilities that has a review board.

(2) An advisory review board shall be composed of a judge or a retired judge of the Supreme Court who shall serve as chairman, a psychiatrist and any three members who constitute a quorum of the review board.

(3) Subsections 30(4), (5) and (6) apply with necessary modifications to the members of an advisory review board.

(4) The five members of an advisory review board constitute a quorum and the recommendation of a four-fifths majority is the recommendation of the advisory review board.

(5) The case of every patient in a psychiatric facility who is detained under the authority of a warrant of the Lieutenant Governor under the *Criminal Code* (Canada) shall be considered by the advisory review board having jurisdiction once in every year, commencing with the year next after the year in which the warrant was issued.

(6) Notwithstanding subsection (5), the advisory review board shall consider the case of any patient to which that subsection applies at any time upon the written request of the Minister.

(7) Section 32 applies with necessary modifications to cases under this section.

(8) Upon the conclusion of an inquiry, the chairman shall prepare a written report of the recommendations of the advisory review board and, within the time prescribed by the regulations, shall transmit a copy thereof to the Lieutenant Governor in Council, and may in his discretion transmit a copy thereof to any other person.

35.(1) In this section, "psychosurgery" means any procedure that, by direct or indirect access to the brain, removes, destroys or interrupts the continuity of histologically normal brain tissue, or which inserts indwelling electrodes for pulsed electrical stimulation for the purpose of altering behaviour or treating psychiatric illness, but does not include neurological procedures used to diagnose or treat organic brain conditions or to diagnose or treat intractable physical pain or epilepsy where these conditions are clearly demonstrable.

(2) Psychiatric treatment shall not be given to an involuntary patient without the consent of the patient or, where the patient has not reached the age of majority or is not mentally competent, the consent of the nearest relative of the patient except under the authority of an order of a regional review board made on the application of the officer in charge.

(3) The consent of an involuntary patient or the nearest relative of an involuntary patient to treatment while an involuntary patient does not include and shall not be deemed to include psychosurgery.

(4) Where,

(a) an involuntary patient or the nearest relative of an involuntary patient, as the case requires, refuses consent or an involuntary patient is not mentally competent and 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 to the patient; and

(b) the attending physician, a psychiatrist who is a member and a psychiatrist who is not a member of the medical staff of the psychiatric facility in which the patient is detained each state in the prescribed form;

(i) that he has examined the patient,

(ii) that he is of the opinion that the mental condition of the patient will be or is likely to be substantially improved by the specific psychiatric treatment or the specific course of psychiatric treatment, and

(iii) that the mental condition of the patient will not or is not likely to improve without the specific treatment or course of treatment,

the attending physician on notice to the patient or the nearest relative, as the case requires, may apply to the regional review board for an order

authorizing the providing of the treatment or course of treatment to the patient.

(5) Where the attending physician applies for a hearing under subsection (4), the regional review board shall appoint a time for and hold the hearing and shall issue its decision within seven days after the completion of the hearing and, where the board is satisfied,

(a) that the mental condition of the patient will be or is likely to be substantially improved by the specific psychiatric treatment or course of treatment for the providing of which authority is sought; and

(b) that the mental condition of the patient will not or is not likely to improve without the specific psychiatric treatment or course of treatment,

the board by order may authorize the providing of the psychiatric treatment or course of treatment specified in the application, but the board shall not authorize and no order of the board is or shall be deemed to be authority to perform psychosurgery.

(6) The attending physician and the patient or, where the patient is not mentally competent, the nearest relative or, if none, the Official Guardian and such other persons as the regional review board may specify are parties to the proceedings before the board.

62. All actions, prosecutions or other proceedings against any person or psychiatric facility for anything done or omitted to be done in pursuance or intended pursuance of this Act or the regulations shall be commenced within six months after the act or omission complained of occurred and not afterwards.

63. No action lies against any psychiatric facility or any officer, employee or servant thereof for a tort of any patient.

64. Every person who contravenes any provision of this Act or the regulations is guilty of an offence and on summary conviction is liable to a fine of not more than \$10,000.

PRINCE EDWARD ISLAND

Mental Health Act, R.S.P.E.I. 1974, c. M-9, as amended.

8. Notwithstanding this or any other Act, admission to a psychiatric facility may be refused by the administrator, on the advice of the physician-in-chief, where the immediate needs in the case of the proposed patient are such that hospitalization is not urgent or necessary.

9. Any person who is believed by a physician to be in need of the observation, care or treatment provided in a psychiatric facility may be admitted thereto as a patient upon the recommendation of that physician.

10.(1) Any person who

(a) suffers from mental disorder of a nature or degree so as to require hospitalization in the interests of his own safety or the safety of others; and

(b) refuses to be admitted as a patient under section 9;

may be admitted as an involuntary patient to a psychiatric facility upon application therefor in the prescribed form signed by a physician.

(2) It shall be stated and shown clearly that the physician signing the application personally examined the person who is the subject of the application and made due inquiry into all of the facts necessary for him to form a satisfactory opinion.

(3) The physician signing the application shall also in the application state the facts upon which he has formed his opinion of the mental disorder, distinguishing the facts observed by him from the facts communicated to him by others, and shall note the date upon which the examination was made.

(4) Every application under subsection (1) shall be completed no later than seven days after the examination referred to therein, and no person shall be admitted to a psychiatric facility upon an application except within fourteen days of the date on which the application was completed.

(5) An application under subsection (1) is sufficient authority

(a) to any person to convey the person who is the subject of the application to a psychiatric facility; and

(b) to the authorities thereof to admit and detain him therein for a period of not more than one month.

11.(1) Where information upon oath is brought before a County Court judge or Provincial Judge that a person, within the limits of his jurisdiction

(a) is believed to be suffering from mental disorder, and

(b) should be examined in the interests of his own safety or the safety of others;

the judge or Provincial Judge may, if he is satisfied that,

(c) such examination is necessary; and

(d) such examination can be arranged in no other way;

issue his order for examination in the prescribed form.

(2) In every order under this section it shall be stated and shown clearly that the judge or Provincial Judge issuing the order made due inquiry into all of the facts necessary for him to form a satisfactory opinion.

(3) An order under this section may be directed to all or any police constables of the locality within which the judge or Provincial Judge has jurisdiction and shall name or otherwise describe the person with respect to whom the order has been made.

(4) An order under this section shall direct, and is sufficient authority for, any police constable to whom it is addressed to take the person named or described therein to an appropriate place where he may be detained for medical examination.

12. Where a police constable observes a person

(a) apparently suffering from mental disorder; and

(b) acting in a disorderly manner;
the police constable may, if he is satisfied that
(c) the person should be examined in the interests of his own
safety or the safety of others; and
(d) the circumstances are such that to proceed under section 11
would be dangerous;
take the person to an appropriate place where he may be detained for
medical examination.

13. An examination referred to in section 11 or 12 shall be conducted
forthwith and, wherever practicable, the place of examination shall be a
psychiatric or other medical facility.

14. A patient admitted under section 9 may, upon completion of the
prescribed form by a physician, be continued as an involuntary patient, and
in any such case section 10 applies *mutatis mutandis*.

15.(1) The period of detention of an involuntary patient may be
extended upon the completion of a certificate of renewal in the prescribed
form by the attending physician after personal examination.

(2) The attending physician shall not complete a certificate of renewal
unless in his opinion the patient

(a) suffers from mental disorder of a nature or degree so as to
require further hospitalization in the interests of his own safety or
the safety of others; and

(b) refuses to continue as a patient in a psychiatric facility.

(3) A certificate of renewal is authority to detain the patient as follows:

(a) a first certificate shall be for not more than two additional
months from the date of expiration of the time specified under
subsection 10(5);

(b) a second certificate shall be for not more than three additional
months from the date of expiration of the first certificate;

(c) a third certificate shall be for not more than six additional
months from the date of expiration of the second certificate;

(d) a fourth certificate shall be for not more than twelve
additional months from the date of expiration of the third
certificate;

(e) each subsequent certificate shall be for not more than twelve
additional months from the date of expiration of the last
certificate issued.

(4) An involuntary patient whose authorized period of detention has
expired shall be deemed to be a voluntary patient.

(5) An involuntary patient whose authorized period of detention has
not expired may be continued as a voluntary patient upon completion of the
prescribed form by the attending physician.

16.(1) Where a judge or Provincial Judge has reason to believe that a
person who appears before him charged with or convicted of an offence
suffers from mental disorder, the judge or Provincial Judge may order the
person to attend a psychiatric facility for examination.

(2) Where an examination is made under this section, the physician-in-chief shall report in writing to the judge or Provincial Judge as to the mental condition of the person.

(3) If the physician-in-chief reports that the person examined needs treatment, the judge or Provincial Judge may order the person to attend a psychiatric facility for treatment.

17.(1) Where a judge or Provincial Judge, on the opinion of a physician, has reason to believe that a person in custody who appears before him charged with an offence suffers from mental disorder, the judge or Provincial Judge may, by order, remand that person for admission as a patient for observation to a psychiatric facility for a period of not more than two months.

(2) Before the expiration of the time mentioned in such order, the physician-in-chief shall report in writing to the judge or Provincial Judge as to the mental condition of the person.

(3) A patient admitted under subsection (1) may, upon completion of the prescribed form by a physician, be continued as an involuntary patient, and in any such case section 10 applies *mutatis mutandis*.

18. Any person who, pursuant to the *Criminal Code* (Canada), R.S.C. 1970, Chap. C-34, is

(a) remanded to custody for observation; or

(b) detained under the authority of a warrant of the Lieutenant Governor,

may be admitted to, detained in, and discharged from a psychiatric facility in accordance with the provisions of the *Criminal Code* (Canada), R.S.C. 1970, Chap. C-34.

20.(1) Upon the advice of the attending physician, the administrator of a psychiatric facility may, if otherwise permitted by law and subject to arrangements being made with the administrator of another psychiatric facility, transfer a patient to the other psychiatric facility upon completing a memorandum of transfer in the prescribed form.

22. Where it appears to the Director

(a) that a patient in a psychiatric facility has come or been brought into Prince Edward Island from elsewhere and his hospitalization is the responsibility of another jurisdiction; or

(b) that it would be in the best interests of a patient in a psychiatric facility to be hospitalized in another jurisdiction;

the Director may, with the authorization of the Minister and upon compliance in Prince Edward Island *mutatis mutandis* with the laws respecting hospitalization in such other jurisdiction, by order in the prescribed form, authorize his transfer thereto.

23.(1) Where the Director has reason to believe that a person suffering

from mental disorder may come or be brought into Prince Edward Island from elsewhere, the Director, with the authorization of the Minister, may issue an order in the prescribed form which is sufficient authority to any person to convey the person named therein to a psychiatric facility and to the authorities thereof to admit and detain him.

(2) A person admitted to a psychiatric facility under subsection (1) shall be deemed to have been admitted as an involuntary patient under section 10.

24.(1) A patient shall be discharged from a psychiatric facility when he is no longer in need of the observation, care and treatment provided therein.

(2) Subsection (1) does not authorize the discharge into the community of a patient who is subject to detention otherwise than under this Act.

25.(1) The Lieutenant Governor in Council shall appoint a review board.

(2) The review board shall be composed of three members, one of whom is a County Court judge and shall act as chairman, one of whom is a physician and one of whom is not a barrister and solicitor or a physician.

(3) The Lieutenant Governor in Council shall appoint alternate members to the review board, and, where for any reason a member is unable or refuses to act, the alternate member appropriate to comply with subsection (2) shall act in his stead.

(4) An officer or servant of, or a person with a direct financial interest in, a psychiatric facility shall not act as a member of the review board when the case of a patient of that facility is being reviewed.

(5) A member shall hold office for the period, not to exceed three years, specified in his appointment, but is eligible for re-appointment at the expiration of his term of office.

(6) The three members of the review board constitute a quorum, and the decision of a majority is the decision of the review board.

26.(1) An involuntary patient, or any person on his behalf, may apply in the prescribed form to the chairman of the review board to inquire into whether the patient suffers from mental disorder of a nature or degree so as to require hospitalization in the interests of his own safety or the safety of others.

(2) An application under subsection (1) may be made

(a) when any certificate of renewal respecting the patient comes into force;

(b) when the patient, after having been admitted to a psychiatric facility, is subsequently continued as an involuntary patient; or

(c) when the patient has been admitted to a psychiatric facility as an involuntary patient under section 10.

(3) An application under subsection (1) may be made at any time by the Minister or the administrator in respect of any involuntary patient.

27.(1) Upon receipt of an application by the chairman, the review board shall, within fourteen days, conduct such inquiry as it considers necessary to reach a decision and may hold a hearing for the purpose of

receiving oral testimony; the hearing may in the discretion of the review board be *in camera*.

(2) Where a hearing is held, the patient may attend the hearing unless otherwise directed by the chairman and, where he does not attend, he may have a person appear as his representative.

(3) Where a hearing is held, the patient or his representative may call witnesses and make submissions and, with the permission of the chairman, may cross-examine witnesses.

(4) The administrator shall, for the purpose of an inquiry, furnish the chairman with such information and reports as the chairman requests.

(5) The review board or any member thereof may interview a patient or other person in private.

28.(1) Upon the conclusion of an inquiry, the chairman shall prepare a written report of the decision of the review board and within the time prescribed by the regulations transmit a copy thereof to the applicant and to the administrator where he is not the applicant.

(2) Upon receipt of a copy of the decision, the administrator shall take any action required to give effect thereto.

(3) No person who has made application to the chairman of the review board under subsection 26(1), may make another application to the chairman of the review board respecting the same matter before the expiration of one month from the date of the board's decision, and not before the expiration of six months in the case of any subsequent application.

29.(1) The case of every patient in a psychiatric facility who is detained under the authority of a warrant of the Lieutenant Governor under the *Criminal Code* (Canada), R.S.C. 1970, Chap. C-34 shall be considered by the review board once in every year, commencing with the year next after the year in which the warrant was issued.

(2) Notwithstanding subsection (1), the review board shall consider the case of any patient to which that subsection applies at any time upon the written request of the Lieutenant Governor in Council, the Minister, the Deputy Minister or the administrator.

(3) Section 27 applies *mutatis mutandis* to cases under this section.

(4) Upon the conclusion of an inquiry under this section, the chairman shall prepare a written report of the recommendations of the review board and, within the time prescribed by the regulations, shall transmit a copy thereof to the Lieutenant Governor in Council, and may in his discretion transmit a copy thereof to any other person.

56.(1) No action, prosecution, or other proceeding shall be brought or shall be instituted against any officer, nurse, clerk, servant or other employee of a psychiatric facility, or against any other person, for any act done in pursuance or execution, or intended execution, of any duty or authority under this Act or the regulations, or in respect of any alleged

neglect or default in the execution of any such duty or authority, without the consent of the Minister of Justice.

(2) All actions and prosecutions against any person for anything done, or omitted to be done, in pursuance of this Act shall be commenced within twelve months after the act or omission complained of has been committed, and not afterwards.

57. No action lies against any psychiatric facility or any officer, employee or servant thereof for a tort of any patient.

58. Every person who contravenes or is a party to the contravention, directly or indirectly, of any provision of this Act or the regulations is guilty of an offence and on summary conviction is liable to a fine of not less than twenty-five dollars, and not more than five hundred dollars, and in default of payment thereof, to a term of imprisonment of not more than one month.

QUEBEC

Mental Patients Protection Act, R.S.Q. 1977, c. P-41.

2. Every establishment must take the necessary measures, within the limitations of its organization and means, to have made without delay a psychiatric clinical examination on any person showing signs of mental disorders likely to endanger the health or security of that person or the health or security of others.

If the establishment is unable to provide such examination because of its organization or means, it shall send such person to a hospital centre or local community service centre.

3. A clinical psychiatric examination must be made by a psychiatrist who is not related or allied to the person examined; however, a physician may make such examination if he is not related or allied to such person when, by reason of urgency, distance and other circumstances, no psychiatrist is available in the region where such person resides.

4. The examination under section 2 may be required from a hospital centre or a local community service centre on behalf of the person showing signs of mental disorders, by any physician entitled by law to practise his profession in Quebec.

5. When a person is detained in a house of detention, such services must be required from a psychiatric establishment for detained persons by a physician whose examination is required by such house of detention, unless such physician believes that public safety is not endangered if such examination is required from a hospital centre and the administrator of the house of detention shares such opinion.

6. Every judge before whom appears a person showing signs of mental disorder likely to make the latter unfit to stand trial shall require such examination from a hospital centre or local community service centre.

7. The psychiatric clinical examination must as far as possible be made within twenty-four hours after request therefor and be followed by a written report signed by the person who made the examination and stating whether or not close treatment is necessary.

8. The report contemplated in section 7 must relate to the fitness of the person examined to stand trial if the examination is made therefor.

It must mention, in all cases, the capacity of such person to administer his property.

9. If the psychiatric clinical examination has been made outside a hospital centre and the report contemplated by section 7 concludes that close treatment is necessary or that the person concerned is incapable of administering his property, the psychiatrist or physician who has submitted such report must send a copy thereof to a hospital centre having a medical record of the patient examined or, in default thereof, to the nearest hospital centre.

No person shall take cognizance of such a report unless authorized to do so by law.

11. No person shall be admitted to close treatment unless his mental condition might endanger his health or security or the health or security of others.

12. No hospital centre may admit a person for close treatment unless he has had a psychiatric clinical examination, unless the report contemplated by section 7 shows the necessity of close treatment and unless such report has been confirmed by the report of another psychiatrist after a psychiatric clinical examination performed by such psychiatrist.

A hospital centre may however admit such person for close treatment of not more than ninety-six hours when a second psychiatrist has not confirmed the report of the first.

13. If a person refuses to undergo a clinical psychiatric examination required for him under section 4 or 5 or the close treatment recommended in the report contemplated in section 7, a judge of the Provincial Court, Court of the Sessions, Youth Court or the municipal courts of the cities of Montreal, Laval or Quebec having jurisdiction in the locality where such person is may order him to have such examination or, as the case may be, undergo close treatment.

Such an order may be issued against the tutor, curator or legal guardian of such person if the refusal comes from such tutor, curator or guardian.

The judge contemplated in section 6 may issue such an order respecting

any person mentioned in such section who refuses to have the psychiatric clinical examination required by such judge.

16. When the motion is intended to place a person under close treatment following a report contemplated in section 7 concluding to that effect, the judge may make the order on seeing the report after having ascertained that all the requirements of this act have been complied with but without deciding on the mental condition of the person who is the object of such report.

17. When the motion is intended to have a person undergo a clinical psychiatric examination, the judge shall question the person respecting whom the motion is made unless the latter is untraceable or has fled or the judge considers it preferable for the health or security of such person or of others not to question him.

18. The judge may order that the person for whom the motion is made be conveyed to a hospital centre so that the order be complied with.

21. The director of professional services or, in his absence, any physician practising in a hospital centre may admit temporarily thereto a person not having undergone a psychiatric clinical examination, if he considers that the mental state of such person poses a serious and immediate threat for such person or others.

Within forty-eight hours such person must have a psychiatric clinical examination; if the report following such examination concludes that close treatment is necessary, the motion contemplated in section 14 must be made to the judge by the director of professional services as if such person refused to have a clinical psychiatric examination.

22. Any person in close treatment in a hospital centre may be transferred to a reception centre within the meaning of the Act respecting health services and social services to continue or terminate therein his close treatment if the physician treating him attests by a certificate which he issues for that purpose that such measure does not endanger the health or safety of such person or of others.

Such certificate must designate the reception centre whereto such person must be transferred and specify the period of time that he must remain there, at the end of which period such person must return to the hospital centre.

23. No hospital centre may keep a person under close treatment for more than twenty-one days after his admission without a new psychiatric clinical examination confirming the necessity to prolong such close treatment.

Such examination must be made again three months after the first and, subsequently, at least every six months, in default of which the close treatment of such person must end.

24. A person shall cease to be under close treatment when:

- (a) he is discharged by the establishment where he is on the recommendation of a psychiatrist by a certificate issued by the latter for that purpose;
- (b) his discharge is ordered by a final judgment of a competent court or by the decision of the Commission.

25. In the case of a person ceasing to be in close treatment without having served the term of imprisonment that he must serve in a house of detention, prison, penitentiary or house of correction, the hospital centre discharging him must take the necessary measures to place him in the custody of such house of detention, prison, penitentiary or house of correction.

26. The director of professional services of any hospital centre where a person is in close treatment may order such person transferred to another hospital centre in Quebec or with the authorization of the Minister, outside Quebec, if in their opinion such measure will not hinder the progress of the mental condition of such person.

27. Every hospital centre or reception centre to which a person is admitted in close treatment must inform such person in writing, in accordance with the regulations, of the rights and recourses granted to him by this act; it must also inform him in writing that his close treatment has terminated as soon as it is ended.

28. Every physician treating a person under close treatment must notify the family of such person or the persons taking care of him, of the arrangements made about him and the measures likely to hasten his recovery. The physician must further notify the person under close treatment unless his mental condition precludes use of such information or if it would be harmful to such person to have knowledge of his condition.

30. Every person who is dissatisfied with a decision rendered under this act respecting him or respecting anyone related or allied to him, may request the Commission to review such decision. The tutor or curator of the person who is the object of the decision and the person having his legal custody may also make such request.

The application for review does not suspend execution unless otherwise decided by the Commission.

31. The establishment in which a person has been admitted for close treatment for thirty days shall without delay send a notice to the Commission giving the name of the person and the date of the commencement of his close treatment.

If the close treatment is continued for six months, the establishment shall send a new notice to the Commission. It must in addition send a notice when the close treatment ends.

The complete medical record of a person under close treatment must be forwarded to the Commission if the latter so requires.

Where the Commission receives a notice sent in accordance with this section, it may make an inquiry and render a decision as if an application for review had been made under section 30.

32. Every person who violates any provision of this act or the regulations or refuses to comply with an order given under such act or regulations is guilty of an offence and is liable, on summary proceeding, in addition to the costs, to a fine of not more than \$200 in the case of an individual and not more than \$1,000 in the case of a corporation.

Part II of the Summary Convictions Act shall apply to such prosecutions.

33. The Government may, by regulation, establish psychiatric establishments for detained persons to receive and treat persons detained under the Criminal Code or any penal law. It may also convert to that purpose any existing psychiatric establishment.

34. The Government may also, by regulation, authorize any psychiatric establishment it designates, to receive and treat persons detained under the Criminal Code or any penal law.

35. The Government shall make regulations on the management, supervision and administration of the establishments contemplated in section 33 or 34 where detained persons are received and treated, and on the security standards to be respected therein.

36. The Government may make agreements, on the conditions it determines, with any government, government body, public or private corporation, person or partnership for the establishment, organization and administration of hospital centres, reception centres or psychiatric establishments for detained persons and generally for the carrying out of this act.

PART I
Short Title and Interpretation

- 1 This Act may be cited as *The Mental Health Services Act*. Short title
- 2 In this Act: Interpretation
- (a) "approved home" means any building, premises or place in respect of which there is a subsisting certificate issued pursuant to section 37 of this Act or pursuant to *The Mental Health Act*; "approved home"
- (b) "attending physician" means the physician who has responsibility for the care and treatment of an in-patient; "attending physician"
- (c) "branch" means Mental Health Services Branch of the department; "branch"
- (d) "chief psychiatrist" means a psychiatrist designated pursuant to section 9; "chief psychiatrist"
- (e) "department" means the department over which the minister presides; "department"
- (f) "director" means the Executive Director of the Mental Health Services Branch of the department; "director"
- (g) "experimental treatment" means any treatment that poses a significant risk of harm to the patient, other than one that is: "experimental treatment"
- (i) commonly accepted for treatment of the mental disorder involved or supported by widely accepted scientific studies; and
- (ii) provided by a qualified health professional;
- (h) "facility" means: "facility"
- (i) a mental health centre;
- (ii) a psychiatric ward;
- (iii) a mental health clinic; or
- (iv) any other building or portion of a building for the care, treatment or training of persons with mental disorders that is designated as a facility;
- (i) "in-patient" means a patient to whom a bed is allocated for overnight stay in an in-patient facility; "in-patient"
- (j) "in-patient facility" means a facility which provides services to in-patients; "in patient facility"
- (k) "involuntary patient" means a patient who is admitted to and detained in an in-patient facility pursuant to section 23 or 24; "involuntary patient"
- (l) "judge" means a judge of Her Majesty's Court of Queen's Bench for Saskatchewan; "judge"

- "mental disorder" (m) "mental disorder" means a disorder of thought, perception, feelings or behaviour that seriously impairs a person's judgment, capacity to recognize reality, ability to associate with others or ability to meet the ordinary demands of life, in respect of which treatment is advisable;
- "mental health centre" (n) "mental health centre" means a place where services are provided to in-patients and out-patients and that is designated by the minister as a mental health centre;
- "mental health clinic" (o) "mental health clinic" means a place where services are provided to out-patients and not to in-patients and that is designated by the minister as a mental health clinic;
- "minister" (p) "minister" means the member of the Executive Council to whom for the time being the administration of this Act is assigned;
- "nearest relative" (q) "nearest relative" means the person first described in this clause who is mentally competent and available:
- (i) the spouse;
 - (ii) a son or daughter who has attained the age of majority;
 - (iii) a parent or guardian;
 - (iv) a brother or sister who has attained the age of majority;
 - (v) any other of the next-of-kin who has attained the age of majority;
- "officer in charge" (r) "officer in charge" means a person appointed pursuant to section 8;
- "official representative" (s) "official representative" means an official representative appointed pursuant to section 10;
- "out-patient" (t) "out-patient" means a patient who is not an in-patient;
- "patient" (u) "patient" means a person receiving:
- (i) diagnostic services for the purpose of determining the existence or nature of; or
 - (ii) care or treatment for;
- a mental disorder pursuant to this Act;
- "physician" (v) "physician" means a duly qualified medical practitioner;
- "prescribed" (w) "prescribed" means prescribed by the Lieutenant Governor in Council pursuant to this Act or *The Mental Health Act*;
- "psychiatric ward" (x) "psychiatric ward" means a ward in a hospital approved pursuant to *The Hospital Standards Act* or any former *Hospital Standards Act* and designated by the minister as a psychiatric ward;

(y) "psychiatrist" means a physician:

"psychiatrist"

(i) who holds a specialist's certificate in psychiatry issued by the Royal College of Physicians and Surgeons of Canada; or

(ii) whose combination of training and experience in psychiatry is satisfactory to the minister and who has been approved by the minister as a psychiatrist for the purposes of this Act;

(z) "psychosurgery" means any procedure that by direct access to the brain removes, destroys or interrupts the normal connections of the brain for the primary purpose of treating a mental disorder or involves the implantation of electrodes, but does not include neurosurgical procedures designed to treat reliably diagnosed organic brain conditions or epilepsy;

"psycho-
surgery"

(aa) "region" means a mental health region established in the regulations;

"region"

(bb) "regional director" means a regional director appointed pursuant to section 7;

"regional
director"

(cc) "review panel" means a review panel appointed pursuant to section 32.

"review panel"

PART IV

General Rights and Obligations

14 Except as provided in this Act, no person who:

- (a) is receiving or has received mental health services; or
- (b) is or has been named in a certificate, warrant or order issued pursuant to section 18, 19, 21, 22, 23 or 24 of this Act or in any similar certificate, warrant or order issued pursuant to *The Mental Health Act* or any former Act respecting mental health.

shall be deprived of any right or privilege enjoyed by other persons solely by reason of receiving or having received mental health services or having been named in the certificate, warrant or order.

Restrictions
as to persons
giving
certificates

15 Except as permitted by the regulations or by the minister, no certificate or form required by this Act or the regulations with respect to any person shall be made, issued, given, completed or signed by a physician who is by blood or marriage closely related to or connected with:

- (a) that person; or
- (b) any physician who makes, issues, gives, completes or signs a certificate or form with respect to that person.

Right to be
informed

16(1) Every person who is apprehended or detained pursuant to section 18, 19, 20, 21, 22, 23 or 24:

- (a) shall be informed promptly of the reasons for his apprehension or detention, as the case may be; and
- (b) is entitled on his own request to receive a copy of the certificate, warrant or order pursuant to which he has been apprehended or is detained, as the case may be, as soon as is reasonably practicable.

(2) Where a person is apprehended or detained pursuant to section 18, 19, 21, 22, 23 or 24 or is transferred pursuant to section 28, an official representative for the region shall be provided with a copy of the certificate, warrant or order pursuant to which the person is or was apprehended, detained or transferred as the case may be, as soon as is reasonably practicable.

PART V

Assessment, Treatment, Admission and Discharge

Voluntary
request for
services

17 Subject to the regulations and to the availability of services that the minister provides, a person may, on his own request:

- (a) receive assessment and treatment services as an out-patient;

(b) with the advice and on the arrangements of a physician with admitting privileges to an in-patient facility, be admitted to an in-patient facility as an in-patient; or

(c) receive other services available pursuant to this Act.

18(1) Subject to the regulations, any person who:

Involuntary
out-patient
examination

(a) in the opinion of an examining physician is suffering from a mental disorder and requires a psychiatric examination to ascertain whether he should be admitted to an in-patient facility pursuant to section 24; and

(b) refuses to submit to the examination mentioned in clause (a);

may, after:

(c) arrangements have been made with a physician who has admitting privileges to an in-patient facility; and

(d) the certificate of the examining physician is issued in accordance with this section;

be conveyed to a place where he may be examined as an out-patient by the physician mentioned in clause (c).

(2) The certificate of a physician in the prescribed form is sufficient authority to any person to apprehend the person who is the subject of the certificate and convey him immediately to the place where the examination is to be conducted by the physician mentioned in clause (1)(c).

(3) Every certificate issued pursuant to subsection (1) is required to:

(a) state that the physician has personally examined the person who is the subject of the certificate and, after due inquiry into the necessary facts relating to the case of the person, has formed the opinion that the person is suffering from a mental disorder and requires a psychiatric examination to ascertain whether he should be admitted to an in-patient facility pursuant to section 24;

(b) state the facts on which the physician has formed his opinion of the mental disorder;

(c) show the date on which the examination was made; and

(d) be signed in the presence of one subscribing witness.

(4) No person shall be conveyed for a psychiatric examination more than seven days after the date on which the examination for the purposes of subsection (1) was made.

(5) A psychiatric examination pursuant to this section shall be conducted as soon as is reasonably practicable, and in all cases within 24 hours, after the person arrives at the place where he is to be examined.

24(1) In this section "physician" means a physician who has admitting privileges to an in-patient facility.

(2) Every certificate issued for the purposes of this section is to be in the prescribed form and is to:

(a) state that the physician has examined the person named in the certificate within the immediately preceding 72 hours and that, on the basis of the examination, he has probable cause to believe that:

(i) the person is suffering from a mental disorder as a result of which he is in need of treatment or care and supervision which can be provided only in an in-patient facility;

(ii) as a result of the mental disorder the person is unable to fully understand and to make an informed decision regarding his need for treatment or care and supervision; and

(iii) as a result of the mental disorder, the person is likely to cause harm to himself or to others or to suffer substantial mental or physical deterioration if he is not detained in an in-patient facility;

(b) state the facts on which the physician has formed his opinion that the person meets the criteria set out in clause (a);

(c) show the date on which the examination was made; and

(d) be signed in the presence of one subscribing witness.

(3) On the issuance of the certificates of two physicians at least one of whom is a psychiatrist:

(a) a person who is not an in-patient in an in-patient facility may be apprehended, conveyed and admitted to an in-patient facility and detained there until the end of the 21st day following the day that he is admitted;

(b) a person who is an in-patient in an in-patient facility may be detained there until the end of the 21st day following the date of the issuance of the first of the two certificates.

(4) Notwithstanding subsection (3), where it is not reasonably practicable to obtain the certificates of two physicians at least one of whom is a psychiatrist, on the issuance of the certificate of one physician:

(a) a person who is not an in-patient in an in-patient facility may be apprehended, conveyed and admitted to an in-patient facility and detained there until the end of the third day following the day that he is admitted;

(b) a person who is an in-patient in an in-patient facility may be detained there until the end of the third day following the date of the issuance of the certificate.

(5) Where a person is detained in an in-patient facility pursuant to subsection (4), a second opinion about his condition is to be obtained as soon as practicable, where the physician who signed the certificate on the basis of which the person is detained in the facility is:

- (a) a psychiatrist, from another physician; or
- (b) not a psychiatrist, from a psychiatrist.

(6) Where:

- (a) a person is detained pursuant to subsection (4); and
- (b) a certificate is issued by the physician who examined the patient pursuant to subsection (5);

the person may be further detained until the end of the 21st day following the date of the issuance of the certificate pursuant to subsection (4).

(7) A person detained in an in-patient facility pursuant to this section may be detained for successive periods of 21 days on the certificates, signed before the end of each 21-day period, of two physicians at least one of whom is a psychiatrist.

(8) No person shall be admitted to an in-patient facility:

- (a) pursuant to clause (3)(a) more than seven days after the date of the first of the two examinations on which the certificates are based;
- (b) pursuant to clause (4)(a) more than seven days after the date of the examination on which the certificate is based.

(9) Where an in-patient who has been detained pursuant to this section indicates a desire to remain as an in-patient pursuant to section 17, the attending physician may issue an order in the prescribed form revoking any certificate then in effect, and in that event he may remain in the facility pursuant to section 17.

Authority
respecting
diagnostic and
treatment
services

25(1) Except in a case of emergency, where a patient is in an in-patient facility pursuant to section 17, no diagnostic or treatment services or procedures are to be carried out on the patient except with his consent or, where he is not competent to consent, with the consent of his nearest relative.

(2) Subject to the regulations and to subsections (3) to (5), the attending physician may perform or prescribe any diagnostic procedures he considers necessary to determine the existence or nature of a mental disorder and administer or prescribe any medication or other treatment that is consistent with good

medical practice and that he considers necessary to treat the mental disorder, to an involuntary patient without that patient's consent.

(3) In the course of on-going diagnosis or treatment, to the extent that it is feasible given the patient's medical condition, the attending physician shall consult with the patient, explain or cause to be explained to the patient the purpose, nature and effect of proposed diagnosis or treatment and give consideration to the views the patient expresses concerning the patient's choice of therapists, the proposed diagnosis or treatment and any alternatives and the manner in which diagnoses or treatments may be provided.

(4) No physician or other person shall administer any treatment that is designated pursuant to clause 43(g) to any involuntary patient, except in accordance with special procedures prescribed for that treatment.

(5) In no case shall a physician or any other person administer psychosurgery or experimental treatment to an involuntary patient.

26(1) A patient who desires to have a person other than his nearest relative authorized to consent on his behalf pursuant to subsection 25(1) may apply to a judge for an order appointing another person to act instead of the nearest relative for the purposes of that subsection.

Person other than nearest relative

(2) Where another person is appointed pursuant to subsection (1), the nearest relative is no longer authorized to consent on behalf of the patient.

(3) An application pursuant to this section may be made by notice of motion.

27 Subject to section 25, where a person is detained in an in-patient facility, the attending physician shall endeavor with all resources reasonably available in the facility to provide the person with care and treatment as a result of which the detention of the person in the facility will no longer be required.

Discontinue care and treatment

28(1) Subject to the regulations and to the terms of any warrant or order authorizing a patient's detention in an in-patient facility pursuant to section 23, the director may, by order in the prescribed form, transfer an involuntary patient from an in-patient facility to any other in-patient facility.

Transfer to another facility

(2) An order issued pursuant to subsection (1) is to include written reasons for the transfer

(3) A patient who is the subject of an order issued pursuant to subsection (1) shall be informed promptly of the reasons for the transfer and is entitled on his own request to receive a copy of the order as soon as is reasonably practicable.

(4) Where a patient is transferred pursuant to subsection (1), the director's order is to be accompanied by the certificates, warrant or order authorizing the detention of the person in the facility from which he is transferred, and the director's order and the certificates, warrant or order continue to be sufficient authority for his detention.

PART VI

Appeal and Review Procedures

32(1) The minister shall appoint a review panel for each region.

Review
panels,
appointment,
duties, etc

(2) Each review panel shall consist of three persons, one of whom is to be a physician and another a solicitor.

(3) A member of a review panel holds office for a term of not more than three years, and is eligible for re-appointment at the expiration of his term of office.

(4) The minister shall designate one of the members of each review panel to be chairman of the review panel and another to be vice-chairman.

(5) Subject to subsection (2), the minister may appoint an alternate member for each member of a review panel, and an alternate member has all the powers of a member when he is acting as a member.

(6) No employee of the Government of Saskatchewan or of any agency of the government or of a facility, no person actively serving as a member of the medical staff of a facility and no person who by blood or marriage is closely related to or connected with a member of that medical staff shall be a member or alternate member of a review panel.

(7) The minister shall provide any secretarial or other assistance to each review panel that he considers necessary.

(8) The function of a review panel is the investigation of appeals submitted pursuant to this Act or the regulations and for the purpose of any such investigation the members of the review panel have all the powers of commissioners pursuant to *The Public Inquiries Act*.

(9) A decision of a majority of the members is the decision of the review panel.

(10) The members of each review panel and the alternate members are to receive any remuneration and reimbursement for expenses that may be determined by the minister.

Notice to
patients
respecting
review panel

33(1) Where a person:

- (a) is detained in an in-patient facility pursuant to section 24; or
- (b) is the subject of an order for a transfer pursuant to section 28;

the attending physician shall immediately notify that person, his nearest relative and an official representative for the region in which the facility is located of:

- (c) the existence and function of the review panel appointed for the region where the facility is located;
- (d) the name and address of the chairman of the review panel; and
- (e) the right of appeal to the review panel, as provided in section 34.

(2) On receipt of a notice pursuant to subsection (1), the official representative shall:

- (a) visit the patient;
- (b) as soon as is reasonably practicable, advise the patient about his right of appeal; and
- (c) provide any assistance that he considers necessary to enable the patient to initiate his appeal, if the patient wishes to do so.

Appeals and
investigation
by review
panel

34(1) In this section "appellant" means a person described in clause 33(1)(a) or (b) who submits an appeal or on whose behalf an appeal is submitted.

(2) Subject to subsection (4), a person described in clause 33(1)(a) or (b) may submit an appeal in writing to the chairman of the review panel alleging that he should not be detained or transferred, as the case may be.

(3) The nearest relative of a person described in clause 33(1)(a) or (b), an official representative or any other person who has a sufficient interest may submit an appeal pursuant to subsection (2) on behalf of the person detained or transferred, as the case may be.

(4) A person described in clause 33(1)(a) has no right of appeal pursuant to this section unless at least two new certificates have been issued pursuant to section 24 with respect to him since he last exercised his right of appeal pursuant to this section.

(5) Where certificates are issued pursuant to section 24 which would authorize the detention of a person in an in-patient facility after the expiration of:

- (a) 21 days;
- (b) six months; or
- (c) any multiple of six months;

following the date of his admission, the attending physician shall so notify the chairman of the review panel for the region in which the facility is located, and for the purposes of this section that notice is deemed to be an appeal by the person being detained.

(6) On receipt by the chairman of a review panel of an appeal pursuant to subsection (2), (3) or (5), the review panel shall:

- (a) immediately carry out any investigation that it considers necessary to speedily determine the validity of the appeal; and
- (b) invite the appellant and other persons considered by the review panel to be affected by the appeal to testify or produce evidence relating to the appeal.

(7) The appellant has the right on an appeal:

- (a) to see any written evidence placed before the review panel;
- (b) to be personally present when any oral evidence is presented to the review panel;
- (c) to adduce evidence;
- (d) to cross examine; and
- (e) to be represented by counsel.

(8) The review panel shall decide whether the appellant shall be detained or transferred, as the case may be.

(9) The chairman of the review panel shall make a written report of the decision of the review panel and shall, before the end of the third business day following the day that the appeal was received, transmit the report to:

- (a) the appellant;
- (b) the nearest relative or official representative, where he submitted the appeal; and
- (c) the officer in charge of the facility in which the appellant is a patient.

(10) Where the review panel does not find in favour of the appellant, the chairman of the review panel shall include in the written report transmitted to the appellant pursuant to clause (9)(a) notice of the right of appeal to Her Majesty's Court of Queen's Bench for Saskatchewan, as provided in section 36.

(11) The officer in charge of a facility where an appellant is detained shall take any action that may be required to give effect to the decision of the review panel.

(12) *The Arbitration Act* does not apply to an investigation pursuant to this section.

Regulations
respecting
appeals and
investigations

35 The Lieutenant Governor in Council may make regulations:

- (a) creating rights of appeal to a review panel in addition to those specified in section 34, and defining the powers of review panels with respect to appeals pursuant to the regulations;
- (b) conferring on review panels any ancillary powers that are considered advisable for carrying out their functions pursuant to this Act and the regulations; and
- (c) regulating practice and procedure before review panels.

Appeal to
Court of
Queen's Bench

36(1) A patient, or a person described in subsection 34(3) on his behalf, may appeal the decision of a review panel respecting an appeal pursuant to section 34 to Her Majesty's Court of Queen's Bench for Saskatchewan within 30 days of the date of the decision.

(2) An appeal pursuant to this section may be made by notice of motion, and the notice of motion is to be served on:

- (a) the director;
- (b) the officer in charge of the facility in which the appellant is a patient; and

- (c) any other persons that the court may direct.
- (3) The practice and procedure of Her Majesty's Court of Queen's Bench for Saskatchewan on an application in chambers apply to an application pursuant to this section, *mutatis mutandis*.
- (4) An appeal pursuant to this section is to be supported by an affidavit of the appellant setting forth fully the facts in support of the appeal.
- (5) In addition to the evidence adduced by the appellant, the court may direct any further evidence to be given that it considers necessary.
- (6) The court may confirm or reverse the decision of the review panel and may make any order that it considers necessary to give effect to its decision.
- (7) The decision of the court pursuant to this section is not subject to appeal.
- (8) The court may make any order as to the costs of an appeal pursuant to this section that it considers appropriate.

YUKON TERRITORY

Mental Health Ordinance, R.O.Y.T. 1971, c. M-7, as amended.

4.(1) Any person may make an application to the court, supported by his affidavit giving reasons therefor, alleging that a person is or is suspected and believed to be a mentally disordered person and requesting an order declaring that such person is a mentally disordered person, respecting his custody or commitment and respecting the management of his property.

(2) Subject to a direction pursuant to section 3, the court may, if satisfied that the application and supporting affidavit warrant a hearing, issue a warrant in the prescribed form to apprehend the person alleged to be mentally disordered and bring him before the court for a hearing.

(3) Any person apparently mentally ill or mentally defective and conducting himself in a manner which may be dangerous to himself or others, may be apprehended without a warrant by a peace officer, and detained until the question of his mental condition is determined by the court.

5.(1) The court shall, at the hearing, hear evidence concerning,

(a) the alleged mental disorder, including the evidence of two medical practitioners;

(b) the residence, name, age and other particulars of the person alleged to be mentally disordered;

(c) the means of support of the person alleged to be mentally disordered and the property, both real and personal, of the person alleged to be mentally disordered;

(d) his marital status and dependents, if any; and

(e) such other matters as the court deems relevant to the case,

but where the evidence mentioned in paragraph (a) is not available the court may dispense with such evidence if having regard to all the circumstances of the case it is proper to do so.

(2) The court has full power to compel attendance of witnesses, the

production of documentary or other evidence and take any other steps it deems necessary for a full and proper hearing.

6.(1) Where the court is not satisfied that the person alleged to be mentally disordered is mentally disordered, it shall order dismissal of the application and make such order as to costs or otherwise as it deems just in the circumstances.

(2) Where the court is satisfied that the person alleged to be mentally disordered is mentally disordered, it shall make an order to that effect, and shall commit the person, by warrant in the prescribed form, in the custody of the Royal Canadian Mounted Police to remain in custody until the pleasure of the Commissioner is known or the person is discharged by law.

(3) Where an order and warrant are made under subsection (2), the court shall cause copies thereof and the evidence produced before it to be sent, as soon as possible, to the Commissioner.

(4) The Commissioner may make any order he deems advisable as to the future custody of the mentally disordered person or may, in his discretion, direct that the hearing be re-opened or that a new hearing be held or that any other inquiry or steps be taken that he deems advisable.

6.1(1) The chief executive officer of an approved institution may admit any person to and detain him in the institution where he is satisfied that the person has been examined by a physician who is of the opinion that the person is a mentally disordered person and

(a) the person has attained the age of nineteen years and requests admission, or

(b) the person has attained the age of sixteen years but has not attained the age of nineteen years and the person and a near relative of the person request that the person be admitted.

(2) Within seventy-two hours of the time of the receipt of notification, in any way, of the desire of a patient who is admitted under this section to leave an approved institution, the chief executive officer of the institution shall discharge the patient from the institution.

(3) Subsection (2) does not apply if the requirements for the detention of the patient under sections 4, 5 and 6 of this Ordinance have been fulfilled.

6.2(1) The chief executive officer of an approved institution may admit a person to and detain him in the institution where the chief executive officer receives two medical certificates in the prescribed form completed by two medical practitioners.

8.(1) The Commissioner may order or any person may apply to a judge of the Territorial Court for an order that a mentally disordered person be declared to be no longer mentally disordered and be discharged by law and respecting any other matters respecting his return from custody and the return of his estate to him as may be deemed just and proper.

SOME RELEVANT PROVISIONS OF PROVINCIAL CORRECTIONAL LEGISLATION

ALBERTA

Corrections Act, R.S.A. 1980, c. C-26, as amended.

9.(1) If the Chief Executive Officer is satisfied that an inmate requires treatment in a hospital or, pursuant to the *Mental Health Act*, requires treatment in a facility under that Act, the Chief Executive Officer may so direct by a written order.

(2) Every inmate transferred to a hospital or facility under subsection (1) remains in custody while he is in the hospital or facility.

(3) When the Chief Executive Officer is advised by the person in charge of the hospital or facility that an inmate no longer requires treatment in the hospital or facility, the Chief Executive Officer shall by written order direct his transfer to a named correctional institution.

(4) A copy of each order under this section shall be delivered to the director of the correctional institution involved and to the person in charge of the hospital or facility involved and the copy of the order so delivered is sufficient authority to release or accept the inmate, as the case may be, in accordance with the order.

...

24. The National Parole Board is hereby authorized to exercise in Alberta the jurisdiction described in section 7 of the *Parole Act* (Canada).

25. The Lieutenant Governor in Council may appoint a Provincial Parole Board of not less than 3 nor more than 9 members.

26.(1) The director of a correctional institution may recommend to the Provincial Parole Board inmates in the correctional institution who in his opinion will benefit from parole.

(2) On receiving a recommendation from a director, the Provincial Parole Board shall examine the circumstances of the person recommended with a view to determining whether he should be released on parole.

(3) Notwithstanding anything in this section, the Provincial Parole Board may review the case of any person sentenced to a correctional

institution and may place on parole any person who appears to the Provincial Parole Board to be suitable for parole.

27.(1) The Provincial Parole Board may, subject to the provisions of any Act of Canada and of this Act, direct the release on parole of a person sentenced to a correctional institution and the director of that correctional institution shall on receipt of the direction release the person on parole.

(2) The Provincial Parole Board shall prescribe the terms and conditions of parole to be observed and carried out by a person released under subsection (1).

31. A person who contravenes this Act or the regulations is guilty of an offence and liable to

- (a) a fine of not more than \$500 and in default of payment to imprisonment for a term not exceeding 3 months,
- (b) imprisonment for a term not exceeding 3 months, or
- (c) both fine and imprisonment.

33. The Lieutenant Governor in Council may make regulations

- (f) requiring an inmate on entry to and during his imprisonment in a correctional institution to submit to searches and to medical, dental and mental examinations; . . .
- (m) respecting the security of inmates and the duties and responsibilities of an employer of inmates; . . .

**Alberta Regulation 138/77 under the *Corrections Act*,
as amended.**

14.(1) Every inmate may be medically examined by a physician, Registered Nurse, or psychiatric nurse.

(2) The medical examination may include

- (a) a dental examination,
- (b) a mental examination,
- (c) blood tests,
- (d) x-rays,
- (e) a urinalysis, and
- (f) any other examination or test considered necessary by the examining physician, Registered Nurse or psychiatric nurse and approved by the director.

17.(1) Where he is of the opinion that

- (a) the mental or physical health of an inmate is likely to be materially impaired by continued imprisonment, or
- (b) an inmate will not survive his sentence,

the attending physician shall report that fact in writing to the director.

(2) On receipt of the attending physician's report under subsection (1), the director shall forthwith

(a) forward the report of his recommendation to the Chief Executive Officer, and

(b) notify the nearest relative of the inmate whose address is known to the director.

(3) Where in the opinion of the attending physician an inmate is suffering from a serious mental or physical illness or requires special medical care the director shall inform the nearest relative whose address is known and the Chief Executive Officer.

19.(1) The director shall ensure that adequate observation, according to the recommendation of the attending physician, is maintained on any inmate whose mental condition requires it.

(2) The attending physician may recommend that an inmate be separated from other inmates within the institution.

BRITISH COLUMBIA

Correction Act, R.S.B.C. 1979, c. 70, as amended.

24.(1) The Board of Parole for the Province of British Columbia, composed of persons as may be appointed by the Lieutenant Governor in Council, is continued.

(2) The Lieutenant Governor in Council may designate one of the members appointed to be chairman of the board, and the members of the board may appoint a vice chairman or an acting chairman.

(4) The chairman or vice chairman or acting chairman and one member constitute a quorum.

25.(1) The board shall examine the circumstances respecting any person detained in a correctional centre convicted of an offence against the law of the Province and sentenced under section 12 to an indeterminate sentence, and may order his release on parole, under conditions specified by the board, to be at large during the indeterminate portion of his sentence.

(2) The board may vary the conditions of the parole.

British Columbia Regulation 284/78 under the *Correction Act*, as amended.

6.(1) The Chairman of the Board of Parole under the *Prisons and Reformatories Act* (Canada) or the Act, a member of that board, an employee of the National Parole Board, or a probation officer appointed under the Act

(a) may interview an inmate, and

(b) shall be given access to all records respecting an inmate, whose release on parole they have jurisdiction to consider.

(2) Notwithstanding subsection (1), medical records concerning an inmate shall only be made available where the senior medical officer gives his approval in writing.

12. Where an officer on duty in a unit

(a) suspects that an inmate in the unit has a serious physical or mental illness or an injury, or

(b) discovers that an inmate in the unit is dead,

the officer shall advise the officer in charge of the unit and the medical officer as soon as reasonably possible.

49. Where a medical officer has evidence that he believes requires proceeding under section 546 of the *Criminal Code*, the medical officer shall advise the director and, on receipt of this evidence, the director shall forward it to the Attorney-General for possible presentation to the Lieutenant-Governor in Council.

50. A correctional centre shall have an area within it suitably equipped and maintained for the health care needs of the inmates.

51.(1) The medical officer for a correctional centre is responsible for attending to the mental and physical health needs of the inmates and shall, at times set by the director, examine each inmate who is ill or complains of illness or whom an officer indicates may require attention.

(2) The medical officer shall oversee the quality of hygiene at the correctional centre and shall keep the director advised of his findings.

(3) The medical officer shall keep an inventory of all controlled drugs, and drugs set out in Schedule A, Part 1, 2, or 3, or Schedule B of the *Pharmacy Act*, under his control and shall keep a written record of each prescription issued to an inmate under his supervision.

52.(1) As soon as practical after he forms an opinion that an inmate requires

(a) special treatment not available at the correctional centre; or

(b) segregation for medical reasons,

a medical officer shall so advise his director in writing.

(2) Forthwith on forming the opinion that an inmate may attempt suicide, a medical officer shall direct an officer to closely supervise the inmate.

MANITOBA

The Corrections Act, R.S.M. 1970, c. C230, as amended.

35. The minister or any person acting under his authority may, where

this appears to be necessary, direct that

(a) any inmate of a correctional institution be removed to a hospital or other medical centre for medical, surgical or other treatment; and

(b) that the inmate be returned from the hospital or other medical centre, as the case may be to the correctional institution from which he was removed.

36.(1) The removal of an inmate from a correctional institution to a hospital under section 35 does not operate as a discharge of the inmate; but he shall be deemed to be still under the custody of the superintendent of the correctional institution from which he was removed.

(2) Where an inmate from a correctional institution is removed to a hospital under section 35, the superintendent of the institution from which he was removed and such other persons as may be designated by the superintendent, have a right of access at all times to the inmate; and the superintendent, where he considers it necessary, may place a person in charge of the inmate at the hospital to which he is removed.

(3) The time spent by an inmate of a correctional institution in a hospital shall be counted as part of the sentence for which he was committed at the institution.

48.(1) The superintendent of a correctional institution to which a person is sentenced may recommend to the Parole Board persons who, in his opinion, will benefit from parole.

(2) An inmate or any person acting on his behalf may apply to the Parole Board for parole.

(3) Upon receiving a recommendation from a superintendent under subsection (1) or an application under subsection (2), the Parole Board shall examine the pertinent circumstances concerning the inmate affected, including the length of sentence and such part thereof that remains to be served by the inmate with a view to determining whether or not the board is satisfied that the inmate should be released on parole.

(4) Notwithstanding anything contained in this section the Parole Board may review whenever it deems advisable the case of any person committed to a correctional institution and may place on parole any such person who appears to the Parole Board to be suitable for parole.

49.(1) The Parole Board may, subject to the provisions of any Act of Canada and of this Act, direct under the hand of the chairman the release on parole of a person sentenced to a correctional institution; and the superintendent shall upon receipt of such written direction release the person on parole.

NEW BRUNSWICK

Corrections Act, R.S.N.B. 1973, c. C-26, as amended.

16.(1) Where a medical practitioner recommends the hospitalization of

a person confined in a correctional institution, the Minister may order that person moved to a hospital or a psychiatric facility designated under the *Mental Health Act* for treatment.

(2) Where a person has been moved to a hospital or a psychiatric facility under subsection (1), the Minister, on the advice of a medical practitioner, may order that person returned to the correctional institution in which he was confined prior to hospitalization.

(3) An order made under subsection (1) does not discharge the person from custody and during the time he is hospitalized he is deemed to be in the custody of the superintendent of the correctional institution in which he was confined prior to hospitalization.

(4) The time spent by a person in a hospital or psychiatric facility under subsection (1) is reckoned the same as if he had spent that time in the correctional institution.

(5) Where the date for the discharge of a person from a correctional institution arises while that person is hospitalized under subsection (1), he shall be discharged from custody on that date and the superintendent of the correctional institution in which he was confined prior to hospitalization shall take the necessary steps to remove that person from custody at that time.

(6) Notwithstanding subsection (5), no person who is hospitalized in a psychiatric facility shall be discharged from that psychiatric facility except in accordance with the provisions of the *Mental Health Act*.

New Brunswick Regulation 67-12 under the *Corrections Act*, as amended.

1.(1) The Correctional Program Director may direct that any prisoner confined in a correctional institution be removed to a hospital for medical, surgical or other treatment as is shown to be necessary.

(2) Any prisoner so removed shall be returned from the hospital to the correctional institution from which he was taken on the direction of the Correctional Program Director.

2.(1) The removal of a prisoner from any correctional institution to a hospital shall not operate as a discharge of the prisoner and he shall be deemed to be still under the custody of the superintendent or jailer of the correctional institution.

(2) The time spent by a prisoner in the hospital shall be reckoned the same as if he had continued that time in the correctional institution.

NEWFOUNDLAND

The Prisons Act, R.S.N. 1970, c. 305, as amended.

18. In the case of the illness of any prisoner in the Penitentiary or other gaol in the province, he may, by order of the Minister, be removed by the Superintendent of the Penitentiary or the keeper of the gaol to any hospital referred to in the order, and in any such case a prisoner shall be deemed to

remain in the custody of the Superintendent or such keeper and shall be subject to the rules and regulations of the Penitentiary or gaol as far as the same are applicable, and the Superintendent or such keeper shall, under an order of the Minister, have power to remove such prisoner back to the Penitentiary or such gaol.

...

20. It shall be the duty of the Superintendent or person for the time being in charge of the Penitentiary to cause a medical examination to be made of every prisoner upon his or her admission to the Penitentiary, or so soon thereafter as he can obtain the services of a medical practitioner to make such examination, and it shall be lawful for such medical examination to include any form of examination or test, including any blood test, ordinarily used for the detection of any disease or condition not apparent on external examination.

...

24.(1) Where, in the opinion of an official of the Department of Justice of the province designated by the Lieutenant-Governor of the province for the purpose, it is necessary or desirable that a prisoner be temporarily absent from the Penitentiary, with or without escort,

- (a) for medical or humanitarian reasons; or
- (b) to assist such prisoner in his rehabilitation.

at any time during his period of imprisonment, the temporary absence of such prisoner may, from time to time, be authorized. . . .

Newfoundland Regulation 84/78 under *The Prisons Act*, as amended.

3.(1) Subject to such duties as may be assigned to him by the Minister under subsection (2) of Section 5 of the Act, the Superintendent shall exercise general supervision and control over the Penitentiary, prisoners and members of the staff, and so far as practicable ensure compliance by the staff and the prisoners with these regulations and with the rules made by him under subsection (3) of Section 10 of the Act, but without prejudice to the foregoing generality, the superintendent shall . . .

- (i) bring to the notice of a medical doctor any complaint or report that a prisoner may be suffering from mental or physical illness.

...

4. . . .

(2) It shall be the duty of every staff member to assist the Superintendent in carrying out his duties under the Act and these regulations, to be courteous, obedient, loyal and efficient, to be impartial to the prisoners, to carry out his duties ³⁴⁰speedily and conscientiously and to conduct himself in a sober and honest manner, including in particular but without prejudice to the foregoing generality to submit himself to be searched in the Penitentiary if called upon by the Superintendent, Assistant

Superintendent or other officer designated by the Superintendent as officer for the time being in charge of the Penitentiary and to direct the attention of the Superintendent, Assistant Superintendent or such other officer to any prisoner who appears to him to be in poor health whether bodily or mentally.

...

5.(1) Subject to paragraph (4), every member of the staff who conducts himself by act of omission or commission in a manner which amounts to conduct likely to bring discredit to the Penitentiary or unbecoming an officer, warden or any other person employed at the Penitentiary, whether or not such conduct takes place in the Penitentiary, or who contravenes any of the provisions of the Act, these regulations or rules made under subsection (3) of Section 10 of the Act shall be liable to one or more of the following punishments, that is to say warning, reprimand, fine up to a maximum of \$100.00, loss or reduction of one annual pay increment, demotion or dismissal.

...

7. Subject to these regulations, during his term of confinement at the Penitentiary, every prisoner shall be given or provided with . . .

(d) adequate medical and dental treatment or advice, and religious instruction. . . .

NORTHWEST TERRITORIES

Corrections Ordinance, R.O.N.W.T. 1974, c. C-18, as amended.

14. . . .

(2) A Superintendent shall be the officer responsible for the safe custody and proper care of the inmates of the correctional centre for which he is designated.

. . . .

25. . . .

(3) Where in the opinion of a medical practitioner it is desirable to restrain a violent inmate by means of drugs for the protection of the inmate or others, the medical practitioner may administer or authorize the administration of drugs to such inmate for that purpose.

. . . .

39. There shall be a Territorial Parole Board consisting of not more than six members appointed by the Commissioner and the Commissioner shall designate two of the members so appointed as the Chairman and the Deputy Chairman of the Board respectively.

. . . .

44.(1) Upon receiving an application for parole, the Board shall examine the circumstances of the inmate applying with a view to determining whether he should be released on parole, and wherever possible the inmate being considered shall be present at the hearing.

(2) The Board may, without an application review the case of any inmate and may place on parole any inmate who appears to the Board to be suitable for parole.

(3) No inmate shall be released on parole until he has served one third of the total sentence imposed by the court.

45.(1) The Board may, subject to any Act of the Parliament of Canada and this Ordinance, direct the release on parole of an inmate and the Superintendent shall, upon receipt of the direction, release the inmate on parole.

(2) The Board, in respect of a person released under subsection (1),

(a) shall prescribe the conditions of parole to be observed by such person and may from time to time add to, alter or remove such conditions; and

(b) may provide for the supervision and guidance of such person for such period as the Board considers desirable

Northwest Territories *Corrections Service Regulations* under the *Corrections Ordinance*, R.R.N.W.T. 1980, Reg. No. 32.

8. The Superintendent shall direct the removal of an inmate to a hospital or other suitable establishment for medical, surgical or other treatment upon the advice of a medical officer or in the case of an extreme medical emergency.

...

17. Where an inmate who is due for discharge suffers from an acute or dangerous illness he shall not be discharged until, in the opinion of the medical officer, it will not injure the inmate's health to discharge him.

...

22. No surgical operation shall be performed on an inmate without his consent except in cases of emergency, when the Superintendent shall be responsible for such consent.

23.(1) The medical officer shall keep under special observation every inmate whose mental condition appears to require it and shall take such steps as he considers proper for the inmate's segregation from other inmates.

(2) Where the medical officer deems it necessary, he shall in co-operation with the Superintendent arrange for the examination and treatment of an inmate under the *Mental Health Ordinance*.

24. The medical officer shall report or make recommendations to the

Superintendent regarding any matter of a medical nature that requires the consideration of the Superintendent.

...

61.(1) In considering an application for parole the Board shall in respect of the candidate, where possible, obtain and consider. . .

(f) a report from the medical officer on the physical and mental health of the candidate; . . .

62. The Board may, in respect of a candidate for parole,

(a) grant parole if the Board considers that the candidate has derived satisfactory benefit from imprisonment and that the rehabilitation of the candidate will be aided by the grant of parole, and where parole is granted the Board shall designate when parole shall commence;

(b) grant parole subject to any terms or conditions it considers necessary;

(c) provide for the guidance and supervision of paroled inmates for such periods as the Board considers desirable;

(d) defer any decision on whether to grant parole to a later meeting; and

(e) refuse to grant parole,

and the Board shall cause the candidate to be notified in writing of its decision under this section.

63. Where a parole has been deferred or refused, a candidate for parole may apply in writing to the Board to grant a further hearing to review his application, and the Board shall advise him whether or not a new hearing will be granted.

64.(1) Where the Board grants parole it shall issue a parole certificate and shall deliver it or cause it to be delivered to the inmate, with copies to the parole supervisor and to the nearest detachment of the Royal Canadian Mounted Police.

(2) A parole certificate shall be signed or marked by the paroled person, the Superintendent and the person designated to supervise the paroled person.

65. Where parole is granted, the term of parole shall include any portion of statutory remission standing to the credit of the paroled person when he is released, but shall not include any period of earned remission standing to his credit at that time.

66.(1) A paroled person shall report to his parole supervisor on his arrival at his destination.

(2) A paroled person shall, on the first day of every month until final discharge, report to his parole supervisor.

NOVA SCOTIA

Court and Penal Institutions Act, R.S.N.S. 1967, c. 67, as amended.

6. The sheriff of each county shall have the care of every jail in the county and of the jail offices, jail yard and keeper's apartment and shall be responsible for the safe custody of prisoners confined in any such jail.

Nova Scotia Regulation 32/79 under the Court and Penal Institutions Act, as amended.

4. On admission of an inmate to the Institution, the Superintendent shall. . .

(d) ensure that an inmate receives a medical examination within ten (10) days following the date of admission.

5. Upon the serious illness of an inmate, the Superintendent shall ensure that the inmate receives medical attention and shall notify a minister of religion, preferably of the denomination to which the inmate belongs, and advise the next of kin as recorded at the time of admission of the inmate and consult with the inmate regarding the persons he desires to be notified of his illness.

...

9. Where, in the opinion of the Superintendent, it is necessary or desirable, a request for Temporary Leave of Absence of an inmate from the institution may be made through the office of the Inspector of Penal Institutions for:

- (a) medical reasons;
- (b) humanitarian reasons;
- (c) rehabilitative reasons.

(2) The Regional Supervisor, Correctional Services, with the approval of the Inspector of Penal Institutions, may authorize daily absences of an inmate from the institution for the purposes of employment, education, training or other activities that are considered by him necessary or advisable to assist in the inmate's rehabilitation or for the purpose of medical treatment or humanitarian reasons not in excess of three (3) days.

...

12.(1) The medical officer for an institution shall be a duly qualified medical practitioner. The medical officer shall control and direct the medical and surgical treatment of all inmates and shall be on call to the institution twenty-four (24) hours a day.

(2) The Superintendent and medical officer shall ensure:

- (a) that proper records are maintained for the receipt and dispensing of all prescribed drugs and medication;. . .

13. When an inmate claims to be unable to work for reasons of sickness or other disability, the medical officer shall examine the inmate and if, in

his opinion, the inmate is not fit to work or his employment should be changed, he shall immediately certify the fact in writing to the Superintendent. Upon receipt of such certification, the inmate shall thereupon be relieved of his work duties or have employment changed, or be admitted to a hospital for medical treatment as directed by the medical officer in accordance with Section 9 of these Regulations.

14. . . .

(2) When an inmate is taken sick or injured, the employee who has care or custody of the inmate shall at once report the fact to the Superintendent.

. . .

(4) In the event an inmate is taken sick or injured and requires transfer to a medical hospital or clinic in the community, the Superintendent shall ensure security measures are taken where required.

. . .

15. . . .

(2) Where any employee uses force beyond the minimum of necessary force for self-defense or to control a violent inmate, the incident shall be immediately reported in writing to the Superintendent.

ONTARIO

Ministry of Correctional Services Act, R.S.O. 1980, c. 275.

10. Every person employed in the administration of this Act, including any person making an inspection, investigation or inquiry under this Act, shall preserve secrecy in respect of all matters that come to his knowledge in the course of his duties, employment, inspection, investigation or inquiry and shall not communicate any such matters to any other person except,

(a) as may be required in connection with the administration of this Act, the *Parole Act* (Canada), the *Penitentiary Act* (Canada), the *Prisons and Reformatories Act* (Canada) or the *Criminal Code* (Canada) or the regulations thereunder;

(b) to the Ombudsman of Ontario or Correctional Investigator of Canada;

(c) in statistical form if the person's name or identity is not revealed therein;

(d) with the approval of the Minister.

...

12.(1) No action or other proceeding for damages shall be instituted against the Deputy Minister or any officer or employee of the Ministry or anyone acting under his authority for any act done in good faith in the execution or intended execution of his duty or for any alleged neglect or default in the execution in good faith of his duty or for any act of an inmate, parolee or probationer while under his custody and supervision.

(2) Subsection (1) does not, by reason of subsections 5(2) and (4) of the *Proceedings Against the Crown Act*, relieve the Crown of liability in respect of a tort committed by a person mentioned in subsection (1) to which it would otherwise be subject, and the Crown is liable under that Act for any such tort in a like manner as if subsection (1) had not been enacted.

...

24.(1) Where a person confined in a correctional institution requires hospital treatment that cannot be supplied at the institution, the director or superintendent shall arrange for the person to receive such treatment at a public hospital and shall report the matter to such persons as the Minister may require.

(2) Where a person confined in a correctional institution requires hospitalization in a psychiatric facility under the *Mental Health Act*, the director or superintendent shall arrange for the person to be so hospitalized and shall report the matter to such persons as the Minister may require.

(3) Where a director or superintendent is unable to have a person hospitalized, he shall notify an employee of the Ministry designated by the Minister for the purpose and the employee shall then make arrangements to have the person hospitalized.

(4) The Minister may by order, direct that an examination be made of an inmate by a psychiatrist or psychologist in a manner prescribed by the regulations for the purpose of assessing the emotional and mental condition of the inmate.

...

31. The Board of Parole is continued and shall be composed of such full-time and part-time members appointed by the Lieutenant Governor in Council as the Lieutenant Governor in Council may consider necessary.

32.(1) The Lieutenant Governor in Council may designate one of the members of the Board to be the chairman thereof.

(2) Three members of the Board constitute a quorum.

...

34. Subject to the regulations, the Board may order the release from custody on parole of any inmate convicted of an offence under any Act of the Legislature, any Act of the Parliament of Canada or against a municipal by-law upon such conditions as the Board may determine.

35. The Board has exclusive jurisdiction to examine into, hear and determine all matters and questions arising under this Part and as to any matter or thing in respect of which any power, authority or discretion is conferred upon the Board, and the action or decision of the Board thereon is final and conclusive and is not open to question or review in any court and no proceedings by or before the Board shall be restrained by injunction, prohibition or the process or proceeding in any court or be removable by application for judicial review or otherwise into any court.

36. Where parole is granted, the term of parole shall include any portion of remission standing to the credit of the parolee when he is released.

37. When required by the Board, it is the duty of every person having information relevant to the suitability of an inmate to be paroled to submit such information to the Board in writing in the form prescribed by the regulations.

45. The *Statutory Powers Procedure Act* does not apply to proceedings for the discipline or transfer of inmates in correctional institutions, for the grievances of inmates, or for the authorization of temporary absences for inmates or to proceedings of the Board notwithstanding anything in that Act.

R.R.O. 1980, Regulation 649 under the *Ministry of Correctional Services Act*.

2.(1) The Superintendent of a correctional institution is responsible for the management of the institution and for the care, health, discipline, safety and custody of the inmates under the Superintendent's authority. . . .

4.(1) There shall be one or more health care professionals in each institution to be responsible for the provision of health care services within the institution and to control and direct the medical and surgical treatment of all inmates.

(2) The health care professional shall ensure that every inmate receives a medical examination as soon as possible after admission to the institution.

(3) The health care professional shall immediately report to the Superintendent whenever the health care professional determines that an inmate is seriously ill.

(5) When an inmate claims to be unable to work by reason of illness or disability, a health care professional shall examine the inmate and if, in his opinion, the inmate is unfit to work or the work should be changed, the health care professional shall immediately report the fact in writing to the Superintendent whereupon the inmate shall be relieved of work duties or have his work changed or be admitted to hospital or elsewhere for medical treatment as directed.

7.(1) No employee shall use force against an inmate unless force is required in order to,

- (a) enforce discipline and maintain order within the institution;
- (b) defend the employee or another employee or inmate from assault;

- (c) control a rebellious or disturbed inmate; or
- (d) conduct a search,

but where force is used against an inmate, the amount of force used shall be reasonable and not excessive having regard to the nature of the threat posed by the inmate and all other circumstances of the case.

(2) Where an employee uses force against an inmate, the employee shall file a written report to the Superintendent indicating the nature of the threat posed by the inmate and all other circumstances of the case.

8. . . .

(3) Notwithstanding clause 2(d), the Superintendent of a lock-up shall not admit into custody at the lock-up any person who is in need of immediate medical attention.

40.(1) The portion of the term of imprisonment that an inmate must serve before parole may be granted is one-third of the total term of imprisonment imposed upon the inmate.

(2) Notwithstanding subsection (1), the Board may parole an inmate at any time where, in the opinion of the Board, compelling or exceptional circumstances exist that warrant the inmate's parole.

(3) Every inmate sentenced to imprisonment in an institution shall be notified in writing by the Board or the Ministry of the inmate's parole eligibility date no later than two months after the date on which the inmate was sentenced.

41.(1) Where an inmate is serving a term of imprisonment of less than six months, the inmate may apply to the Board at any time after the parole eligibility date for parole.

(2) The Board is not required to hold a hearing before considering and deciding upon an application for parole referred to in subsection (1).

42.(1) Where an inmate is serving a term of imprisonment of six months or more, the Board shall consider the inmate for parole after the parole eligibility date notwithstanding that the inmate has not applied for parole.

(2) An inmate referred to in subsection (1) is entitled to a hearing before the Board unless the inmate, in writing, waives the right to the hearing, but if the inmate subsequently revokes the waiver before the Board makes a decision regarding the parole, the Board shall proceed to conduct a hearing of the matter.

43.(1) Where the Board conducts a hearing to determine whether or not an inmate is a suitable inmate to be granted parole, the Board may obtain and consider any information that the Board considers useful and relevant regarding the character, abilities and prospects of the inmate, and in particular the Board may obtain and consider,

- (a) particulars of the inmate's trial, conviction and sentence;
- (b) particulars of the inmate's criminal record;
- (c) information from persons knowledgeable about the inmate's

background and living conditions before the inmate was confined in the institution;

(d) a report from the Superintendent of the institution assessing the progress made by the inmate towards rehabilitation, and

(e) a report from a health care professional concerning the physical condition and mental health of the inmate.

(2) The Board shall give each inmate an opportunity to attend before it at the hearing to present arguments and submissions on his own behalf.

(3) Upon consideration of the matters referred to in subsection (1), and the arguments and submissions of the inmate, the Board may,

(a) grant parole upon such terms and conditions as it considers necessary;

(b) defer its decision; or

(c) refuse to grant parole,

and the Board shall notify the inmate in writing of its decision and the reasons for the decision.

44. An inmate who is aggrieved by a decision of the Board may apply to the Board for a new hearing and a review of the decision and the Board shall decide whether or not to grant the hearing and review and shall notify the inmate forthwith.



PRINCE EDWARD ISLAND

Jails Act, R.S.P.E.I. 1974, c. J-1.

20.(1) The Minister of Justice may direct in writing that any person confined to any jail of the province whose imprisonment is based or ordered on the authority of the laws of Canada or of this province or a municipality shall be removed to a hospital for such surgical operation or other treatment as shall be shown to the Minister of Justice to be urgently necessary.

(2) A removal under subsection (1) may be to any hospital directed by the Minister of Justice, whether or not the hospital is in the county in which the prisoner is confined.

21. The prisoner referred to in section 20 shall be returned from the hospital to the jail from which he was taken on the direction of the Minister of Justice.

22.(1) The removal of a prisoner from a jail to a hospital, either in or out of the county in which the jail is situated shall not operate as a discharge of the prisoner, but he is deemed to be still under the custody of the sheriff of the county wherein the jail is situated, and the sheriff shall have the right at all times of ingress or egress to the prisoner and to place a bailiff in charge; but the time from his removal from jail until his return thereto from the hospital shall be reckoned the same as if he had continued that time in jail.

(2) If during his stay in the hospital a prisoner's time expires or the fine

and costs for which he was imprisoned are paid, he shall *ipso facto* stand fully discharged.

27. Where it is shown to the satisfaction of the Minister of Justice that a person confined to a jail should be hospitalized in a psychiatric facility under the *Mental Health Act* R.S.P.E.I. 1974, Cap. M-9, the Minister of Justice may allow the hospitalization pursuant to the *Mental Health Act* R.S.P.E.I. 1974, Cap. M-9, and where such person is so hospitalized he is deemed to be confined to jail.

Prince Edward Island Revised Regulation under the *Jails Act*.

6. A superintendent shall be responsible for the management of the jail and for the care, health, discipline, safety and custody of its inmates.

7. A Superintendent shall . . .

(k) ensure that no prisoner who is unconscious or who appears to be in need of immediate medical attention shall be admitted to the jail until the prisoner has been medically examined by a physician and a medical certificate is produced, signed by the examining physician, certifying the prisoner as being fit for admission; . . .

14. A correctional officer shall . . .

(t) in the event of a serious illness or injury to a prisoner, summon an ambulance and accompany the prisoner to a hospital and if the prisoner is admitted to the hospital, remain with him until relieved; . . .

***Parole Act* R.S.P.E.I. 1974, c. P-1 (as yet unproclaimed).**

6. Subject to the regulations, the board may

(a) order the release on parole of any prisoner upon such conditions as the board deems proper;

(b) revoke or suspend a parole; and

(c) recommit a paroled person to any jail in the province for the unexpired portion of his sentence, but where that person is a paroled juvenile delinquent he shall be recommitted to the place from which he was paroled.

QUEBEC

O.C. 1299-79 under the *Probation and Houses of Detention Act*, R.S.Q. 1977, c. P-26, as amended.

6. An officer performs his duties with respect towards imprisoned persons by complying with the following standards and principles: . . .

(b) all information or documents concerning an imprisoned

person are confidential; only persons authorized by the Director General or by the warden may consult them or disclose their content.

Communicating any information or document concerning an imprisoned person may be done only with the latter's consent, except where his safety or the safety of a third party or of the establishment may be threatened; . . .

19. An imprisoned person must receive the health care that his condition requires.

20. An imprisoned person whose condition so requires must be transferred to a hospital centre.

21. An imprisoned person may not be subjected to medical and scientific experiments that may be detrimental to his mental or physical integrity.

22. A health professional of the establishment must submit a report to the warden each time he considers that the mental or physical health of an imprisoned person has been or will be affected by the detention conditions imposed on him or by their prolongation.

SASKATCHEWAN

The Corrections Act, R.S.S. 1978, c. C-40.

41.(1) The Release Authority, consisting of the director, the chief probation officer, the director of community corrections and not more than two other persons appointed by the minister, is continued.

(2) The director shall be the chairman of the Release Authority and in the absence of the director the person appointed director in his stead shall act as chairman.

42.(1) The chief executive officer of a correctional facility to which a person is sentenced may recommend to the Release Authority persons who, in his opinion, will benefit from parole.

(2) Upon receiving a recommendation from a chief executive officer as mentioned in subsection (1), the Release Authority shall examine the pertinent circumstances concerning the person affected with a view to determining whether he should be released on parole.

(3) Notwithstanding any other provision of this section but subject to section 40, the Release Authority may review whenever it deems advisable the case of any person committed to a correctional facility and may place on parole any such person who appears to the Release Authority to be suitable for parole.

43.(1) The Release Authority may, subject to the provisions of any Act of Canada and of this Act, direct under the hand of the chairman the release on parole of a person sentenced to a correctional facility; and the chief

executive officer shall upon receipt of such written direction release the person on parole.

(2) The Release Authority shall prescribe the terms and conditions of parole to be observed and carried out by a person released under subsection (1); and the chief probation officer or his designated representative is responsible for the supervision of the person while on parole.

(3) The sentence of a person on parole continues in force and effect until the expiration thereof according to law.

...

47. Every officer and employee working under the authority of the division or of this Act, regardless of the classification of his employment, has the power to exercise custodial authority over and is a lawful guardian of persons committed to a correctional facility authorized under this Act.

...

50.(1) Any person who, within a correctional facility, its precincts or environs, contravenes any of the rules or regulations of the facility or conducts himself in a manner that is detrimental to the maintenance of discipline in the facility or to the behavior of any person detained therein is guilty of an offence and may be proceeded against or summarily arrested by a peace officer or by any person constituted a peace officer under section 49.

(2) Every person who is guilty of an offence under subsection (1) is liable on summary conviction to a fine of not less than \$50 or more than \$500 or to imprisonment for not less than one month or more than six months or to both such fine and imprisonment.

YUKON TERRITORY

Corrections Ordinance, R.O.Y.T. 1971, c. C-19.1, as amended.

9.(1) A superintendent, upon the advice of a medical practitioner, or in the case of a medical emergency, shall arrange for any inmate of a correctional institution to be removed to a hospital, or other suitable facility, for medical, surgical or other treatment.

...

35.(1) Every person who violates any provision of this Ordinance or the regulations commits an offence and is liable, on summary conviction, to a fine not exceeding five hundred dollars or to imprisonment for a term not exceeding six months, or to both fine and imprisonment.

Commissioner's Order 1973/161 under the *Juvenile Delinquents Act (Canada)* and the *Corrections Ordinance*, as amended.

3.(1) The Superintendent of a gaol is the officer responsible for the safe custody and proper care of the inmates of the gaol. . . .

6. . . .

(2) Notwithstanding the provisions of sub-section (1), the Superintendent may direct that an inmate may be removed to a hospital or other suitable establishment for medical, surgical or other treatment. . . .

20. In every gaol a suitable section shall be equipped and furnished in a manner proper for the medical care and treatment of sick inmates.

21. The Medical Officer shall attend professionally on all inmates.

25. The Medical Officer shall visit a gaol as often as is necessary, and, on each visit, shall attend every sick inmate, every inmate who complains of sickness and every other inmate to whom his attention is especially directed.

27.(1) When a Medical Officer has reason to believe that any inmate has suicidal tendencies, he shall immediately report the fact to the Superintendent.

(2) The Superintendent, on receiving a report referred to in sub-section (1), shall immediately direct that the inmate be observed at frequent intervals.

28.(1) The Medical Officer shall keep under special observation every inmate whose mental condition appears to require it and shall take such steps as he considers proper for the inmate's segregation from other inmates.

(2) Where the Medical Officer deems it necessary, he shall arrange for the certification of an inmate under the Insane Persons Ordinance.

29. The Medical Officer shall report in writing to the Superintendent any matter of a medical nature that, in the opinion of the Medical Officer, requires the consideration of the Director.

30.(1) The Medical Officer shall report in writing to the Superintendent on any inmate who, in the opinion of the Medical Officer, requires special care and in the report he shall make any recommendations he deems advisable for:

(a) the alteration of the diet or treatment of the inmate; . . .

31. The Medical Officer shall give notice to the Superintendent in

writing when an inmate appears to be seriously ill and is likely to require removal to an outside hospital.

32.(1) The Medical Officer shall report in writing to the Superintendent, with such recommendations that he thinks suitable, when he has reason to believe that:

(a) an inmate's physical or mental health is likely to be affected injuriously by continued imprisonment or by any conditions of imprisonment;

(b) the life of an inmate is or will be endangered by imprisonment.

APPENDIX C

SOME FEDERAL LEGISLATION RELATING TO MENTALLY ILL OFFENDERS

CANADA

Criminal Code, R.S.C. 1970, c. C-34, as amended.

465.(1) A justice acting under this Part may . . .

(c) by order in writing,

(i) direct an accused to attend, at a place or before a person specified in the order and within a time specified therein, for observation, or

(ii) remand an accused to such custody as the justice directs for observation for a period not exceeding thirty days, where, in his opinion, supported by the evidence, or where the prosecutor and the accused consent, by the report in writing, of at least one duly qualified medical practitioner, there is reason to believe that

(iii) the accused may be mentally ill, or

(iv) the balance of the mind of the accused may be disturbed, where the accused is a female person charged with an offence arising out of the death of her newly-born child; . . .

(2) Notwithstanding paragraph (1)(c), a justice acting under this Part may remand an accused in accordance with that paragraph

(a) for a period not exceeding thirty days without having heard the evidence or considered the report of a duly qualified medical practitioner where compelling circumstances exist for so doing and where a medical practitioner is not readily available to examine the accused and give evidence or submit a report; and

(b) for a period of more than thirty days but not exceeding sixty days where he is satisfied that observation for such a period is required in all the circumstances of the case and his opinion is supported by the evidence or, where the prosecutor and the accused consent, by the report in writing, of at least one duly qualified medical practitioner.

(3) Where, as a result of observations made pursuant to an order issued under paragraph (1)(c), it appears to a justice that there is sufficient reason to doubt that the accused is, on account of insanity, capable of conducting his defence, the justice shall direct that an issue be tried whether the accused

is then, on account of insanity, unfit to conduct his defence at the preliminary inquiry.

(4) Where the justice directs the trial of an issue under subsection (3), he shall proceed in accordance with section 543 in so far as that section may be applied.

542.(1) Where, upon the trial of an accused who is charged with an indictable offence, evidence is given that the accused was insane at the time the offence was committed and the accused is acquitted,

(a) the jury, or

(b) the judge or magistrate, where there is no jury,

shall find whether the accused was insane at the time the offence was committed and shall declare whether he is acquitted on account of insanity.

(2) Where the accused is found to have been insane at the time the offence was committed, the court, judge or magistrate before whom the trial is held shall order that he be kept in strict custody in the place and in the manner that the court, judge or magistrate directs, until the pleasure of the lieutenant governor of the province is known.

543.(1) A court, judge or magistrate may, at any time before verdict, where it appears that there is sufficient reason to doubt that the accused is, on account of insanity, capable of conducting his defence, direct that an issue be tried whether the accused is then, on account of insanity, unfit to stand his trial.

(2) A court, judge or magistrate may, at any time before verdict or sentence, when of the opinion, supported by the evidence or, where the prosecutor and the accused consent, by the report in writing, of at least one duly qualified medical practitioner, that there is reason to believe that

(a) an accused is mentally ill, or

(b) the balance of the mind of an accused is disturbed, where the accused is a female person charged with an offence arising out of the death of her newly-born child,

by order in writing

(c) direct the accused to attend, at a place or before a person specified in the order and within a time specified therein, for observation, or

(d) remand the accused to such custody as the court, judge or magistrate directs for observation for a period not exceeding thirty days.

(2.1) Notwithstanding subsection (2), a court, judge or magistrate may remand an accused in accordance with that subsection

(a) for a period not exceeding thirty days without having heard the evidence or considered the report of a duly qualified medical practitioner where compelling circumstances exist for so doing and where a medical practitioner is not readily available to examine the accused and give evidence or submit a report; and

(b) for a period of more than thirty days but not exceeding sixty

days where he is satisfied that observation for such a period is required in all the circumstances of the case and his opinion is supported by the evidence or, where the prosecutor and the accused consent, by the report in writing, of at least one duly qualified medical practitioner. . . .

(6) Where the verdict is that the accused is unfit on account of insanity to stand his trial, the court, judge or magistrate shall order that the accused be kept in custody until the pleasure of the lieutenant governor of the province is known, and any plea that has been pleaded shall be set aside and the jury shall be discharged. . . .

544. Where an accused who is charged with an indictable offence is brought before a court, judge or magistrate to be discharged for want of prosecution and the accused appears to be insane, the court, judge or magistrate shall proceed in accordance with section 543 in so far as that section may be applied.

545.(1) Where an accused is, pursuant to this Part, found to be insane, the lieutenant governor of the province in which he is detained may make an order

(a) for the safe custody of the accused in a place and manner directed by him, or

(b) if in his opinion it would be in the best interest of the accused and not contrary to the interest of the public, for the discharge of the accused either absolutely or subject to such conditions as he prescribes.

(2) An accused to whom paragraph (1)(a) applies may, by warrant signed by an officer authorized for that purpose by the lieutenant governor of the province in which he is detained, be transferred for the purposes of his rehabilitation to any other place in Canada specified in the warrant with the consent of the person in charge of such place.

(3) A warrant mentioned in subsection (2) is sufficient authority for any person who has custody of the accused to deliver the accused to the person in charge of the place specified in the warrant and for such last mentioned person to detain the accused in the manner specified in the order mentioned in subsection (1).

(4) A peace officer who has reasonable and probable grounds to believe that an accused to whom paragraph (1)(b) applies has violated any condition prescribed in the order for his discharge may arrest the accused without warrant.

(5) Where an accused has been arrested pursuant to subsection (4), he shall be dealt with in accordance with the following provisions:

(a) where a justice having jurisdiction in the territorial division in which the accused has been arrested is available within a period of twenty-four hours after the arrest of the accused by a peace officer, the accused shall be taken before a justice without unreasonable delay and in any event within that period; and

(b) where a justice having jurisdiction in the territorial division in which the accused has been arrested is not available within a

(a) not later than six months after the making of the order referred to in that subsection relating to that person, and

(b) at least once in every twelve month period following the review required pursuant to paragraph (a) so long as the person remains in custody under the order,

and forthwith after each review the board shall report to the lieutenant governor setting out fully the results of such review and stating

(c) where the person in custody was found unfit on account of insanity to stand his trial, whether, in the opinion of the board, that person has recovered sufficiently to stand his trial,

(d) where the person in custody was found not guilty on account of insanity, whether, in the opinion of the board, that person has recovered and, if so, whether in its opinion it is in the interest of the public and of that person for the lieutenant governor to order that he be discharged absolutely or subject to such conditions as the lieutenant governor may prescribe,

(e) where the person in custody was removed from a prison pursuant to subsection 546(1), whether, in the opinion of the board, that person has recovered or partially recovered, or

(f) any recommendations that it considers desirable in the interests of recovery of the person to whom such review relates and that are not contrary to the public interest.

(6) In addition to any review required to be made under subsection (5), the board shall review any case referred to in subsection (1) when requested to do so by the lieutenant governor and shall forthwith after such review report to the lieutenant governor in accordance with subsection (5).

(7) For the purposes of a review under this section, the chairman of the board has all the powers that are conferred by sections 4 and 5 of the *Inquiries Act* on commissioners appointed under Part I of that Act.

608.2(1) A judge of the court of appeal may, by order in writing,

(a) direct an appellant to attend, at a place or before a person specified in the order and within a time specified therein, for observation, or

(b) remand an appellant to such custody as the judge directs for observation for a period not exceeding thirty days,

where, in his opinion, supported by the evidence or, where the appellant and the respondent consent, by the report in writing, of at least one duly qualified medical practitioner, there is reason to believe that

(c) the appellant may be mentally ill, or

(d) the balance of the mind of the appellant is disturbed, where the appellant is a female person charged with an offence arising out of the death of her newly-born child.

(2) Notwithstanding subsection (1), a judge of the court of appeal may remand an appellant in accordance therewith

(a) for a period not exceeding thirty days without having heard the evidence or considered the report of a duly qualified medical

practitioner where compelling circumstances exist for so doing and where a medical practitioner is not readily available to examine the accused and give evidence or submit a report; and
(b) for a period of more than thirty days but not exceeding sixty days where he is satisfied that observation for such a period is required in all the circumstances of the case and his opinion is supported by the evidence or, where the appellant and the respondent consent, by the report in writing, of at least one duly qualified medical practitioner.

687. In this Part,

"court" means the court by which an offender in relation to whom an application under this Part is made was convicted, or a superior court of criminal jurisdiction;

"serious personal injury offence" means

(a) an indictable offence (other than high treason, treason, first degree murder or second degree murder) involving

(i) the use or attempted use of violence against another person, or

(ii) conduct, endangering or likely to endanger the life or safety of another person or inflicting or likely to inflict severe psychological damage upon another person,

and for which the offender may be sentenced to imprisonment for ten years or more, or

(b) an offence mentioned in section 144 (rape) or 145 (attempted rape) or an offence or attempt to commit an offence mentioned in section 146 (sexual intercourse with a female under fourteen or between fourteen and sixteen), 149 (indecent assault on a female), 156 (indecent assault on a male) or 157 (gross indecency).

688. Where, upon an application made under this Part following the conviction of a person for an offence but before the offender is sentenced therefor, it is established to the satisfaction of the court

(a) that the offence for which the offender has been convicted is a serious personal injury offence described in paragraph (a) of the definition of that expression in section 687 and the offender constitutes a threat to the life, safety or physical or mental well-being of other persons on the basis of evidence establishing

(i) a pattern of repetitive behaviour by the offender, of which the offence for which he has been convicted forms a part, showing a failure to restrain his behaviour and a likelihood of his causing death or injury to other persons, or inflicting severe psychological damage upon other persons through failure in the future to restrain his behaviour,

(ii) a pattern of persistent aggressive behaviour by the offender, of which the offence for which he has been convicted forms a part, showing a substantial degree of indifference on the part

of the offender as to the reasonably foreseeable consequences to other persons of his behaviour, or

(iii) any behaviour by the offender, associated with the offence for which he has been convicted, that is of such a brutal nature as to compel the conclusion that his behaviour in the future is unlikely to be inhibited by normal standards of behavioural restraint, or

(b) that the offence for which the offender has been convicted is a serious personal injury offence described in paragraph (b) of the definition of that expression in section 687 and the offender, by his conduct in any sexual matter including that involved in the commission of the offence for which he has been convicted, has shown a failure to control his sexual impulses and a likelihood of his causing injury, pain or other evil to other persons through failure in the future to control his sexual impulses,

the court may find the offender to be a dangerous offender and may thereupon impose a sentence of detention in a penitentiary for an indeterminate period, in lieu of any other sentence that might be imposed for the offence for which the offender has been convicted.

689.(1) Where an application under this Part has been made, the court shall hear and determine the application except that no such application shall be heard unless

(a) the Attorney General of the province in which the offender was tried has, either before or after the making of the application, consented to the application;

(b) at least seven days notice has been given to the offender by the prosecutor, following the making of the application, outlining the basis on which it is intended to found the application; and

(c) a copy of the notice has been filed with the clerk of the court or the magistrate, as the case may be.

(2) An application under this Part shall be heard and determined by the court without a jury.

(3) For the purposes of an application under this Part, where an offender admits any allegations contained in the notice referred to in paragraph (1)(b), no proof of those allegations is required.

(4) The production of a document purporting to contain any nomination or consent that may be made or given by the Attorney General under this Part and purporting to be signed by the Attorney General is, in the absence of any evidence to the contrary, proof of that nomination or consent without proof of the signature or the official character of the person appearing to have signed the document.

690.(1) On the hearing of an application under this Part, the court shall hear the evidence of at least two psychiatrists and all other evidence that, in its opinion, is relevant, including the evidence of any psychologist or criminologist called as a witness by the prosecution or the offender.

(2) One of the psychiatrists referred to in subsection (1) shall be nominated by the prosecution and one shall be nominated by the offender.

(3) If the offender fails or refuses to nominate a psychiatrist pursuant to this section, the court shall nominate a psychiatrist on behalf of the offender.

(4) Nothing in this section shall be construed to enlarge the number of expert witnesses that may be called without the leave of the court or judge under section 7 of the *Canada Evidence Act*.

691.(1) A court to which an application is made under this Part may, by order in writing,

(a) direct the offender in relation to whom the application is made to attend, at a place or before a person specified in the order and within a time specified therein, for observation, or

(b) remand the offender in such custody as the court directs, for a period not exceeding thirty days, for observation,

where in its opinion, supported by the evidence of, or where the prosecutor and the offender consent, supported by the report in writing of, at least one duly qualified medical practitioner, there is reason to believe that evidence might be obtained as a result of such observation that would be relevant to the application.

(2) Notwithstanding subsection (1), a court to which an application is made under this Part may remand the offender to which that application relates in accordance with that subsection

(a) for a period not exceeding thirty days without having heard the evidence or considered the report of a duly qualified medical practitioner where compelling circumstances exist for so doing and where a medical practitioner is not readily available to examine the offender and give evidence or submit a report; and

(b) for a period of more than thirty but not more than sixty days where it is satisfied that observation for such a period is required in all the circumstances of the case and its opinion is supported by the evidence of, or where the prosecutor and the offender consent, by the report in writing of, at least one duly qualified medical practitioner.

692. Without prejudice to the right of the offender to tender evidence as to his character and repute, evidence of character and repute may, if the court thinks fit, be admitted on the question whether the offender is or is not a dangerous offender.

693.(1) The offender shall be present at the hearing of the application under this Part and if at the time the application is to be heard

(a) he is confined in a prison, the court may order, in writing, the person having the custody of the accused to bring him before the court; or

(b) he is not confined in a prison, the court shall issue a summons or a warrant to compel the accused to attend before the court and the provisions of Part XIV relating to summons and warrant are applicable *mutatis mutandis*.

(2) Notwithstanding subsection (1), the court may

- (a) cause the offender to be removed and to be kept out of court, where he misconducts himself by interrupting the proceedings so that to continue the proceedings in his presence would not be feasible; or
- (b) permit the offender to be out of court during the whole or any part of the hearing on such conditions as the court considers proper.

694.(1) A person who is sentenced to detention in a penitentiary for an indeterminate period under this Part may appeal to the court of appeal against that sentence on any ground of law or fact or mixed law and fact.

(2) The Attorney General may appeal to the court of appeal against the dismissal of an application for an order under this Part on any ground of law.

(3) On an appeal against a sentence of detention in a penitentiary for an indeterminate period the court of appeal may

- (a) quash such sentence and impose any sentence that might have been imposed in respect of the offence for which the appellant was convicted, or order a new hearing; or
- (b) dismiss the appeal.

(4) On an appeal against the dismissal of an application for an order under this Part the court of appeal may

- (a) allow the appeal, set aside any sentence imposed in respect of the offence for which the respondent was convicted and impose a sentence of detention in a penitentiary for an indeterminate period, or order a new hearing; or
- (b) dismiss the appeal.

(5) A judgment of the court of appeal imposing a sentence pursuant to this section has the same force and effect as if it were a sentence passed by the trial court.

(6) Notwithstanding subsection 649(1), a sentence imposed on an offender by the court of appeal pursuant to this section shall be deemed to have commenced when the offender was sentenced by the court by which he was convicted.

(7) The provisions of Part XVIII with respect to procedure on appeals apply, *mutatis mutandis*, to appeals under this section.

695. Where a court, pursuant to section 688, finds an offender to be a dangerous offender and imposes a sentence of detention in a penitentiary for an indeterminate period, the court shall order that a copy of all reports or testimony given by psychiatrists, psychologists or criminologists and any observations of the court with respect to the reasons for the sentence, together with a transcript of the trial of the dangerous offender be forwarded to the Solicitor General of Canada for his information.

695.1(1) Subject to subsection (2), where a person is in custody under a sentence of detention in a penitentiary for an indeterminate period, the National Parole Board shall, forthwith after the expiration of three years from the day on which that person was taken into custody and not later

than every two years thereafter, review the condition, history and circumstances of that person for the purpose of determining whether he should be granted parole under the *Parole Act* and, if so, on what conditions.

(2) Where a person is in custody under a sentence of detention in a penitentiary for an indeterminate period that was imposed before the *Criminal Law Amendment Act, 1977* came into force, the National Parole Board shall, at least once in every year, review the condition, history and circumstances of that person for the purpose of determining whether he should be granted parole under the *Parole Act* and, if so, on what conditions.

738. . . .

(5) Notwithstanding subsection (1), the summary conviction court may, at any time before convicting a defendant or making an order against him or dismissing the information, as the case may be, when of the opinion, supported by the evidence, or, where the prosecutor and defendant consent, by the report in writing, of at least one duly qualified medical practitioner, that there is reason to believe that the defendant is mentally ill, by order in writing,

(a) direct the defendant to attend, at a place or before a person specified in the order and within a time specified therein, for observation; or

(b) remand the defendant to such custody as the court directs for observation for a period not exceeding thirty days.

(6) Notwithstanding subsection (5), a summary conviction court may remand the defendant in accordance therewith

(a) for a period not exceeding thirty days without having heard the evidence or considered the report of a duly qualified medical practitioner where compelling circumstances exist for so doing and where a medical practitioner is not readily available to examine the accused and give evidence or submit a report; and

(b) for a period of more than thirty days but not exceeding sixty days where it is satisfied that observation for such a period is required in all the circumstances of the case and that opinion is supported by the evidence or, where the prosecutor and the accused consent, by the report in writing, of at least one duly qualified medical practitioner.

(7) Where, as a result of observations made pursuant to an order issued under subsection (5), it appears to a summary conviction court that there is sufficient reason to doubt that a defendant is, on account of insanity, capable of conducting his defence, the summary conviction court shall direct that an issue be tried as to whether the defendant is then, on account of insanity, unfit to stand his trial.

(8) Where a summary conviction court directs the trial of an issue under subsection (7), it shall proceed in accordance with section 543 in so far as that section may be applied.

Parole Act, R.S.C. 1970, c. P-2, as amended.

6. Subject to this Act, the *Penitentiary Act* and the *Prisons and Reformatories Act*, the Board has exclusive jurisdiction and absolute discretion to grant or refuse to grant parole or a temporary absence without escort pursuant to the *Penitentiary Act* and to revoke parole or terminate day parole.

7.(1) Where, in the case of a person sentenced to a term of imprisonment in respect of which the Board has exclusive jurisdiction to grant, refuse to grant or revoke parole, that person is at the time of such sentence or at any time during such term of imprisonment sentenced to a term of imprisonment imposed under an enactment of a provincial legislature that is to be served either concurrently with or immediately after the expiration of the term of imprisonment in respect of which the Board has exclusive jurisdiction, the Board has, subject to this Act, exclusive jurisdiction and absolute discretion to grant, refuse to grant or revoke parole in relation to both such terms of imprisonment. . . .

- 8.(1) The Board shall at the times prescribed by the regulations
- (a) review the case of every inmate who is sentenced to imprisonment in or transferred to a penitentiary for two years or more, other than the case of any such inmate who advises the Board in writing that he does not wish to be granted parole by the Board, and who has not, in writing, revoked such advice; and
 - (b) review such cases of inmates serving a sentence of imprisonment of less than two years as are prescribed by the regulations, upon application by or on behalf of the inmate.

(2) Upon reviewing the case of an inmate as required by subsection (1) the Board shall decide whether or not to grant parole.

- 10.(1) The Board may
- (a) grant parole to an inmate, subject to any terms or conditions it considers desirable, if the Board considers that
 - (i) in the case of a grant of parole other than day parole, the inmate has derived the maximum benefit from imprisonment,
 - (ii) the reform and rehabilitation of the inmate will be aided by the grant of parole, and
 - (iii) the release of the inmate on parole would not constitute an undue risk to society;
 - (b) impose any terms and conditions that it considers desirable in respect of an inmate who is subject to mandatory supervision;
 - (c) [repealed]
 - (d) grant discharge from parole to any paroled inmate, except an inmate on day parole or a paroled inmate who was sentenced to death or to imprisonment for life as a minimum punishment; and
 - (e) in its discretion, revoke the parole of any paroled inmate other than a paroled inmate to whom discharge from parole has been

granted, or revoke the parole of any person who is in custody pursuant to a warrant issued under section 16 notwithstanding that his sentence has expired.

(2) The Board or any person designated by the Chairman may terminate a temporary absence without escort granted to an inmate pursuant to sections 26.1 or 26.2 of the *Penitentiary Act* or the day parole of any paroled inmate and, by a warrant in writing, authorize the apprehension of the inmate and his recommitment to custody as provided in this Act.

11. Subject to such regulations as the Governor in Council may make in that behalf, the Board is not required, in considering whether parole should be granted or revoked, to personally interview the inmate or any person on his behalf.

Parole Regulations, C.R.C. 1978, c. 1249, as amended.

PART I

3.(1) This Part does not apply to a provincial parole board. . . .

4. These Regulations are subject to section 28 of the *Criminal Law Amendment Act (No. 2), 1976*, and to section 674 of the *Criminal Code*.

5. Subject to sections 6 to 8 and section 11.1, the portion of the term of imprisonment that an inmate must serve before full parole may be granted is one-third of the term of imprisonment imposed on him or seven years, whichever is the lesser.

6. The portion of the term of imprisonment that an inmate sentenced to imprisonment for life must serve before full parole may be granted is as follows:

- (a) where the inmate is sentenced to imprisonment for life otherwise than as a minimum punishment, seven years,
- (b) where the inmate is sentenced to imprisonment for life as a minimum punishment before January 4, 1968, seven years, and
- (c) where the inmate is sentenced to imprisonment for life as a minimum punishment on or after January 4, 1968, but before January 1, 1974, ten years,

minus any time spent in custody between the day on which the inmate was arrested and taken into custody in respect of the offence for which he was sentenced to imprisonment for life and the day the sentence was imposed.

7. The portion of the term of imprisonment that an inmate in respect of whom a sentence of death was commuted to imprisonment for life before January 1, 1974 must serve before full parole may be granted is ten years minus any time spent in custody between the day on which the inmate was arrested and taken into custody in respect of the offence for which he was sentenced to death and the day the sentence was commuted to a sentence of imprisonment for life.

8.(1) Subject to subsection (2), where an inmate on whom a sentence of imprisonment of five years or more has been imposed for an offence for which he was liable to imprisonment for ten years or more and the offence involved conduct that

- (a) seriously endangered the life or safety of any person,
- (b) resulted in serious bodily harm to any person, or
- (c) resulted in severe psychological damage to any person,

the portion of the term of imprisonment that the inmate must serve before full parole may be granted is one-half of the term of imprisonment so imposed or seven years, whichever is the lesser.

(2) Subsection (1) does not apply to an inmate unless the inmate has been convicted of the offence referred to in that subsection after the coming into force of these Regulations and within ten years of the expiration of a term of imprisonment imposed on that inmate of five years or more for an offence for which he was liable to imprisonment for ten years or more that involved conduct described in paragraph (1)(a), (b) or (c).

9. Subject to sections 10 and 11.1 the portion of the term of imprisonment that an inmate must serve before day parole may be granted is as follows:

- (a) where the inmate was, before October 15, 1977, sentenced to preventive detention, one year;
- (b) where the inmate was, on or after October 15, 1977, sentenced to detention in a penitentiary for an indeterminate period, three years;
- (c) where the term of imprisonment imposed on an inmate is twelve years or more, the term of imprisonment prescribed by section 5 minus two years;
- (d) where the term of imprisonment imposed on the inmate is less than twelve years, but is two years or more, one-half the term of imprisonment prescribed by section 5 or six months, whichever is the greater; and
- (e) where the term of imprisonment imposed on the inmate is less than two years, one-half the term of imprisonment prescribed by section 5.

10. The portion of the term of imprisonment that an inmate sentenced to imprisonment for life must serve before day parole may be granted is as follows:

- (a) where the inmate is sentenced to imprisonment for life otherwise than as a minimum punishment, five years;
- (b) where the inmate is sentenced to imprisonment for life as a minimum punishment before January 4, 1968, the term of imprisonment prescribed by paragraph 6(b) minus three years; and
- (c) where the inmate is sentenced to imprisonment for life as a minimum punishment on or after January 4, 1968, but before January 1, 1974, the term of imprisonment prescribed by paragraph 6(c) minus three years.

11. The portion of the term of imprisonment that an inmate in respect of whom a sentence of death was commuted to imprisonment for life before January 1, 1974, must serve before day parole may be granted is the term of imprisonment prescribed by section 7 minus three years.

11.1 The Board may grant full parole or day parole to an inmate, other than an inmate referred to in sections 6 to 8, paragraph 9(a) or (b) or section 10 or 11, before the inmate has served the portion of the term of imprisonment prescribed by section 5 or 9, as the case may be, if

- (a) the inmate is terminally ill;
- (b) the inmate's physical or mental health is likely to suffer serious damage if he continues to be held in confinement; or
- (c) there is a deportation order made against the inmate under the *Immigration Act, 1976* and the inmate is to be detained under that Act until deported.

12.(1) Subject to subsection (2), the portion of the term of imprisonment that an inmate must serve before temporary absence may be authorized is as follows:

- (a) where the inmate is serving a sentence of imprisonment for life, the period of time required to be served by the inmate to reach his full parole eligibility date, minus three years;
- (b) where the inmate is serving a term of imprisonment other than a sentence of imprisonment for life, one-half the period of time required to be served by the inmate to reach his full parole eligibility date or six months, whichever is the greater;
- (c) where the inmate has been sentenced to detention in a penitentiary for an indeterminate period, three years.

(2) Subsection (1) does not apply

- (a) to an inmate admitted to a penitentiary prior to the coming into force of this section; or
- (b) to an inmate whose life or health is in immediate danger and temporary absence without escort is required in order to administer emergency medical treatment.

13. An inmate sentenced to

- (a) imprisonment for life,
- (b) a term of imprisonment of two years or more, or
- (c) detention in a penitentiary for an indeterminate period

shall be notified, in writing, by the Board of his

- (d) full parole eligibility date,
- (e) day parole eligibility date, and
- (f) temporary absence eligibility date,

within six months of his admission to a penitentiary.

14. The review for full parole required by paragraph 8(1)(a) of the Act shall be carried out by the Board on the inmate's full parole eligibility date unless the Board has, of its own motion or on application by or on behalf of the inmate, reviewed the case of the inmate prior to that date.

15.(1) Subject to subsections (2) and (3), the review referred to in section 14 shall be by way of a hearing before not less than two members of the Board unless the inmate requests, in writing, that the review be conducted without a hearing.

(2) Where it is not possible to comply with subsection (1) because the inmate is not in lawful custody, the review referred to in that subsection shall be carried out as soon as practical after the Board is informed of the inmate's return to custody.

(3) Subsection (1) does not apply to an inmate detained in a provincial institution unless the inmate is a federal inmate.

16.(1) Where the Board conducts a review referred to in section 14 and does not, at that time, grant the inmate a full parole, the Board shall, during the period the inmate remains in custody, review the case of the inmate

(a) on the day that is two years after the date of the inmate's full parole eligibility date, and

(b) thereafter on the day that is two years from the date of the immediately preceding review,

until full parole is granted or the inmate's sentence has expired according to law.

(2) Subsection (1) does not apply where the Board has, of its own motion or on application by or on behalf of an inmate, reviewed the case of the inmate after that inmate's full parole eligibility date and before the time prescribed by paragraph (1)(a) or (b), as the case may be.

17.(1) Subject to subsection (3), the Board shall furnish an inmate whose case is to be reviewed for full parole pursuant to paragraph 8(1)(a) of the Act, orally or in writing, with all relevant information in the possession of the Board.

(2) Where the Board decides to provide an inmate with information in writing referred to in subsection (1), such information shall be provided at least fifteen days before the review.

(3) The Board is not required pursuant to subsection (1) to furnish an inmate with any information

(a) contained in a document prepared before the coming into force of this section;

(b) described in paragraphs 54(a) to (g) of the *Canadian Human Rights Act*.

18.(1) Subject to subsection (2), the cases of inmates serving a sentence of less than two years that must be reviewed by the Board pursuant to paragraph 8(1)(b) of the Act are those cases in which

(a) the Board has received from or on behalf of an inmate an application for full parole; and

(b) the application is received

(i) not earlier than four months before the inmate's full parole eligibility date, and

(ii) not later than four months before the expiration of two-thirds of the term of imprisonment to which the inmate was sentenced.

(2) The Board is not required to review any application described in subsection (1) that is received within six months of a previous decision to deny parole to that inmate.

19.(1) When the Board has carried out the review required by paragraph 8(1) (a) or (b) of the Act, it shall, as soon as possible after the completion of the review, inform the inmate, orally or in writing, of its decision as to whether or not full parole has been granted.

(2) Where the decision referred to in subsection (1) is not to grant full parole to the inmate, the Board shall, within fifteen days after making the decision, inform the inmate, in writing, of the reasons for the decision and the time when the Board will review his case in accordance with section 16.

22.(1) Where a decision is made by the Board in respect of a federal inmate that

(a) denies full parole to that inmate, other than to an inmate referred to in section 11.1,

(b) revokes the parole granted to that inmate, or

(c) revokes the mandatory supervision of that inmate,

the inmate may request the Board to re-examine the decision.

(2) Where the request referred to in subsection (1) is received within thirty days of the date the inmate is notified of the decision by the Board, the Board shall, and in any other case the Board may, cause the decision to be re-examined.

(3) A re-examination under this section shall

(a) be conducted by Board members who did not participate in the decision being re-examined; and

(b) be conducted by way of a re-examination of the material on which the decision being re-examined was rendered by the Board, together with any other relevant information that was not available at the time of that decision.

23.(1) Subject to subsection (3), the minimum number of members of the Board who must vote before a parole may be granted or denied is as follows:

(a) where the inmate is

(i) sentenced to imprisonment for life as a minimum punishment,

(ii) serving a sentence of imprisonment for life to which a sentence of death has been commuted,

(iii) serving a sentence of detention in a penitentiary for an indefinite period, or

(iv) serving a sentence of preventive detention,

seven members;

(b) where the inmate is sentenced to imprisonment for life imposed otherwise than as a minimum punishment or is serving a term of imprisonment of ten years or more or terms of

imprisonment the aggregate of which is ten years or more, five members;

(c) where the inmate is sentenced to imprisonment of five years or more, but less than ten years, or is serving terms of imprisonment the aggregate of which is five years or more, but less than ten years, three members; and

(d) where the inmate is sentenced to a term of imprisonment of less than five years or terms of imprisonment the aggregate of which is less than five years, two members.

(2) Subject to subsection (3), the minimum number of members of the Board who must vote before temporary absence may be granted or denied is as follows:

(a) where the inmate is sentenced to imprisonment for life imposed as a minimum punishment or to which a sentence of death has been commuted, or is serving a sentence of detention in a penitentiary for an indeterminate period, seven members; and

(b) where the inmate is serving a sentence other than a sentence described in paragraph (a), two members, unless the grant of parole to him would require more than two members, in which case the authorization of temporary absence requires the same number of votes as are required to grant full parole until the first temporary absence has been authorized and thereafter two members.

(3) Where, at any time during the voting on a review of a case of an inmate to grant or deny parole or temporary absence

(a) more than one-third of the members of the Board voting, in the case of an inmate referred to in paragraph (1)(a) or (2)(a), or

(b) more than one-half of the members of the Board voting, in any case other than a case referred to in paragraph (a) where the number of members required to vote exceeds two

have voted to deny parole or temporary absence, the minimum number of members who must vote on the review is such number as have voted at the time the last vote to deny parole or temporary absence, as the case may be, is cast.

(4) The minimum number of members of the Board who must vote in case of a revocation of parole or mandatory supervision or in any other case not provided for by subsection (1) or (2) is two members.

(5) Nothing in this section prohibits the Chairman of the Board from directing that any number of members of the Board greater than the minimum prescribed by this section shall consider a case and cast their votes.

24.(1) Subject to subsection (2), the minimum number of affirmative votes by members of the Board required to grant parole or temporary absence is as follows:

(a) in any case referred to in paragraph 23(1)(a) or (2)(a), two-thirds of the number of members of the Board voting; and

(b) in any case other than a case referred to in paragraph 23(1)(a)

or (2)(a), a majority of the number of members of the Board voting.

(2) Where the minimum number of members prescribed by this section to vote on a review of a case of any inmate is two, the decision in that case shall require

(a) unanimity of those votes; or

(b) where there is no unanimity of votes, the assignment by the Chairman of the Board of a further member to cast his vote and thereupon the decision shall be effected by majority vote.

PART II

27. This Part applies to a provincial parole board.

28. Subject to sections 29 to 31.1, the portion of the term of imprisonment that an inmate must serve before full parole may be granted is one-third of the term of imprisonment imposed on him or seven years, whichever is the lesser.

29. Where an inmate is sentenced to imprisonment for life otherwise than as a minimum punishment, the portion of the term of imprisonment that the inmate must serve before full parole may be granted is seven years minus any time spent in custody between the day on which the inmate was arrested and taken into custody in respect of the offence for which he was sentenced to imprisonment for life and the day the sentence was imposed.

30.(1) Subject to subsection (2), where an inmate on whom a sentence of imprisonment of five years or more has been imposed for an offence for which he was liable to imprisonment for ten years or more and the offence involved conduct that

(a) seriously endangered the life or safety of any person,

(b) resulted in serious bodily harm to any person, or

(c) resulted in severe psychological damage to any person,

the portion of the term of imprisonment that the inmate must serve before full parole may be granted is one-half of the term of imprisonment so imposed or seven years, whichever is the lesser.

(2) Subsection (1) does not apply to an inmate unless the inmate has been convicted of the offence referred to in that subsection after the coming into force of this Part and within ten years of the expiration of a term of imprisonment imposed on that inmate of five years or more for an offence for which he was liable to imprisonment for ten years or more that involved conduct described in paragraph (1)(a), (b) or (c).

31.(1) Subject to section 31.1 the portion of the term of imprisonment that an inmate must serve before day parole may be granted is as follows:

(a) where the term of imprisonment imposed on the inmate is twelve years or more, the term of imprisonment prescribed by section 28 minus two years;

(b) where the term of imprisonment imposed on the inmate is less

than twelve years, but is two years or more, one-half the term of imprisonment prescribed by section 28 or six months, whichever is the greater;

(c) where the term of imprisonment imposed on the inmate is less than two years, one-half the term of imprisonment prescribed by section 28; and

(d) where the inmate is sentenced to imprisonment for life otherwise than as a minimum punishment, five years.

(2) Nothing in this section requires a provincial parole board to receive or consider an application for day parole.

31.1 A provincial parole board may grant full parole or day parole to an inmate, other than an inmate referred to in section 29 or 30, before the inmate has served the portion of the term of imprisonment prescribed by section 28 or 31, as the case may be, if

(a) the inmate is terminally ill;

(b) the inmate's physical or mental health is likely to suffer serious damage if he continues to be held in confinement; or

(c) there is a deportation order made against the inmate under the *Immigration Act, 1976* and the inmate is to be detained under that Act until deported.

32.(1) Subject to subsections (2) and (3), a provincial parole board shall review the case of an inmate when the board receives an application for full parole made by or on behalf of that inmate.

(2) Where it is not possible to comply with subsection (1) because the inmate is not in lawful custody, the review referred to in that subsection shall be carried out as soon as practical after the provincial parole board is informed of the inmate's return to custody.

(3) A provincial parole board is not required to review the case of an inmate where the application referred to in subsection (1) is received

(a) within six months of a previous decision in respect of that inmate to deny full parole where the term of imprisonment being served is less than two years; or

(b) within two years of a previous decision in respect of that inmate to deny full parole where the term of imprisonment being served is two years or more.

33.(1) When a provincial parole board has carried out a review required by subsection 32(1), it shall, as soon as possible after the completion of the review, inform the inmate, orally or in writing, of its decision as to whether full parole has been granted or denied.

(2) Where the decision referred to in subsection (1) is not to grant full parole to the inmate, the provincial parole board shall, within fifteen days after making the decision, inform the inmate, in writing, of the reasons for the decision.

34. Nothing in these Regulations requires a provincial parole board, in

considering whether, in respect of an inmate, parole should be granted or revoked, to personally interview the inmate or any person on his behalf.

36.(1) The minimum number of members of a provincial parole board who must vote before a parole may be granted or denied is as follows:

(a) where the inmate is sentenced to imprisonment for life imposed otherwise than as a minimum punishment or is serving a term of imprisonment of ten years or more or terms of imprisonment the aggregate of which is ten years or more, five members;

(b) where the inmate is sentenced to imprisonment of five years or more, but less than ten years, or is serving terms of imprisonment the aggregate of which is five years or more, but less than ten years, three members; and

(c) where the inmate is sentenced to a term of imprisonment of less than five years or terms of imprisonment the aggregate of which is less than five years, two members.

(2) Nothing in subsection (1) prohibits the chairman of a provincial parole board from directing that any number of members of the board greater than the minimum prescribed by that subsection shall consider a case and cast their votes.

37.(1) Subject to subsection (2), the minimum number of affirmative votes required to grant parole is

(a) a majority of the minimum number of members required to vote pursuant to section 36; or

(b) a majority of the number of members voting, where the number of members voting is greater than the minimum number required to vote pursuant to section 36.

(2) Where the minimum number of members prescribed by section 36 to vote on a review of a case of any inmate is two, the decision in that case shall require

(a) unanimity of those votes; or

(b) where there is no unanimity, the assignment by the chairman of the provincial parole board of a further member of the board to cast his vote and thereupon the decision shall be affected by a majority vote.

Penitentiary Act, R.S.C. 1970, c. P-6, as amended.

19.(1) The Minister may, with the approval of the Governor in Council, enter into an agreement with the government of any province to provide for the custody, in a mental hospital or other appropriate institution operated by the province, of persons who, having been sentenced or committed to penitentiary, are found to be mentally ill or mentally defective at any time during confinement in penitentiary.

(2) Where no agreement has been made pursuant to subsection (1)

between the Minister and the government of any province from which a mentally ill or mentally defective person is sentenced or committed to penitentiary, the officer in charge of the penitentiary may, on the advice of the penitentiary physician or psychiatrist, refuse to accept custody of that person under the sentence or committal or, if custody of that person has been accepted, may, under the authority of a written direction by the Commissioner, return that person to the prison or other place of confinement from which he was received. . . .

(4) A person who, pursuant to subsection (1), is confined in a provincial hospital or other institution shall, during the term of his confinement therein, be deemed to be confined in a penitentiary.

...

26.2(1) Where, pursuant to an agreement under subsection 19(1), an inmate has been admitted to a provincially operated mental hospital or to any other provincially operated institution in which the liberty of the patients is normally subject to restrictions, the officer in charge of the provincial institution may permit temporary absences from that institution within the limits prescribed in paragraph 26(b)

(a) with escort, when he is delegated that authority by the officer in charge of the penitentiary in which the inmate was last confined; and

(b) without escort, when he is delegated that authority by the National Parole Board.

***Penitentiary Service Regulations, C.R.C. 1978, c. 1251,
as amended.***

16. Every inmate shall be provided, in accordance with directives, with the essential medical and dental care that he requires.

...

20.(1) There shall be, at each institution, an appropriate program of inmate activities designed, as far as practicable, to prepare inmates, upon discharge, to assume their responsibilities as citizens and to conform to the requirements of the law.

(2) For the purpose of giving effect to subsection (1) the Commissioner shall, so far as practicable, make available to each inmate who is capable of benefitting therefrom, academic or vocational training, instructive and productive work, religious and recreational activities and psychiatric, psychological and social counselling.

...

23. The records of the Service concerning inmates and former inmates are confidential and information therein shall not be disclosed to any person except as authorized by directives.

1. Section 2 of the *Criminal Code* is amended by adding thereto, in alphabetical order within the section, the following definitions:

“mental disorder” means a disease of the mind and includes a disability of the mind;

“unfit to stand trial” means, in respect of an accused, the inability of the accused on account of mental disorder to conduct a defence at any stage of the proceedings in respect of an offence charged against the accused or to instruct counsel to do so and, in particular, the inability of the accused to

(a) understand the nature or object of the proceedings,

(b) understand the possible consequences of the proceedings, or

(c) communicate with counsel;”

2. Section 16 of the said Act is repealed and the following substituted therefor:

“16. No person shall be convicted or discharged under section 662.1 of an offence in respect of an act or omission on

the part of that person that occurred while that person suffered from a mental disorder that rendered him incapable of appreciating the nature and quality of the act or omission or of knowing that the act or omission is wrong.”

3. The heading preceding section 542 and sections 542 to 547 of the said Act are repealed and the following substituted therefor:

“Mental Disorder

542. For the purposes of sections 543 to 547.36,

“accused” includes a defendant in summary conviction proceedings and an accused in respect of whom a verdict of not criminally responsible by reason of mental disorder has been rendered;

“assessment” includes observation and examination;

“court” means a court, including a summary conviction court within the meaning of section 720, judge, justice or provincial court judge and includes a judge of the court of appeal within the meaning of section 601;

“disposition” means a disposition made under section 547.28;

“disposition report” means a report on the mental condition of an accused made by a person who has made an assessment of that person pursuant to an order made under section 544 or to whom responsibility for the assessment or treatment of the accused has been assigned by virtue of a disposition;

“party”, in respect of proceedings to determine the appropriate disposition to be made by a court or Review Board in respect of an accused, means

(a) the accused,

(b) the hospital or person in charge of any other place where the accused is detained or is to attend pursuant to an order made under section 544 or subsection 547.28(1),

(c) the Attorney General of the province where the disposition is to be

made, on the application of the Attorney General to the court or Review Board,

(d) any other person having a substantial interest in the proceedings designated by the court or Review Board as a party to the proceedings, or

(e) where the disposition is to be made by a court, the prosecutor of the charge against the accused;

"prescribed" means prescribed by regulations made by the Governor in Council;

"qualified medical practitioner" means a person duly qualified by provincial law to practise medicine;

"Review Board" means, in respect of any province, the board established or designated for that province pursuant to section 547.21.

Rules of Evidence

543. (1) Where an assessment of the mental condition of an accused or the treatment of an accused is carried out by virtue of an order made under subsection 544(1) or a disposition made under section 547.28, any statement made by the accused to the person specified in the order or responsible for that assessment or treatment of the accused or to a person acting under the direction of that person, during the course and for the purposes of that assessment or treatment, is privileged and, subject to subsections (2) to (4), no evidence of or relating to that statement is admissible without the consent of the accused in any proceeding before a court, tribunal, body or person with jurisdiction to compel the production of evidence, other than a prosecution for perjury.

(2) The privilege under subsection (1) does not apply at

(a) a hearing to determine the fitness of the accused to stand trial in respect of a statement made by the accused during the course of an assessment made by

virtue of an order under subsection 544(1) for the purpose of determining whether the accused is unfit to stand trial; or

(b) a hearing held by a court pursuant to subsection 547.22(1) or by a Review Board pursuant to section 547.24 or 547.32 in respect of a statement made by the accused during the course of an assessment made by virtue of an order under subsection 544(1) for the purpose of determining the appropriate disposition to be made by the court or Review Board in respect of the accused.

(3) A statement is not privileged under subsection (1) where the accused puts in issue his mental condition at the time of the offence charged, but the statement is admissible only on that issue.

(4) Where an accused testifies at a proceeding and his testimony is inconsistent in a material particular with a statement referred to in subsection (1) that the accused made previously, evidence of that previous statement is admissible in the proceeding but only to challenge the credibility of the accused.

Remands

544. (1) Subject to subsection (3) and section 546, a court having jurisdiction over an accused in respect of an offence may, on its own motion or on application of the accused or the prosecutor, at any stage of proceedings against the accused, make an order for an assessment of the mental condition of the accused for a purpose mentioned in subsection (2) where the court has reasonable grounds to believe that evidence of the mental condition of the accused may be necessary for that purpose.

(2) A court may make an order under subsection (1) in respect of an accused for the purpose of determining

(a) whether the accused is unfit to stand trial;

(b) whether the accused suffered from a mental disorder referred to in section 16 at the time the act or omission charged against the accused occurred;

(c) where a verdict of unfit to stand trial or not criminally responsible on account of mental disorder has been rendered in respect of the accused, the appropriate disposition to be made in respect of the accused pursuant to subsection 547.22(1) or section 547.24; or

(d) where the accused has been convicted of the offence, whether an order under subsection 662.2(1) should be made in respect of the accused.

(3) The prosecutor may not make an application for an order under subsection (1) for a purpose mentioned in paragraph (2)(a), (b) or (d) unless

(a) the accused has been prosecuted by indictment; or

(b) the accused has put in issue the mental condition of the accused.

(4) An order made under subsection (1) may be in Form 45.

545. (1) Subject to this section, an order made under subsection 544(1) shall specify

(a) the person by whom or the place where the assessment is to be made;

(b) whether the accused is to be remanded in custody for the period during which the assessment is to be made; and

(c) the period, not exceeding thirty days, during which the assessment is to be made by that person or at that place.

(2) A court may make an order under subsection 544(1) for a period not exceeding sixty days where the court is satisfied that compelling circumstances exist that warrant the order being made for such period.

(3) Where an order in respect of an accused is made under subsection 544(1) for a period not exceeding thirty days, the court may, on its own motion or on the application of the accused or the prosecutor made during the period in which the order is in force or on the expiration of that period, where the court is satisfied that a longer period is required for the assessment of the mental condition of the accused, grant one extension of the order for a period not exceeding thirty days.

(4) An order in respect of an accused made under subsection 544(1) for the purpose of determining whether the accused is unfit to stand trial shall not be made for a period exceeding three clear days but, on the application of the accused or the prosecutor made during the period in which the order is in force or on the expiration of the order, the court may, where the court is satisfied that a longer period is required for the assessment of the mental condition of the accused for that purpose, grant

(a) one extension and, where necessary, a second extension of the order for a period not exceeding thirty days in respect of that first or second extension; or

(b) one extension of the order for a period not exceeding sixty days, where the court is satisfied that compelling circumstances exist that warrant the extension being granted for such period.

(5) Notwithstanding subsection (4), an order in respect of an accused made under subsection 544(1) for the purpose referred to in subsection (4) may be made initially for a period exceeding three clear days but not exceeding

(a) thirty days, where the accused and the prosecutor consent thereto; or

(b) sixty days, where the court is satisfied that compelling circumstances exist that warrant the order being made for such period.

(6) Where an order in respect of an accused is made under subsection (5) for a

period exceeding three clear days but not exceeding thirty days, the court may grant one extension of the order for a period not exceeding thirty days.

(7) Where an extension of an order made under subsection 544(1) is granted pursuant to this section, the court may vary the conditions under which the order is made.

546. (1) Subject to subsection (2), an accused shall not be remanded in custody pursuant to an order made under subsection 544(1) unless

(a) the accused consents thereto;

(b) the accused is required to be detained in custody in respect of any other matter or by virtue of any other provision of this Act;

(c) the court is satisfied that detention of the accused in custody is necessary to assess the mental condition of the accused; or

(d) the prosecutor, having been given a reasonable opportunity to do so, shows cause why the detention of the accused in custody is justified within the meaning of subsection 457(7).

(2) An accused shall be remanded in custody pursuant to an order made under subsection 544(1) in the circumstances and under the conditions set out in subsections 457(5.1) and 457.7(2), applied in respect of this section with such modifications as the circumstances require.

(3) Where a court has made an order under subsection 544(1) in respect of an accused charged with an offence, during the period in which that order is in force, an order for the interim release or detention of the accused may not be made or by virtue of any provision of Part XIV or section 608 in respect of that offence or an included offence.

(4) The court may, at any time while an order in respect of an accused made by the court under subsection 544(1) is in force, on cause being shown, vary the terms and

conditions respecting the interim release or detention of the accused specified in the order in such manner as the court considers appropriate in the circumstances.

547. Subject to section 547.15, no order made under subsection 544(1) shall authorize any psychiatric or other treatment of the accused or direct the accused to submit to such treatment without the consent for that treatment given by the accused or a person who, according to the laws of the province where the order is made, is authorized to give such consent for the accused.

Disposition Reports

547.1 (1) An order made under subsection 544(1) may require that the person who makes an assessment of the mental condition of the accused pursuant to the order prepare a report in writing of the results of the assessment.

(2) Subject to paragraph 547.27(1)(g), where a disposition report is required to be made in writing pursuant to an order of a court made under subsection 544(1), the report shall be filed with the court within such period as may be fixed by the court.

(3) Where a disposition report is filed with a court that made an order under subsection 544(1) for the purpose of determining the appropriate disposition to be made by a Review Board in respect of an accused pursuant to section 547.24, the court or the clerk or other appropriate officer of the court shall, forthwith after the report is filed, cause the report to be sent to the Review Board.

(4) Subject to subsections 547.27(2) to (5), where a disposition report is filed with a court pursuant to subsection (2), copies thereof shall be provided forthwith to the prosecutor, the accused and counsel, if any, representing the accused.

Issue of Fitness to Stand Trial

547.11 (1) An accused shall be presumed fit to stand trial unless the court is satisfied on a balance of probabilities that the accused is unfit to stand trial.

(2) Where a court having jurisdiction over an accused in respect of an offence has, at any stage of the proceedings, reasonable grounds to believe that the accused is unfit to stand trial, the court may direct that an issue be tried whether the accused is then unfit to stand trial.

(3) A direction may be made pursuant to subsection (2) by the court on its own motion or on application of the accused or the prosecutor but the prosecutor may not make such an application unless the accused is prosecuted by indictment.

(4) Where an application is made under subsection (3) by the accused or the prosecutor, the burden of proving that the accused is unfit to stand trial is on the applicant.

547.12 Where the court has reasonable grounds to believe that an accused is unfit to stand trial, the court shall, if the accused is not represented by counsel, assign counsel to act on behalf of the accused.

547.13 For the purposes of subsection 547.11(2), the following provisions apply:

(a) the court may postpone directing the trial of the issue

(i) where the issue arises before the close of the case for the prosecution at the preliminary inquiry, until a time not later than the time the accused is called on to answer to the charge, or

(ii) where the issue arises before the close of the case for the prosecution at the trial, until a time not later than the opening of the case for the defence or, on motion of the accused, such later time as the court may direct;

(b) where the trial is held or is to be held before a court composed of a judge and jury,

(i) if the judge directs the issue to be tried before the accused is given in charge to a jury for trial on the indictment, it shall be tried by the number of jurors required to try the issues in respect of the indictment in the province in which the trial is being or is to be held, and

(ii) if the judge directs the issue to be tried after the accused has been given in charge to a jury for trial on the indictment, the jurors shall be sworn to try that issue in addition to the issues in respect of which they are already sworn;

(c) where the trial is held or is to be held before a court, other than a court composed of a judge and jury, the court shall try the issue and render a verdict; and

(d) where the issue arises before a court at a preliminary inquiry or any other stage of the proceedings, the court shall try the issue and render a verdict.

547.14 (1) Where the verdict in respect of an issue directed to be tried pursuant to subsection 547.11(2) is that the accused is fit to stand trial, the arraignment, preliminary inquiry, trial or other stage of the proceedings, as the case may be, shall proceed as if no such issue had been directed to be tried.

(2) Where the verdict in respect of an issue directed to be tried pursuant to subsection 547.11(2) is that the accused is unfit to stand trial, a disposition shall be made in respect of the accused pursuant to subsection 547.22(1) or section 547.24 and any plea that has been made shall be set aside and the jury discharged.

(3) Where the court has postponed directing the trial of the issue pursuant to paragraph 547.13(a) and the accused is discharged or acquitted at the close of the

case for the prosecution, the issue shall not be tried.

(4) No proceeding pursuant to section 547.11 shall prevent the accused from being tried subsequently on the indictment unless the trial of the issue was postponed pursuant to subparagraph 547.13(a)(ii) and the accused was discharged or acquitted at the close of the case for the prosecution.

547.15 (1) Subject to this section, the court or Review Board may, after notice given to the accused within the time and in the manner prescribed, where it is satisfied, on the evidence of a qualified medical practitioner described in subsection (2), that a specific treatment should be administered to the accused for the purpose of rendering the accused fit to stand trial,

(a) authorize that treatment of the accused, and

(b) where the accused is not detained in custody, direct the accused to submit to that treatment,

by the person or at the place and for the purpose specified in an order made under subsection 544(2)(a) or a disposition made under paragraph 547.28(1)(b) during any period in which the order or disposition is in force specified by the court or Review Board and subject to any other conditions that the court or Review Board considers appropriate.

(2) For the purposes of subsection (1), the evidence of a qualified medical practitioner shall state that the practitioner

(a) has assessed the mental condition of the accused; and

(b) is of the opinion that the accused, at the time of the examination, was unfit to stand trial, that a specific psychiatric or other treatment will likely render the accused fit to stand trial within the period specified by the practitioner and that without such treatment the accused is likely to remain unfit to stand trial.

(3) An accused in respect of whom a motion is made pursuant to subsection (1)

may challenge the motion and adduce any evidence for that purpose.

(4) A court or Review Board shall not authorize, and no authorization given pursuant to subsection (1) is or shall be deemed to include, authority to perform psychosurgery or electroconvulsive therapy.

(5) In subsection (4),

“electroconvulsive therapy” means a procedure for the treatment of certain mental disorders that induces, by electrical stimulation of the brain, a series of generalized convulsions;

“psychosurgery” means any procedure that

(a) by direct access to the brain, removes, destroys or interrupts the continuity of histologically normal brain tissue; or

(b) inserts indwelling electrodes for pulsed electrical stimulation for the purpose of altering behaviour or treating psychiatric illness,

but does not include neurological procedures used to diagnose or treat organic brain conditions or to diagnose or treat intractable physical pain or epilepsy where those conditions are clearly demonstrable.

(6) The court or Review Board shall not authorize treatment pursuant to subsection (1) without the consent of the hospital or person in charge of the place where the accused is to be detained for treatment or of the person to whom responsibility for the treatment of the accused is assigned by the court or Review Board.

(7) The court or Review Board may authorize treatment of an accused pursuant to subsection (1) without the consent for that treatment given by the accused or a person who, according to the laws of the province where the order is made, is authorized to give such consent for the accused.

547.16 An accused may be detained in a hospital or other place pursuant to an order made under subsection 544(1) or paragraph 547.28(1)(a) after the accused has become fit to stand trial until the completion of the trial or other proceedings during which the order was made of the accused where the court or Review Board that made the order has reasonable grounds to believe that the accused will, if the accused does not remain in the hospital or other place, become unfit to stand trial.

547.17 (1) Where a verdict of unfit to stand trial has been rendered in respect of an accused, the accused or the prosecutor, whoever intends to prove that the accused has subsequently become fit to stand trial, has the burden of proof of satisfying the court that the accused has become fit to stand trial.

(2) The burden of proof referred to in subsection (1) is discharged by proof on a balance of probabilities.

Defence of Mental Disorder

547.18 (1) In this section and sections 547.19 and 547.2, "mental disorder" means a mental disorder referred to in section 16.

(2) An accused shall be presumed not to have been suffering from a mental disorder at the time of the commission of the alleged offence unless the court is satisfied on a balance of probabilities that the accused was suffering from a mental disorder at that time.

(3) Where the court has reasonable grounds to believe that an accused suffered from a mental disorder at the time of the commission of the alleged offence, the court may, on its own motion, raise that issue.

(4) Subject to subsection (5), an accused or the prosecutor may adduce evidence for the purpose of establishing that the accused suffered from a mental disorder at the time of the commission of the alleged offence.

(5) Where an accused has not put in issue the mental condition of the accused at the time of the commission of the alleged offence, the court before whom the trial is held may permit the prosecutor to adduce evidence for the purpose of establishing that the accused suffered from a mental disorder at that time where the alleged offence is an indictable offence and the court is satisfied that

(a) the evidence previously adduced in the case, other than evidence in relation to the mental condition of the accused, would warrant the jury, or the court where there is no jury, being satisfied beyond a reasonable doubt that the accused committed the alleged offence;

(b) the admission of the evidence of mental disorder to be adduced by the prosecutor would not prejudice the accused in his defence; and

(c) the interests of justice require the evidence of mental disorder to be adduced by the prosecutor given

(i) the nature and seriousness of the alleged offence,

(ii) the extent to which the accused may be a danger to the public, and

(iii) the substantial nature of the evidence to be adduced by the prosecutor indicating that the accused lacked the intent required to commit the offence.

(6) Where the issue of mental disorder at the time of the commission of an alleged offence is raised, the burden of proof with respect to that issue is on the proponent.

547.19 Where, at the trial of an accused charged with an offence, the jury, or the judge or provincial court judge, where there is no jury, finds that an accused committed the act or omission that formed the basis of the charge and that the accused suffered from a mental disorder at the time of the commission of that act or omission, the jury, judge or provincial court judge shall declare that

the accused committed that act or omission and render a verdict of not criminally responsible on account of mental disorder.

547.2 (1) For greater certainty, where an accused is found to have committed an act or omission that formed the basis of an alleged offence charged against the accused and a verdict of not criminally responsible on account of mental disorder is rendered in respect of an accused, the accused shall be deemed not to have been acquitted or found guilty or convicted of the offence except that

(a) the accused may plead *autrefois convict* in respect of any subsequent charge relating to that offence;

(b) any court may consider the verdict in considering an application for judicial interim release or in considering what dispositions to make or sentence to impose for any offence; and

(c) the National Parole Board or any provincial parole board may consider the verdict in considering an application for parole or pardon in respect of any other offence.

(2) No application form for or relating to

(a) employment in any department, as defined in section 2 of the *Financial Administration Act*,

(b) employment by any Crown corporation as defined in section 95 of the *Financial Administration Act*,

(c) enrolment in the Canadian Forces, or

(d) employment on or in connection with the operation of any work, undertaking or business that is within the legislative authority of the Parliament of Canada,

shall contain any question that by its terms requires the applicant to disclose that he has been charged with or found to have committed an offence in respect of which he has been discharged absolutely under paragraph 547.28(1)(d) or has completed all the dispositions.

(3) Any person who uses or authorizes the use of an application form in contravention of subsection (2) is guilty of an offence punishable on summary conviction.

(4) For greater certainty, a verdict of not criminally responsible on account of mental disorder is not a previous conviction for the purposes of any offence under any Act of Parliament for which a greater punishment is prescribed by reason of previous convictions.

Dispositions and Continuing Review

547.21 (1) A Review Board shall be established or designated for each province and consist of not less than five members appointed by the lieutenant governor in council of the province.

(2) Among the members of a Review Board of a province shall be

(a) at least one person duly qualified by the laws of the province to practise psychiatry; and

(b) where only one member is a psychiatrist referred to in paragraph (a), at least one other duly qualified mental health professional.

(3) Subject to subsection (4), the chairman of the Review Board of a province shall be a judge of the Federal Court or of a superior, district or county court of the province or a person who has retired from such office.

(4) Where the person acting as chairman of the Review Board of a province that was established prior to the coming into force of this section is not a judge or other person referred to in subsection (3), that person may continue to act as chairman of that Review Board until the expiration of his term of office if at least one other member of that Review Board is a member of the bar of the province or a judge or other person referred to in subsection (3).

547.22 (1) Where, during any proceedings, a verdict of unfit to stand trial or not criminally responsible on account of mental disorder is rendered in respect of an accused, the court before which the proceedings are held shall determine when the Review Board will likely hold a hearing to make a disposition in respect of the accused pursuant to section 547.24 and, where the court is of the opinion that

(a) the Board will not hold a hearing for that purpose within a reasonable time after the rendering of the verdict,

(b) the court can readily make a disposition in respect of the accused, and

(c) a disposition should be made forthwith,

the court may, of its own motion, and shall, on the application of the accused or the prosecutor, hold a hearing in accordance with section 547.24 and make a disposition in respect of the accused.

(2) No disposition made by a court pursuant to subsection (1), other than an absolute discharge, shall continue in force for more than three months after the date on which the disposition came into force.

547.23 (1) Where a court does not make a disposition in respect of an accused pursuant to subsection 547.22(1), any order for the interim release or detention of the accused under or by virtue of any provision of Part XIV or section 544 or 608 that is in force at the time a verdict referred to in subsection 547.22(1) is made continues in force, subject to its terms, until a disposition in respect of the accused is made by the Board pursuant to section 547.24.

(2) Notwithstanding subsection (1), a court may, on cause being shown, vacate any order referred to in subsection (1) previously made by that court and make any other such order that the court considers to be appropriate in the circumstances.

547.24 Where a verdict of unfit to stand trial or not criminally responsible on

account of mental disorder is rendered in respect of an accused, the Board shall, as soon as practicable after the rendering of the verdict and, where the court has made a disposition in respect of the accused pursuant to subsection 547.22(1), not later than the expiration of that disposition, hold a hearing in accordance with section 547.27 and make a disposition in respect of the accused.

547.25 (1) For the purposes of sections 547.24, 547.27, 547.28 and 547.32, the chairman of a Review Board has all the powers that are conferred by sections 4 and 5 of the *Inquiries Act* on commissioners appointed under Part I of that Act.

547.26 (1) The Review Board of each province may, subject to the approval of the lieutenant governor in council of the province, make rules not inconsistent with this Act or any other Act of Parliament respecting the practice and procedure before the Review Board and any rules so made apply to any proceeding within the jurisdiction of the Review Board for which the rules are made.

(2) Rules of a Review Board made under subsection (1) shall be published in the *Canada Gazette*.

(3) Notwithstanding anything in this section, the Governor in Council may make regulations to secure uniformity in the rules of Review Boards made under subsection (1), and all uniform rules made under this subsection prevail over the rules made under subsection (1) and have effect as if enacted by this Act.

547.27 (1) The following rules apply to a hearing held by a court or Review Board to determine the appropriate disposition to be made in respect of an accused:

(a) the hearing or any part thereof may be held in private where the court or Review Board considers it to be in the best interests of the accused and not contrary to the interests of the public to do so;

(b) the accused or any other party to the proceedings has the right to be represented by counsel;

(c) the court or Review Board shall, if the accused is not represented by counsel, assign counsel to act on behalf of the accused where, in the interests of justice, the accused requires counsel so to act;

(d) notice of the hearing stating the date and time of the hearing, the place at which it is to be held and the right of the accused to be represented at the hearing by counsel shall be given to the parties and the Attorney General of the province where the disposition is to be made within the time and in the manner prescribed or where the hearing is before the court, within such time and in such manner as may be determined by the court;

(e) subject to paragraph (f), the accused has the right to be present during the whole of the hearing;

(f) the court or the chairman of the Review Board before which the hearing is held may

(i) cause the accused to be removed and to be kept from the place where the hearing is being held where the accused misconducts himself by interrupting the hearing so that to continue the hearing in the presence of the accused would not be feasible,

(ii) permit the accused to be out of the place where the hearing is held during the whole or any part of the hearing on such conditions as the court or chairman of the Review Board considers proper, or

(iii) cause the accused to be removed and to be kept out of the place where the hearing is being held on being satisfied that failure to do so might have an adverse effect on the mental condition of the accused;

(g) where a disposition report relating to an accused is required to be submitted to the court or Review Board in writing, it shall be submitted to the

court or Review Board not later than two clear days prior to the date fixed for the hearing or such other time as may be fixed by the court or Review Board or specified by the rules of the court or Review Board;

(h) any party to the proceedings may tender written submissions to the court or Review Board, after having served a copy thereof on the other parties, at any time prior to the date fixed for the hearing;

(i) any party to the proceedings may adduce evidence, make oral submissions, call witnesses and cross-examine any witness called by any other party and, where a disposition report is submitted in writing to the court or Review Board, may, subject to subsections (3) to (6), on application to the court or Review Board, cross-examine the person who made the report;

(j) a party to the proceedings may not compel the attendance of witnesses at the hearing, but may request the court or the Chairman of the Board to do so;

(k) subject to subsections (3) to (6), any disposition report submitted to the court or Review Board and any other written information before the court or Review Board in respect of the accused that is relevant to the hearing shall be available for inspection by, and the court or Review Board shall cause a copy thereof to be given to, each of the parties to the proceedings and counsel, if any, representing the accused; and

(l) the court or Review Board shall cause a record of the proceedings to be kept.

(2) Failure to give notice in accordance with paragraph (1)(d) or to submit a report within the period referred to in paragraph (1)(g) or any other procedural irregularity at the hearing does not affect the validity of the proceedings unless the accused suffered substantial prejudice thereby.

(3) The court or Review Board shall withhold the whole or any part of a disposition report or any other information referred to in paragraph (1)(k) relating to the accused from

(a) the accused, where the court or Review Board, after examining the report or other information, is satisfied that disclosure of the report or part thereof or other information

(i) would be likely to endanger the life or safety of a third party, or

(ii) would, based on the statement in the report of, or evidence given in the absence of the accused by, the qualified medical practitioner to whom responsibility for the assessment or treatment of the accused has been assigned, seriously impair the treatment or recovery of the accused,

unless the court or Review Board is satisfied that such disclosure is essential in the interests of justice; and

(b) a party, other than the accused or Attorney General, where disclosure of the report or part thereof or other information, in the opinion of the court or Review Board, is not necessary for the proceeding and might be prejudicial to the accused.

(4) Where a disposition report or part thereof has been withheld from the accused or party pursuant to subsection (3), a court or Review Board shall exclude the accused or any other party, other than the Attorney General, from the hearing during

(a) the oral presentation of such report or part thereof; or

(b) the questioning by the court or Review Board or the cross-examination of any person concerning the contents of such report or part thereof.

(5) Any disposition report shall form part of the record of the proceedings in respect of which it was prepared.

(6) Subject to subsections (8) to (10), the court or Review Board

(a) may, on the application of the accused, order that any disposition report relating to the accused or any part of any such report shall not be made available for inspection, and that the contents thereof shall not be disclosed, to any person other than a person to whom a copy of the report is given pursuant to this section, where the court or Review Board is of the opinion that disclosure of such report or part thereof would be seriously prejudicial to the accused and that, in the circumstances, such prejudice takes precedence over the public interest in the disclosure; and

(b) shall make an order referred to in paragraph (a) in respect of a disposition report or any part thereof, where the report or part has been withheld from the accused or a party pursuant to subsection (3).

(7) No person shall publish in any newspaper within the meaning of section 261 or broadcast any disposition report or part thereof in respect of which an order has been made under subsection (6).

(8) On request to a court or Review Board, any disposition report or part thereof relating to an accused in respect of which an order is made under subsection (6)

(a) shall be made available for inspection to any person who is deemed, or any person within a class of persons that is deemed, by the court or Review Board to have a valid interest in the report or part thereof for research or statistical purposes, if the court or Review Board is satisfied that the disclosure is desirable in the public interest; and

(b) may, in the discretion of the court or Review Board, be made available for inspection to any person

(i) who is deemed, or is within a class of persons that is deemed, by the court or Review Board to have a valid

interest in the report or part thereof for the purposes of the proper administration of justice, or

(ii) at the request of or with the consent in writing of the accused, if the court or Review Board is satisfied that a copy of the report or part thereof would not be given, or the contents thereof disclosed, to the accused where it has been withheld from the accused pursuant to paragraph (3)(a) or if the court or Review Board is satisfied that the reasons for withholding the report or part thereof from the accused pursuant to paragraph (3)(a) no longer exist.

(9) Any person to whom a disposition report or part thereof is made available for inspection under subsection (8) may be given any information contained in the report or part and may be given a copy of the report or part.

(10) Where a report or any part thereof is made available for inspection to any person under paragraph (8)(a), that person may subsequently disclose any information contained in the report or part for the purposes referred to in that paragraph, but may not disclose the information in any form that could reasonably be expected to identify any person to whom it relates.

(11) Before any disposition report or part thereof is made available for inspection or a copy thereof is given to any person, the court shall ensure that the information contained therein accurately reflects any findings of fact in relation to disputed matters that have been resolved by the court.

(12) Except as otherwise provided in this section, nothing in this section limits the powers that a court may exercise apart from this section.

547.28 (1) Before making a disposition in respect of an accused pursuant to subsection 547.22(1) or section 547.24, the court or Review Board shall consider any disposition report submitted to it, any representations or submissions made by a

party to the proceeding and any other relevant information before it, and the court or Review Board shall then, taking into consideration the need to protect the public from dangerous persons and the reintegration of the accused into society and other needs of the accused, make any one of the following dispositions that is the least onerous or restrictive in the circumstances, or any number thereof that are not inconsistent with each other:

(a) subject to subsections (3) to (5), by order direct that the accused be detained in a hospital or other appropriate place, subject to such conditions as the court or Review Board considers appropriate;

(b) subject to section 547.15, where a verdict of unfit to stand trial has been rendered in respect of the accused, authorize the treatment of the accused and, where the accused is not detained in custody, direct the accused to submit to such treatment;

(c) by order direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate and in the interest of the reintegration of the accused into society and the safety of the public; and

(d) if, in the opinion of the court or Review Board, it would be in the interest of the reintegration of the accused into society and the accused is not a significant risk to the safety of the public, by order direct that the accused be discharged absolutely.

(2) Where the court or Review Board makes an order in respect of an accused under paragraph (1)(a), the court or Review Board shall issue or cause to be issued a warrant of committal, which may be in form 8.

(3) Where the Review Board makes an order in respect of an accused under paragraph (1)(a), the Review Board may delegate to the person in whose custody the accused is to be placed pursuant to the order authority to direct that the restrictions on the liberty of the accused be

increased or decreased within the limits and subject to any conditions set out in the order and any direction so made shall, for the purposes of this Act, be deemed to be an order made by the Review Board under paragraph (1)(a). 5

(4) Where the person to whom authority is delegated pursuant to subsection (3) increases the restrictions on the liberty of the accused, that person shall forthwith 10 notify the Review Board of that increase.

(5) No order may be made by a court or Review Board under paragraph (1)(a) without the consent of the hospital or person in charge of any other place where 15 the accused is to be detained.

547.29 (1) A disposition shall come into force on the date on which it is made or on such later date as the court or Review Board specifies therein. 20

(2) Subject to subsections (4) to (6), an accused shall not be subject, in respect of an offence charged against the accused, to one or more dispositions made under paragraph 547.28(1)(a), (b) or (c) during a 25 period longer than

(a) where the accused was charged with having committed an offence mentioned in subsection (3),

(i) ten years, or 30

(ii) the maximum period during which an accused is liable to imprisonment in respect of the offence,

whichever period is the shorter; or

(b) where the accused was charged with 35 having committed any offence, other than an offence mentioned in subsection (3),

(i) two years, or

(ii) the maximum period during 40 which an accused is liable to imprisonment in respect of the offence,

whichever period is the shorter.

(3) For the purposes of paragraph (2)(a), the accused may be subject to one 45

or more dispositions during the period referred to in that paragraph in respect of

(a) an offence against any of the following provisions of this Act, namely,

(i) section 47 (high treason), 5

(ii) section 49 (acts intended to alarm Her Majesty or break public peace),

(iii) section 50 (assisting alien enemy to leave Canada, or omitting to prevent treason), 10

(iv) section 51 (intimidating Parliament or legislature),

(v) section 52 (sabotage),

(vi) section 53 (inciting to mutiny),

(vii) section 75 (piracy by law of 15 nations),

(viii) section 76.1 (hijacking),

(ix) section 76.2 (endangering safety of aircraft in flight and rendering aircraft incapable of flight), 20

(x) section 76.3 (offensive weapons and explosive substances),

(xi) section 78 (breach of duty),

(xii) section 79 (using explosives),

(xiii) section 80 (possessing explosives without lawful excuse), 25

(xiv) section 83 (use of firearm during commission of offence, etc.),

(xv) section 84 (pointing a firearm),

(xvi) section 85 (possession of 30 weapon or imitation),

(xvii) section 146 (sexual intercourse with female under fourteen),

(xviii) section 150 (incest),

(xix) section 155 (buggery or bestiality), 35

(xx) section 203 (causing death by criminal negligence),

(xxi) section 204 (causing bodily harm by criminal negligence), 40

(xxii) section 212 (murder),

(xxiii) section 213 (murder in commission of offences),

(xxiv) section 215 (manslaughter),

(xxv) paragraph 229(a) (administering 45 noxious thing with intent to endanger life or cause bodily harm),

(xxvi) section 230 (overcoming resistance to commission of offence),

(xxvii) section 232 (interfering with 50 transportation facilities),

(xxviii) subsection 233(3) (dangerous operation causing bodily harm) or 233(4) (dangerous operation causing death),
 (xxix) subsection 239(2) (impaired driving causing bodily harm) or 239(3) (impaired driving causing death),
 (xxx) section 243.2 (impeding attempt to save life),
 (xxxi) section 245 (assault),
 (xxxii) section 245.1 (assault with a weapon or causing bodily harm),
 (xxxiii) section 245.2 (aggravated assault),
 (xxxiv) section 245.3 (unlawfully causing bodily harm),
 (xxxv) section 246.1 (sexual assault),
 (xxxvi) section 246.2 (sexual assault with a weapon, threats to a third party or causing bodily harm),
 (xxxvii) section 246.3 (aggravated sexual assault),
 (xxxviii) subsection 247(1) (kidnapping) or 247(2) (forcible confinement),
 (xxxix) section 247.1 (hostage taking),
 (xl) section 250 (abduction of person under fourteen),
 (xli) section 250.1 (abduction in contravention of custody order),
 (xlii) section 250.2 (abduction where no custody order),
 (xliii) section 251 (procuring miscarriage),
 (xliv) section 303 (robbery),
 (xlv) section 304 (stopping mail with intent),
 (xlvi) section 305 (extortion),
 (xlvii) section 306 (breaking and entering with intent, committing offence or breaking out),
 (xlviii) section 387(2) (mischief that causes actual danger to life),
 (xlix) section 387.1 (attack on premises, etc., of internationally protected person), or
 (l) section 389 (arson);
 (b) an offence against section 4 of the *War Measures Act*;

(c) an offence against section 19 of the *Atomic Energy Control Act*;
 (d) an offence against section 34 or 42 (trafficking) of the *Food and Drugs Act*;
 (e) an offence against section (3) (possession), 4 (trafficking) or 5 (importing and exporting) of the *Narcotic Control Act*;
 (f) an offence against section (3) (spying), 4 (wrongful communication, etc., of information) or 5 (unauthorized use of uniforms, falsification of reports, etc.) of the *Official Secrets Act*; or
 (g) a conspiracy or an attempt to commit or being an accessory after the fact in relation to, or any counselling in relation to, an offence mentioned in paragraphs (a) to (f).

(4) Where the accused was charged with having committed first degree murder, the accused may be subject for life to one or more dispositions made under paragraph 547.28(1)(a), (b) or (c).

(5) Where a verdict of unfit to stand trial has been rendered in respect of an accused, the prosecutor shall

- (i) not later than two years after the verdict and every two years thereafter until the accused is discharged absolutely or tried in respect of the offence, or
- (ii) on application of the accused, at such other time as the court may order, satisfy a court having jurisdiction in respect of the offence with which the accused was charged, at an inquiry held in the manner determined by the court, that sufficient admissible evidence can be

adduced at that time to put the accused on trial.

(6) The court may order that an inquiry referred to in subsection (5) be held in accordance with Part XV. 5

(7) Where, on the completion of an inquiry held pursuant to subsection (5), a court is of the opinion that sufficient admissible evidence cannot be adduced to put the accused on trial, the court shall discharge the accused absolutely. 10

547.3 (1) After making a disposition in respect of an accused, the court or Review Board shall state its reasons for making the disposition in the record of the proceedings and shall provide or cause to be provided 15

- (a) a copy of the disposition, and
- (b) on request, a transcript of the proceedings or a copy of the reasons for the disposition 20

to any party to the proceeding.

(2) Notwithstanding subsection (1), where a party has been excluded from a hearing pursuant to subsection 547.27(4), the transcript of the proceedings provided to the party shall exclude the portions of the hearing during which the party was excluded. 25

(3) Where a disposition is made by a court, the court shall, forthwith after making the disposition, cause a transcript of the hearing held by it pursuant to section 547.22 and any document or information relating thereto in the possession of the court to be sent to the Review Board having jurisdiction in respect of the matter. 30

547.31 (1) Any party to the proceedings may appeal against a disposition made by a court or Review Board on any ground of appeal that involves a question of law alone or fact alone or a question of mixed law and fact to the court of appeal of the province within which the court exercises its jurisdiction. 40 45

(2) An appeal under subsection (1) shall be brought within ten days from the date of the disposition appealed from or within such further time as the court having jurisdiction to hear the appeal considers appropriate in the circumstances. 5

(3) Where a party appeals against a disposition made by a court or Review Board, the court or Review Board shall forthwith file with the court to which the appeal is made the record of the proceedings in which the disposition was made. 10

(4) The record filed pursuant to subsection (3) shall constitute the record in the appeal. 15

(5) On an appeal against a disposition made by a court or Review Board taken pursuant to subsection (1), the court to which the appeal is taken may

- (a) exercise all the powers of the court or Review Board and substitute its opinion for that of the court or Review Board; or 20

(b) refer the matter back to the court or Review Board for rehearing, in whole or in part, in accordance with such directions as the court to which the appeal is taken considers appropriate. 25

(6) Subject to subsection 547.32(4), where an appeal against a disposition made in respect of an accused by a court or Review Board is taken by any party under subsection (1), the court or Review Board may, on application of that party after notice given to each of the other parties within the time and in the manner prescribed, make an order making the disposition, if any, that was in force in respect of the accused immediately before the coming into force of the disposition appealed from applicable in respect of the accused until all proceedings in respect of the appeal have been completed, where the court or Review Board is satisfied that the mental condition of the accused justifies the making of the order. 30 35 40 45

(7) Where the court or Review Board makes an order under subsection (6), it

shall forthwith cause a copy of the order to be sent to each of the parties to the proceedings.

(8) Where an order is made pursuant to subsection (6),

(a) the appeal taken under subsection (1) shall be heard within thirty days after the order is made or such shorter period as may be fixed by the rules of the court; and

(b) a judge of the court to which the appeal is made may give such directions as the judge thinks necessary for expediting the appeal and rendering the judgment by the court on the appeal.

547.32 (1) Where a disposition is made in respect of an accused by a Review Board under paragraph 547.28(1)(a), (b) or (c), the Review Board shall, not later than twelve months after the making of the disposition and every twelve months thereafter so long as a disposition made under paragraph 547.28(1)(a), (b) or (c) remains in force in respect of the accused, hold a hearing in accordance with section 547.27.

(2) Where an accused is being detained in a hospital or other place pursuant to an order made under paragraph 547.28(1)(a) and

(a) the person in whose custody the accused was placed by virtue of the order has increased significantly the restrictions on the liberty of the accused, or

(b) the hospital or person in charge of any other place where the accused is being detained requests a review of the order,

the Review Board shall hold a hearing in accordance with section 547.27 as soon as practicable after being notified of such increase or request.

(3) A Review Board may, at any time, hold a hearing in accordance with section 547.27 on the request of the accused or any other party to the proceedings.

(4) At a hearing held pursuant to subsection (1), (2) or (3), the Review Board shall review the disposition and, except where a determination is made under subsection (5) that the accused is fit to stand trial, make any disposition that is appropriate in the circumstances, and sections 547.28 to 547.33 apply, with such modifications as the circumstances require, to a disposition made pursuant to this section.

(5) Where a Review Board reviews a disposition in respect of an accused who has been found unfit to stand trial, it shall determine whether, in its opinion, the accused is, at the time of the review, fit to stand trial.

(6) Before holding a hearing pursuant to subsection (1), (2) or (3), the Review Board

(a) where the accused in respect of whom the hearing is to be held is detained in custody, shall order the person having the custody of the accused to bring the accused before the Review Board at the time and place fixed by the hearing; and

(b) in any other case, may, by summons or warrant, compel the accused in respect of whom the hearing is to be held to appear before the Review Board at the time and place fixed for the hearing.

(7) Where a review of a disposition in respect of which an appeal is taken under section 547.31 by any party is commenced under this section on the request of that party, the appeal shall be deemed to have been abandoned.

547.33 (1) Where a disposition in respect of an accused charged with an offence is made under paragraph 547.28(1)(a) and the accused is required to be detained in custody in respect of another alleged offence or conviction of another offence, the disposition shall not come into force or shall be suspended, as the case may be, until the accused is no longer required to be detained in custody

5: The said Act is further amended by adding thereto, immediately after section 662.1 thereof, the following section:

in respect of that other alleged offence or conviction.

(2) Where a disposition in respect of an accused charged with an offence is made under paragraph 547.28(1)(a) and the accused is convicted or discharged under section 662.1 in respect of another offence but is not sentenced to a term of imprisonment in respect of that other offence, the disposition shall come into force and continue in force in accordance with its terms subject to subsections 547.28(2) to (6) and any probation order made in respect of that other offence shall, notwithstanding subsection 664(1), come into force on the expiration of the disposition order or be suspended until the expiration thereof, as the case may be.

“662.2 (1) Subject to subsection (2), where a court imposes a sentence of imprisonment on an offender and finds, based on a disposition report in respect of the offender, that, at the time sentence is imposed, the offender is suffering from a serious mental disorder that is not likely to be substantially improved unless the offender receives treatment in a hospital or other place, other than a prison, the court may order, as part of the sentence of imprisonment, that the offender be detained for treatment for a period not exceeding sixty days and subject to such terms and conditions as the court considers appropriate in a hospital or other place, other than a prison, where treatment of the mental disorder is available.

(2) No order may be made under subsection (1) in respect of an offender unless the offender and the hospital or other institution or person in charge of the place where the offender is to be detained consent to the order and the terms and conditions thereof.

(3) Nothing in subsection (2) shall be construed as making unnecessary the obtaining of any authorization or consent to treatment of any person that is or may be required, otherwise than under this Act.

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