7

Mental health

Gerald B. Robertson

7.1 Introduction

This chapter discusses the rights of psychiatric patients in the common law jurisdictions of Canada. Its main focus is the system of civil commitment, whereby individuals are certified under provincial mental health legislation and detained in a psychiatric facility without their consent, and (in some provinces) treated without their consent. These individuals are usually referred to as ‘formal’ or ‘involuntary’ patients, signaling the key issue that their stay in hospital is non-consensual (Robertson 1994). This chapter also examines the rights of patients who are detained in a psychiatric facility pursuant to the criminal justice system, having been found not criminally responsible by reason of mental disorder or unfit to stand trial.

In Canada, civil commitment is a matter exclusively within provincial jurisdiction (Constitution Act 1867, sections 92(7), 92(13)). This means that the specific details of the criteria and process for civil commitment, as well as the rights of involuntary patients, can vary across Canada (Ambrosini and Joncas 2013). However, although there are some differences, for the most part the concepts are similar in each province. For the purposes of this chapter, the discussion will focus mainly on the law of Alberta (Alberta Mental Health Act 2000), but significant differences in other provinces will be noted.

By contrast, psychiatric detention under the criminal justice system, for those who have been found not criminally responsible by reason of mental disorder or unfit to stand trial, is a matter of federal jurisdiction (Criminal Code 1985). Hence, its interpretation and application are ultimately (through decisions of the Supreme Court of Canada) uniform across Canada.

7.2 Civil commitment

7.2.1 The process

The right to be free from unwanted medical treatment (and by extension unwanted hospitalization) has been recognized for centuries in the common law. One hundred years ago Mr Justice Cardozo stated that ‘every human being of adult years and sound mind has a right to determine what shall be done with his own body’ (Schloendorff v. Society of New York Hospital [1914]
Mental health

105 NE 92, p. 93). This principle has been affirmed by the Supreme Court of Canada on numerous occasions, and is codified in legislation in some provinces; it is also entrenched in, and protected by, the Constitution through the Canadian Charter of Rights and Freedoms (Charter) (Picard and Robertson 2007; Verdun-Jones and Lawrence, 2013). Its essence was captured by the Supreme Court of Canada in Starson v. Swayze, 2003 SCC 32, in the statement that ‘[t]he right to refuse unwanted medical treatment is fundamental to a person’s dignity and autonomy’ (para. 75).

Nonetheless, like most common and civil law countries, Canada recognizes that civil commitment is an exception to this fundamental right, and that in certain circumstances individuals who are suffering from a mental illness may be detained in hospital without their consent (Ambrosini and Joncas, 2013; Carver, 2011; Gray et al. 2008; Robertson, 1994).

The system of civil commitment in Canada is almost entirely non-judicial. In most cases, individuals are committed as involuntary psychiatric patients not by judges, not by lawyers, but by doctors. In the words of one commentator, ‘civil commitment represents the most significant deprivation of liberty without judicial process that is sanctioned by our society today. We have elected to leave the issue of involuntary commitment almost entirely to the discretion of psychiatrists’ (Anand 1979: 251). Of course, this is not to say that there are no legal protections or safeguards built into the system. As we shall see, involuntary patients do have a number of legal rights. Nonetheless, it is important to understand that, at least initially, the process of civil commitment is one that rests primarily in the hands of the medical profession.

In most situations, civil commitment is triggered by a physician issuing a certificate which states that, based upon an examination of the patient, the physician is of the opinion that the patient meets the criteria for formal admission to a psychiatric hospital. The physician need not be a psychiatrist (Ambrosini and Joncas 2013; Robertson 1994), and indeed in practice, this first certificate will typically be signed by a family (or emergency room) physician.

The purpose (and effect) of the first certificate is to provide legal authority for the individual to be taken to a psychiatric hospital for a period of further assessment. The authorized period of assessment varies across Canada, but usually the maximum period is between 24 and 72 hours (Ambrosini and Joncas 2013; Robertson 1994). After this period has expired, the individual must be released unless a second certificate is issued, in which case the patient is then formally admitted to the psychiatric hospital for a specific period of time. In Alberta, the period of hospitalization based on the first pair of certificates is one month, but (like all provinces) it can be extended ad infinitum with the issuance of new renewal certificates (Alberta Mental Health Act, section 8). In other words, so long as two physicians are of the opinion that the criteria are still met, the patient can be kept at the hospital indefinitely.

In order for the patient to be legally detained under the Mental Health Act, not only must the criteria for admission be satisfied, but also the physicians who issue the certificates must comply with the procedural requirements of the Act. Failure to do so may result in the patient’s detention being illegal and a successful action for false imprisonment (Dr. X v. Everson, 2013 ONSC 6134; Robertson 1994).

7.2.2 The criteria

7.2.2.1 Mental disorder

In most provinces, three requirements must be satisfied before a patient can be civilly committed. The first is that the individual is suffering from a ‘mental disorder.’ In Alberta this is defined as ‘a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs
(i) judgment, (ii) behaviour, (iii) capacity to recognize reality, or (iv) ability to meet the ordinary demands of life’ (Alberta Mental Health Act, section 1(1)(g)).

Most provinces and territories adopt this type of functional definition, although a few (for example, Ontario) adopt a much more open-ended definition, such as ‘any disease or disability of the mind’ (Carver 2011; Gray et al. 2008; Robertson 1994).

### 7.2.2.2 Dangerousness, harm, and health deterioration

This is by far the most contentious requirement, both in the sense of academic commentary and also in the context of proceedings where patients appeal their certification (which is discussed below). In these proceedings, the diagnosis of a ‘mental disorder’ (the first criterion for civil commitment) is seldom disputed. The same is true of the third criterion (discussed below). The real focus of contention will be whether the patient satisfies the second criterion.

Until relatively recently, many provinces articulated this criterion in the language of ‘dangerousness.’ Under this scheme, in order to be committed, an individual must pose a ‘danger’ to self or others, and the danger must be serious and imminent (Carver 2011; Robertson 1994). However, in recent years, there has been a legislative trend away from the ‘dangerousness’ test in favor of one which focuses on harm or health deterioration (Ambrosini and Joncas 2013; Carver 2011), a trend which is not without its critics (Kaiser 2009).

The Alberta Mental Health Act, which was amended in 2009 (Marshall 2010), is typical of this development. It now provides that, in order to issue a certificate of civil commitment, the physician must be of the opinion that the individual is ‘likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment’ (Alberta Mental Health Act, section 2).

The change in language from ‘danger’ to ‘harm’ may be of little consequence. It is likely that these terms are approximately the same (Carver 2011). What is significant, however, is the inclusion of the ‘deterioration’ component in the new criteria, which is essentially a return to the days where patients could be committed for the protection of their own mental health (the welfare test) (Robertson 1994). In the past, the welfare test as basis for civil commitment has been held by some courts to be contrary to the Charter and hence unconstitutional (Carver 2011; Robertson 1994). It is interesting, however, that the current legislation in Ontario, the Mental Health Act 1990, encompassing the ‘deterioration’ criterion, has recently been held not to contravene the Charter (P.S. v. Ontario, 2013 ONSC 2970). Relying on previous Ontario decisions, the Court held that the Mental Health Act safeguards the patient’s substantive rights and complies with the procedural component of the principles of fundamental justice, as required by the Charter.

### 7.2.2.3 Not suitable as a voluntary patient

The third criterion for civil commitment in most provinces is that the individual must not be suitable for admission to a psychiatric facility other than as a voluntary patient (Ambrosini and Joncas 2013; Robertson 1994). This requirement reflects the underlying principle that civil commitment should be viewed as a last resort, and thus should not be used (absent exceptional circumstances) if the individual is willing to be admitted (or remain) as a voluntary patient (Carver 2011).

It follows from this that the most common example of this third criterion being satisfied is where the person refuses to be admitted (or continue) as a voluntary patient in a psychiatric facility (Robertson 1994, 2010). Clearly, in this situation, the person is not suitable to be a
voluntary patient if he or she is not willing to consent to being one. However, there are other situations in which this third criterion may be satisfied, even where the patient is willing to remain voluntarily in the hospital. One is where the individual lacks the necessary mental capacity to be a voluntary patient (Robertson 1994, 2010). Another is where the restrictions that are required to be placed on the patient’s freedom of movement and other liberties are incompatible with the status of a voluntary patient, for example limits on how often the patient can leave the unit (Robertson 2010).

Lastly, and most controversially, in practice it is quite common for individuals to be certified, even though they are willing to remain at the hospital voluntarily, because they refuse to consent to medical treatment. The purpose of the certification in this type of case is to take advantage of the provisions (in some provinces) which allow for treatment of involuntary psychiatric patients without consent, which is discussed below. The individual’s refusal of consent arguably makes them ‘unsuitable’ to be a voluntary patient, because otherwise they cannot be treated (Robertson 2010).

The ‘need for treatment’ rationale is sometimes used even in cases where the patient is already legally detained in hospital and hence does not need to be civilly committed in order to be kept there. The most common example of this involves patients who are detained pursuant to the criminal justice system, having been found not criminally responsible of a criminal charge by reason of mental disorder (which is discussed below). If these patients refuse consent to medical treatment (and hence cannot be treated if they are mentally competent), in some provinces it is the practice to certify them under the Mental Health Act so as to take advantage of the provisions of that Act which allow for treatment without consent (Robertson 2010).

7.2.2.4 Other criteria

While most jurisdictions within Canada only have the three criteria for civil commitment discussed above, some impose other requirements. In particular, in Newfoundland and Saskatchewan, civil committal applies only to individuals who lack the mental capacity to consent to treatment (and for whom, therefore, the consent of a substitute will be needed), thus ensuring that those who are committed can be treated (Ambrosini and Joncas 2013). The purpose of this requirement is to avoid the situation which has arisen in some provinces where mentally competent patients who refuse treatment are committed, thereby effectively ‘warehousing’ them in hospital indefinitely without treatment (Carter 2011).

Likewise, some provinces (in particular British Columbia and Newfoundland) make ‘treatability’ a requirement for civil commitment. In other words, a person cannot be made an involuntary patient unless their underlying mental condition is amenable to treatment (Ambrosini and Joncas 2013; Carver 2011).

7.2.3 Community treatment orders

Five provinces – Alberta, Newfoundland, Nova Scotia, Ontario, and Saskatchewan – have enacted legislation which enables psychiatric patients to receive treatment in the community rather than in a hospital, under the provisions of a community treatment order (‘CTO’) (Carver 2011; Gray et al. 2008). Often this type of legislation is introduced by the government in response to a much publicized tragic event involving violence by a person suffering from a mental illness, such as the fatal shooting of the television sports broadcaster Brian Smith in Ontario in 1995 (Carver 2002; Wandzura 2008) and the fatal shooting of an RCMP officer in Alberta in 2004 (Carver 2010; Gray et al. 2012).
The primary target group of the CTO is the chronically mentally ill. It seeks to address the ‘revolving door’ problem, whereby patients are committed to a psychiatric hospital, receive treatment and improve to the point where they are no longer certifiable and must be discharged, only to discontinue their medication, deteriorate, and once more become certifiable, and the cycle begins again (Carver 2011; Marshall 2010). The CTO aims to break the cycle by providing an ‘incentive’ to the patient to continue taking medication. A patient who is discharged from hospital on a CTO is required to comply with the terms of the treatment plan incorporated into the CTO, which typically requires the patient attend specified, regular appointments to receive medication. If patients fail to do so, or breach other conditions in the CTO, they can be brought back into hospital – hence the ‘incentive’ to continue with medication.

The term ‘community treatment order’ is somewhat misleading in its use of the word ‘order.’ There does not have to be a court order; rather, a CTO is issued by physicians, if certain criteria are satisfied, as set forth in the legislation. These criteria tend to reflect the ‘revolving door’ problem which the CTO seeks to address. For example, in Alberta, the criteria for a CTO are as follows (Alberta Mental Health Act 2000, section 9.1). First, the patient must be certifiable, that is the patient meets the criteria for civil commitment under the Mental Health Act. Second, within the past three years the patient must have been a formal patient in a psychiatric facility or an approved hospital on more than two occasions or for a total of more than 30 days, or have been subject to a CTO. Unlike other provinces (Carter 2011; Gray et al. 2012), Alberta makes an exception to this requirement and provides (in limited circumstances) for a CTO even where the patient has not been previously hospitalized. In addition, for all CTOs there is the very important requirement that the treatment which the patient requires must be available in the community.

The CTO must be accompanied by a treatment plan which, among other things, sets out the proposed treatment which the patient must follow, the dates and place where the patient must attend treatment, and also identifies the health professional who is responsible for supervising the CTO.

The issue of the patient’s consent to a CTO varies significantly across Canada. Some provinces require the consent of the patient (or if incompetent, the substitute’s consent) in all cases. Others provide that a CTO can only be issued if the patient is incompetent. In Alberta, consent is required but can be dispensed with by the physician who issues the CTO (Carver 2011; Gray et al. 2012; Marshall 2010).

The CTO regime is not without its critics. Some view it as stigmatizing persons with mental disability who are living in the community by suggesting that they must be supervised by the state (Carver 2011). Others argue that the CTO is a form of ‘coercion,’ whereby the patient is ‘forced’ to agree to accept treatment in order to avoid being readmitted to hospital (Carver 2002; Kaiser 2009). Despite these (and other) criticisms, the CTO legislation in Ontario has been held not to contravene the Canadian Charter of Rights and Freedoms (Thompson v. Ontario (Attorney General), 2013 ONSC 5392).

Empirical studies show that the success of CTOs in Canada has been mixed. For example, they are rarely used in Saskatchewan and Ontario (Carver 2002; Gray et al. 2008; Wandzura 2008). However, by contrast, studies indicate that in Alberta (the most recent province to introduce CTOs – in 2010), their use is frequent and increasing (Orr et al. 2012). These studies also tend to confirm what commentators have said for many years, namely that, above all, the key to the success of CTOs is that the government must ensure that there are sufficient mental health resources in the community so that the patient can access the treatment and support which is needed. Otherwise, physicians and other healthcare professionals will see little point in issuing a CTO (Dawson 2010).
7.3 Rights of involuntary patients

7.3.1 Introduction

Because civil commitment is such a significant infringement on the patient’s right to autonomy and freedom, mental health legislation attempts to balance this by conferring various rights on involuntary patients. This is especially true in light of the Charter, with provincial governments increasingly concerned about the prospect of a constitutional challenge to their mental health legislation, amending it to include more rights for involuntary patients (Robertson 1994).

Another theme which is evident in the legislation is an attempt to ensure that the rights which are conferred on patients are meaningful and can be exercised effectively, either by patients or by someone on their behalf. This will be discussed in relation to many of the rights set out below.

7.3.2 The right to be informed

The Canadian Charter of Rights and Freedoms embodies the principle that, upon detention, individuals have a right to be informed of the reasons for the detention. Likewise, the Supreme Court of Canada has recognized that a patient must be informed of all material information relating to their treatment (Reibl v. Hughes [1980] 2 SCR 880). These principles are reflected in the Alberta Mental Health Act, which provides that upon admission, a voluntary patient has the right to be informed of the reasons for the admission, and the right to apply for a review of the admission (Robertson 1994). Because involuntary admission constitutes ‘detention’ within the meaning of section 10 of the Charter, the patient must also be advised of the right to retain and instruct legal counsel without delay (Robertson 1994).

This is an example of legislation attempting to confer meaningful rights upon patients rather than illusory ones. It recognizes that at the time of admission, many involuntary patients will be in the acute phase of a psychotic illness and may therefore not be capable of understanding the information which they are given with respect to the reasons for the admission and their right of appeal. Some provinces have attempted to address this problem with measures such as a requirement of verbal (rather than written) information, repetition of information, and the use of specially trained ‘rights advisors’ (Gray et al. 2008).

In addition, some provinces require that the information be given to the patient’s ‘nearest relative’ as well as to the patient, in case the patient is not able to understand it or act upon it (Robertson 1994). While laudable in its aim, this provision fails to take into account the fact that in many cases it will be the patient’s nearest relative who has initiated the process of civil commitment and thus will be unlikely to encourage or assist the patient to launch an appeal of the certification.

7.3.3 The right to apply to the Review Panel

As was discussed earlier, the process of civil commitment is largely a non-judicial one, involving a physician’s certificate rather than a court order. Hence it is important that involuntary patients be given a legal avenue to appeal their certificates where they believe that the criteria for commitment are not satisfied or where there has been some defect or irregularity in the process. At the same time, however, it is essential that this appeal process ensues quickly, or it risks being meaningless. In particular, statistics show that most involuntary patients are discharged from hospital within one month of their initial admission (Robertson 1994). This means that, unless the
right of appeal can be exercised quickly, it becomes illusory, because most patients will have been discharged from hospital before their appeal can be heard.

In most Canadian provinces this need for a timely appeal process is recognized by the creation of a special mental health review panel to hear appeals from involuntary patients (Gray et al. 2008). Alberta’s scheme is fairly typical of this model. The Mental Health Act establishes a Review Panel comprising a lawyer (who chairs the proceedings), a psychiatrist, a physician, and a lay member. All involuntary patients have the right to appeal their certification to the Review Panel, which must hold a hearing within 21 days of receiving the patient's application (Alberta Mental Health Act, section 40). Individuals who are subject to a community treatment order also have the right to appeal this to the Review Panel. Unlike most other provinces, Alberta does not restrict the number of times a patient can apply to the Review Panel for a review of the certificates. Patients can appeal as often as they want, subject only to the chair's discretion to refuse to convene a hearing if he or she reasonably believes that the application is frivolous, vexatious, or not made in good faith, or that there has been no significant change in circumstances since the last appeal (Alberta Mental Health Act, section 38).

The proceedings are relatively informal and the Review Panel is not bound by strict rules of evidence. Nevertheless, it has an overriding duty to act fairly, which is reflected in many of the procedural safeguards contained in the legislation, such as the patient's right to be present at the hearing, the right to adduce evidence and cross-examine witnesses, and the right to be represented by legal counsel (Robertson 1994).

The object of the proceedings is to determine whether, at the time the appeal is heard, the patient meets the criteria for civil commitment. This timeframe is important, because as a result of treatment received in hospital, a patient who was certifiable at the date of admission may no longer meet the criteria for certification by the time the appeal is heard. The onus of establishing that the criteria are satisfied rests with the hospital (Alberta Mental Health Act, section 42). If the Review Panel concludes that the criteria are no longer met, it will cancel the certificates and the patient will be free to leave the hospital.

The legislation also recognizes that the right to apply to the Review Panel may be an empty right for patients who do not understand it or are unable to assert it, and whose nearest relative is not interested in initiating an appeal (Robertson 1994). Hence the Mental Health Act provides for mandatory review by the Review Panel every six months, if the patient has not applied for a review during that time (Alberta Mental Health Act, section 39). As is discussed below, the Review Panel also has jurisdiction in certain matters relating to the psychiatric treatment of involuntary patients.

### 7.3.4 The right to refuse treatment

As has already been discussed, a patient's right to refuse medical treatment is well established and is protected under common law, by statute, and by the Canadian Charter of Rights and Freedoms (Picard and Robertson 2007; Verdun-Jones and Lawrence 2013). Despite this, when it comes to involuntary psychiatric patients, their right to refuse treatment is not uniformly recognized in Canadian mental health legislation. The position varies considerably from province to province. As Peter Carver has noted, ‘[t]he question of whether competent involuntary patients should have the right in law to refuse psychiatric treatment is the most disputed issue in mental health law’ (Carver 2011: 356).

The meaning of ’competence’ to make treatment decisions is defined in most Canadian mental health legislation and tends to be fairly uniform. For example, the Alberta legislation provides that a person is competent to make treatment decisions if he or she ‘is able
to understand the subject-matter relating to the decisions and able to appreciate the consequences of making the decisions’ (Alberta Mental Health Act, section 26). In the leading decision in Starson v. Swayze, the Supreme Court of Canada emphasized that the test for competence focuses on the patients’ ability to understand (and not just their actual understanding). It also emphasized that patients should not be viewed as mentally incompetent merely because they refuse to consent to treatment which others consider to be in their best interests (Carver 2011).

In some provinces (Saskatchewan and Newfoundland), the issue of the competent involuntary patient’s right to refuse treatment does not arise. This is because, as we have seen, incapacity is a precondition of civil commitment in those provinces, and hence there is no such thing as a ‘competent’ involuntary patient.

The approach taken in the other Canadian provinces and territories on the issue of the right to refuse psychiatric treatment can be categorized into three groups (Carver 2011). At one end of the spectrum the mental health legislation in some provinces (such as Ontario) expressly recognizes the competent patient’s right to refuse psychiatric treatment. It provides no exceptions to this right, and no power to override the competent patient’s decision to exercise it (Carver 2011; Robertson 1994). In the context of Ontario’s mental health legislation, the right to refuse treatment has also been held by the Ontario Court of Appeal to be protected by the Canadian Charter of Rights and Freedoms and hence is a constitutional right (Fleming v. Reid, [1991] 4 OR (3d) 74).

The approach taken in Ontario is not without its critics, who view it as unacceptable to ‘warehouse’ persons with mental illness by detaining them in a psychiatric hospital without treatment (Gray et al. 2008; Solomon et al. 2009).

At the other end of the spectrum are provinces such as British Columbia, where the legislation takes away the right of involuntary patients to refuse treatment and provides that they are deemed to consent to treatment (Carver 2011; Verdun-Jones and Lawrence 2013). This approach also has many critics (Verdun-Jones and Lawrence 2013), who view it as a fundamental interference with patient autonomy and who question its constitutional validity in light of the decision in Fleming v. Reid.

In the third group of provinces (which includes Alberta), the legislation attempts to find a middle ground by recognizing the competent patient’s right to refuse treatment but providing that this can be overridden if the treatment is in the patient’s best interests (Carver 2011; Robertson 1994). In Alberta, this power to override the patient’s refusal is conferred on the Review Panel. On the application of the attending physician, the Review Panel can grant a treatment order notwithstanding the patient’s refusal of consent, if it considers that the treatment is in the patient’s best interests having regard to four specific factors, namely: (1) whether or not the mental condition of the patient will be or is likely to be improved by the treatment; (2) whether the patient’s condition will deteriorate or is likely to deteriorate without the treatment; (3) whether or not the anticipated benefit from the treatment outweighs the risk of harm to the patient; and (4) whether or not the treatment is the least restrictive and least intrusive that meets the requirements of the other three factors (Alberta Mental Health Act, section 29).

This middle ground – which one writer refers to as a ‘watered-down’ right to refuse treatment (Verdun-Jones 1988: 58) – may also be vulnerable to challenge under the Charter, particularly in light of statistics which show that most applications to the Review Panel to override the competent patient’s refusal are successful (Robertson 1994). In other words, this approach does not really protect the patient’s right to refuse treatment in any meaningful way if that refusal can quickly, and easily, be overturned by the Review Panel.
7.4 Patients detained in hospital under the forensic system

7.4.1 Introduction

Hospitalization in a psychiatric facility also occurs within the criminal justice system, if an individual charged with a criminal offence is found by the court to be not criminally responsible by reason of mental disorder ("NCR"), or unfit to stand trial.

7.4.1.1 Not criminally responsible

A verdict of NCR will be entered if it is established that at the time of the offence the accused was suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission, or of knowing that it was wrong (Criminal Code 1985, section 16(1)). ‘Wrong’ means morally wrong, not necessarily legally wrong (Barrett and Shandler 2006).

Every person is presumed to be capable of criminal responsibility, and hence the burden of proof of establishing an NCR defense (the required standard of proof being a balance of probabilities) rests with the party who raises the defense (Criminal Code 1985, sections 16(2)–(3)).

Both the accused and the prosecution (under more limited circumstances) can raise the NCR defense (Barrett and Shandler 2006; Bloom 2013b).

7.4.1.2 Unfit to stand trial

Being ‘unfit to stand trial’ is defined as meaning that the accused is unable, on account of mental disorder, to conduct a defense or to instruct counsel to do so, and in particular unable on account of mental disorder to: (a) understand the nature or object of the proceedings; (b) understand the possible consequences of the proceedings; or (c) communicate with counsel (Criminal Code, section 2).

The leading case on the meaning of fitness is the decision in R v. Taylor [1992] 11 OR (3d) 323, in which the Ontario Court of Appeal established the ‘limited cognitive capacity’ test. This sets a fairly low threshold. In particular, the ability to understand the nature and possible consequences of the proceedings need only be rudimentary. Moreover, with respect to the ability to communicate with counsel, it is not necessary that the accused be capable of giving instructions to counsel which are in the accused’s best interests. It is sufficient that the accused is capable of relating the necessary facts to enable counsel to properly present a defense (Barrett and Shandler 2006; Bloom 2013a). Testimonial incompetence (the inability to give evidence) does not in itself render an accused unfit to stand trial, nor does amnesia of the events surrounding the offence (R v. Morrissey, 2007 ONCA 770).

7.4.2 The Review Board process

In all cases where there is a finding of unfit to stand trial, and where in all cases (unless the court grants an absolute discharge) there is a verdict of NCR, the individual then comes within the jurisdiction of the provincial or territorial Review Board, which must convene a hearing within 45 days of the verdict. The Review Board is established under the Criminal Code for each province and territory and its purpose is to determine the appropriate disposition for the NCR or unfit accused. It sits with a minimum quorum of three members, at least one of whom must be a
judge or lawyer (who acts as chair) and at least one of whom must be a psychiatrist (Barrett and Shandler 2006; Carver and Langlois-Klassen 2006; Lamba 2013).

Proceedings before the Review Board are conducted in as informal a manner as is appropriate in the circumstances. Nonetheless, the accused has several important legal rights in the proceedings. These include the right to be present at the hearing (subject to the Review Board’s power to exclude the accused in exceptional circumstances), the right to adduce evidence, cross-examine witnesses, and make oral or written submissions, and the right to be represented by legal counsel. In addition, the Review Board must provide reasons for its decision, and any party to the hearing (including the accused) has a right of appeal to the provincial Court of Appeal (Barrett and Shandler 2006; Carver and Langlois-Klassen 2006; Lamba 2013).

7.4.2.1 The NCR accused

An NCR accused must be seen by the Review Board within 45 days of the NCR verdict, and thereafter at least once every year. This annual review will continue so long as the accused remains under the jurisdiction of the Review Board (i.e. until an absolute discharge is granted). At each review, the first issue which the Review Board must determine is whether the individual poses a significant threat to the safety of the public. In making this assessment, there is no presumption that the individual poses a threat (no matter how serious the index offence), nor is there any onus of proof in the ordinary adversarial sense. The Review Board’s role is an inquisitorial one. Hence it must take reasonable steps to satisfy itself whether the individual poses a significant threat to the safety of the public. The ‘significant threat’ threshold requires that the individual pose a real risk of physical or psychological harm to members of the public from conduct that is criminal in nature. Neither a ‘miniscule risk of grave harm’ nor a ‘high risk of trivial harm’ will be sufficient to meet this test (Winko v. British Columbia (Forensic Psychiatric Institute) [1999] 2 SCR 625; Carver and Langlois-Klassen 2006; Lamba 2013).

If the ‘significant threat’ test is not satisfied, the Review Board must grant an absolute discharge. This means that the individual is no longer under the jurisdiction of the Review Board and has no restrictions to his or her liberty. On the other hand, if the individual is judged to be a significant threat, the Review Board’s jurisdiction continues and it has the power to order either that the individual be detained in a psychiatric facility or be conditionally discharged into the community. In both cases the Review Board must decide what restrictions or extensions should be ordered with respect to the individual’s liberty. For example, where the Board decides that the NCR accused should be detained in a psychiatric facility, it will then decide what privileges, if any, to grant, such as passes to the hospital grounds and the city (with or without hospital staff) and other travel privileges. Likewise, where a conditional discharge is granted, the Review Board will typically restrict the individual’s freedom, such as requiring that he or she live in specified or approved accommodation, and by restricting travel. The Review Board is required to make a disposition which is the least onerous and least restrictive to the accused, consistent with public safety (Carver and Langlois-Klassen 2006; Lamba 2013).

Individuals found NCR remain under the jurisdiction of the Review Board indefinitely, potentially for life, until they are granted an absolute discharge on the grounds that they no longer pose a significant threat to the safety of the public.

The government of Canada has recently introduced significant changes to the legislation dealing with NCR accused and the Review Board process. These legislative changes have been passed by the House of Commons, and are currently before the Senate (Not Criminally Responsible Reform Act). If enacted, the changes will significantly affect the rights of some NCR accused.
In particular, the proposed legislation will remove the requirement that the Review Board’s disposition must be the least onerous and restrictive to the accused. In addition, it will empower the courts to designate an NCR accused as ‘high risk’ in cases of a serious personal injury offence, if the court is satisfied that there is a substantial likelihood that the accused will use violence that could endanger the life or safety of another person, or if the court is of the opinion that the acts involved in the offense were of such a brutal nature as to indicate a risk of grave physical or psychological harm to another person. The effect of such a designation is significant. In particular, it means that a ‘high-risk’ accused must be detained in hospital and will not be permitted to leave, even temporarily, except in very limited circumstances and subject to very strict conditions.

These legislative changes have been criticized by many commentators, including the Canadian Bar Association (2013), the Criminal Lawyers’ Association (2013), and the chairs of many of the provincial Review Boards (Guly 2013; McKnight 2013; Taddese 2013). The thrust of these criticisms is that the reforms are unfair to NCR accused; they are an unnecessary and inappropriate restriction on the discretion and powers of the Review Board; and they will lead to many mentally ill offenders ending up in jail (without access to proper mental health treatment or programs) rather than in hospital, because they will choose not to raise the NCR defense.

7.4.2.2 The unfit accused

As is the case with an NCR accused, an unfit accused must be seen by the Review Board within 45 days of the court’s finding of unfitness, and then at least annually thereafter. The first issue which the Review Board must consider at each review is whether the accused remains unfit to stand trial. If the Review Board concludes that the accused has become fit, the matter is referred back to court, at which time the court will make the final determination of whether the accused is fit to stand trial. If, on the other hand, the Review Board concludes that the accused remains unfit, it then makes a disposition in the same manner as for an NCR accused, with one very important exception: it cannot grant an absolute discharge for an unfit accused, even if it considers that the accused does not pose a significant threat to public safety. The Review Board, applying the overriding principle of the least onerous and least restrictive disposition consistent with public safety, must decide whether the accused should be detained in hospital (and with what privileges, if any) or be discharged from hospital subject to conditions. In both cases the unfit accused remains under the jurisdiction of the Review Board (Barrett and Shandler 2006).

The Review Board’s inability to grant an absolute discharge for an unfit accused who poses no significant threat to public safety creates considerable injustice for the ‘permanently unfit’ individual, that is someone who is unlikely ever to become fit to stand trial. In response to the Supreme Court of Canada’s ruling in R v. Demers, 2004 SCC 46, that this infringes the Charter and hence is unconstitutional, the Criminal Code was amended to address the problem of the permanently unfit. Although the Review Board still cannot grant an absolute discharge, it can now recommend to the court that the criminal proceedings be stayed, if it considers that the accused (1) does not pose a significant threat to public safety, and (2) will likely never become fit to stand trial. The court will then hold an inquiry (which it can also do of its own motion), to determine whether these two criteria are satisfied, and also whether a stay of proceedings would be in the interests of the proper administration of justice. If the proceedings are stayed, the individual ceases to be under the jurisdiction of the Review Board (Barrett and Shandler 2006; Bloom 2013a).
7.4.2.3 Charter remedies

Review Boards have recently been held to be courts of competent jurisdiction under the Canadian Charter of Rights and Freedoms (R v. Conway, 2010 SCC 22). This means that they have the authority to consider constitutional challenges to the legislation and grant Charter remedies (such as damages or declaratory relief) where the accused’s Charter rights have been infringed (Lamba 2013; Zuckerberg 2011). It is not entirely clear what Charter remedies a Review Board would be able to grant. What is clear, however, from Conway is that a Review Board can only grant Charter remedies which fit within the Board’s statutory scheme. In particular, the Review Board could not grant an order for absolute discharge as a Charter remedy for an NCR accused whom it considered to be a significant threat to public safety (Barrett and Shandler 2006).

7.4.2.4 Psychiatric treatment without consent

The right to refuse medical treatment is reflected in the Criminal Code with respect to NCR individuals, in that neither the court nor the Review Board can include in its disposition a requirement that the patient undergo treatment, unless the patient consents (Criminal Code 1985, section 672.55).

The position is different, however, with respect to an accused who has been found unfit to stand trial. Recognizing the importance of ensuring that criminal charges be dealt with in a timely manner and the potential unfairness in having an unfit accused remain under the jurisdiction of the Review Board indefinitely, the Criminal Code permits the court (but not the Review Board) to order treatment for the individual, even in the absence of consent, for a period not exceeding 60 days, for the purpose of making the accused fit to stand trial (Barrett and Shandler 2006; Bloom 2013a). This type of order tends to be used sparingly, not only because of its intrusive nature, but also because it requires the consent of the hospital and many hospital administrators and physicians are reluctant to be involved in treating a patient without consent (Barrett and Shandler 2006).

Although Review Boards lack the authority to prescribe treatment, the Supreme Court of Canada has held that they do have the power to impose orders or attach conditions regarding the supervision of treatment (Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services), 2006 SCC 7). This would include, for example, the power to direct the hospital to undertake a comprehensive review of the patient’s diagnosis and treatment, obtain an independent risk assessment, and issue recommendations and suggestions with respect to treatment. This supervisory role regarding treatment represents a significant expansion of the Review Board’s jurisdiction. It shows that the Review Board ‘should play an active role in addressing problems arising [in] the therapeutic relationship between the forensic system and the individual patient’ (Carver and Langlois-Klassen 2006: 18).

Despite the fact that the Criminal Code prohibits treatment without consent for NCR patients, in some provinces this can be circumvented by certifying the patient under the provincial Mental Health Act (even although the patient is already detained in hospital under the forensic system), thereby taking advantage of the provisions of the Mental Health Act which allow treatment to be authorized without consent (Robertson 2010).

7.5 Conclusion

In our examination of the rights of involuntary psychiatric patients in Canada, the theme which is most apparent is that the legislation seeks to strike an appropriate balance between
competing interests. In the context of the criminal law, where individuals are detained in hospital by reason of having been found not criminally responsible or unfit to stand trial, the balance which the legislation attempts to strike is between the safety of the public and the right of the patient to be reintegrated into society. Likewise, for patients who are certified under provincial mental health legislation, the law seeks to strike an appropriate balance between the patient’s Charter rights and society’s interest in protecting the public from harm, while ensuring that persons with mental illness receive the treatment they need. In this context, the patient’s right to refuse psychiatric treatment remains the most difficult and most controversial issue.

References

Mental health


**Canadian legislation**


Constitution Act 1867.


*Not Criminally Responsible Reform Act*, Bill C-14 (formerly Bill C-54), 41st Parliament of Canada, Second Session, 2013.

**Canadian cases**

*Dr. X v. Everson*, 2013 ONSC 6134 (Ontario).


*Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services)*, 2006 SCC 7 (British Columbia).

*P.S. v. Ontario*, 2013 ONSC 2970 (Ontario).


*R v. Demers*, 2004 SCC 46 (Quebec).


**American case**