Ontario

A Report
of the
Ontario Council of Health

1979

Committee on
Mental Health Services
in Ontario

Legal Task Force

Part I: Civil Rights and the Mentally Ill
The Criminal Justice System and Mental Health Services

ERRATUM

Page 30: Quotation in the last paragraph of text should follow the existing footnote, so that the text reads:

"and society at large. In this case, we recommend a specific wording:

(pg. 31) Rec. 12. THAT Section 8, ..."

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senior advisory body to the
Minister of Health

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Part II: The Criminal Justice System and Mental Health Services

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August 20, 1979

Honourable Dennis R. Timbrell
Minister of Health
10th floor, Hepburn Block
Queen's Park
Toronto, Ontario

Dear Mr. Minister:

I am pleased to submit to you the Report of the Legal Task Force, Committee on Mental Health Services in Ontario. The recommendations in this report were endorsed both by the Committee and by Council.

The major findings of this and other sub-groups are incorporated in the Report on Mental Health Services, also submitted to you today. However, Council considered that the various issues dealt with in detail by the Legal Task Force, which because of their technical nature could not be adequately covered in the main report, were of sufficient importance to transmit to you in full.

Council recognized that some recommendations could require rather extensive alterations to existing procedures and will thus require careful study by staff in your Ministry and other interested parties. May I assure you that those who helped develop this important document would be pleased to co-operate in any further work considered desirable.

Yours sincerely,

S. W. Martin
Chairman

Enclosure

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PART II: THE CRIMINAL JUSTICE SYSTEM AND MENTAL HEALTH SERVICES

Introduction

Pursuant to The Ministry of Health Act, 1972, on March 2, 1977, the Honourable Dennis Timbrell, Minister of Health of Ontario, referred several questions to the Ontario Council of Health for study and report. The questions concerned review of The Mental Health Act of Ontario, R.S.O. 1970, c. 269, and the Regulations thereunder. They were set out as follows in the Minister's letter:

1. Involuntary hospitalization and the rights of the patient;
2. The right of the patient to refuse treatment;
3. The right of the patient to treatment;
4. Confidentiality of information respecting the patient;
5. Special requirements, if any, with respect to minors;
6. Appropriate powers and responsibilities of non-medical staff;
7. Management of the estates of current and former patients;
8. Examination, care, and treatment of persons charged with or convicted of an offence;
9. The authority and responsibilities of a peace officer in connection with the apprehension and conveyance of persons for the purposes of the Act;
10. The appropriate extent, if any, of immunity of a psychiatric facility and its staff from liability for injury or damage caused by a patient;
11. Any other matters that the Council wishes to consider.

As a result of this reference, a special committee of the Ontario Council of Health, the Committee on Mental Health Services in Ontario, was established. The terms of reference of the study were then enlarged, with the approval of the Minister, to include consideration of the sufficiency and effectiveness of mental health services in Ontario. The Committee on Mental Health Services in Ontario began its work in the summer of 1977 and established a number of task forces. At the end of 1977 the Legal Task Force was established to prepare a study on the legal aspects of the Minister's reference.

The Membership of the Legal Task Force reflects the desire of the Ontario Council of Health for representation from the psychiatric profession, the legal profession and schools of law, from institutions, and from laymen informed in the mental health field.

The members of the Legal Task Force are:

Brian A. Crane, Q.C., Chairman
W. Bruce Affleck, Q.C.[1]
Dorothy Burwell, R.N., M.A.[2]
Prof. Bernard Dickens, LL.B., L.L.M., Ph.D.
Prof. Johann W. Mohr, Ph.D.
R. J. Pearce, B.Comm., D.H.A.
F. Xavier Plaus, Ph.D., C.Psych.
Prof. Ronald Price, B.A., L.L.B., Q.C.
R. E. Stokes, M.D., D.Psych., F.R.C.P.(C)
Elizabeth J. Trueman, B.A., B.C.L., L.L.B.
R. E. Turner, M.D., F.R.C.P.(C)

The terms of reference of the Legal Task Force (as established by the Committee on Mental Health Services in Ontario) follow:

Generally to assess and report on the statutes and common law of Canada and Ontario as they relate to mental health services in Ontario, and in particular:

1. To review The Mental Health Act, The Health Disciplines Act, The Police Act, The Public Trustee Act and others and to recommend changes in them, if required, regarding:
   a) the procedures and purpose of examination for involuntary hospitalization, including the authority and responsibility of peace officers and other persons in connection with the apprehension and conveyance of persons for such hospitalization;
   b) the rights of treatment, including the right to demand treatment, the right to refuse treatment, the involuntary treatment and/or hospitalization of patients and the review procedure of the involuntary treatment and/or treatment of patients;
   c) the legal implications of the different methods of initiating examination and treatment;
   d) the powers, responsibilities and immunities of medical and non-medical personnel involved in treatment;
   e) the roles, responsibilities and immunities of mental health facilities, whether psychiatric hospitals, general hospitals, experimental and

[1]For health reasons, Mr. Affleck did not participate actively in most of the Task Force's work.
[2]Sister Marion Barron, who resigned from the Task Force in June, 1978, was replaced by Mrs. Burwell at that time.

research facilities, teaching hospitals, homes for special care, distress centres or others;

f) the administration of patients' estates, including the judgement of incompetency, the role of the Public Trustee and Committees and the release of estates;

g) the confidentiality of patients' histories and medical records and the disclosure of such material;

h) the examination and treatment of persons held in custody under the Criminal Code; and

i) special requirements concerning minor patients.

2. To assess and make recommendations concerning psychiatric facilities required for the administration of criminal justice in Ontario, including facilities for pre-trial assessment, pre-sentence examination and reports, and forensic psychiatry.

3. To consider and make recommendations on changes, if required, in The Judicature Act, The Police Act, The Child Welfare Act and other statutes that will improve the administration of criminal justice regarding pre-trial assessment, pre-sentence reports, the power of judges, the power and immunities of peace officers, the use of expert witnesses, the admissibility and compellability of medical records, the use of Lieutenant Governor's warrants and the rights of appeal to high courts on decisions on involuntary treatment/committal and incompetency.

4. To comment on the degree of compliance and on the effect of existing legislation on the care of patients.

5. To consider and report forthwith on the effects of proposed interim changes to The Mental Health Act and other statutes.

6. To consider and comment, as required, on legislation in other appropriate jurisdictions, particulary Quebec, British Columbia, Manitoba and Saskatchewan, concering:

a) rights to treatment and rights to refuse treatment;

b) involuntary treatment and review procedures;

c) confidentiality of patients' records;

d) the administration of estates of mental patients;

e) the roles and immunities of health care professionals, their assistants and mental health facilities; and

f) legal aspects of the organization of mental health care delivery.

7. To consider other questions of a legal nature and in particular to assist other task forces as required in relation to the roles of the professions involved in mental health services and the roles of governmental, public and private hospitals and other facilities, ministries, and authorities, charged with responsibilities for mental health care.

8. To recommend an on-going method for the review and amendment of Ontario's mental health legislation.

On December 3, 1977, the Minister of Health introduced in the Ontario Legislature amendments (then Bill 124) to The Mental Health Act, which covered several of the matters that had been referred to the Ontario Council of Health, in particular: "involuntary hospitalization and the rights of the patient", "confidentiality of information respecting the patient", "management of the estates of current and former patients" and "the authority and responsibilities of peace officers in connection with the apprehension and conveyance of persons for the purposes of The Mental Health Act". The Minister stated that such amendments were needed urgently.

At its first meeting the Legal Task Force concluded that, since these amendments covered a good part of the matters referred to the Ontario Council of Health, it would be appropriate to begin by considering the amendments introduced in the Legislature. This was approved by the Committee on Mental Health Services. As a result, the Legal Task Force solicited briefs on the amendments from interested persons and associations in the province of Ontario. The Task Force also met with officials of the Ministry of Health to discuss the amendments. (It was not possible for the Task Force to hold hearings because of shortage of time.)

A good many briefs received by the Task Force were statements or letters sent by medical practitioners who were opposed to two particular features of the legislation:

1. the test required under Section 8 of "safety" or "dangerousness" in order to provide authority for a person to be conveyed for examination to a psychiatric facility, and
2. the time (72 hours) required for the assessment of a patient in a psychiatric facility in order to determine whether the patient should be compulsorily detained.

Similar representations were received by the Minister of Health.

In addition, the Task Force received a number of submissions from associations representing the voluntary sector, from lawyers, and from police forces.

In all, briefs were received from more than thirty sources, including:

- Advocates Society
- Association for Relatives and Friends of the Mentally Ill
- Association of Ontario Boards of Health
- The Board of Metropolitan Toronto Forensic Services (METFORS)
- Brantford Police Force, Chief of Police
- Canadian Civil Liberties Association
- Chatham Police Force, Chief of Police
- Citizens Commission on Human Rights (The Church of Scientology)

— City of Orillia, Chief of Police
— City of Pembroke Police Department, Chief of Police
— City of Peterborough, Chief of Police
— City of Windsor, Police Department, Chief of Police
— Civil Liberties Association/National Capital Region
— Clarke Institute of Psychiatry
— College of Family Physicians of Canada
— Correctional Law and Legal Assistance Project, Kingston
— The Elizabeth Fry Society
— Hamilton-Wentworth Regional Police, Chief of Police
— London Police Department
— Mental Health/Ottawa
— Metropolitan Toronto Police
— Niagara Regional Police, Chief of Police
— North Bay Police Force, Deputy Chief of Police
— Ontario Association of Professional Social Workers
— Ontario Association for the Mentally Retarded
— Ontario Psychological Association
— Ontario Psychiatric Association
— Ontario Society of Occupational Therapists
— The Parkdale Community Legal Services
— Registered Nurses' Association of Ontario
— St. Leonard's Society of Canada
— Waterloo Regional Police, Chief of Police
— Women's Counselling Referral and Educational Centre

The Task Force devoted attention to the two issues of most concern to medical practitioners, but also gave extensive consideration to matters of concern to other interested professionals, such as the duties of police officers, the powers of justices of the peace, and the responsibility of the Public Trustee in administering the estates of psychiatric patients. As a result of this work, an interim report was prepared by the Task Force in April, 1978.

This report was approved by the Ontario Council of Health and submitted to the Minister at the beginning of June, 1978. Because the amendments (Bill 19) were before the legislature, the Minister authorized submission of the report directly to the Committee on Social Development, which had not yet debated the legislation; this was done by the Minister at the conclusion of the Committee's hearings. Some of the recommendations of the Task Force were considered by the Committee but no changes were made in the legislation as a result of the report.

While the legislation was in committee, however, additional amendments were introduced, in particular regarding the procedure to be followed for the approval of psychosurgery and a revised procedure for boards of review.

The new legislation received Third Reading on June 23, 1978. Except for certain provisions (the amendments on boards of review and a provision concerning notification of Legal Aid authorities on commitment of a person to a psychiatric facility) the Act was proclaimed in force on November 1, 1978.

In the months of May and June, 1978, the Legal Task Force participated in the public hearings held by the Committee on Mental Health Services. During that time it received additional written briefs, which have been given consideration, and held special meetings and consultations with a variety of people, including:

Mr. Justice P. de Cory
Mr. Justice P. Galligan
Mr. Justice E. Haines
Mr. Justice H. Krever
Mr. Justice G. A. Martin
of the Supreme Court of Ontario

Chief Judge F. C. Hayes
Associate Chief Judge H. A. Rice
Judge N. J. Nadeau, North Bay
of the Provincial Courts of Ontario (Criminal Division)

Judge F. C. Cornish, County Court of York
Mr. E. Thompson, Deputy County Court Clerk, Judicial District of York
of the County Courts

Mr. A. J. McComiskey, Q.C.
The Public Trustee

Mr. L. W. Perry, Q.C.
The Official Guardian

Mr. K. Jarvis, Q.C., Secretary
of the Law Society of Upper Canada

Mr. G. S. Sharpe, Legal Branch
Dr. P. J. Lynes, Consulting Services Branch
Mr. W. C. Jappy, Psychiatric Hospitals Branch
of the Ministry of Health

Mr. D. Rutherford, Director, Legal Services
Mr. D. Barnhorst, Consultant, Children's Services Division
Mr. R. G. Gathercole, Faculty of Law, University of Toronto
(Consultant to Children's Services Division)
of the Ministry of Community and Social Services

The Task Force had the benefit of a great deal of research that had been done by Gilbert Sharpe, legal advisor to the Minister, comparing legislation in Canada, the United States, and the United Kingdom. The Committee was also assisted throughout the summer months by Anne Corbett, a third-year law student at the University of Toronto, who did much analytical work and without whose assistance this report could not have been completed on time.

The Committee met frequently throughout the latter part of 1978 and in January, 1979. In addition, subgroups have worked on specific sections of the report that deal with civil rights, compulsory commitment, the right to treatment, consent to treatment, and the management of patients' estates.

The view has been expressed from time to time by members of the Committee on Mental Health Services in Ontario (and by others outside the project) that we should attempt to prepare a "model Mental Health Act". This task we have declined to undertake, because we feel that the degree of consensus in the community on the important subjects covered by The Mental Health Act is, at this time, insufficient. Moreover, legislative drafting requires very special skills; the Task Force could not seriously attempt it without extraordinary staff resources. At certain places in our report, however, we suggest a particular form of words that, at some time in the future, may be of use to the legislative draftsman.

Part I of this report concerns the legal problems that arise out of the treatment and care of mentally ill persons, and not all of those. Most of the problems are focused on a single process: the handling of the patient who, because of his mental disorder, is unwilling to be treated, or even to be examined. The Mental Health Act authorizes the intervention of the state so that such a person may be examined and, if necessary, treated, and perhaps confined in a psychiatric facility. The difficulties of providing for the welfare of the patient and the eventual cure or remission of his illness and preserving essential civil rights at the same time are examined in detail in subsequent chapters.

At an early stage in its proceedings the Committee recognized that the examination and treatment of persons in the criminal justice system should be considered separately and consequently this subject is dealt with in Part II.

There are certain other legal subjects that we have not attempted to survey. These include the legal liability of medical practitioners, police officers, and paramedical personnel in connection with the detention, care and treatment of mentally ill persons. Also, we have not considered the legal roles of the various mental health professions. Both of these questions have been dealt with by CMHSO.

Part I

Civil Rights and the Mentally Ill

Summary of Recommendations

I — AN APPROACH TO LEGISLATIVE REFORM

1. THAT legislation governing the treatment and care of mentally ill persons and the management of their assets be incorporated in a single statute so as to avoid confusion and ensure consistency. (p. 15)

2. THAT there by a review of all Ontario statutes affecting the rights and legal disabilities of mentally ill persons in order that inconsistencies be eliminated and legal concepts be reviewed in the light of contemporary attitudes and knowledge. (p. 15)

II — THE CIVIL RIGHTS OF THE MENTALLY ILL

3. THAT all Ontario statutes be reviewed to eliminate or to recast, disqualifications imposed on persons who are, or have been, mentally ill. (p. 19)

4. THAT, at the time of admission and at the time of any change of the patient's status, each patient and, where appropriate, the nearest relative or other person nominated by the patient be advised, both orally and in writing, as to:
   - the status and rights of the patient;
   - the policies of the hospital;
   - the avenues of appeal available to the patient;
   - any changes in the status of the patient;
   - access to the review board;
   - availability of legal aid. (p. 20)

5. THAT the procedure, address and telephone number for the local legal aid office be posted in visible areas of the hospital. Legal aid counsel should be assigned to all designated psychiatric facilities and the patient should be so informed. (p. 21)

6. THAT a patient have the right to communicate with his lawyer or legal aid duty counsel in private. (p. 21)

7. THAT section 28(1) of The Mental Health Act be amended to delete the requirement of automatic notice to the area director under the Ontario Legal Aid Plan upon a patient's involuntary admission into a psychiatric facility. (p. 21)

8. THAT Section 26a of The Mental Health Act, 1978 be amended as follows:

   a) Subsections (5) to (9) should be placed in a *separate* section rather than being dealt with in a section on voluntary disclosure.

   b) Subsections (1) to (4) should be drafted in mandatory language requiring disclosure unless it is likely to result in harm to the treatment or recovery of the patient or to a third party.

   c) The same tests and procedures should be applied by the Court in deciding the issue of privilege with respect to documents as with respect to oral testimony. (This would probably require combining ss. (7) and (9)).

   d) The criteria to be applied by a Court to decide whether to permit the privilege should include:

      1) whether the evidence is relevant and of sufficient probative value as to require disclosure;

      2) whether disclosure is likely to result in harm to the treatment or recovery of the patient or injury or harm to the mental or physical condition of another person; and

      3) whether, in any event, disclosure is required in the public interest.

   e) In order to protect confidentiality, there should be a specific section authorizing hearings *in camera* along the following lines:

      "On any such hearing the judge may, either on the application of a party or on his own motion, order that the hearing and subsequent proceedings take place *in camera* or in the absence of the person or persons referred to in the record and that any proceedings with respect to the contents of the record not be reported in the press or make any other such order in order to preserve the confidential nature of the record in an appropriate case". (p. 23)

III — THE INVOLUNTARY PATIENT — CIVIL COMMITMENT OF THE MENTALLY ILL

9. THAT the Section 8 application for psychiatric assessment continue to be authorized by a physician unless otherwise designated by The Mental Health Act or Regulations. This would allow a degree of flexibility which could apply to areas in which medical personnel are unavailable. (p. 29)

10. a) THAT the application for psychiatric assessment be to a judge of the Provincial Court, Criminal Division or to a judge of the Provincial Court, Family Division, or in those areas where a Provincial Court judge may not be available, to an appropriately designated Justice of the Peace.

    b) THAT the Act should provide for applications to be heard *ex parte,* or an urgent basis, and *in camera.* (p. 27)

11. THAT Section 10 of The Mental Health Act be amended to:

    a) provide that the discretion of the police officer be limited to the cases of apprehended physical harm to the person, to others or to property arising out of apparent mental disorder, and

    b) permit the police officer to act when he has reasonable grounds to believe, rather than only when he has actually observed a person acting in a disorderly manner.

    c) make it clear that the police officer may intervene if the person is in a public or private place. (p. 27)

12. THAT Section 8, subsection (1) of The Mental Health Act be amended to read:

    "8(1) Where a physician examines a person and the physician is of the opinion that the person is apparently suffering from a mental disorder of a nature or quality that requires immediate hospitalization in order to prevent:

    a) serious harm to the mental or physical condition of such person; or

    b) serious harm to the mental or physical condition of another person;

    and such person is not suitable for admission as an informal patient, the physician may make application in the prescribed form for a psyciatric assessment of the person".

    THAT appropriate amendments be made to sections 9, 10 and 13. (p. 31)

13. a) THAT a form be designed in greater detail with questions of a specific nature; and

b) THAT the failure to complete the form be made a matter of professional misconduct. (p. 31)

14. THAT provision be made for those involuntarily held for psychiatric assessment (under Sub-sections 8, 9(4) and 10 of The Mental Health Act) to be given "basic care" which would include such routine management as treatment without consent of unsanitary states, cuts, bruises, etc., in order to keep the patient clean and in good order. (p. 32)

15. THAT Section 13 be amended to provide that a patient may be detained for a period of 30 days under a certificate of involuntary admission and on renewal for an additional two months etc. (p. 33)

IV — THE REVIEW PROCESS

16. THAT the review board:

a) have the authority to make recommendations to the institutions or to the Ministry of Health as to the administration of the institution insofar as matters coming to its attention make this appropriate;

b) be required to publish annual reports. (p. 38)

17. THAT the review board continue to serve as an agency of *external* review by retaining the principle that its membership is entirely *independent* of the hospitals concerned. (p. 38)

18. THAT the review boards established under The Mental Health Act be amalgamated into a single Mental Health Review Board for the province with a permanent staff. The Board should be comprised of a combination of full-time and part-time appointments on a three-year appointment basis. (p. 39)

19. THAT psychiatrists serve in the capacity of independent expert, advisor or assessor to the review board but that such a psychiatrist advisor should not be a member of the review board. (p. 40)

20. THAT the Act be amended to provide that each patient would have the right to secure an independent medical opinion in connection with proceedings before the Board. (p. 41)

21. THAT, notwithstanding Section 30e(1) of The Mental Health Act, it be in order, prior to a formal hearing of the review board, for investigation or consideration of the subject matter of the hearing to take place, including communication with the patient or any other party, as follows: by the psychiatrist advisor of the board, who would report to the board at the hearing; and by a member of the board with the consent of the parties to the proceedings, or counsel. (p. 46)

22. THAT procedures be adopted that will minimize the unnecessary calling of witnesses at board proceedings. This would include the following:
    a) The review board should make it a practice to ensure that a staff member thoroughly acquainted with each case is in attendance.
    b) A standard form of notice should be adopted to indicate to the attending physician or other hospital staff and facility when attendance will be required at review board proceedings. (p. 47)
23. THAT procedures should be established by regulation to ensure appropriate notice to parties in advance of review board hearings. (p. 47)
24. THAT the review board should continue the practice of conducting its proceedings in private and should be entitled to exclude therefrom any person other than a "party". (p. 48)
25. THAT all such amendments to The Mental Health Act as may be required, to Section 26a or otherwise, be enacted to make it clear: that the review board is entitled to complete access to the clinical record and to all documents and opinions that are relevant to any case; and that the provision prohibiting hospital staff from disclosing, "before any body", any "knowledge or information in respect of a patient obtained in the course of" assessment, treatment or employment, without consent or a determination of the Divisional Court, have no application to proceedings before the review board. (p. 49)
26. THAT the board be empowered, in its discretion, to refuse a patient access to information or opinions if such disclosure is likely to be harmful to the treatment or recovery of the patient or harmful to other persons. Prior to such refusal, the board should be required to advise the patient that it proposes to withhold material from him and permit the patient or his counsel an opportunity to make representation. The decision of the board refusing access should be reviewable upon application to the Divisional Court. (p. 49)
27. THAT the review board be authorized to disclose confidential matter to counsel on a formal undertaking that it will not be discussed or information revealed to any other person, subject to any amendment being made, if necessary, to the Rules of Professional Conduct of the Law Society of Upper Canada recognizing the right of a solicitor to enter into such an undertaking and making it a matter of professional complaint to fail to honor it. (p. 50)
28. THAT the obligation of the review board to inform an unrepresented patient of his rights before the board in regard to collecting and giving evidence, questioning witnesses and making submissions, be clarified by statute, regulation or rule; and

THAT the issues of burden and quantum of proof in all proceedings before the review board be clarified by statute, regulation or rule; and

THAT formal directions be set out concerning provision of interpreters in proceedings before review boards. (p. 50)

29. THAT the initial mandatory review date provided for in Section 28(6) of The Mental Health Act be advanced to provide for such review upon completion of a 2nd certificate of renewal. Subsequent mandatory review hearings should continue to be required after every 4th certificate of renewal (every year), although consideration should be given to whether more frequent mandatory review hearings are desirable in the first year or so of hospitalization; and

    THAT a more informal type of review procedure, referred to as a "file review", be available in certain situations, including mandatory reviews, unless the patient or his relative requests a full hearing, and the circumstances otherwise indicate that an informal review is appropriate. (p. 52)

30. THAT study be given to possible modes of expedited review in particular kinds of cases coming before review boards. (p. 52)

31. a) THAT there be no appeal to the courts from board decisions on questions of fact; and

    b) THAT judicial review of board decisions be available on grounds of errors of law or jurisdiction, complete absence of evidence and application of inappropriate criteria; and that such review be by way of application for judicial review to the Divisional Court rather than appeal; and that section 30f of The Mental Health Act be repealed;

    c) THAT, if there is doubt about the application of The Judicial Review Procedure Act, 1971 to proceedings before review boards, The Mental Health Act be amended to provide specifically for relief under that statute. (p. 53)

32. THAT the review board cause a full record of proceedings to be kept, and also give reasons in writing if requested by any party. Upon request by a party, but as a matter entirely for its discretion, the board should have authority to arrange for transcription of evidence by a court reporter. (p. 53)

33. THAT the Ministry study what application, if any, the provisions of The Mental Health Act relating to regional review boards have to persons held in a psychiatric facility under one or another form of criminal process. (p. 54)

VI — CONSENT TO TREATMENT

34. THAT an informal competent patient required to leave a psychiatric facility upon his refusing recommended treatment may appeal to the review board on the question whether the proposed treatment is likely substantially to improve the patient's condition, and the patient's condition is not likely to improve under any alternative treatment.

    Note: The legal aid support of the patient's recourse to the regional review board has financial implications. (p. 60)

35. THAT upon admission of an adult patient to a *psychiatric facility,* whether as an informal or an involuntary patient, a physician shall examine the patient to determine whether he is mentally competent *to give and refuse consent to treatment.* (p. 61)

36. THAT a facility treating an incompetent adult upon surrogate consent be required periodically to review that consent. Surrogate consent should be of finite duration, such as an initial 60 days and four months thereafter. Treatment of an incompetent thereafter, without appropriate renewal, should be only upon service of notice upon the Official Guardian. (p. 62)

37. THAT the status of patient incompetence (for purposes of treatment) be periodically reviewed, such as after the initial 60 days and every four months thereafter, notice of initial and continuing incompetence being served on the surrogate and the patient, the latter being able to appeal to the regional review board. (cf. Rec. 49 & 50)

    Note: (This may have financial implications in terms of legal aid support). (p. 62)

38. THAT the provincial age of majority for psychiatric (and other) consents be sixteen years. Minors below sixteen, if considered competent by two physicians, should be able to give autonomous consent. (p. 63)

39. THAT a competent minor aged 12 or over should be able to challenge before the regional review board the assessment that he satisfies Section 7 criteria. He should also be able to challenge that he needs the specific treatment proposed, and may require that available alternatives be disclosed if they exist; and

40. THAT a minor aged 14 found incompetent have the right to challenge the incompetency finding before the regional review board, and be subject to periodic reassesment as under Rec. 39 above.

    Note: (Again, legal aid support may result in increased cost). (p. 64)

41. THAT, since involuntary detention does not in itself justify non-consensual treatment, the right of the involuntary patient to choose between treatments be protected to the greatest extent possible consistent with the patient's welfare. (p. 65)

42. THAT those refused party status by a board be empowered to apply to a Provincial Court (Family Division) for such status, and that administration of treatment be withheld for a reasonable time pending the outcome of appeal (but not of any further appeal if the court declines to grant party status), subject to emergency treatment provisions. It is further recommended that applicants for party status appealing to the Court against refusal be eligible under the Legal Aid Act. (p. 67)

43. THAT a competent patient and the nearest relative of an incompetent patient have a right to refuse consent to a specific treatment, which the regional review board cannot overcome by its consent power. The only exceptions should be:
    a) when the attending physician applies to the board and satisfies the board that a patient or nearest relative of an incompetent patient has been offered a reasonable range of alternative available treatments and has refused them all; and
    b) when the attending physician shows with compelling evidence that only one treatment has any likelihood of being effective in the case of a patient, and that the patient or nearest relative has refused consent to it. (p. 68)

44. THAT, when application is made to the review board for its consent to specified treatment refused by or on behalf of a patient, comparable notification be served, and legal aid be equally available, as when certification of involuntary admission and of renewal are challenged before the regional review board, after notification to the area director under The Legal Aid Act. (p. 68)

45. THAT, for emergency cases, a provision comparable to Section 49 of Hospital Management Regulation 729 (under The Public Hospitals Act) be enacted. This would permit treatment without consent where the attending physician believes delay in obtaining consent would endanger the life, limb or vital organ, or the mental health, of the patient, and so states in writing. (p. 69)

46. THAT for the benefit of patients in need of non-psychiatric emergency treatment falling short of surgery (and indeed for everyone else), Section 49a be amended to permit diagnostic and non-surgical treatment without consent in emergency. Alternatively, Sections 49 and 49a might

be combined to permit emergency, diagnostic, medical or surgical treatment. (p. 69)

47. THAT psychosurgery be made lawful upon the involuntary patient's own free request, and upon approval of an appropriately composed Psychosurgery Committee in a Group A hospital. Notice of the patient's request should be served on the nearest relative or, where none, upon the Official Guardian, a person receiving notice being entitled to take part in the hearing, and to appoint a physician to receive copies of submissions. (p. 71)

VII — THE MANAGEMENT OF ASSETS AND GUARDIANSHIP

48. THAT access to the services of the Public Trustee be available to all incompetent persons, and

    THAT all psychiatrists be permitted to assess their patients, whether or not they are patients of a psychiatric facility, for competence to manage their affairs and, where indicated, to issue a certificate of incompetence appointing the Public Trustee. (p. 75)

49. THAT a person who has been declared incompetent to manage his affairs should have the right to request a periodic review of his status as incompetent, by the Review Board, if he is within its jurisdiction, and otherwise by the County Court. (p. 76)

50. THAT, where a person has been declared incompetent, a reassessment of his competence to manage his affairs be conducted annually by a physician in a psychiatric facility, or by a psychiatrist, and the results of the reassessment be communicated to the Public Trustee or filed with the County Court. If reassessment determines that the person is competent, a discharge from the incompetency certificate should be granted. (cf. Rec. 37) (p. 76)

51. THAT the Public Trustee establish several regional offices in Ontario to make his services accessible to incompetent persons in locations outside Toronto. Where no regional office is conveniently located, the Public Trustee should appoint a local trust company, a lawyer, or other professional to act. (p. 78)

52. THAT the application to County Court for appointment under The Mental Incompetency Act be retained but enquiry by the Court into the applicant's fitness to act as committee and representation of the views of close family or friends should be permitted by the Act. (p. 79)

53. THAT the law be amended to provide a practical and inexpensive means so that a competent person who wishes to provide for the management

of his assets during his possible incompetence be able to make an "incompetency trust" and name trustees to manage his property for his benefit, if he becomes incompetent. (p. 81)

54. THAT the Public Trustee, wherever possible, consult and use the assistance of willing and capable relatives and friends in the management of the estate of an incompetent person. (p. 81)

55. THAT the principle be retained that the estate of an incompetent person must be managed exclusively for the benefit of that person and his dependents. (p. 83)

56. THAT the principle be retained that anyone who manages the assets of another person can be called upon to give an account of his management. (p. 83)

57. THAT the Public Trustee be granted management and investment powers that are like those of a trustee, to eliminate the restrictions that committeeship may place on his ability to manage the estates of incompetent persons for their benefit. (p. 83)

58. THAT the Public Trustee have access to information from the attending physician about the extent and duration of a person's incompetence to assist in the management of his estate. (p. 83)

59. THAT the Public Trustee take all necessary steps, in the early stages of the management of an estate, to assist in dealing with immediate financial problems. (p. 83)

60. THAT the Mental Incompetency Act should not permit that custody of the person be granted as an accessory of management powers over the estate of an incompetent person. (p. 85)

61. THAT where an incompetent person is a party to a legal action involving personal rights, and has the Public Trustee as his committee, the Public Trustee be empowered to represent him. (p. 86)

62. THAT the rules prescribing representation of incompetent persons be revised and consolidated into a system that provides a coherent set of rules allowing an incompetent person to be represented by the same official or authorized person in legal matters affecting the incompetent person. (p. 86)

VIII — THE PSYCHIATRIC HOSPITAL AND THE COMMUNITY

63. THAT provincial psychiatric hospitals be supervised by boards of management drawn from the community. As this will require statutory change, we would recommend, as an intermediate step, the establishment of advisory committees for all psychiatric hospitals in Ontario. It

would be appropriate to have representation from the office of the Director of Legal Aid, local citizens' groups such as the Mental Health Association and Friends and Relatives Associations, as well as liaison representatives from the District Health Council on such advisory committees or governing boards. (p. 90)

I — An Approach to Legislative Reform

1. Attitudes and Perceptions

Some years ago, the Canadian Mental Health Association identified as one of the most significant problems of the mentally ill the idea that mental patients are "different", and to be kept at arm's length. The image of the asylum, in which patients were treated much like criminals, still persists, and underlies current attitudes and perceptions.

From a legal perspective, concern about the custodial aspects of treatment of the mentally ill has dominated public debate in Britain and North America. While there is little concern about compulsory vaccination or education, there is clear apprehension about compulsory confinement of the mentally ill.

A recent example of public attitudes is the debate in the Provincial Legislature on the amendments to The Mental Health Act. Put simply, most members felt that the "dangers" of curtailment of the civil rights of mentally ill persons implicit in their confinement were so serious that a formal legal process was required to ensure that abuses would not take place. The medical establishment, on the other hand, reacted to the amendments with complaints about the rigidity of the legal process and its inconsistency with the principles of care and treatment. One might identify in medical ranks an antagonism to the civil liberties' advocates; perhaps, also the healing professionals felt they were betrayed by being characterized as insensitive and over-protective custodians of unwilling mental patients.

This polarization of opinion indicates that there is still great fear of the mental hospital, of being irreversibly trapped in the system, and of the traumas of isolation and psychiatric therapy.

In addition to politicians and committed professionals, a number of associations and individual citizens expressed views to our Task Force. The Ontario Council of Health also gave a further opportunity for many voices

to be heard in its extensive public hearings. What follows is a sampling of those opinions, selected to illustrate different attitudes:

The Advocates Society:

". . .Legislation which is fair to the mentally ill and to society is extremely difficult to structure. . . .The experience of the Society's committee has been that physicians and mental health institutions are well-meaning and do not confine patients unreasonably. It is our view that the existing relatively simple system is preferable to a complex structure of checks and balances. . . .the concern for the liberty of the patient should not outbalance the other factors. . . .the new regulations. . .may result in greater injustice than the simplicity of the present system."

The Citizens Commission on Human Rights:
(sponsored by the Church of Scientology)

"A person's liberty should not be taken away from him except by due process of law after having been found guilty of a criminal act or, if by leaving him free, there is immediate physical danger to himself or others . . .if only a small percentage of the patient population is actually dangerous, then on what basis are the majority of patients committed?

Mental Health/Ontario:

"The existing 'safety standard' for committal should be changed to the 'dangerous standard' as set out in Bill 19. . .Committal should only be used as a last resort. . .No person should be involuntarily admitted until alternatives have been explored and found to be unsuitable. . .Custodial decisions involving the over-riding of individual freedom of choice are social not medical decisions. . .The ultimate decision-makers should be representative of, and appointed by, the community".

Ontario Association of Chiefs of Police:

"Police officers are instructed to consider three things when dealing with a mentally disturbed person. Firstly, they must protect the public; secondly, they must protect their own lives; and thirdly, they must treat the mentally ill person as humanely as possible. . .

"Police participation in dealing with mental patients usually comes during an emergency situation. Often the safety of the mentally disturbed person or another citizen is in jeopardy. It is not surprising that, to the police, the prime concern is for the immediate and continuing safety of all involved. When the mental patient reaches hospital, the concern of the physician is for diagnosis and treatment. . . .It is essential that mental patients be handled with care and consideration. It is even more essential that they be handled in such a way that no physical harm should be done

to them or to others. . . .It is our opinion that a mentally disordered person is entitled to the same procedural fairness and should benefit from the same protection of personal liberty as any other individual. . ."

Chatham Police Force:

"In smaller municipalities we do experience some problem in having a person admitted to a psychiatric facility. . . .We have found a general hesitation on the part of some general practitioners to act. It appears to me that they, as well as all who are charged with the administration of this Act, have a fear of possible litigation over any action they might take. . . .as police officers operating within the terms of the proposed Act, we are often called upon to assist a medical practitioner in subduing violent patients and really have very little protection under the law for injuries to a patient or ourselves. In the past I have seen instances where the behaviour subsided back to normal and the police officers accused of either interference or brutality."

Parkdale Community Legal Services:

"Our main concerns focus upon the uncertainty and inconsistency which exist in the application of criteria for involuntary admissions to psychiatric facilities. . . .Numerous consultations with experienced professionals in the field of mental health have led us to conclude that the most suitable approach to involuntary admissions to psychiatric facilities, is that of a short-term *crisis intervention* model. *Where a person apparently suffering from mental illness, by way of overt act, threat, or neglect, creates imminent danger to the life or safety of himself or others,* he or she may be properly detained in a psychiatric facility for the purposes of a psychiatric examination. This provision of course, carries the proviso that the person refuses or is unsuitable for voluntary admission."

It is clear that there is a degree of dissatisfaction with and confusion about the laws affecting the status, care and treatment of the mentally ill. We have reviewed the present law—which is, in fact, scattered throughout the statute books of Ontario—and identified certain general principles that may serve as a basis for legislative reform. We have also discussed, in Chapter V, the statistical and cost implications of changes suggested in this report.

2. The Present Law

The Mental Health Act may be the primary legislation governing the care and treatment of the mentally ill and their status in law, but it does not con-

tain many of the most important provisions that affect their care, treatment, or status. These appear in several other statutes, which, incidentally and sometimes haphazardly, affect the mentally ill.

Where a mentally ill person becomes a patient in a provincially operated psychiatric hospital, for example, The Mental Health Act and The Mental Hospitals Act govern his care and treatment, including such matters as consent to treatment, confidentiality of records, and access to the services of the Public Trustee. If the same person is treated for mental illness in a non-psychiatric unit of a public general hospital, however, his treatment and care are governed by The Public Hospitals Act. But if he becomes a patient in a psychiatric unit of a public general hospital, both The Mental Health Act and The Public Hospitals Act apply. A mentally ill person who is retarded may be resident in a facility governed by The Developmental Services Act. And, even though the same patient could be receiving the same treatment in each situation, the provisions of all these statutes are inconsistent in approach and terminology.

It appears that the many statutes that contain incidental provisions regarding the legal rights and disabilities of the mentally ill have never been codified or even examined as a whole. A partial list of the statutes includes The Devolution of Estates Act, the various Elections Acts, The Evidence Act, the Judicature Act, The Marriage Act, The Succession Law Reform Act, and The Trustee Act. These Acts represent an accumulation of laws reflecting the attitudes towards the mentally ill of previous eras in Ontario's history; clearly, a thorough review and consolidation are indicated. Such a review and consideration are particularly important with respect to The Mental Health Act, The Mental Hospitals Act, and The Mental Incompetency Act.

Confusion also exists in the area of the management of the assets of mentally ill persons and their representation in legal cases. These matters are discussed in detail in Chapter VII.

Consequently we recommend:

Rec. 1. THAT legislation governing the treatment and care of mentally ill persons and the management of their assets be incorporated in a single statute so as to avoid confusion and ensure consistency.

Rec. 2. THAT there be a review of all Ontario statutes affecting the rights and legal disabilities of mentally ill persons in order that inconsistencies be eliminated and legal concepts be reviewed in the light of contemporary attitudes and knowledge.

3. General Principles

We are concerned with the welfare of patients and with their necessary legal protection. It is important to ensure that there shall not be abuses of any system, and persons should not be detained against their will any longer than is necessary. This is a fundamental value of our society. It is probably also fundamental to give care and treatment to persons who are ill and to establish an environment that is conducive to those ends. But the need for providing the patient with necessary care and legal protection and the need for providing society with protection are not always in harmony. To recommend procedures that are fair to all parties and will preserve a therapeutic environment to the greatest extent possible has been our constant concern. This is an area in which common sense and practical experience must be given due attention and a realistic solution must be sought.

Any new legal institution (whether it be a unified family court, a new legal aid scheme or a small claims court) must be justified in practical terms. Will it solve the problem? Will it consume too much professional time? Will it require significant additional expenditure to be effective? Can it be adapted easily to meet new circumstances? Wherever possible, we have tested our recommendations against these standards.

Finally, the Legislature, in enacting the amendments to The Mental Health Act in 1978, made clear their concern with the intrusion of the state into the private lives of citizens, and we have tried to recognize this concern. (Issues dealing with the civil rights of patients are dealt with in Chapter II).

We are agreed that the following principles are important:

1. Compulsory confinement and treatment should be limited to cases in which alternative voluntary procedures are clearly inappropriate.
2. Where compulsory procedures are necessary, legal safeguards must be introduced in order to ensure that such procedures are not abused.
3. The tendency in the last few years is for greater emphasis to be placed on legal safeguards than on medical discretion, and this must be recognized as a component of social change.
4. Nevertheless, too much concern with legal protections and procedures may encumber assessment and treatment, and turn a system of care into a formal adversary process.
5. On balance, the process for compulsory commitment and treatment should be fair, flexible and efficient and the responsibility for its operation must continue to rest primarily on medical and institutional personnel.

6. The mentally disordered person who is subjected to restraint pursuant to The Mental Health Act is nevertheless entitled to all rights and privileges of a citizen unless those rights are specifically curtailed.
7. Finally, it is not enough for legal protection to be introduced on an individual basis; the institutions which house long-term involuntary patients under The Mental Health Act should be accountable to the community.

II — The Civil Rights of the Mentally Ill

The Minister of Health asked the Council to study "involuntary hospitalization and the rights of the patient", and many briefs have urged attention to the "civil rights" of patients. This chapter therefore considers the rights of the mentally ill who are, or have been, patients in psychiatric facilities. This concern reflects the interest of society in defining more precisely the rights of persons, such as inmates, the mentally ill, and children, whose freedom is restricted. At the same time, with the dissolution of family ties, there is considerable pressure to keep closer track of people at risk through records in data banks and reporting mechanisms such as have been developed in child abuse legislation. This erosion of traditional privacy emphasizes the importance of statutory standards.

Basic Civil Rights

It is important to emphasize that all citizens have rights unless those rights have been taken away by law; the basic rights (and duties) of a citizen (for example those expressed in the Canadian Bill of Rights) are enjoyed by persons who are or have been mentally ill. Unquestionably, however, the rights of persons who are committed to psychiatric facilities as involuntary patients under The Mental Health Act are seriously restricted. The employment of force and chemical restraints, the necessity to obtain consent for treatment and the mechanisms for appeal raise important questions that are examined in detail in subsequent chapters. It is necessary to emphasize here the belief of the task force that, if compulsory procedures are necessary, they must be clearly stated in the law together with appropriate safeguards.

Legal Disabilities

As noted in Chapter II above, a number of statutes impose particular disabilities on persons who are under some form of mental disorder; these

restrictions are unrelated to the mental health services that are the primary focus of our study. We wish to note that many statutory disabilities (such as restrictions on the right to vote) were based on simplistic notions of the consequences of mental illness; and these ideas are completely at variance with modern knowledge of the comprehension and rationality of the mentally ill. One can no longer say that a person who has experienced a serious and disabling psychosis should be permanently disqualified from any of the rights of a citizen.

Included in the disqualifications are the following which have been drawn to our attention:

1) The Provincial Elections Act, RSO 1970, Chapter 142, Section II

   Patients in mental hospitals and mentally incompetent persons in homes for special care cannot vote in provincial elections.

2) The Evidence Act, RSO 1970, Chapter 151, Section 15

   Evidence given by mentally incompetent persons cannot be relied upon without corroboration.

3) The Marriage Act, RSO 1970, Chapter 261, Section II

   Mentally ill persons cannot obtain a marriage licence.

To correct the situation, taking into consideration current knowledge about mental disorders, we would recommend:

Rec. 3. THAT all Ontario statutes be reviewed to eliminate or to recast, disqualifications imposed on persons who are, or have been, mentally ill.

Legal Advice

The briefs and public hearings reflected some concern that patients and their families are inadequately informed of their rights and of modes of appeal.

We feel that it is of the greatest importance that all involuntary patients in psychiatric facilities be fully informed of their legal rights on admission and when their status is changed. The Ministry of Health has published a pamphlet, "Mental Health and Patients' Rights", to be provided to patients and relatives. This goes a long way toward providing patients with the necessary information. However, the provision of a pamphlet—which may not be read or understood—is only part of the task of communication. Hospital staff must be ever conscious of the need to explain a patient's right in appropriate circumstances.

We therefore recommend:

Rec. 4. THAT, at the time of admission and at the time of any change of the patient's status, each patient and, where appropriate, the nearest relative or other person nominated by the patient be advised, both orally and in writing, as to:

— the status and rights of the patient;
— the policies of the hospital;
— the avenues of appeal available to the patient;
— any changes in the status of the patient;
— access to the review board;
— availability of legal aid.

Preferably, a printed brochure such as the Ministry's recent pamphlet "Mental Health and Patients' Rights" should be given to the patient and/or family. The information brochure should include a description of avenues of appeal available to the patient, in fairly simple language, preferably listing in sequence the steps to be taken. This pamphlet should be available in several languages. In addition, hospital staff should be encouraged to explain the pamphlet and to answer patients' enquiries promptly, competently and directly.

It has been suggested that a lawyer might well explain the rights of a person admitted as an involuntary patient to a patient so admitted. In fact, the new amendments in the Mental Health Act provide:

s.28 (1) An attending physician who completes a certificate of involuntary admission or a certificate of renewal shall give or transmit a notice in writing of completion and filing of the certificate to the patient who is the subject of the certificate and *to the area director of the area, in accordance with the Legal Aid Act* in which the psychiatric facility is located. (As yet unproclaimed, emphasis added).

This amendment apparently would require the Area Director to make arrangements for an interview between the patient and a legal aid counsel. We have grave doubts about the usefulness of its provision. While patients have a right to be informed, they also have a right to privacy, a right to keep their condition confidential, and to not be bothered by outsiders. We feel that unsolicited attendance of legal aid counsel, however well-intentioned, is an unnecessary intrusion into the medical setting of the hospital. However, it is essential that legal aid be readily available if requested by patients or relatives. This can be accomplished by providing appropriate information and by the attendance of duty counsel at the institution at regular intervals. As is now the practice in most areas, duty counsel should

be assigned to all psychiatric hospitals so that a legal aid clinic may be held at the hospital at regular intervals to provide assistance that may be needed on all legal problems. We do agree with the recommendation of the CMHA that there should be a statutory guarantee of the right of a patient to meet with legal counsel in private.

We therefore recommend:

Rec. 5. THAT the procedure, address and telephone number for the local legal aid office be posted in visible areas of the hospital. Legal aid duty counsel should be assigned to all designated psychiatric facilities and the patient should be so informed.

Rec. 6. THAT a patient have the right to communicate with his lawyer or legal aid duty counsel in private.

Rec. 7. THAT section 28(1) of The Mental Health Act be amended to delete the requirement of automatic notice to the area director under the Ontario Legal Aid Plan upon a patient's involuntary admission into a psychiatric facility.

Communications

Section 19 of The Mental Health Act guarantees unrestricted written communication to and from patients. It prohibits the opening, examination or withholding of such communication unless the officer in charge or a person acting under his authority has reasonable and probable cause to believe that:

1) the contents of the communication to a patient would interfere with his treatment or cause the patient unnecessary distress,
   or
2) the contents of the communication from a patient would be unreasonably offensive to the addressee or prejudice the best interests of the patient.

(By s.19 even these restrictions may not interfere with written communications with lawyers, a member of a review board, or a member of the Legislature). We feel that these protections satisfactorily ensure the free flow and privacy of written communications and we have not been referred to instances of abuse.

Psychiatric Records

A limited attempt has been made in the recent amendments (s.26a) to allow access to medical records by the patient and his advisors while protecting

their confidentiality. These provisions are discussed below, in Chapter IV.

Others, particularly the Royal Commission on the Confidentiality of Health Records (chaired by Mr. Justice H. Krever), are looking into this question. Furthermore, since the principles of confidentiality are of general application, we feel that a comprehensive approach to this question is required. We are sympathetic to many of the recommendations expressed by CMHA in its thoughtful brief to the Krever Commission. In these circumstances we have decided to refrain from an extensive analysis of the problem and content ourselves with the following comments.

Section 26a deals with four cases:

a. disclosure of the psychiatric record by a psychiatric facility with the consent of the patient and others;

b. disclosure for the purpose of research;

c. disclosure of the record pursuant to a court order or subpeona;

d. disclosure of any knowledge or information about a patient in the course of a court proceeding.

We have received no substantial criticism of the right of the patient to receive his psychiatric record unless his physician decides that it would do him harm to have access. In fact we feel that s.26a is an excellent improvement in the law, and note that it accords with the approach to medical records used in federal legislation.

The Section 26a(3) is drafted in permissive language, however; "the officer in charge may disclose. . ." It would be preferable if the statute clearly spelled out the officer in charge *shall* disclose unless such disclosure is not in the best interests of the patient. (This style has in fact been used in subsections (5) to (9)).

Subsections (5) to (9) of Section 26a set up a scheme that establishes, in the context of legal proceedings, for the first time in Ontario, a qualified psychiatrist/patient privilege that can be claimed by an officer in charge or a physician in legal proceedings. Since they deal with such a new and important matter (and logically might even be placed in The Evidence Act rather than The Mental Health Act) we feel that subsections (5) to (9) should be placed in a separate section.

These subsections also establish one formula for claiming privilege in respect of documents (the "clinical record"), and another for claiming privilege in respect of oral testimony (ss.(5) to (8) deal with documents; ss.(9) deals with oral testimony). For example, ss.(9) regards the patient's consent to the release of information as relevant while ss.(7) and (8) do not. This does not seem logical since, if there is to be a privilege it should attach

to *confidential* information, regardless of whether it is recorded in writing or merely in the doctor's mind.

With these considerations in mind, we recommend:

Rec. 8. THAT Section 26a of The Mental Health Act, 1978 be amended as follows:

a. Subsections (5) to (9) should be placed in a *separate* section rather than being dealt with in a section on voluntary disclosure.

b. Subsections (1) to (4) should be drafted in mandatory language requiring disclosure unless it is likely to result in harm to the treatment or recovery of the patient or to a third party.

c. The same tests and procedures should be applied by the Court in deciding the issue of privilege with respect to documents as with respect to oral testimony. (This would probably require combining ss.7. and 9.)

d. The criteria to be applied by a Court to decide whether to permit the privilege should include:

1. whether the evidence is relevant and of sufficient probative value as to require disclosure;

2. whether disclosure is likely to result in harm to the treatment or recovery of the patient or injury or harm to the mental or physical condition of another person; and

3. whether, in any event, disclosure is required in the public interest.

e. In order to protect confidentiality, there should be a specific section authorizing hearings *in camera* along the following lines:

"On any such hearing the judge may, either on the application of a party or on his own motion, order that the hearing and subsequent proceedings take place *in camera* or in the absence of the person or persons referred to in the record and that any proceedings with respect to the contents of the record not be reported in the press or make any other such order in order to preserve the confidential nature of the record in an appropriate case".

(These provisions are also discussed in Chapter IV below.)

Other Rights

Claims have been made for the need to guarantee patients in psychiatric institutions free sexual expression and compensation for work done in the

institution. In our view, neither of these claims should be recognized in law; both are matters for reasonable discretion on the part of the administration of the hospital.

With respect to sexual expression the paramount concern appears to us to be the need to prevent exploitation of vulnerable patients. In such a situation the hospital must exercise reasonable care to prevent such exploitation or it would be liable in law for any damage that would result.

With respect to compensation for institutional labour, the question is not whether compensation shall be paid (for this is the general practice), but whether such compensation should be at competitive rates. The emphasis throughout is on therapeutic goals rather than production for profit and we feel that there is no reason to legislate a level of wages in such a system.

III — The Involuntary Patient — Civil Commitment of the Mentally Ill

Under *The Mental Health Act*, Ontario in common with many other jurisdictions has adopted the following general scheme for the hospitalization of a person who is seriously ill but who will not attend hospital on a voluntary basis:

a. by order of a physician, a police officer or a judge, the unwilling patient is compelled to *attend* a specialized psychiatric hospital for examination;

b. At the hospital an *examination* occurs, at the conclusion of which there may be a decision to commit;

c. *internal review* of such decision occurs at those intervals when renewal certificates are required;

d. *external review* of the above steps is made by an independent board.

This scheme for commitment and review is well accepted and has operated in this province for several years. However, there has been criticism of the process of compulsory admission for assessment and of the functioning of boards of review. It has also been emphasized that commitment is equivalent to incarceration and must be resorted to only in extreme cases.

A. ADMISSION TO HOSPITAL FOR EXAMINATION

It must be borne in mind that any legal process—(and the step-by-step procedure outlined above is essentially a legal rather than a medical procedure) —must be viewed *as a whole*. The keystone of the procedure under The Mental Health Act for example, is not the initial examination; this determination is often made by a physician who is not a psychiatrist. The really important stage of the process is the comprehensive examination at the psychiatric hospital.

Thus it would be unwise to legislate protections so elaborate that it would be overly difficult to have persons taken to hospital for examination. Instead, we feel that the initial procedure must be sufficiently flexible so that there is a high probability that seriously ill persons will get to hospital for assessment; once they are there, the period of assessment must also be long enough to allow the job to be done.

The Mental Health Act recognizes three routes to hospital:

1. Examination by a physician and completion of a form for admission; this authorizes the conveyance of the person to hospital and his examination. (s.8)
2. Conveyance by a police officer on his own initiative to a psychiatric or health facility for examination. (s.10)
3. An order by a justice of the peace after receiving evidence; this authorizes conveyance to a psychiatric or health facility for examination. (s.9)

1. Examination by a Physician

In practice it will be a physician, under section 8 of The Mental Health Act who will authorize the admission of a mentally ill person to hospital for assessment. There is no question of the appropriateness of a physician, but should para-medical personnel be given this authority as well?

There is precedent for this: In Alberta, admission can be authorized by two physicians *or* by a physician and a "therapist"; while in Great Britain, certain specifically designated social workers have the authority to refer persons to hospital for assessment. The Law Reform Comission of Manitoba has suggested the power might be given to a psychiatric nurse. It has been brought to our attention that in certain circumstances, as in remote areas, physicians are not always available, and certain other persons, such as psychiatric social workers and public health nurses, should be authorized to fulfill this function. We support this view and, therefore, recommend:

Rec. 9. THAT the Section 8 application for psychiatric assessment continue to be authorized by a physician unless otherwise designated by The Mental Health Act or Regulations. This would allow a degree of flexibility which could apply to areas in which medical personnel are unavailable.

2. The Justice of the Peace

From the briefs submitted and the public hearings, it is clear that Justice of the Peace procedure (Section 9) is rarely used. If it is considered necessary,

however, to preserve a judicial hearing for the purpose of forcing an examination then the procedure should be before an experienced judicial officer, such as a judge of the Provincial Court.

It is important to note that this section does not contemplate a lengthy judicial adversary proceeding with both parties represented. We feel that this intent would be clarified if it were made clear that the application could be made *ex parte.* Also, such application should be heard as a matter of urgency and *in camera.*

We therefore recommend:

Rec. 10 a. THAT the application for psychiatric assessment be to a judge of the Provincial Court, Criminal Division or to a judge of the Provincial Court, Family Division, or in those areas where a Provincial Court judge may not be available, to an appropriately designated Justice of the Peace.

b. THAT the Act should provide for applications to be heard ex parte, *or an urgent basis, and* in camera.

3. The Powers of the Police

It is important for police officers to have clear powers, but we do not feel that the wide discretion of a physician should be granted to a police officer; thus we would not agree that the police officer, on his own, should be given the power to intervene in any case of non-violent behaviour (e.g. a recluse). Only specific overt behaviour that would justify conveyance to a hospital for examination (such as the threat of *physical injury to self or others or physical destruction of property)* justify police intervention.

We feel that the police officer should be able to act in cases where he "has reasonable grounds to believe" such actions may occur. The present requirement that he "observe a person" would so limit a police officer that his ability to act would be restricted to those cases in which he has actually observed a person exhibiting a violent form of behaviour; it would not permit him to act in cases in which he has arrived immediately after a psychotic episode and the person has quieted down. The police officer should also be able to intervene when the person is "in a public or private place". The police have advised us that they are uncertain as to their authority if the person is in a private home.

We therefore recommend:

Rec. 11. THAT Section 10 of The Mental Health Act be amended to:

a. provide that the discretion of the police officer be limited to the cases of apprehended physical harm to the person, to others or

to property arising out of apparent mental disorder, and

b. permit the police officer to act when he has reasonable grounds to believe, rather than only when he has actually observed a person acting in a disorderly manner.

c. make it clear that the police officer may intervene if the person is in a public or private place.

The most difficult issue faced by the Task Force was the legal test that should be employed to support an order for examination in hospital, under section 8, 9, or 10.*

Under the 1967 Mental Health Act a patient suffering mental disorder was ordered to be hospitalized "in the interests of his own *safety* or the *safety* of others". (s.8, 1967 Act, emphasis added).

The 1978 amendments have changed this test and now provide that the physician (or police officer or justice of the peace) may order an examination if he finds mental disorder that may result in:

a. *serious bodily harm* to the person;

b. *serious bodily harm* to another person; or

c. *imminent and serious physical impairment* of the person".

(s. 8, 1978 amendments, emphasis added)

Serious bodily harm: That mentally disordered persons who are likely to seriously injure others or themselves should be taken to hospital for assessment as soon as possible is beyond debate. But what is a "serious harm"? Does a family fight that results in blows (if it resulted from mental disorder) indicate that *serious* bodily harm is likely to occur in the future?

Imminent physical impairment: The 1978 amendments provide for the admission of persons who are suffering from a mental disorder that will likely result in "imminent and serious physical impairment of the person". This is meant to provide for the elderly recluse who is wasting away and may well starve. But what is "imminent" in such cases?

Harms not contemplated: We are concerned that the present legislation excludes the physical destruction of property, the wasting of assets, and severe emotional damage to the immediate family. The following clinical

*The question of the criteria to be employed is not easily resolved. Ontario has followed many American States in emphasizing dangerousness; other provinces and the United Kingdom provide more flexibility in their legislation. The Manitoba Law Reform Commission (which dealt with the matter in its report February 12, 1979), was unable to reach a *unanimous* recommendation and was divided between the broad criteria of the Alberta Act (which 2 members favoured) and the new Ontario legislation (which 3 members favoured).

examples are a sample of cases that would not be caught by the amendments to the Mental Health Act:

1. Recently a psychiatrist committed a patient in a manic state. Within a period of 2 weeks she had bought a very expensive car, decided to remove the furniture from her home and rented a hotel suite for herself and her two children. The largest part of the family's hard-earned savings was depleted. No rational discussion or argument would convince her that she was ill. It was only after medical treatment that she became aware that she had experienced a manic episode. During her manic phase she was not dangerous to herself or others in the usual sense.
2. A 53-year old, middle-class housewife was brought to a physician by her husband. She had been a very efficient homemaker, a good wife and mother, and had had an active social life until she began to pray excessively, up to twelve, fourteen or even sixteen hours a day. There was a dramatic change in her personality. She rarely went out to meet people but instead stayed in the house praying. Her family was tremendously concerned, watching her deteriorate for three months. She was successfully treated but, because she appeared to be completely well, she discontinued her medication. Some years later she experienced a second attack of acute schizophrenia and refused to enter the hospital again. She has not done harm to herself or others but she is harming her social life and her reputation and is causing unimaginable pain to her family. Treatment cannot be forced under the new amendment to the Mental Health Act.
3. A 39-year old married professional man has begun to suspect his friends and his wife. He is becoming increasingly accusatory, more isolated, and is letting his home deteriorate. He is quite certain that there is a conspiracy against him. He believes that he has no alternative but to go the United States and live there on a farm. His wife is extremely upset, and since her husband has the financial resources to go to the United States, she suspects that he in fact will leave the country. He does not appear to be physically dangerous to himself or others, but his mental condition is likely to persist if it remains untreated, and his wife and child would suffer severe emotional harm. However, he cannot be compelled under the new amendment to enter hospital and accept treatment.

The issue is described in the following terms in the reprint of the Manitoba Law Reform Commission.

> "One category of patient is the patient who is causing severe emotional or mental stress, psychological harm not physical harm, to family or friends. Another is the usually "manic depressive" individual, who, by

reason of his illness, has wasted and/or is continuing to waste his assets to the detriment of the family. Both of these examples are major problems to which such legislation is not addressed. Examples abound of family members, especially children, friends and business associates, who suffer emotionally as a result of the strain they must endure in day-to-day contact with the afflicted person. And, if we accept that an individual can inflict on another mental damage which is as great as physical damage, then the criteria for admission for psychiatric care should be broadened".

It is our view that admission to hospital for examination is justified in all cases in which there is mental disorder and *serious physical or emotional* harm may be anticipated. It must be remembered that the admission to hospital for assessment, while important in itself, is not the final decision to commit. Furthermore, with modern treatment most patients are released or become voluntary within a short time.

In addition, the legislative scheme should be relatively simple and easily understood. Section 8*seems unnecessarily complex having regard to those, usually busy, G.P.s, who will have to apply it in emergency situations.

We do not feel the present emphasis on *bodily harm* (or indeed the former emphasis on *safety*) is adequate to deal with all serious emergencies which arise from mental disorder. We feel that a simpler test that will give the practitioner greater flexibility is in the interests of the individual, the family, and society at large. In this case, we recommend a specific wording:

> "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".

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*8. 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;

Rec. 12. THAT Section 8, subsection (1) of The Mental Health Act be amended to read:

"8. (1) Where a physician examines a person and the physician is of the opinion that the person is apparently suffering from a mental disorder of a nature or quality that requires immediate hospitalization in order to prevent:

(a) serious harm to the mental or physical condition of such person; or

(b) serious harm to the mental or physical condition of another person;

and such person is not suitable for admission as an informal patient, the physician may make application in the prescribed form for a psychiatric assessment of the person".

THAT appropriate amendments be made to sections 9, 10 and 13.

Much criticism has been directed to the inadequacy of Form 1 (the application for admission) as completed by physicians. Doctors are notoriously busy and often do not complete patient records in an adequate fashion. Nevertheless, there is no justification for failure to make a full written report when the doctor is carrying out a function that will curtail the liberty of the citizen. In view of the demonstrated inadequacy* of completion of the forms, we would recommend:

Rec. 13. a. THAT a form be designed in greater detail with questions of a specific nature; and

b. THAT the failure to complete the form be made a matter of professional misconduct.

A new form has been introduced by the Ministry of Health, and we understand that its effectiveness is now under review.

B. HOSPITALIZATION OF THE MENTALLY ILL

Examination

As we have emphasized, the examination in hospital is the important stage. The examination is to be carried out by a specialist with the advantage of a clinical setting, proper tests and review of the patient's history.

Much attention has been given to the time allowed for the examination. The 1967 Act (and the Acts of the other provinces) allow 30 days. The 1978 amendments as drafted provided 72 hours; after further consideration, this

*Sopinka & Griffiths, Study Conducted for Canadian Civil Liberties Association

was expanded to 120 hours. The Ministry is conducting a study of all involuntary admissions after November 1, 1978, which will indicate how the time-limit is working.

Although it may seem obvious, the right to examine a patient implies the right to provide minimal or basic care, i.e. impose necessary restraints, either by physical or (more commonly) by chemical means, and to test the patient to find what is wrong with him. These procedures are inevitable and necessary for an effective examination.

Under s.8 (5)(b) of the Act, the admission to hospital for examination is authority "to restrain, observe and examine" the patient. "Restrain" is defined (Section 1) to include physical and chemical means of restraint. The deletion of the phrase "and care for him", which was in the earlier Bill, is inexplicable. All patients in hospital must be cared for. The absence of these words is unlikely to create practical difficulties. At the examination stage, however, the institution has no right to embark on a cure or course of treatment.

The concept of "basic care", which should, perhaps, be clarified to include such matters as keeping a patient comfortable, refers to routine management, and does not include any invasive procedure (although this may be undertaken as restraint).

We feel that Section 8 (5)(b) and its analogues should be extended to give authority "to restrain, observe, and deliver basic care to" the patient undergoing detention for assessment, and we therefore recommend:

Rec. 14. THAT provision be made for those involuntarily held for psychiatric assessment (under Sub-sections 8, 9(4) and 10 of The Mental Health Act) to be given "basic care" which would include such routine management as treatment without consent of unsanitary states, cuts, bruises, etc., in order to keep the patient clean and in good order.

Commitment

Under Section 13 of The Mental Health Act, after examination, the attending physician may complete a certificate of involuntary admission (commitment) under which the patient is forced to stay in the institution as an involuntary patient

a. on a first certificate, 2 weeks (2 months*) ("certificate of involuntary admission")

b. on a second certificate, 1 month (3 months*) ("first certificate of renewal");

*The figures in brackets represent the time limits in the previous legislation.

c. on a third certificate, 2 months (6 months*) ("second certificate of renewal");

d. on a fourth and subsequent certificate, 3 months (12 months*) ("third certificate of renewal").

It will be seen that a very significant change has been achieved by the amendments. At the expiry of a certificate, a patient will be released unless the attending physician certifies that the patient is not suitable for admission as an involuntary patient and meets the Section 8 criteria.

Also, it is now possible to make application to the review board after each step above (a-d). Review is mandatory at the commencement of the "fourth certificate of renewal" (6 months and 2 weeks after the first certificate) and thereafter at the end of each 12-month period.

However, the initial certificate now gives authority to detain for only two weeks, rather than one month. The first period of 2 weeks seems too short for initial treatment (and would not even permit any effective appeal) and we recommend the first certificate be for a period of one month.

Rec. 15. THAT Section 13 be amended to provide that a patient may be detained for a period of 30 days under a certificate of involuntary admission and on renewal for an additional two months etc.

**The figures in brackets represent the time limits in the previous legislation.*

IV — The Review Process

The Mental Health Act provides for external review through the establishment of an independent "review board" (s. 27), now designated by the 1978 amendments as the "regional review board" (s. 2(1a)).

We have emphasized that the process under which persons suffering from mental disorder may be subject to involuntary commitment, must, like any other essentially *legal* process, be viewed as an integrated whole. While comprehensive assessment at the psychiatric hospital is the keystone of the existing procedure, the system of external review is the heart of the control system in Ontario legislation.

The 1978 amendments include provisions that alter in important respects the sections relating to the review process, especially in matters of procedure. These provisions raise issues of consequence which are discussed in this chapter. Not all of these provisions have yet been proclaimed in force.

We have come to the view, for reasons that follow, that a re-consideration of the role, organization and procedure of review boards under the Act is now indicated. In saying this, we emphasize that the differing conceptions of the review boards, and of the principles that should govern their operation, are not easily reconciled. Practical considerations, not the least of economy, add to the difficulty of the questions to be resolved. In some measure, these issues have been with us since the establishment of review boards under the 1967 Mental Health Act. It seems to us, however, that they take on an added dimension and urgency in consequence of the amendments that have now been introduced.

1. The Problem

The aspect of the problem that is immediately apparent concerns the volume of cases that boards may be called upon to process under the amended provisions relating to access to a "regional review board". The relevant statutory provisions (which have been summarized in Chapter III

of this report) are central to a consideration of the review board system.

Subject to any administrative adjustments in hospital practice that may occur, the 1978 amendments might be expected to increase substantially the number of cases coming before the review board (see also Chapter V). Patients will be eligible to apply earlier, at a stage when they are probably more likely to apply, and at more frequent intervals. Added to this is the new obligation to provide automatic reviews in a significant number of cases, and to hear as well applications for compulsory treatment. The question that this presents is whether, as a practical matter, the board can continue to function on the informal part-time basis that now obtains.

We have no way of knowing the impact on hospital populations from the pressure to complete assessments within five days, or however many patients move from involuntary to informal status on the 4th or the 18th day of hospitalization, but it is of interest to note that, prior to the amendments, hospital records showed a very large transfer of patients from involuntary to informal status on the 30th day of hospital confinement — the day before a certificate of renewal would have been required.*

Similarly, the new requirements of mandatory periodic review of long-term patients will create a consequent increase in the workload of the boards. Again, however, we cannot predict how many patients will be discharged or changed to informal status just prior to the mandatory review dates.

We are thus left with an uncertain problem of prediction. It does seem to us, nonetheless, that the increase in cases before the boards is likely to be substantial. The period of time required for some boards to schedule hearings at present seems quite out of keeping with what is contemplated by the new provisions. How quickly the boards could respond and how readily they could cope with this increase in volume of work without a substantial change in their character are issues of signal importance. When one adds the factor of increased cost, the dimensions of the issues are manifest.

Under the 1967 Act, the board was directed to "conduct such inquiry as it considers necessary to reach a decision" (s. 29(1)). This is the common form of language used where a board is made the master of its own procedure. The Act provided that the board "may hold a hearing"; it was not required to do so. The Act further provided that the board "or any member thereof may interview a patient or other person in private", thus facilitating

*The records at one psychiatric hospital for a two-month period show 40 patients received on physicians' applications for psychiatric assessment under Section 8 of the Act, of whom 5 were discharged and 17 were admitted as informal patients within 5 days, and 18 were admitted on certificates of involuntary admission. The number of first renewal forms completed in each of the two months was 5. Thus, there would have been 18 persons eligible to apply to the board after 5 days hospitalization, and 10 after 19 days.

an inquiry without the necessity of extensive presentation of evidence. In some cases, this appears to have been the principal means of the board informing itself, with a considerable saving in time. Review Boards in different regions were by no means uniform in their approach but loose specifications as to procedural requirements lent support to interpretations tending to view the process as quite an informal one.

While some questions may remain unanswered, it is clear that much more is mandated under the amendments. Section 28 indicates that "the person may. . .require. . .a hearing", and is to receive formal notice of that right. Section 30(e) substantially curtails the practice of having interviews conducted with the patient or other person in private. The rules in regard to admissibility of evidence and what may be taken into account are now formalized. Availability of an appeal appears to contemplate the maintaining of a formal record of the proceedings, at least of some sort.

All of much of this appears understandable in the light of both the thrust of the amendment package and the criticisms that have been made of the review process. It cannot be gainsaid, however, that enactment of these provisions in their existing form would have a quite marked effect on the operation of the boards. Indeed, they have such potential for increasing the difficulties that there is a ready temptation to seek a compromise that would turn the concept of review into a mere symbolic and token exercise. The risk of compromising the whole legislative scheme is, we think, a real one. It seems evident that these considerations, taken with the probable increase in the volume of work, requires a rethinking of what may be expected from the boards, at least as presently constituted.

2. Functions of the Board

In order to place our recommendations in proper context, it is necessary to indicate first our view of the functions of the boards.

At the risk of oversimplification, we note that two general perceptions of the review process and what it entails have been apparent in discussions. One conceives of it as a relatively narrow, formalized type of review, concerned with ensuring that legal documentation is in order and that the clinical record or other available material supports the decision to refuse release. So regarded, review is essentially a "fail-safe" procedure. Any "second guessing" of what are seen as matters of medical judgement is limited, in the main, to cases of patent error. The other view assumes that review contemplates a full hearing of a quasi-judicial nature, conducted in accordance with standards of natural justice as required in administrative law, that is designed to determine whether, in law and in fact, the criteria for involuntary admission existed and continue to exist.

Such differences in perception of the review process did not arise out of the 1978 legislative revision; this only served to highlight what has been evident in professional discussion and in the apparently varying practices of different regional boards in the province. These partially conflicting views have been masked because boards themselves have not been subject to judicial review, and do not report in any detailed or public way.

Such informal evidence as is available tends to support the conclusion that a psychiatrist serving as a member is often the effective decision-maker, either because the psychiatrist has alone reviewed the clinical record or interviewed the patient, or because other members of the board generally defer to the psychiatrist in what they are inclined to view as a medical matter. In the past, most boards seem to have taken the first view.

It is our view that the second, or "full review", approach is desirable. This is clearly what is contemplated by the 1978 amendments, which reflect the awareness that review boards are intended to provide the larger scale basis for review that has found favour in current approaches to legislative change. Such an approach would suggest the following functions for the regional review boards:

a) To review involuntary *hospitalization*, i.e. "to inquire as to whether a patient suffers from a mental disorder of a nature or degree so as to require hospitalization in the interests of his own safety or the safety of others".

b) to receive and deal with appeals against declarations of *incompetence* and extensions of incompetence determinations.

c) to receive applications for and authorize compulsory psychiatric *treatment* in situations where an involuntary patient refuses consent to necessary treatment, or has not reached the age of majority, or is not mentally competent and consent cannot otherwise be obtained.

d) to make rulings with respect to *alternative treatments* that might be offered to a patient where that patient or those representing him are prepared to consent to one mode of treatment but not to another.

e) to review submissions appealing against denial of *visitation rights.*

f) to review appeals by patients who have been refused access to their own *clinical record.*

g) to make recommendations as to the *administration* of the institution insofar as matters coming before it make this appropriate.

h) to prepare and publish *annual reports* of the board's activities and operations.

We consider provisions of the kind contained in the Nova Scotia statute S.N.S. 1977 c.45, s.55 appropriate to the role of a review board, and would suggest that similar provisions be incorporated into The Mental Health Act.

In accordance with the above considerations, we recommend:

Rec. 16. THAT the review board:

a) have the authority to make recommendations to the institutions or to the Ministry of Health as to the administration of the institution insofar as matters coming to its attention make this appropriate;

b) be required to publish annual reports.

The consequences of these functions for the boards and their members must be considered. It would appear that, if the boards are to be asked to perform a decision-making function in relation to matters of treatment, the composition of the board and the qualifications of its members become all the more important. Boards must feel confident about discharging functions conferred upon them by statute; the public must also be able to have confidence that these functions are being discharged competently.

3. Composition of the Board

The Task Force has received a number of recommendations concerning the composition of review boards. It has been variously suggested: that there should be a local board for each community in which a psychiatric facility exists, in order to provide a closer link to the community and to permit more rapid response to applications for review, as will be required under the amended Act; that the board should reflect the socio-economic and sexual mix of the population; and that a full-time, professional membership is required, because of the anticipated change in the amount and type of work that boards will be expected to perform. Concern has also been expressed about the role of psychiatrists as members of review boards.

We reiterate the principle of external review by an *independent* board. The review board should continue to retain absolute independence from the hospital by an independent membership. We therefore recommend:

Rec. 17. THAT the review board continue to serve as an agency of external review by retaining the principle that its membership is entirely independent of the hospitals concerned.

We are also of the view that at least some full-time membership on review boards is now required. It is no longer practicable for the boards to operate solely with part-time members and casual staff.

Having regard to the distances to be travelled within the province, however, it is questionable whether it would be feasible to operate solely with full-time review board membership. In any event, we consider that it is important to continue to have representation from local communities that is best provided by part-time members. We therefore recommend a combination of full-time and part-time appointments. Both should be on a three-year appointment basis, as is now provided for under the present Act (s.27). We consider that such a system would not only serve to meet the immediate needs arising from the 1978 amendments, but would also enable the Board to evolve in terms of professional qualifications and to develop an accumulated body of shared experience (much of it documented, as in annual reports). Also, while the board can continue to function with panels on a regional basis the time has come for a permanent full-time secretariat. We therefore recommend:

Rec. 18. THAT the review boards established under The Mental Health Act be amalgamated into a single Mental Health Review Board for the province with a permanent staff. The Board should be comprised of a combination of full-time and part-time appointments on a three-year appointment basis.

We also consider that in general psychiatrists should no longer continue to serve as members and as expert advisors to the review board. While we appreciate this may be controversial, we are nonetheless persuaded that the arguments in support of it are compelling.

In common practice, prior to the hearing, the psychiatrist member of the board interviews the patient privately and reviews the hospital record. He then reports to the full board. Why this course is followed is readily understandable. The psychiatrist is able to form an independent professional opinion of the patient, using the standard interview techniques employed in making a medical assessment; his doing so may mean a considerable saving in time for the board. So natural is this method of proceeding, in fact, that the better part of the psychiatrist's contribution to the process might be lost if he were precluded from functioning in this way.

There is a real problem with this procedure, however, in terms of the way in which evidence is ordinarily received in a formal hearing. In effect, the psychiatrist has become a "witness" before the very board of which he is a member — a witness who is, unlike other witnesses, not readily amenable to questioning concerning the basis of his opinion.

It may be noted that an as yet unproclaimed amendment to the Act (s. 30e(1)) states expressly that members of a board "shall not have taken part before the hearing in any investigation or consideration of the subject mat-

ter of the hearing and shall not communicate directly or indirectly in relation. . .(thereto). . .with any person", subject to conditions stated. This provision gives legislative statement to the accepted view as to how evidence in an adjudicative context is properly obtained. It will be evident that the way in which review boards have been proceeding rests most uncomfortably with it.

We have noted the concern commonly expressed that review boards merely "rubber stamp" the conclusions of their psychiatric members. Such fears can only be reinforced by a procedure whereby the psychiatrist makes a prior and much more detailed assessment of the case than that made by the other members. Nor, having regard to what is known from the research literature on decision-making in deliberative groups, one can say that such fears are entirely groundless.

This is not to say that there will necessarily be unfairness in the result. It is not difficult to appreciate, however, that there might be an appearance of unfairness. This alone is reason enough, we think, to propose a change in the psychiatrist's role. While we feel that each board should have an independent psychiatrist advisor, this psychiatrist should not serve as a full member of the board.

Under such a procedure, we see no reason why the psychiatrist should not conduct file reviews and advance interviews of patients, and report to the board at the hearing, as is now done. As we envisage it, he would be subject to questioning by both the board and the patient or counsel if his opinion were in any way at issue. As is accepted with the role of "assessor", he might himself direct questions to assist the board. We have no doubt — it is, perhaps, inevitable — that the psychiatrist advisor's opinion would continue to be most influential in review board proceedings. We do not attempt to develop here the details or full procedural implications of the psychiatrist's new role. There is a literature on all three of the models listed*, and the most appropriate role for the psychiatrist may well involve some combination of all three.

Rec. 19. THAT psychiatrists serve in the capacity of independent expert, advisor or assessor to the review board but that such a psychiatrist advisor should not be a member of the review board.

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*In regard to the role of "assessor", *e.g.* see *Rules of Practice* of the Supreme Court of Ontario, Rule 267; General Rules and Orders of the Federal Court of Canada, Rule 492; Macaulay, "Assessors in Criminal Trials in West Africa", (1960) *Criminal Law Review* 748; Mawer, "Juries and Assessors in Criminal Trials in Some Commonwealth Countries: A Preliminary Survey", (1961) 10 *International and Comparative Law Quarterly* 892.

Questions have arisen in proceedings before the review board as to the right of a patient to obtain an independent medical opinion that could be submitted to the board together with the medical opinion of the supervising psychiatrist. Under the new amendments, it would seem that the review board would be obliged to receive any evidence tendered on behalf of a patient, whether such evidence be obtained from the hospital staff or from outside consultants, as to his mental condition. In view of this, it would seem appropriate for a provision to be inserted in the Act making it clear that a patient would have the right to be examined, at his own expense, by an independent consultant and providing for the evidence of that consultant to be placed before the board.

Moreover, we consider that (since it would ordinarily be inadvisable for a board to order discharge of a patient without taking into account psychiatric evidence, whether from the attending physician, the psychiatric advisor, or the patient's own independent psychiatrist) it should be open to the board, upon request by, or on behalf of, the patient, in appropriate cases to recommend a psychiatric examination by a physician of the patient's own choice. Such a recommendation would ordinarily carry weight with the Legal Aid Director if the patient were eligible for legal aid. Such matters could be provided for under Rules to be established for the new Mental Health Review Board for the province.

Rec. 20. THAT the Act be amended to provide that each patient would have the right to secure an independent medical opinion in connection with proceedings before the Board.

4. Procedures of the Board

Reference has been made to important changes introduced by the 1978 amendments to the Act in the procedure before review boards. As noted, not all of the amendments have yet been proclaimed in force. It is convenient here, at the risk of some repetition, to list the principal changes*:

a) *Hearing*

"(T)he patient or any person on his behalf is entitled to a hearing", and upon giving notice in writing "may so require such a hearing" (s. 28(2)). The board is required to "appoint a time and place for and hold the hearing" (s. 30b). Previously, the Act provided that the board

*The section numbers provided are those in the Act as amended, even though not all of the provisions are proclaimed. For convenience, provisions are listed as "former", even though they are still in effect because the provisions repealing and replacing them are unproclaimed.

"shall conduct such inquiry as it considers necessary and *may* hold a hearing"; former s. 29(1).

b) *Notice*

Notice in writing of entitlement to a hearing in respect of involuntary hospitalization, or a certificate of incompetence or notice of continuance thereof, is to be transmitted "to the patient. . .and to the area director. . ." under the Ontario Legal Aid Plan (ss. 28(1); 39(2)); and application for an order authorizing compulsory treatment requires only "notice to the patient or the nearest relative" (s.31a(4)). Previously no formal requirement of notice was included in the Act.

c) *Parties*

"The attending physician, the patient or other person who has required the hearing and such other persons as the. . .board may specify" are made "parties to the proceedings" (s. 30a), with certain rights attaching to that status. The Act formerly provided only that "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" (former s. 29(2)).

d) *Interviewing the patients*

"Members of a. . .board holding a hearing shall not have taken part before the hearing in any investigation or consideration of the subject-matter of the hearing" or "communicate. . .in relation. . .(thereto) . . .with any person or with any party or his representative except under notice to and opportunity for all parties to participate. . ." (s. 30e). Previously the Act provided that the "board or any member thereof may interview a patient or other person in private" (former s. 29(5)).

e) *Evidence*

The findings of fact. . .(at). . .a hearing shall be heard exclusively on evidence admissible. . .or matters that may be noticed under sections 15 and 16 of *The Statutory Powers Procedure Act, 1971* (s. 30e(3)) — i.e., matters formally proved in evidence, or subject to judicial notice or notice that can be taken "of any generally recognized scientific or technical facts, information, or opinions within its scientific or specialized knowledge". No such restriction appeared under the former provisions.

f) *Documentary Evidence*

"A party. . .shall be afforded an opportunity to examine and to copy, before the hearing, any written or documentary evidence. . .or any report" that will be produced or given in evidence at the hearing (s. 30d(1)); also, "a party. . .or the counsel or agent representing a party, or both, is entitled to examine and to copy any clinical record prepared in respect of the patient" (s. 30(d) (2)), although this is made "(s)ubject to section 26a" to which further reference is made below.

g) *Witnesses*

The former provisions stated that "(w)here 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" (former s. 29(3)). (No such provision is carried over into the new sections; presumably this is because The Statutory Powers Procedure Act, 1971 is applicable (see below), and provides in s. 10 thereof that a "party to proceedings may at a hearing. . .call and examine witnesses and present his arguments and submissions", and (without permission) "conduct cross-examinations of witnesses at a hearing reasonably required for a full and fair disclosure of the facts in relation to which they have given evidence").

h) *In-Camera*

The former provisions stated that a hearing "in the discretion of the review board may be *in camera*" (s. 29(1)). No such provision is carried over into the new sections — again presumably because s. 9 of The Statutory Powers Procedure Act, 1971 conferring a power to hold *in camera* hearings was considered to apply.

i) *Appeal*

"A party to proceedings before a. . .board may appeal from its decision. . .to the county or district court. . .on questions of law or fact or both" (s. 30f(1) and (3)), whereupon the "board shall forthwith file in the. . .court the record of the proceedings before it in which the decision was made" (s.30 f(2)); the court is empowered to "exercise all the powers of the. . .board", to "substitute its opinion for that of the attending physician or of the. . .board", and to "refer the matter back to the. . .board for rehearing. . .in accordance with such directions as the court considers proper" (s. 30f (4)-(6)). No right of appeal was provided for under the prior provisions.

The right to a hearing seems to bring review board proceedings within the provisions of The Statutory Powers Procedure Act, 1971 which "applies to proceedings by a tribunal in the exercise of a statutory power of decision. . .where the tribunal is required. . .(by law). . .to hold or to afford to the parties. . .an opportunity for a hearing before making a decision", subject to certain exceptions that are not here applicable (SPPA, s.3). Under this legislation:

a) Anyone who is a "party" to the proceedings before the board would be entitled as of right to be represented by counsel or an agent (ss. 10(a) and 23).

b) The board would be required to give "parties reasonable notice of the hearing" (s.6).

c) The board would be empowered to "require any person, including a party", to attend to give evidence and to produce in evidence documents requested (s. 12), and would be able to initiate contempt proceedings for failure to comply (s. 13).

d) The board would be required, in respect of its final decision, to "give reasons in writing. . .if requested by a party" (s. 17).

e) The board would be required to "compile a record of any proceedings in which a hearing has been held, including "all documentary evidence filed" and "the transcript, if any, of the oral evidence given at the hearing" (s. 20).

f) The board would be subject to the Statutory Powers Procedure Rules Committee in regard to its procedures.

g) Independent of the provisions relating to appeal, relief would be available against the board by way of application for judicial review under The Judicial Review Procedure Act, 1971 on grounds of jurisdiction defect, error of law and lack of evidence in its proceedings.

It requires little reflection to appreciate that the choice of appropriate procedural provisions for review boards under The Mental Health Act poses questions of some difficulty. These cannot be addressed in detail in a report of this kind. Time and resources limit the Task Force to observations and recommendations that are necessarily somewhat general.

It is relevant to note that experience with the review board process is not particularly widespread among legal or other professionals. One can understand that persons who come to a study of The Mental Health Act would be concerned about the paucity of formal pro-

cedural safeguards that have attached to review board proceedings. This concern has been shared by a number of persons who have had occasion to participate in or observe review board proceedings at first hand. At the same time, such evidence as is available suggests that our review board system has, in the main, performed with commendable fairness and reasonable effectiveness within the operational mandate given it.

An increasing infusion of "natural justice" or "due process" safeguards into decision-making processes affecting substantial interests of the citizen is a notable theme in modern administrative law. The Task Force supports, in principle, the efforts to achieve this objective in the amendments to the Act. At the same time, we are of the view that the board will lose its informality, and with it much of its effectiveness, if it becomes too much like a court in its modes of procedure.

Moreover, while liberty cannot be reduced to a matter of cost accounting neither should costs be ignored — and not the least costs in the time of health professionals — if the safeguards purchased offer what is at best marginal added protection.

a) *Notice and Assistance*

Issues relating to the civil rights of patients have been discussed in Chapter II. (Notice and assistance are examined there under the heading "Legal Advice"). Here we reaffirm our support of the principle of written notice of the right to make application to the review board and of the principle of assistance to patients in taking steps to secure access to the board. (See Recommendations 4-7, in Chapter II).

To safeguard patients' privacy, we have recommended that Section 28(1) be amended to remove the requirement for automatic notice to the Legal Aid Plan (Rec. 7., Chapter II).

We would reiterate that there is also an obligation to discuss with patients held on an involuntary basis whether they wish to appear before the review board — even if there has been no specific request from the patient in that regard.

b) *Investigation by the Board*

For reasons that follow from our discussion of the role of the psychiatrist above, we feel that Section 30e(1) of the Act is unduly restrictive in its present effect. The time, expense and delays involved in board hearings would increase considerably if some form of prior investigation and consideration of the subject matter were forbidden the board in all cases.

It is contemplated in our recommendation that the psychiatrist advisor not serve as a member of the board, that it would be open to the psychiatrist to review the clinical record, interview the patient, attending physician and, if necessary, hospital staff, and report to the board at the "hearing".

We also recommend that a member of the board be permitted to perform these same functions with the consent of the "parties to the proceedings" or counsel. This recommendation is again made in the interests of practical efficiency, and relates to our recommendation (Rec. 29) for a less formal kind of board "hearing" in some cases. (It is germane to note that The Statutory Powers Procedure Act, 1971 itself permits (s.4) a decision to be given "without compliance with any. . .requirement of this Act, where the parties have waived such . . .compliance").

In further support of this recommendation, we would point out that, if all information to be considered by the board could only be communicated at the hearing, the number of hospital staff required to attend at board proceedings to give evidence, prove the contents of hospital records, and the like would substantially increase. Indeed, if strict proof of such matters as nurses' ward notes were required — and board members report that these are often helpful in understanding a patient's behaviour — there would be added the further practical difficulty of accommodating the schedules of staff who are on shifts. It is common experience that being available to appear before the review board when a case is called can cause considerable sacrifice of staff time. We are not persuaded that the added benefits to the patient of Section 30e(1), as it would now apply, justify such potential costs in staff time.

It is recommended:

Rec. 21. THAT, notwithstanding Section 30e(1) of The Mental Health Act, it be in order, prior to a formal hearing of the review board, for investigation or consideration of the subject matter of the hearing to take place, including communication with the patient or any other party, as follows: by the psychiatrist advisor of the board, who would report to the board at the hearing; and by a member of the board with the consent of the parties to the proceedings, or counsel.

However, it is a common complaint that the attending physician is often not present at board proceedings while the staff member who attends with the clinical or other records is frequently not familiar in any detail with the patient's case. We consider that a staff member

thoroughly acquainted with the case should be in attendance, and we believe that this should be required by the board where necessary.

In this regard we also refer to the powers of the board to compel the attendance of witnesses by summons under Section 12 of The Statutory Powers Procedure Act, 1971. We consider this procedure to be unduly cumbersome; in any event, we think it should not be necessary. A standard form of notice should be adopted to indicate to the attending physician or other hospital staff when attendance will be required at board proceedings.

We would, therefore, recommend:

Rec. 22. THAT procedures be adopted that will minimize the unnecessary calling of witnesses at board proceedings. This would include the following:

a) The review board should make it a practice to ensure that a staff member thoroughly acquainted with each case is in attendance.

b) A standard form of notice should be adopted to indicate to the attending physician or other hospital staff and facility when attendance will be required at review board proceedings.

c) *Notice of Hearing*

While the Act makes provision for notice of a right to hearing, it does not, unlike many such statutes, contain a specific provision relating to the amount of notice that must be given of the time and date of the hearing itself. (Note, however, the general provision in The Statutory Powers Procedure Act, 1971 (s. 6) that the "parties to any proceeding shall be given reasonable notice of the hearing").

There are practical problems involved in regard to notice. The board, especially under the amendments, is required to schedule board hearings with considerable dispatch. At the same time, "natural justice" requires that any party have sufficient advance notice in order to be able to prepare, arrange for counsel, and so on. The problem is complicated by difficulties of relying upon the mails and by the fact that the board, under present arrangements, does not have a staff to look after such arrangements. Moreover, the number of "parties" who will be required to have formal notice is increased by the amendments.

We recommend:

Rec. 23. THAT procedures should be established by regulation to ensure appropriate notice to parties in advance of review board hearings.

d) *In Camera Proceedings*

We consider that the practice of conducting review board proceedings in private should continue and that the board should be entitled to exclude therefrom any person other than a "party". If Section 9 of The Statutory Powers Procedure Act, 1971 is not sufficiently inclusive to support the current practice of *in camera* proceedings, a specific power should be granted to the board to that end. We recommend:

Rec. 24. THAT the review board should continue the practice of conducting its proceedings in private and should be entitled to exclude therefrom any person other than a "party".

e) *Confidential Information Before The Board*

The new Section 26a of The Mental Health Act, which imposes restrictions on the disclosure of information concerning patients, creates potential difficulties for review board proceedings.

A provision that will disappear with the proclamation of the remaining 1978 amendments directs the officer in charge, "for the purpose of an inquiry", to "furnish the chairman with such information and reports as the chairman requests" (s. 29(4)). Section 26a(3) permits disclosure by the officer in charge only to certain designated persons unless "with the consent of the patient" or, if the patient is a minor or mentally incompetent, "with the consent of the nearest relative". The list of designated persons includes "any person employed . . .on the staff. . .for the purpose of assessing or treating. . .the patient"; it does not include the review board. One interpretation suggested for this provision is that the board could only review the clinical record with the consent of the applicant — an assuredly bizarre result.

While the provision lacks something in clarity, we doubt that this is a necessary or even correct interpretation of it, since, under The Statutory Powers Procedure Act, 1971 (s. 12), the board has the power to compel production of documents in evidence. Section 26a(5), which directs the officer in charge to "disclose, transmit or permit the examination of a clinical record pursuant to a subpoena, order, direction or notice or similar requirement in respect of a matter in issue . . .under any Act", should also apply to review board proceedings.

This, however, does not end the problems presented by Section 26a. The right of any party "to examine and to copy any clinical record" under Section 30d(2) is made subject to Section 26a and hence could be enforced only with consent of the patient unless the board had directed its production. Moreover, where the attending physician

states in writing that disclosure of any part of the clinical record "is likely to result in harm to the treatment or recovery of the patient" or "injury to the mental condition. . .or. . .bodily harm to a third person", the material could only be disclosed before the board "under an order of the Divisional Court, made after a hearing from which the public is excluded and. . .held on notice to the attending physician" (s.26a(6)). If the material were ultimately ordered disclosed, the Act makes it clear that any "party", *including the patient*, would be entitled "to examine and to copy" it, as well as to hear it if it were considered in evidence (ss. 30d(1) and 30e(3)).

As if all of this were not enough, Section 26a(9) provides that "(n)o person shall disclose. . .before any body, any knowledge or information in respect of a patient obtained in the course of assessing or treating. . .the patient. . .or in the course of his employment in the psychiatric facility" without the consent of the patient, or (where appropriate) the nearest relative, or without a court determination "that the disclosure is essential in the interests of justice". No exception is made in regard to testimony before the review board.

We feel the review board should have the right of access to all documents and opinions that are relevant to the case. With reference to Section 26a of the Act, therefore, we recommend:

Rec. 25. THAT all such amendments to The Mental Health Act as may be required, to Section 26a or otherwise, be enacted to make it clear: that the review board is entitled to complete access to the clinical record and to all documents and opinions that are relevant to any case; and that the provision prohibiting hospital staff from disclosing, "before any body", any "knowledge or information in respect of a patient obtained in the course of" assessment, treatment or employment, without consent or a determination of the Divisional Court, have no application to proceedings before the review board.

Rec. 26. THAT the board be empowered, in its discretion, to refuse a patient access to information or opinions if such disclosure is likely to be harmful to the treatment or recovery of the patient or harmful to other persons. Prior to such refusal, the board should be required to advise the patient that it proposes to withhold material from him and permit the patient or his counsel an opportunity to make representation. The decision of the board refusing access should be reviewable upon application to the Divisional Court.

*Rec. 27. THAT the review board be authorized to disclose confidential matter to counsel on a formal undertaking that it will not be discussed or information revealed to any other person, subject to any amendment being made, if necessary, to the Rules of Professional Conduct of the Law Society of Upper Canada recognizing the right of a solicitor to enter into such an undertaking and making it a matter of professional complaint to fail to honour it.**

f. *Conduct of Hearings*

Our brief comments arise from reports made by observers at review board hearings.

While commenting on the general feeling of sympathy and fairness that characterized hearings monitored, observers expressed concern in two areas not otherwise discussed in this report. First, it was noted that it was not uniform practice to advise an unrepresented applicant of his rights in regard to giving and calling evidence, questioning witnesses, and making submissions. These are all rights now guaranteed by statute. Without adding unduly to the formality of the proceedings, we consider that such rights should be communicated by the board to parties before it. Second, observers have noted some lack of clarity about where the burden of proof lies, and in what quantum, in respect of issues before the board. These issues take on greater significance in our view because of the more restrictive criteria for involuntary hospitalization that now obtain under the Act. We believe that these basic questions of evidentiary burden should be clarified by statute, regulation, or rule.

Also, we are advised that problems of language difference are not uncommon in review board proceedings. Sometimes interpreters may be required to assist applicants, and, on occasion, hospital staff. The matter is of such potential importance that formal directions should be provided in regard to provision of interpreters. We recommend:

Rec. 28. THAT the obligation of the review board to inform an unrepresented patient of his rights before the board in regard to collecting and giving evidence, questioning witnesses and making submissions, be clarified by statute, regulation or rule; and

THAT the issues of burden and quantum of proof in all pro-

**A procedure similar to that proposed is established by Rule for the Anti-Dumping Tribunal under The Anti-Dumping Act, R.S.C. 1970, Ch. A-15. This procedure is expected to be commented upon by the Law Reform Commission of Canada.*

ceedings before the review board be clarified by statute, regulation or rule; and

THAT formal directions be set out concerning provision of interpreters in proceedings before review boards.

g. ***Hearings By File Review Or Single Member***

We think that the new provisions of the Act requiring periodic mandatory review are salutary. They serve to compel attention to those patients who would not be inclined to make application for review on their own. They also serve as a kind of peer review upon attending staff to ensure that all available avenues of treatment continue to be actively pursued. There is evidence, indeed, that the very fact that a hearing date has been set forms part of the dynamic that brings some patients to the point of discharge. We have, however, two observations to make.

First, we are of the view that the benefits of mandatory review would continue to accrue, and to do so with wider benefit, if the initial mandatory review date were earlier. The Act now provides (s. 28(6)) that an automatic review will be held upon completion of a 4th certificate of renewal — *i.e.*, after 6 months, 2 weeks and 5 days. We consider that a mandatory review should occur upon completion of the second certificate of renewal. Subsequent mandatory review might continue to be required after every 4th certificate of renewal (1 year), or perhaps held more frequently during the first year or so of hospitalization (as is provided for under the new Nova Scotia statute (s. 56)).

Second, we think that for purposes of a mandatory review a "file review" may be sufficient in many cases (again we have reference to the 1977 Nova Scotia statute, (s. 56-58). We suggest a procedure such as the following. The patient or his appropriate representative would be advised in advance of the date set for the review. Notice would be given of the right to a hearing if requested, and of the procedure to be followed if a hearing is not requested. In the latter event, someone delegated — a member of the board, or possibly its psychiatrist advisor — would review the hospital file, possibly also interviewing the patient and the attending physician. A report would then be presented to a panel of the board. The report could be acted upon without the necessity of a formal hearing where such would serve little purpose. It would always be open to the board, however, to direct a full hearing in any case that it thought desirable, either on the recommendation of its delegate or on its own motion.

We recommend:

Rec. 29. THAT the initial mandatory review date provided for in Section 28(6) of The Mental Health Act be advanced to provide for such review upon completion of a 2nd certificate of renewal. Subsequent mandatory review hearings should continue to be required after every 4th certificate of renewal (every year), although consideration should be given to whether more frequent mandatory review hearings are desirable in the first year or so of hospitalization; and

THAT a more informal type of review procedure, referred to as a "file review", be available in certain situations, including mandatory reviews, unless the patient or his relative requests a full hearing, and the circumstances otherwise indicate that an informal review is appropriate.

We note as well that there are occasionally situations in which it is difficult to arrange for the appearance of the patient at a board hearing. Procedures of the kind outlined might prove to be suited to that kind of problem.

Another alternative that might be explored is a hearing by a single member of the board upon consent. We feel as well that study should be given to rules pertaining to this and to other possible modes of expedited review. We therefore also recommend:

Rec. 30. THAT study be given to possible modes of expedited review in particular kinds of cases coming before review boards.

h. *Review of Board Decisions*

In the opinion of the Task Force, while questions of law should be subject to appeal it is not necessary to provide an appeal to the courts from decisions on questions of fact. Procedures by way of appeal are slow and costly, while mental states are often transient. Problems of transcribing testimony at board proceedings would greatly increase, and cases would be rare in which a court would ever overide the specialized board of review on an issue of fact. We are fortified in this view by reports from other jurisdictions that their provisions for appeal are rarely, if ever, utilized.

We are strongly of the view, however, that review of board decisions — on such grounds as errors of law or jurisdiction, complete absence of evidence, and application of inappropriate criteria for decision — is

very much needed in order to ensure that board proceedings conform to the requirements of law. Review of these grounds, however, is more appropriately provided by application for judicial review under The Judicial Review Procedure Act, 1971.

Therefore, we suggest that Section 30f of the Act be repealed. Further, if there is doubt about the application of The Judicial Review Procedure Act to proceedings before review boards, The Mental Health Act should be amended to provide specifically for relief under that statute. We recommend:

Rec. 31 *a) THAT there be no appeal to the courts from board decisions on questions of fact; and*

b) THAT judicial review of board decisions be available on grounds of errors of law or jurisdiction, complete absence of evidence and application of inappropriate criteria; and that such review be by way of application for judicial review to the Divisional Court rather than appeal; and that section 30f of The Mental Health Act be repealed;

c) THAT, if there is doubt about the application of The Judicial Review Procedure Act, 1971 to proceedings before review boards, The Mental Health Act be amended to provide specifically for relief under that statute.

i. ***Record of the Board***

The board should cause a full record of proceedings to be kept, and also give reasons in writing if requested by any party (both as required by The Statutory Powers Procedure Act, 1971). As part of the record, the board should note any points that may be placed in issue by a party or counsel that could later form the basis for an application for judicial review.

Upon request by a party, and in its discretion, the board should have authority to arrange for transcription of evidence by a court reporter. We consider, however, that it should not ordinarily be necessary to have evidence transcribed. We recommend:

Rec. 32. *THAT the review board cause a full record of proceedings to be kept, and also give reasons in writing if requested by any party. Upon request by a party, but as a matter entirely for its discretion, the board should have authority to arrange for transcription of evidence by a court reporter.*

5. Patients Held Under Criminal Process

Questions have been raised before the Task Force that we feel it incumbent upon us to record, if not address, concerning patients confined in a psychiatric facility under one or another form of criminal process. These may include confinements under warrant of remand; transfer from the federal or provincial systems; and confinement under authority of an order or warrant of the Lieutenant Governor.

Should any of the above classes of patients have access to the "regional review board" or Mental Health Review Board, in respect of any type of types of decision? Questions of competency and enforced psychiatric treatment may well be appropriate for consideration in that forum; issues of compulsory hospital confinement are less evidently so. Because these matters raise issues of a different order, we do not feel prepared to make recommendations on them in this review of the civil commitment process.

Finally we note the interrelation under The Mental Health Act between the provisions relating to the "regional review board" and those applicable to the Advisory Review Board. It has been suggested to the Task Force that the 1978 amendments have implications for Advisory Review Board proceedings that may be a source of difficulty. We commend this matter for study to the Ministry and recommend:

Rec. 33. THAT the Ministry study what application, if any, the provisions of The Mental Health Act relating to regional review boards have to persons held in a psychiatric facility under one or another form of criminal process.

V — Administrative Implications of the Amendments

The Mental Health Act, 1978 provides new requirements for the frequency of assessment and review of the status of involuntary patients. This chapter discusses the expected impact of these changes on some administrative aspects of the management of the involuntary patient, with particular reference to the role of review boards.

Consistent and reliable statistical data regarding patients in psychiatric facilities is extremely difficult to obtain. Furthermore, such data as is available is not necessarily comparable across the various types of psychiatric facilities, nor is it consistent over time. In order to assess the changes on assessments and reviews, three pieces of information would be needed:

1. the number of psychiatric inpatients,
2. the number committed involuntarily,
3. the change in status of these patients by length of stay.

The table below shows the percentage of commitments to provincial psychiatric hospitals, psychiatric units of public hospitals and community psychiatric hospitals.* Given that over 5,000 patients are committed involuntarily each year, the population under discussion is considerable.

	1975	*1976*	*% Growth*
Provincial Psychiatric Hospitals			
• Total Admissions	16,071	14,467	(20%)
• Commitments	4,561	4,735	4%
• % Commitments to Total	28%	33%	
Psychiatric Units of Public Hospitals			
• Total Admissions	28,159	28,679	2%
• Commitments	316	519	64%
• % Commitments to Total	1%	2%	

*Psychiatric Hospitals Branch, Ministry of Health

	1975	1976	% Growth
Community Psychiatric Hospitals			
• Total Admissions	5,078	4,601	(9%)
• Commitments	301	197	(34%)
• % Commitments to Total	6%	4%	
All Psychiatric Inpatients			
• Total Admissions	49,308	47,747	(3%)
• Commitments	5,178	5,451	5%
• % Commitments to Total	11%	11%	

Information regarding change of status of involuntary patients by length of stay was not available for either psychiatric units of public hospitals or for community psychiatric hospitals. For the provincial psychiatric hospitals, however, it is known that some 72% of involuntary patients have their status changed within 30 days. These patients are either discharged, made "informal", transferred, or have died. What is significant, moreover, is that just over half of the involuntary patients in provincial psychiatric hospitals had their status changed on the 30th day following admission.

The last factor mentioned above becomes all the more important when it is recalled that the legislation prior to the amendments allowed for an original period of committal of one month, then renewal certificates of two months, three months, six, and twelve months. The Mental Health Act, 1978 permits an involuntary patient to be sent to a psychiatric facility for assessment. The patient may stay in this facility for a maximum of five days before assessment by a second physician. If committed, the certificate of involuntary admission will be valid for an additional fourteen days. Following that, if the patient's condition warrants, the certificate may be further renewed for one month, then another two months, and then additional periods of three months each.

The significant difference is thus in the timing of the first assessment, i.e. at the end of five days plus two weeks, or 19 days maximum. This contrasts with 30 days maximum under the previous legislation. If the rate of changes of status of involuntary patients remains similar to that under the previous Act in terms of lengths of stay, then it is apparent that the number of assessments in the first month following commitment will increase substantially, as all patients still involuntary from day 19 to 30 will now have to be reassessed. However, if the rate of changes of status of involuntary patients remains similar in terms of the timing of the second assessment, then the number of assessments in the first month following commitment will not

increase, and many more patients than under the previous legislation will have their status changed before 19 days. Under this latter assumption, it will be the workload of the physicians which will increase; under the former, it will be the workload of the review boards. With data since the proclamation of the revisions still sparse, it is difficult to project which case will be the actual situation; most likely, it will be a compromise between these two extremes.

The Mental Health Act, 1978 will also affect the number of regional review board hearings directly. Under this Act, applications for hearings may be made at any time, once a certificate has been completed; previously, applications had to await renewals of certificates. In other words, applications can now be made as early as the issuance of the initial certificate (at latest the sixth day following arrival at the institution); this contrasts with the previous situation when applications had to await the issuance of a renewal certificate (as late as the 31st day following arrival). While, as mentioned previously, data following the proclamation of the amendments is sparse, such figures as are available indicate that the number of requests for hearing will increase substantially. (In one region of the province, for example, the number of requests for hearings following proclamation represented 42% of all hearings for the year — and these were made in only two months).

The workload of the regional review boards will also be significantly affected by the amendment which equates every fourth certificate of renewal with an automatic request for a review board hearing. (Fourth certificates of renewal under the revised Act will take place after a maximum of 5 days plus 2 weeks plus 6 months. Subsequent fourth renewals will each be a maximum of 12 months later). Thus, should the lengths of stay of involuntary patients remain unchanged from those under the previous legislation, the number of review board hearings will increase by the number of patients still involuntary for periods between six and seven months, and again for patients still involuntary each further twelve-month period.

In 1977/1978, the regional review boards reviewed 299 cases. (Advisory Boards, who annually review patients under Lieutenant Governor's Warrants, reviewed a further 248 cases in 1977). The combined cost of advisory and regional review boards was $162,230 in 1977/1978*. If one assumes the average review cost to be just $300, then the extent of the increase in costs of reviews will increase in some multiple of this figure. The Minister of Health has stated, however, that such increased costs will be funded, justified by the belief that additional reviews are important in ensuring the principles of the commitment process.

*Executive Secretary, Health Boards Secretariat, Correspondence, October 11, 78

Nevertheless, even if cost is not to be considered, it is obvious that the workload of the regional review boards will change both in magnitude and in frequency, in order to comply with the amendments. The ramifications on the current structure and operation of the review boards under the amendments, and possible changes to this concept, are discussed in Chapter IV.

VI — Consent to Treatment

The principles of consent to treatment by patients in psychiatric facilities whether voluntary (informal), or involuntary are examined in this Chapter.

Voluntary Adult Patients

"Informal" (voluntary) patients are admitted to psychiatric facilities in order to be treated. Their consent to be treated is implied from their willing entry to and residence in psychiatric facilities; provided, of course, that they are not unable to consent by reason of their mental illness. If they oppose treatment in general or any treatment in particular, they are free to leave. However, since the function of the facility and the individual psychiatrist is to provide appropriate therapy, rather than to merely provide residential or custodial care, the voluntary patient can be required to leave the facility if he refuses to consent to recommended treatment.

The voluntary patient is admitted to a mental health facility because he "is in need of observation, care and treatment" (The Mental Health Act, Section 7). While a patient of the facility (in-patient or out-patient) the competent informal patient is expected to consent to recommended treatment. Consent to treatment may be implied from voluntary entry to the facility, or from attendance as an out-patient; it may also be given expressly in writing, perhaps to comply with hospital regulations.

This may appear to respect the competent patient's autonomy with regard to consent to treatment: neither the patient nor the community is exposed to risk of serious harm.

While a voluntary patient who declines treatment may have no right to remain in a facility, the possibility of removal may exert pressure to comply with a particular form of treatment he finds objectionable. The threat of explusion may deny him the power to select between treatment options, and subject the patient to the attending psychiatrist's preference.

The power of a voluntary patient to decline a specific treatment should be fully protected. When an informal patient refuses a specific treatment recommended by his attending psychiatrist and believes that he is required to leave the facility because of his refusal, he should be able to invoke a procedure based on Section 31a(5). This should require the psychiatrist on application of the patient to satisfy the regional review board:

(i) 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; and

(ii) 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 written notice requiring a voluntary patient to withdraw from a facility should include information as to his right and the means to invoke this procedure, and the notice should be suspended while the invoked procedure is pending. The voluntary patient should be eligible for legal aid in invoking this procedure. Only if refusal of the specific treatment is shown to be a refusal of treatment that is both necessary and the sole treatment likely to be effective should the informal patient's withdrawal from the facility be compelled. We, therefore, recommend:

Rec. 34. THAT an informal competent patient required to leave a psychiatric facility upon his refusing recommended treatment may appeal to the review board on the question whether the proposed treatment is likely substantially to improve the patient's condition, and the patient's condition is not likely to improve under any alternative treatment.

Note: The legal aid support of the patient's recourse to the regional review board has financial implications.

A mentally *incompetent* adult may permit himself to be amitted to a facility as a voluntary patient because he is in "need of. . .care or treatment".

Acceptance of admission and treatment with no more than token resistance may constitute consent in fact, even though consent has come from another person, such as a spouse or other relative as *de facto* guardian. More problematic is the case of the incompetent adult who resists the care and treatment he needs, and to which another person consents on his behalf.

A *guardian* of an incompetent person has responsibilities for his welfare (some of which may be imposed under the Criminal Code); these responsibilities may be met by admission of the incompetent person to a psychiatric or other health facility. Regulation 729 in Sections 49 and 49a, recognizes and indeed constitutes a dispositive legal power in one person over another.

It is not the duty of psychiatric or other health facilities to monitor the good faith with which such power is exercised, only to treat, on a physician's recommendation, where treatment is necessary. A guardian's motives may be worthy or they may be questionable, but the facility cannot be required to examine the motives of those with responsibility and the power of placement over incompetent persons.

While the presence of a physician's recommendation may confirm the regularity of an informal patient's need for admission under Section 7, it does not resolve the issue of that patient's mental competence to give and decline independent consent to treatment. However, Section 32 provides that:

> "(1) Forthwith upon the admission of a patient to a psychiatric facility, a physician shall examine the patient to determine whether or not he is competent to manage his estate; and
>
> "(2) The attending physician may examine a patient. . .at any time to determine whether or not the patient. . .is competent to manage his estate".

Judgement regarding the patient's capacity to manage his property should not be extended to his capacity to manage his person.

It is recommended:

Rec. 35. THAT upon admission of an adult patient to a psychiatric facility, whether as an informal or an involuntary patient, a physician shall examine the patient to determine whether he is mentally competent to give and refuse consent to treatment.

Since mental competence is presumed by law, a finding of competence will not require periodic review; no examination for incompetency should be conducted after such finding without due cause.

Consent is a continuing condition of medical treatment, whether consent comes from the patient or a surrogate. Where surrogate consent is not to an isolated procedure, comparable to surgery, but to detention and to a course of treatment, a facility has an interest, in protection both of its patient and of its own authority, to ensure that continuous consent exists.

If, in anticipation of expiry of consent, a facility had to renew its authorization, regular contact with the surrogate would be maintained, and the latter would be alerted to his continuing responsibility for the incompetent patient's welfare. Disappearance, death, or other unavailability of the surrogate would also be detected, in which case other authority for detention and treatment of the patient might be sought. Accordingly, we recommend that surrogate consent should be of limited duration, for instance not exceeding an initial 60 days and four months thereafter.

If surrogate consent were to expire unrenewed, a compliant incompetent patient could be retained and treated upon notice served upon the Official Guardian, but the patient hostile to residence in the facility and/or to treatment would have to be released.

It is therefore recommended:

Rec. 36. THAT a facility treating an incompetent adult upon surrogate consent be required periodically to review that consent. Surrogate consent should be of finite duration, such as an initial 60 days and four months thereafter. Treatment of an incompetent thereafter, without appropriate renewal, should be only upon service of notice upon the Official Guardian.

Facilities also have a duty to periodically review the competency of a patient, say every six months. Periodic certificates of continuing incompetency should be served both on the surrogate and also on the patient. The patient should have a right to appeal to the regional review board against an initial or subsequent finding of incompetence, and be so informed. Psychiatric facilities should be made aware of their legal liability for detention of a voluntary patient, and for treatment, upon mere surrogate consent, of a nonconsenting or resistant incompetent person whose surrogate consent has expired.

We therefore recommend:

Rec. 37. THAT the status of patient incompetence (for purposes of treatment) be periodically reviewed, such as after the initial 60 days and every four months thereafter, notice of initial and continuing incompetence being served on the surrogate and the patient, the latter being able to appeal to the regional board. (cf. Rec. 49, 50)

Note: (This may have financial implications in terms of legal aid support.)

Voluntary Minor Patients

(1) *Age*

The provincial age of majority is eighteen years, but public hospital Regulation 729, Section 49, sets sixteen as the age of medical consent, including consent to surgery. This is consistent with the Child Welfare Act's cut-off age of parental responsibility.

Further, in 1975, the Uniform Law Conference of Canada recommended a uniform Medical Consent of Minors Act in which sixteen is a general age of competence*; the principle that a mature minor may acquire competence at a lower age upon an individual basis, is also recognized in Ontario case law.

We would suggest that the provincial age of medical consent be set by legislation at sixteen years, with provision for consent at a lower age if an individual minor displays competence, and this competence is evidenced by two written medical opinions.

Rec. 38. THAT the provincial age of majority for psychiatric (and other) consents be sixteen years. Minors below sixteen, if considered competent by two physicians, should be able to give autonomous consent.

(2) *Admission And Treatment*

Under the Child Welfare Act, a child (a person aged under sixteen) is "in need of protection":

> "where the person in whose charge he is neglects or refuses to provide or obtain proper medical, surgical or other recognized remedial care or treatment necessary for his health or well-being, or refuses to permit such care or treatment to be supplied to the child when it is recommended by a legally qualified medical practitioner".

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*The proposed uniform act provides in Section 3(1) that:

"The consent to medical treatment of a minor who has not attained the age of sixteen years (the age of consent to medical treatment contained in Section 2) is as effective as it would be if he had attained the age of majority where, in the opinion of a legally qualified medical practitioner or dentist attending the minor, supported by the written opinion of one other legally qualified medical practitioner or dentist, as the case may be,

(a) the minor is capable of understanding the nature and consequences of the medical treatment, and

(b) the medical treatment and the procedure to be used is in the best interests of the minor and his continuing health and well-being".

A duty to provide necessary treatment and to consent to this treatment on behalf of persons who have charge of children is therefore implied.

This parental legal duty of medical care (that binds not only parents but also those who act *in loco parentis*, such as foster parents or directors of children's institutions) may appear to be discharged by approving the admission of a child who "is believed to be in need of observation, care and treatment provided in a psychiatric facility". This does not, however, take into consideration the possible refusal of the mentally competent, mature minor to accept admission or treatment. Parental consent is neither a necessary condition of admission and treatment (since a mature minor may seek admission and treatment independently of parental consent) nor a sufficient condition. The mature mentally competent minor has a right of objection.

Since such a minor is an informal or voluntary — albeit perhaps unwilling — patient, however, the procedural protections available for patients legally classified as involuntary under The Mental Health Act are unavailable to him. Accordingly, we would suggest that a minor be given the right to challenge before the regional review board, both his admission to the facility on the basis of being in need of care and treatment, or a specific treatment offered him to which he objects.

The age of recognizing such a right is problematic; juveniles charged with delinquency may, in principle, have legal counsel from the age of seven, but recent proposals would raise this age to twelve. Since loss of home life and personal liberty are equally at stake, legal counsel should be available for the appeal recommended above, and the right of appeal of the minor should exist from age twelve. (Where the minor is found incompetent, however, it is recommended that a right to challenge that finding before the regional review board be constituted at the age of fourteen).

It is recommended:

Rec. 39. THAT a competent minor aged 12 or over should be able to challenge before the regional review board the assessment that he satisfies Section 7 criteria. He should also be able to challenge that he needs the specific treatment proposed, and may require that available alternatives be disclosed if they exist; and

Rec. 40. THAT a minor aged 14 found incompetent have the right to challenge the incompetency finding before the regional review board, and be subject to periodic reassessment as under Rec. 39 above.

Note: (Again, legal aid support may result in increased cost).

Involuntary Patients

In contrast to voluntary patients (whose consent to treatment may be implied), involuntary patients are detained — willingly or not — in facilities because they may harm themselves or others (Section 8 and 13(1)(c) of The Mental Health Act).

Accordingly, the basis of detention of an involuntary patient is danger, not treatability, and one may consider two possible approaches to treatment of a patient so detained. One is to impose a duty upon a detaining facility to deliver the necessary treatment services; this imposes a reciprocal duty upon the patient to accept or permit such treatment. The second approach is to separate treatment from detention and handle psychiatric treatment like any other medical treatment; in this approach psychiatric treatment of an involuntarily detained patient is subject to his consent, although there is still a duty to treat.

In principle, Ontario legislation follows the second approach; we agree that this approach is preferable because it respects the autonomy of the patient compulsorily detained, and his right of choice regarding treatments. Under the Mental Health Act if the individual is competent to give or refuse consent to treatment, a nearest relative may act on his behalf, and if no nearest relative exists or can be found, the regional review board may act in his best interests.

It is recommended; consistent with the above recommendations on voluntary patients:

Rec. 41. THAT, since involuntary detention does not in itself justify non-consensual treatment, the right of the involuntary patient to choose between treatments be protected to the greatest extent possible consistent with the patient's welfare.

The involuntary patient is not free to leave the institution, or to seek treatment elsewhere; if not offered treatment, such patient is effectively denied treatment. Accordingly, to offer the involuntary patient diagnostic assessment in order to provide appropriate treatment may appear to be a duty of the physician, but the patient is under no duty to give consent to treatment or assessment. However, The Mental Health Act expressly states that a regional review board may afford a practitioner the right to treat a non-consenting and even an actively objecting patient.

The Mental Health Act requires consent in these terms:

> "Psychiatric treatment shall not be given to an involuntary patient without the consent of the patient, or where the patient. . .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". (Section 31a(2)).

"Psychiatric treatment" is not defined, however, except by exclusion of "psychosurgery"*. The Act also provides that "the regional review board shall not authorize and no order of the board is or shall be deemed to be authority to perform "psychosurgery" (Section 31a(5)).

The Act deals in consent-obtaining procedures, but does not identify what information a patient, or another on his behalf, should be given in order to consent. In this The Act is consistent with other medical legislation (notably The Health Disciplines Act), which does not detail the type of information that must be given for a patient's consent to be legally effective. This appears appropriate, in that a physician proposing treatment must assess on an individual basis the capacity of the person whose consent is sought to understand information, and must pitch the information at a suitable level. It may be bad medical practice (and legal malpractice) to over-inform this person and distort his exercise of choice regarding treatment. In all cases, the physician bears responsibility for seeking consent that is informed appropriately to the circumstances of the individual case, and bears responsibility for acting without that consent.

Legislation cannot replace clinical judgement with a statutory formula. Accordingly, it is not proposed that the legislation should specify the detail a patient should be given, about drug or other treatments, in order to render consent informed.

Under the Act consent may be obtained from the patient, or where the patient is not competent, from the nearest relative. If the incompetent patient has no nearest relative, the attending physician, after examination of the patient, may apply to the regional review board for its authorization to provide specified treatment. The application is determined after a hearing at which the attending physician, the Official Guardian, and such other persons as the regional review board may specify, are parties. (Section 31 a(2)).

It may also be desirable, however, to recognize an appeal procedure for others if they are refused party status by the board. Many patients have abandoned or been abandoned by their families (those persons constituting "nearest relatives"), but have companions or friends who deeply care for their welfare. The interests of such non-related persons — or of some organizations — should be recognized. The provisions of The Statutory Powers

*Section 31a(3) enacts that:

"The consent of an involuntary patient or the nearest relative of an involuntary patient to treatment while an involuntary patient does not and shall not be deemed to include psychosurgery".

Procedure Act may be too cumbersome, however, and appeal to the county or district court level may be more suitable.

Rec. 42. THAT those refused party status by a board be empowered to apply to a Provincial Court (Family Division) for such status, and that administration of treatment be withheld for a reasonable time pending the outcome of appeal (but not of any further appeal if the court declines to grant party status), subject to emergency treatment provisions. It is further recommended that applicants for party status appealing to the Court against refusal be eligible under the Legal Aid Act.

The Section 31a(4) considers in parallel the quite different situation that arises when an involuntary patient who is competent or the nearest relative of an incompetent patient, expressly refuses consent to a proposed specific treatment. This veto of a specific treatment may be overcome by an order to the regional review board, after a hearing convened on application of the attending physician, notice of which was served on the patient (or nearest relative, as the case may be).

The Act refers to a patient who (or whose nearest relative refuses consent to a specific psychiatric treatment or a specific course of psychiatric treatment because that specific treatment is objectionable, or because of a reluctance to accept any treatment. It should be made clear that, while the involuntary patient and the person responsible for an incompetent patient both have the duty to accept effective treatment, neither is required to accept a treatment arbitrarily. Only when there is a specific treatment that is effective, and there is no other effective treatment, may the board compel acceptance of the treament. It should also be noted that the burden is on the physician to demonstrate the unique efficacy of the proposed treatment.

The procedural provisions for the review should be comparable to those under Sections 30a to 30f. In addition, as is the case with reviews of involuntary admissions or commitments, the patient (or nearest relative) should be enabled to obtain legal aid.

Where an incompetent patient has no nearest relative, the attending physician may apply to the regional review board for its consent to give specified treatment at a hearing of which the Official Guardian has notice, and at which the Official Guardian and others approved by that board may be parties. Others the board refuses to recognize as parties, whether individuals or organizations, have no appeal rights.

Section 31a(4) considers together consent to treatment regarding an incompetent patient with no nearest relative (see above), and a competent patient (or incompetent patient having a nearest relative), when consent to a

specified treatment is expressly refused. The regional review board may give an effective consent to treatment in both cases. The cases are quite different in nature and principle, however, and the legislation should recognize these different principles.

Rec. 43. THAT a competent patient and the nearest relative of an incompetent patient have a right to refuse consent to a specific treatment, which the regional review board cannot overcome by its consent power. The only exceptions should be:

a) when the attending physician applies to the board and satisfies the board that the patient or nearest relative of an incompetent patient has been offered a reasonable range of alternative available treaments and has refused them all; and

b) when the attending physician shows with compelling evidence that only one treatment has any likelihood of being effective in the case of a patient, and that the patient or nearest relative has refused consent to it.

Rec. 44. THAT, when application is made to the review board for its consent to specified treatment refused by or on behalf of a patient, comparable notification be served, and legal aid be equally available, as when certification of involuntary admission and of renewal are challenged before the regional review board, after notification to the area director under The Legal Aid Act.

Special Consents

(1) *Treatment in Emergency*

In emergency, provisions for treatment comparable to those applicable to general public hospitals should apply. These should provide that, notwithstanding Section 31a(2) of The Mental Health Act, but subject to Section 31a(3) (on psychosurgery), consent should not be necessary where the attending physician believes that an emergency exists, and that delay in obtaining consent would endanger the life or a limb or vital organ or the mental health of the patient. The attending physician should be required to write and sign a statement to this effect as soon as possible, explaining the assessment of emergency and the anticipated effects of a delay in treatment.

(2) *Nonpsychiatric Treatment in Emergency*

Where a psychiatric patient is transferred to (or within) a general hospital for emergency treatment, he falls under the consent provision of

Hospital Management Reg. 729 (Public Hospitals Act, Sub-section 49 and 49a). It may be desirable to extend the provision of emergency surgery without consent that exists at present and allows a spouse, parent, guardian or next-of-kin to give written consent to diagnostic testing and medical treatment where mental disability prevents the patient from doing so, and requires surrogate consent to diagnosis or medical treatment in emergency. This is really a matter for the Hospital Management Regulations, of course, rather than for The Mental Health Act. Revision of these Regulations is currently in hand in the Ministry of Health, however, and recommendation of this amendment appears appropriate:

Rec. 45. THAT, for emergency cases, a provision comparable to Section 49 of Hospital Management Regulation 729 (under The Public Hospitals Act) be enacted. This would permit treatment without consent where the attending physician believes delay in obtaining consent would endanger the life, limb or vital organ, or the mental health, of the patient, and so states in writing.

Rec. 46. THAT for the benefit of patients in need of non-psychiatric emergency treatment falling short of surgery (and indeed for everyone else), Section 49a be amended to permit diagnostic and non-surgical treatment without consent in emergency. Alternatively, Sections 49 and 49a might be combined to permit emergency, diagnostic, medical or surgical treatment.

Regarding non-psychiatric medical emergency treatment of a psychiatric patient transferred out of a psychiatric hospital or unit to a general ward of a public hospital, Section 49 of Regulation 729 (under The Public Hospitals Act) permits emergency surgery without consent. Section 49a permits emergency diagnosis and (non-surgical) medical treatment where the patient cannot consent, upon written consent of a spouse, parent, guardian or next-of-kin. The Section does not allow diagnosis or non-surgical treatment in emergency without consent of this nature.

(3) *Electroconvulsive Therapy* (ECT)

That this treatment is contentious was apparent in the public hearings; this may justify its receiving special consideration. The psychiatric profession disagrees as to the efficacy and long-term effects of this treatment. The balance of scientific evidence attests to its effectiveness, but the Professional Standards and Practice Council of the Canadian

Psychiatric Association in its *Position Paper on Electroconvulsive Therapy* (April, 1978) recommends that, where consent is refused, a second psychiatric opinion should be obtained before its administration is proposed. Accordingly, it may be acceptable to permit ECT as appropriate treatment, provided that the right of the patient or nearest relative to refuse consent is reinforced, as proposed above.

(4) *Psychosurgery*

Psychosurgery does not pose a major problem in psychiatric practice, since it is seldom employed, and then only under heavy safeguards. The observations in this section aim to embody these safeguards. The recommendation follows the *Position Paper on Psychosurgery* (April, 1978) presented by the Professional Standards and Practice Council of the Canadian Psychiatric Association.

Psychosurgery is now defined as (Section 31a(1)):

> "any procedure that, by direct or indirect access to the brain, removes, destroys or interrupts the continuity of histologically normal brain tissues, 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."

The amended Mental Health Act has no express provisions on the procedure, except to exclude consent to it from formal consent procedures. But no means is available for special consent; only an informal (voluntary) patient, whom the legislation does not cover, may submit to psychosurgery.

A case exists for precluding performance of the procedure upon surrogate consent on behalf of an involuntary patient, but for making it available to the fully informed, competent involuntary patient. An analogy may be made with therapeutic abortion; the patient should appear as an applicant, acting with the support of his attending physician, before a hospital Psychosurgery Committee. The procedure should be performed only in those psychiatric facilities that are Group A hospitals (Reg. 726 under The Public Hospitals Act), and then only with approval of the hospital's Psychosurgery Committee. This Committee should be composed of not less than two members of the medical staff (including at least one psychiatrist and one neurosurgeon) and a lawyer; up to perhaps two other persons, such as chaplain or layperson, may also be appointed. The applicant's attending physician, and any

other person making a submission regarding the application, should preferably not be a member of the Psychosurgery Committee considering that application.

The Psychosurgery Committee should meet to consider the involuntary patient's application, including his capacity to give free and informed consent, and the nature of the information he has received. A decision to approve the psychosurgery (which may be conditional, for instance, on further information being given to the patient) must be unanimous.

Notice of application should be served on the nearest relative (or, if none, the Official Guardian),and who may make representations when the patient's application is considered.

Psychosurgery performed without approval of a Psychosurgery Committee should be deemed to lack the patient's consent, and should constitute "professional misconduct" under Section 26(31) of Reg. 577/75 under The Health Disciplines Act.

Rec. 47. THAT psychosurgery be made lawful upon the involuntary patient's own free request, and upon approval of an appropriately composed Psychosurgery Committee in a Group A hospital. Notice of the patient's request should be served on the nearest relative or, where none, upon the Official Guardian, a person receiving notice being entitled to take part in the hearing, and to appoint a physician to receive copies of submissions.

VII — The Management of Assets and Guardianship

In this chapter, we discuss the concept of incompetence to manage financial affairs, the principles to be applied for the protection of incompetent persons and their assets, the existing laws and difficulties arising from them, and present recommendations designed to resolve some of the problems and improve consistency.

1. The Incompetent Person

A person declared incompetent to manage his estate does not have the degree of mental capacity or rationality required by various branches of the law, particularly the law of contract, to deal with his property, e.g., to exercise his rights to receive income or assets such as a house or a car. Incompetence to manage can arise from many causes, such as disease, physical injury, retardation, mental illness, or senility. For example, an accident victim who has lapsed into a coma is a mentally incompetent person. However, it must be stressed that a person who is mentally ill is not necessarily incompetent to manage his affairs.

It is clear in our law, however, that a person who has been determined by a court or a physician to be incompetent to manage his financial affairs cannot deal with his property in a way that is legally valid, although some acts of an incompetent person with respect to his property may be held to be valid if the transaction was fair and the other party did not have reason to suspect that the person was not competent.

A person who is incompetent to manage his financial affairs may not be incompetent in law for other purposes. In each case, a court would inquire whether the person has the specific degree of understanding necessary to do the particular act that is in question, for example, to make a will or give consent to treatment.

Responsibility for the financial affairs of a mentally incompetent person can lie with one of several agencies, as described in the following

sections. It is important to recognize, however, that management of and power over the assets of the incompetent person does not include custody or power over the person. Trusteeship of assets and guardianship of the person are quite separate offices.

Our analysis of the present law and of public comment and criticism have led us to consider the following principles important to recommendations concerning the management and control of the property of incompetent persons:

a. *Freedom of Choice*

In contrast to the ability (even of an incompetent person under certain circumstances) to make a will to dispose of one's assets after death, under present law, generally it is not possible to provide in advance for the management of assets in the event of future incompetence. A power of attorney made prior to a period of incompetence does not remain valid (see Section 4.d below for a more detailed discussion of this problem). Thus, the present law denies an individual the power of determining how and by whom his assets are to be managed should he become incompetent.

b. *Accessibility*

Where a person is not capable of managing his own affairs, he should have access to services that see to the management of his property in a responsible way and for his benefit. This should not depend on his geographic location, his financial means, the goodwill of his friends and relatives or the institution from whom he receives care and treatment.

c. *Response to Immediate Financial Problems*

Immediate financial problems resulting from a declaration of incompetence should be dealt with promptly in the first stage of management of an estate and should be made a primary responsibility of the Public Trustee or his representative. The more traditional concerns of the Public Trustee (the inventory and management of assets on a longer-term basis) should come into play as the period of incompetence lengthens.

d. *Management Philosophy*

Property should be managed for the benefit of an incompetent person and his dependents only, in a way that is appropriate to the individual's circumstances.

The Public Trustee's management powers should be extended from committeeship to a form of trusteeship; this would enable him to con-

vert assets in order to increase revenue, and even to operate the business of an incompetent person. His duties should include the choice of a scheme of management that is suited to the incompetent person's circumstances, including the likely duration of his incapacity.

e. *Role of the Courts*

The County Court should be the forum for review of all declarations of incompetence that are not subject to review by a review board.

The County Court should also continue to hear applications for the appointment of a private individual to manage the estate of an incompetent person. The skills and experience of the person seeking the appointment should be a relevant consideration. Where the Court makes such an appointment, it should grant the necessary management powers and require the person appointed to return to give an account of his management.

2. Determination of Incompetence under The Mental Health Act

The Mental Health Act, section 32 — which applies to patients and out-patients in psychiatric hospitals and psychiatric facilities located in general hospitals, designated in Schedule I of that Act — provides that a patient, whether voluntary or involuntary, who is admitted to a psychiatric facility, shall be examined "forthwith" by a physician to determine whether he is competent to manage his estate. The physician's determination of competence or incompetence to manage is entered, with reasons, into the patient's record. If the person is determined incompetent to manage, the physician completes a certificate of incompetence in the form prescribed by the Act and it is forwarded to the Public Trustee who becomes "committee" of the person's estate upon receiving it. (Where a patient or out-patient has *not* been declared incompetent to manage, he or she may voluntarily appoint the Public Trustee as committee (see Section 4.a, below, p. 76). There are similar provisions in The Developmental Services Act that apply to retarded persons who are residents of a facility under that Act.

Section 32 of The Mental Health Act, however, applies only to patients in psychiatric hospitals and psychiatric facilities located in general hospitals, designated in Schedule I of the Act. Any other persons who have become unable to manage their financial affairs cannot be declared incompetent under The Mental Health Act, nor appoint the Public Trustee or have him appointed for them. Instead, an application to a County Court must be made by someone who wishes to manage the incompetent person's financial affairs for him. The processing of the

application takes about three months, costs an estimated $600 to $800, and, in addition, will only be made if there is someone interested enough to take on the management of the estate. Furthermore, in many cases, the estate is too small to bear the expense.

The Mental Health Act offers an expedient, low cost means for assuring the efficient management of an incompetent person's estate which should be available to all such persons, whether or not they are patients of a psychiatric facility.

Rec. 48. THAT access to the services of the Public Trustee be available to all incompetent persons, and

THAT all psychiatrists be permitted to assess their patients, whether or not they are patients of a psychiatric facility, for competence to manage their affairs and, where indicated, to issue a certificate of incompetence appointing the Public Trustee.

3. Appeal and Discharge from a Declaration of Incompetence

Where a certificate of incompetence has been issued under The Mental Health Act and there is no application for review, the Public Trustee manages the estate until the certificate is cancelled by the attending physician, the appointment is revoked by the patient or out-patient who voluntarily made it, the patient is discharged without a notice of continuance, or the notice of continuance expires.

Where a certificate of incompetence has been issued under The Mental Health Act, the person declared incompetent can apply to the chairman of the review board and a review of the declaration will be held. The person is limited to one review every six months.

A patient declared incompetent who is being discharged must be examined for competence. If he remains incompetent, a notice of continuance is sent to the Public Trustee, and such notice extends the Public Trustee's management for six months.

Where a person's incompetence will extend beyond this period, the Public Trustee applies to the Supreme Court for an indefinite extension of his management. In this case, the management continues until the Court orders it relinquished, on evidence that the person has regained his competence. The Act does not give the Court power to order the person to be examined for competence by a physician. An application for discharge of this order can be brought one year or more after the order, or sooner, if the Court gives leave. A discharge of the order is granted if the Court is satisfied that the person has recovered competence.

Both The Mental Health Act and The Mental Incompetency Act place the major responsibility for initiating the review proceedings on the person who is declared incompetent. The physician who completed the certificate of incompetence is not required to reassess the person's capacity to manage his affairs. Even more disturbingly, a declaration of incompetence under The Mental Incompetency Act remains permanent until the incompetent person dies or applies to have it removed. For many reasons, including timidity, ignorance, and lack of funds, an individual may hesitate to begin a formal review procedure. An informal review, in the form of periodic reassessment of competence by a psychiatrist or a physician would safeguard the interests of such individuals and, in some cases, save the cost of a formal review.

Consequently, our recommendations concerning review of the declaration of incompetency are:

Rec. 49 *THAT a person who has been declared incompetent to manage his affairs should have the right to request a periodic review of his status as incompetent, by the Review Board, if he is within its jurisdiction, and otherwise by the County Court.*

Rec. 50. *THAT, where a person has been declared incompetent, a reassessment of his competence to manage his affairs be conducted annually by a physician in a psychiatric facility, or by a psychiatrist, and the results of the reassessment be communicated to the Public Trustee or filed with the County Court. If reassessment determines that the person is competent, a discharge from the incompetency certificate should be granted. (cf. Rec. 37)*

4. The Management of Assets

The efficient management of assets of an incompetent person can be achieved in several ways. The agency most commonly entrusted with this task is the Public Trustee. His functions are described below.

a. *The Public Trustee*

The Public Trustee is the statutory "committee" for patients or out-patients in a psychiatric facility and residents in a Developmental Services facility for whom a certificate of incompetence has been issued; he may also be appointed by the patient, out-patient, or resident.

The Public Trustee's powers are derived primarily from The Mental Health Act, The Public Trustee Act, and The Developmental Services Act. All powers of attorney are declared to be void against the Public Trustee. The Public Trustee cannot delegate any responsibility to

manage an estate, but may appoint agents to perform specific tasks under the Public Trustee's direction.

The Public Trustee can be compared to a trust company in private industry except that his operations are more specialized than those of a trust company. The office in Toronto — his only office — has a staff of 155, with a large estates department whose employees function like trust officers in a trust company, and a legal department of twelve lawyers, four of whom specialize in patients' estates. There is no organization in Ontario that is more experienced in handling estates of incompetent persons because of the Office's responsibility under The Mental Health Act and The Developmental Services Act. (The Public Trustee also has specialized responsibilities under other statutes.)

The Public Trustee may be called upon by a former patient, outpatient, or resident to render an account of his administration in the same way that a trustee or guardian may be, but is accountable to no other person.

As discussed in Section 2 above, the services of the Public Trustee should be available to all incompetent persons, whether or not they are patients of a psychiatric facility, for the efficient management of their assets.

The implementation of our Recommendation 48, that all incompetent persons have access to the Public Trustee's Services may well increase the number of estates under his management. To assess the magnitude of caseload, we obtained information from the Public Trustee which indicates that, just prior to proclamation of the 1978 amendments to The Mental Health Act, there were about 11,660 active patients' estates with average assets of $10,603. There are an additional 5,600 inactive estates with no assets, primarily estates of residents of facilities under The Developmental Services Act. An additional 640 estates are managed by the Public Trustee under The Mental Incompetency Act. They have an average value of $17,000. The Public Trustee notes that more than half of the persons for whom he acts are in receipt of Old Age Security benefits and, therefore, over age 65.

From the Psychiatric Hospitals Branch, we learned that the psychiatric hospitals in the Province had between about 1,800 and 2,100 patients who had been declared incompetent in the years 1976 and 1977.

However, the Public Trustee's office does not receive public moneys to pay the cost of estate management. Under The Mental Health Act, the Public Trustee is authorized to charge fees not in excess of those that a private trustee could charge for the same services. Generally the fees are permitted to vary with the size and complexity of the estate,

the time spent, and the degree of skill required to manage the assets. The estates are charged a small percentage of capital that is received or paid out of the estate, of income received and expenses paid, and of the net asset value held in the estate. These fees are enough to finance the Public Trustee's management and to allow that no charges be made against estates in cases of poverty or hardship.

In submissions to the Committee on Mental Health Services and the open hearings, the most frequent comment regarding the management of patients' assets concerned the fact that the single location of the Public Trustee's office, in Toronto, results in serious practical problems. Incompetent psychiatric patients in more remote areas may not be declared incompetent simply because the Public Trustee is too far away to provide efficient services. Thus these patients are deprived of these services, and the experience and objectivity of the Public Trustee. To make the Public Trustee's services more widely available, we recommend:

Rec. 51. THAT the Public Trustee establish several regional offices in Ontario to make his services accessible to incompetent persons in locations outside Toronto. Where no regional office is conveniently located, the Public Trustee should appoint a local trust company, a lawyer, or other professional to act.

b. *The Official Guardian*

The Official Guardian exercises powers under 28 statutes. (The office is created by section 107 of The Judicature Act.) The Official Guardian does not manage the property of incompetent persons or have custody of them. He can, however, represent them in legal actions, as "next friend" if they sue, or as "guardian *ad litem*" if they defend. As such, the Official Guardian can represent incompetent persons in actions related to their personal rights, e.g., regarding the custody of children, as well as to their property rights, and it is only in these roles that he may be concerned with matters relating to the management of assets. However, the Official Guardian does not usually represent people for whom the Public Trustee or a private committee has power to act. Furthermore, the Official Guardian must be appointed by the court in each case and rarely opposes applications by relatives of the incompetent person to act instead of the Official Guardian.

The Official Guardian's principal role is to represent people in legal actions. Amounts of money won by the Official Guardian for mentally incompetent persons are held by the Supreme Court and can be dealt with only by a judge's order. These amounts would be released to

the Public Trustee if he requested it, or to a private committee if the funds were necessary for the maintenance of the incompetent person.

(Guardianship and custody are discussed in section 6, below).

c. *A Committee under The Mental Incompetency Act*

Any person, including a creditor, can apply to be appointed as "a Committee" of the estate and/or person of an incompetent person under The Mental Incompetency Act. (In practice, applicants are usually close relatives of elderly persons). There is no requirement for the applicant to demonstrate that he has the qualifications or experience necessary to manage the assets. Other family members or friends of the incompetent have no standing under the Act to present their views on who should be appointed and how the estate should be managed. The Act gives them only a right to appeal from the County Court's order, at additional cost to all parties.

The powers of the committee are those set out in the scheme of management ordered by the Court. This order will include a plan for the care of the mental incompetent (if committee of the person) and for dealing with his assets. The committee is usually ordered to do certain things, e.g., to make mortgage payments, to sell property; not much is left to his discretion.

The committee must post a bond, file an inventory of the estate, and present his accounts to the Court at the time ordered. He must return to court to request additional powers, if they become necessary. The supervisory powers of the court over the committee protect the incompetent person, but at the same time add to the inconvenience and expense of proceeding under The Mental Incompetency Act. The committeeship lasts until the death of the incompetent or until a discharge order is made by the Court upon application by the former incompetent.

We would recommend:

Rec. 52. THAT the application to County Court for appointment under The Mental Incompetency Act be retained but enquiry by the Court into the applicant's fitness to act as committee and representation of the views of close family or friends should be permitted by the Act.

d. *Powers of Attorney and Trusts*

When a person has become incompetent, no one can be authorized to manage his financial affairs except through The Mental Health Act

and The Mental Incompetency Act. However, it is certain that estate management is sometimes carried out by unauthorized persons, in various ways, and not necessarily to the detriment of the incompetent person.

The extent to which powers of attorney are used for this purpose would be difficult to ascertain, but it seems clear that limitations on their validity are not well understood.

In law, an incompetent person does not have the capacity to appoint an attorney to act for him. Furthermore, the validity of a previously made power of attorney is very doubtful once the person has become incompetent.

If the attorney appointed transacts business under an invalid power of attorney, the transactions can be attacked as invalid and the person acting may be held personally liable. This does not contribute to the orderly management of the incompetent person's estate.

When a person can foresee his future incompetence to manage his financial affairs, it is possible but expensive and cumbersome to plan for the situation. This could be done by means of a trust created by the person for his own benefit, to which all his property would be transferred. A relative, friend, trust company, or a combination of them could be appointed as trustee. Once constituted, the trust is subject to the same rules as ordinary *inter vivos* trusts, which can be the source of inconvenience to the person while he remains competent.

Because different degrees of mental capacity are required for different legal acts, a person who has become incompetent to manage his financial affairs may have the capacity to place his assets in trust for himself. Similarly, if a person's mental capacity is restored to him from time to time, trust documents may be executed by him in these periods. The validity of these documents is always open to attack in court on the basis that the person was in fact not competent to execute them.

Consequently, it is difficult and expensive for a person to make plans for the management of his estate to take effect after he becomes incompetent. Any available means are cumbersome and little used.

To allow for proper financial planning, a competent person should be able to provide for the management of his assets in the event of his future incompetence. As part of his will or in a document similar to a will, an "incompetency trust" could designate a friend, relative, or advisor to manage his estate, give instructions about the sale or retention of assets, e.g., a home, make provision for income benefits to dependents, and allow specified relatives or friends to make use of certain property. Unlike a will, the "incompetency trust" would not

necessarily give away the person's property because, at his death, the terms of his will would come into effect.

An "incompetency trust", like a will, should be a document which a lawyer would usually draw. As for a will in a simple estate, lawyer's fees are likely to be modest.

To rectify this situation, and in view of the importance of the principle involved, we recommend:

Rec. 53. THAT the law be amended to provide a practical and inexpensive means so that a competent person who wishes to provide for the management of his assets during his possible incompetence be able to make an "incompetency trust" and name trustees to manage his property for his benefit, if he becomes incompetent.

It appears that incompetent persons, especially if they are elderly, will transfer the ownership of their property to relatives who are managing their affairs without being legally appointed to do so. This transfer may or may not be accompanied by the intention that the property be given as a gift to the relative. However, it may be difficult to prove at a later date what the purpose of the transfer was. When the incompetent person dies, beneficiaries under his will may never enjoy the gifts he intended to give them.

Other informal estate management arrangements are no doubt to be found, many of which operate to the benefit of the incompetent person. The debate continues over the comparative merits of having private matters of family property dealt with by the Public Trustee, who is experienced and objective, or by a family member or friend, who is compassionate and non-bureaucratic. This cannot be resolved here. However, informal arrangements involving private individuals do not protect the incompetent person from dishonest or inept management. While this may occur in only a few cases, the incompetent person is unlikely to complain on his own behalf. The supervision of a court or other official body protects him. However, in many cases, it is in the best interests of the incompetent person that friends or family participate in management of his assets.

Rec. 54. THAT the Public Trustee, wherever possible, consult and use the assistance of willing and capable relatives and friends in the management of the estate of an incompetent person.

5. Management Procedures

Whether under The Mental Health Act or The Mental Incompetency Act, the committee (including the Public Trustee) commences his man-

agement by taking an inventory of the estate, ascertaining the assets and liabilities. The financial needs of the incompetent person are determined. The nature of the assets is considered. If there are wasting assets in the estate (for example, an inventory of perishable goods like fruit and vegetables), these will be sold while they still have a value. Other assets that will depreciate over time, such as a car, will be sold if there is no reasonable likelihood that the owner will recover and use them. Other investments that mature will be reinvested in property of the same nature.

The role of the committee is not the same as that of a trustee. A committee protects the assets of an incompetent person, keeps them in recognizable form unless they are deteriorating, and returns them to the owner if he recovers his competence to manage his affairs. A trustee has a duty to make investment decisions. Under The Trustee Act, a trustee is restricted to low-risk, income-earning investment, but a trust deed can widen the trustee's investment powers, even to the extent that the trustee operates a business held in the trust.

A committee and a trustee have in common the duty to manage the estate for the exclusive benefit of the beneficiaries. In the case of an incompetent's estate, the beneficiaries are the incompetent person and his dependant(s). Heirs, legatees, and creditors do not fall within the class of beneficiaries.

The Public Trustee must act within the limits imposed on a committee, however. In practice, this would make it impossible for the Public Trustee to reinvest matured savings bonds in anything but saving bonds, even when guaranteed investment certificates offered comparative security and higher interest. It also, as another example, prohibits the sale of the house of an elderly incompetent who will never live there again, even where the proceeds could be invested to provide supplementary income. A form of trustee powers could be devised that would enable the Public Trustee to provide better service in the management of incompetents' estates.

Under The Mental Incompetency Act, the committee appointed must also manage the estate exactly in accordance with the scheme of management approved by the judge. The discretion granted to the committee is not usually extensive and he must return to County Court if unforeseen circumstances arise.

Under The Mental Health Act, and within the limits just given, the Public Trustee has all the rights and powers with respect to the assets of an estate that their owner would have if he were of full age and sound mind. There are some assets, especially a private business operated by the incompetent person, where the exercise of those rights and powers is best

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done by an expert. It would be particularly useful if the incompetent person could designate an appropriate person in advance in an "incompetency trust" (see Section 2.a., above).

The extent and duration of the incompetence of the person whose property is managed is an important factor in planning the management of the assets. Where the person is likely to recover in a short time, the correct strategy is probably to avoid any major transactions in the estate. If the incompetence is permanent, substantial readjustments may be necessary. It is therefore essential that the Public Trustee have access to information about the incompetent's condition, as it affects property matters.

Criticisms have been made about the time that elapses before the Public Trustee begins to manage an estate. Although there is requirement for the Public Trustee to act immediately in an emergency, opinions have been expressed that the initial financial problems encountered by a person declared incompetent and by his family are not handled by the Public Trustee. In practice, it takes about three weeks before the Public Trustee has obtained information about estate assets and liabilities. Similarly, the length of time between a request by an incompetent person regarding some financial matter and action by the Public Trustee has been criticized.

In these areas, we make the following recommendations:

Rec. 55 THAT the principle be retained that the estate of an incompetent person must be managed exclusively for the benefit of that person and his dependants.

Rec. 56. THAT the principle be retained that anyone who manages the assets of another person can be called upon to give an account of his management.

Rec. 57. THAT the Public Trustee be granted management and investment powers that are like those of a trustee, to eliminate the restrictions that committeeship may place on his ability to manage the estates of incompetent persons for their benefit.

Rec. 58. THAT the Public Trustee have access to information from the attending physician about the extent and duration of a person's incompetence to assist in the management of his estate.

Rec. 59. THAT the Public Trustee take all necessary steps, in the early stages of the management of an estate, to assist in dealing with immediate financial problems.

6. Guardianship and Custody

The historical separation between guardianship and estate management is well-founded. On the one hand, a guardian who does not manage assets is not hindered by this in his guardianship, provided he receives an allowance for his ward's expenses. On the other hand, a knowledge of the person's financial needs, his state of health, and similar information are necessary to the trustee's management of the estate, but custody is not.

Guardians are appointed for children under 18; for example, where a will names a guardian for an orphaned child, the Surrogate Court confirms the appointment. The guardian assumes the powers and responsibilities of a parent towards the child. In the same situation, a trust is usually created under the will to hold the assets. The guardian will receive an allowance from the trustee for the expenses of the orphan. Trusteesnip and guardianship are separate offices.

In the present law, there is no procedure for the appointment of a guardian for an adult who suffers from mental illness or mental limitation. An incompetent adult is his own guardian and in his own custody.

The Public Trustee therefore has no powers over the person of an incompetent. The Public Trustee can bind the incompetent's estate, for example, to an agreement to sell a house, but cannot affect the incompetent's personal rights and obligations.

Both the Public Trustee and the Official Guardian will act for incompetents in property matters, but the Official Guardian can also act in personal matters, actions, the custody of children, for example. However, the Official Guardian does not have guardianship of any adult.

The Mental Incompetency Act deals primarily with the property rights of incompetent persons. However, there is reference to custody of the person in Section 4, set out below, which is never again taken up in the statute.

4-(1) Subject to *The Mental Hospitals Act*, the court has all the powers, jurisdiction and authority of Her Majesty over and in relation to the persons and estates of mentally incompetent persons, including the care and the commitment of the custody of mentally incompetent persons and of their persons and estates.

4-(2) The court may make orders for the custody of mentally incompetent persons and the management of their estates, and every such order takes effect, as to the custody of the person, immediately and, as to the custody of the estate, upon the completion of the committee's security. (R.S.O. 1960, c.237,s.2.)

This section has almost never been used in practice. Its presence in a statute dealing with property matters is clearly anomalous, because it makes custody of the person a mere accessory to the management of the estate.

There have apparently been a few cases where custody of the person has been granted to the parents of adults who need help in coping with the demands of everyday life and who are not competent to manage their financial affairs. The intention is to give the parents a status similar to that of legal guardians. There is no legislation in the province, except for the vague reference in section 4, that can be used to give one adult any kind of legal status regarding the personal rights of another adult who is incompetent.

We have not studied in detail the need for guardianship law for adults, but it seems clear that the issue of guardianship should not continue to be regarded under The Mental Incompetency Act as one of the incidents of estate management. The criteria applied to decide whether a person's financial affairs should be managed by a committee are not necessarily the same that will determine whether he will benefit from a guardian. We therefore recommend:

Rec. 60. THAT the Mental Incompetency Act should not permit that custody of the person be granted as an accessory of management powers over the estate of an incompetent person.

7. Representation in Legal Actions

A private committee under The Mental Incompetency Act can represent the incompetent person if:

1. His powers as committee are appropriately extended in the order under The Mental Incompetency Act appointing him, and
2. The judge presiding in the action appoints him.

Where a patient or out-patient who is involved in a legal action has no committee under The Mental Incompetency Act, The Mental Health Act requires that the documents be served on the Public Trustee as well as on the patient or out-patient (or sometimes the officer in charge). Similar rules are contained in The Developmental Services Act. This does not imply, however, that the Public Trustee can represent the patient or out-patient. Representation requires the following:

1. The legal action concerns property rights,
2. The person has been declared incompetent to manage his affairs, so that the Public Trustee is his committee, and

3. The Public Trustee is appointed by the judge presiding in the legal action to represent the incompetent person.

Otherwise, the Official Guardian is empowered by statute to represent persons of unsound mind who have not been declared incompetent under The Mental Health Act or The Mental Incompetency Act, regardless of whether or not they are patients or out-patients of a psychiatric facility. He, too, must be appointed by the presiding judge. However, the Official Guardian does not usually apply to be appointed where there are family members who are willing to act on behalf of the incompetent person.

A retarded person who is a resident of a developmental services facility and who has the Public Trustee as his committee can be represented by the Public Trustee in property matters, or a committee under The Mental Incompetency Act can be empowered to represent him in all matters. But if the retarded person has no committee and is an adult, the Official Guardian is not empowered to act for him because the retarded person does not suffer from "a disease of the mind". If the retarded person has no family member who can be appointed to act for him, the present laws leave him to look after his own interests.

The rules concerning representation of mentally incompetent persons in legal actions and other matters involving their legal rights are scattered through many statutes which do not provide a coherent set of rules for the representation of the incompetent in legal matters. It is therefore recommended:

Rec. 61. THAT where an incompetent person is a party to a legal action involving personal rights, and has the Public Trustee as his committee, the Public Trustee be empowered to represent him.

Rec. 62. THAT the rules prescribing representation of incompetent persons be revised and consolidated into a system that provides a coherent set of rules allowing an incompetent person to be represented by the same official or authorized person in legal matters affecting the incompetent person.

VIII — The Psychiatric Hospital and the Community

The enunciation of civil rights in The Mental Health Act establishes a clear standard for hospital administrators that may be enforced in the courts. In addition, at the present time the office of the provincial Ombudsman has a special staff to handle complaints from patients in psychiatric hospitals. In other hospitals, such as hospitals under The Public Hospitals Act, the Ombudsman has no jurisdiction; perhaps consideration should be given to extending his jurisdiction, or setting up a similar service to receive the complaints of patients in such hospitals. In some hospitals, we are advised, a patients ombudsman has been established on an experimental basis.

However, in the milieu of the psychiatric hospital legal reforms may not be as important as the accountability that results when an institution is subject to review and examination on a regular basis by an outside agency. We have observed a definite trend towards bringing the large psychiatric hospitals into a much closer relationship with the community, a process which will ensure the maintenance of standards and should improve the lot of the long-term patient.

Thus, under The Public Institutions Act, 1974, The Public Institutions Inspection Panel (formerly the Grand Jury) makes unannounced inspections of provincial psychiatric hospitals at approximately six-month intervals. This group is drawn from local citizens. While the inspection panels may not be qualified to make professional judgements on the operation of the clinical components of the hospitals, they can provide an effective vehicle for expressing public opinion about the more evident components, such as physical plant and patient care environment.

However, the panel only meets the higher administrative group in the hospital. The Director of Nursing, for example, who administers the greatest amount of care by the largest groups of health workers may or may not have an interview with any of the panel members.

In addition, all provincial psychiatric hospitals voluntarily undergo inspection by the Canadian Council on Hospital Accreditation. The

CCHA's fourteen member Board is nominated by its five participating organizations (Canadian Hospital Association, Royal College of Physicians and Surgeons of Canada, L'Association des medecins de langue francaise du Canada, and the Canadian Nurses Association). In addition, there is an observer from the relevant provincial health ministry.

Accreditation is a voluntary process: the hospital must invite the CCHA to survey its facilities. The main objectives of the CCHA include the following:

a) To conduct a survey and accreditation program for Canadian hospitals in all their aspects which will encourage Canadian physicians, all health professionals, hospitals, and related organizations and agencies voluntarily to maintain and develop, *according to the needs of the community,* essential services for health promotion, prevention of ill health, diagnosis and therapy through the coordinated efforts of all health workers with the governing bodies in their hospital or related organization agency.

b) To develop standards for hospital and related health care *consistent with the needs of the community* and in keeping with the development in the health and social fields and to assist all persons, hospitals and related agencies to attain these standards through educational, consultative and other appropriate means; and

c) To assume other related responsibilities and to conduct such other activities as *are compatible with community needs,* the continuing evolution of the health and social field and the operation of the hospital accreditation program in all its aspects.

Although accreditation standards are country-wide, allowances are made for adherence to specific provincial and local statutes and regulations.

In order to address the special requirements for mental health services, the CCHA published, in 1975, a "Guide to Accreditation of Canadian Mental Health Services". This Guide applies to mental health services, whether located as divisions of a general hospital or in a "free-standing" psychiatric hospital, and whether specializing in the care of adults or children or some specific aspect of mental health care such as mental retardation. The Guide is to be used in conjunction with the more general "Guide To Hospital Accreditation". By taking this approach to the survey and accreditation of mental health services, the CCHA hoped to address those elements which are specific to mental health services, while at the same time refraining from overemphasizing the specialization of treatment settings.

Mental health facilities are surveyed according to the Mental Health Services Guide, for those services that are specifically psychiatric in content.

When other services are available (for example, acute medical attention), they must meet the standards of the general Guide. The same is true for psychiatric services in general hospitals; these have to meet the standards of the Mental Health Services Guide, while other services of the hospital are surveyed according to the general Guide. The standards for mental health services differ from those for other health services in two principal areas: staffing and physical environment. Regarding staffing, the standards for psychiatric nursing are similar to those for general care, when the difference in direct nursing hours is taken into account. The Mental Health Services Guide recognizes, however, that "in some specialized services, all, or nearly all of the direct personal care provided to patients or clients may be administered by non-nursing disciplines, such as child care workers, mental health workers, psychiatric aides, attendants, social-rehabilitation therapists, etc."* Rather than dictating the types of staff involvement, the Guide states that where such groups are involved in the direct care of the patient, the principles to be applied to the organization of such personnel must be those that apply to the nursing service per se. Furthermore, there must be appropriate nursing and medical staff representation on the committees of these groups, to the extent that in some cases, where the other groups are not permitted to undertake certain functions (as stated by provincial statutes), these staff groups must report to a nurse or other qualified health professional with appropriate post-graduate education, experience and demonstrated competence.

On the subject of environmental services and physical facilities, the general Guide specifies standards for hospital construction; safety, sanitation and patient comfort; environmental service departments (housekeeping, laundry maintenance and central service); infection control; and disaster plans. The Mental Health Services Guide reiterates these general standards, but also adds specific requirements regarding patient care, such as:

> "The environment of the mental health Services shall contribute to the establishing and enhancing a positive and desirable self-image for the client, and preserving human dignity.
>
> "The physical facilities shall promote the client's perceptual clarity in awareness of the surroundings."

The fact that all of Ontario's provincial psychiatric hospitals have achieved CCHA accreditation status is evidence that these facilities are conscious of their image both in the health field and to the public in general.

*Source: "Guide to Accreditation of Canadian Mental Health Services, 1975" Canadian Council on Hospital Accreditation, page 12.

There is one area, however, that suggests that the provincial psychiatric hospitals are not as accountable to the public as are other institutions. One of the major portions of the accreditation survey deals with the composition of the institutions' management board. The Mental Health Services Guide states that the "governing body has the legal and moral responsibility for the conduct of the Service in all its aspects for maintenance and improvement in standards of patient care. It is responsible to the patient or client, the *community* and the sponsoring organization(s)" (emphasis added). The standards concerning the governing body cover such items as by-laws; meetings and minutes, appointments of chief executive officers and department heads; establishment and maintenance of policies and procedures; reviews and audits; etc.

The provincial psychiatric hospitals in effect circumvent the need for community management boards because the Psychiatric Hospitals Branch of the Ministry of Health acts as the governing body; the director of this branch *de facto* chairs each facility's "board". The major difficulties inherent in this situation are lack of community involvement and the possibility of conflict of interest.

In the case of a public hospital it is up to the chief executive officer and thus to the board to decide on actions to be taken in light of the accreditation survey. The hospital is free, within legal and financial limits, to alter the functioning of the hospital to achieve, maintain, upgrade to and/or correct for accreditation standards.

This is not necessarily the case with the provincial psychiatric hospitals. These facilities are already managed under the fiscal and operational guidelines of the Ministry of Health. Since there is no outside group that can put pressure on the Ministry of Health to alter either the financial or management guidelines of the Ministry itself, there is no objective body, and particularly no community voice, that can affect the direction of the institution.

In order to allow for a degree of objectivity and to encourage provincial psychiatric hospitals to become fully responsive to local needs and services, we would recommend:

Rec. 63. THAT provincial psychiatric hospitals be supervised by boards of management drawn from the community. As this will require statutory change, we would recommend, as an intermediate step, the establishment of advisory committees for all psychiatric hospitals in Ontario. It would be appropriate to have representation from the office of the Director of Legal Aid, local citizen's groups such as the Mental Health Association and Friends and Relatives Associations, as well as liaison representatives from the District Health Council on such advisory committees or governing boards.

Part II

The Criminal Justice System and Mental Health Services

Summary of Recommendations

This Part, because it does not direct itself to one specific issue or one specific piece of legislation, and because it is based on supporting documents and submissions which themselves contain a great number of detailed recommendations, is a summary of issues from which only the major recommendations have been drawn. In essence, there is one pressing issue: *who should be responsible for developments in this area?* Before this issue is resolved, it is impossible to provide a set of detailed recommendations without further confusing the issues. We must even express the warning that a further study of details may increase the dissatisfaction experienced in the field since the major unmet needs have been expressed by various groups for a number of years. In many areas of the province the ability to cope with demands has, in fact, decreased rather than increased.

It is in this light that we recommend:

1. THAT the Ministry of Health in consultation with the Ministries of the Attorney General, Solicitor General, Correctional Services, Community and Social Services and the Secretariat for Justice clarify the responsibility for mental health services in relation to the administration of justice.
2. THAT, because of the complexity of legislation, jurisdiction and administrative procedures, the responsibility be vested in a body, such as a Forensic Psychiatric Services Commission.
3. THAT such a body develop a master plan concerning the needs of the various regions in Ontario in relation to the criminal justice agencies such as the police, the crown and defence, the courts, correctional services and community agencies.

4. THAT such a plan include in addition to provisions for consultation, outpatient and inpatient examination and treatment, the development of educational and research programmes.
5. THAT special consideration be given to the development of secure facilities in the psychiatric hospitals on a regional basis and that special institutions such as Penetanguishene and St. Thomas be reserved for special cases.
6. THAT a policy be developed concerning the transportation of accused persons or offenders to and from mental health facilities.
7. THAT special consideration be given to areas of the province, such as the north, where geography and population demand a different service delivery pattern.
8. THAT consultation concerning the development of federal legislation in criminal law and procedure be coordinated by the body responsible for service delivery and that this body be also charged with assisting in the development of complementary provincial legislation.
9. THAT forensic psychiatric services provide an interphase between criminal justice agencies and general mental health services with a special emphasis on prevention through their cooperation with criminal justice agencies, especially the police.
10. THAT there is already a considerable body of knowledge and positions in the background materials of this report and that further study is not recommended until the responsibility for developments in this area has been consolidated and vested in a designated government agency.

General

Part I of the report of the Legal Task Force concerned itself with issues in the civil law area such as commitment, consent to treatment, patient's rights, patient's estates, and review procedures. There are a number of compelling reasons why the needs of those that come to the mental health services through the auspices of the criminal law should be examined separately.

Criminal law and procedure are federal powers; the administration of justice is a provincial matter. This administration is, however, split into many jurisdictions, government departments and other agencies. Police, courts and correctional services relate to different provincial ministries and certain aspects such as sentences of 2 years and over are under federal jurisdiction. Mental health is a provincial matter and yet there has been a long history of problems in the care of mentally disturbed offenders because of jurisdictional uncertainty.

Although in various details the division of and the relationship between federal and provincial powers are complex, it can safely be said that within the framework of the criminal law, the province has greater powers and greater flexibility in establishing psychiatric services for the criminal process than it is able to use at the present time.

As we will attempt to show, there is a large grey area between civil and criminal processes in this field which does not only affect the offender but also the public understanding of matters such as civil commitment. The criteria for commitment which involve the subject of dangerousness, bodily harm (or in circumscribed form of safety to self and others) brings civil commitment close to what is seen as preventive detention. It can be argued that the widespread public concern in this area and the insistence on legal safeguards is related to the understanding of this issue as a quasi criminal matter. Issues in criminal law, on the other hand, which are open-ended, such as the present provisions in the case of unfitness to stand trial or a finding of not guilty by reason of insanity, bring people into the mental health system and their future fate is largely determined by decisions made in this system. In a number of cases from examination to treatment both civil as well as criminal authorization is used.

A further aspect of this report is concern about services. In dealing with the criminal justice system and its relation to mental health services, it was felt that both aspects should be dealt with together. There is a historical uncertainty whether special mental health services should be created for and attached to the criminal justice system, or whether general mental health services should be used. We will examine this problem and attempt to outline various models of service delivery systems.

The Law Reform Commission of Canada presented a report to the Parliament of Canada on Mental Disorder in the Criminal Process in 1976, and federal departments are now in the process of working towards the implementation of this report. Our Task Force has solicited submissions from both provincial as well as federal agencies in the criminal justice system to ascertain present positions. In addition to the literature in this area, concerns brought to the attention of CMHSO were taken into consideration and special studies pertaining to the Ontario scene have been used. Nevertheless, the report restricts itself to the major concerns in summarized form. At this stage it can do no more than provide a basis for policy decisions which must precede more detailed work on specific issues.

One major issue which has not been dealt with in this report concerns children. The Task Force on Family Court Clinics of the Ministry of Community and Social Services has submitted its report in June of 1978 and in the submission we have received from the Provincial Judge's Association (Family Division) it is recommended that the responsibility for children's

services remain with the Ministry of Community and Social Services. Nevertheless, the submission echoes our major finding that with the exception of some urban areas, mental health services for the courts are in some areas "totally inadequate and in some others totally nonexistent". Although it makes good sense that children's services remain consolidated and therefore, functionally separated from adult services, on the actual service delivery level the relationship will still have to be worked out, especially in areas where services must be shared.

I — The Legal Process

The Law Reform Commission of Canada in its report on Metal Disorder in the Criminal Process, has set out the interaction between the mental health and the criminal justice system. Legal aspects of the recommendations of that report (Appendix I) pertain predominantly to the criminal law and thus are directed to the federal government; but there are, of course, service implications which mainly affect the provinces.

Bill C-21* already contains a number of sections concerning the relationship between the criminal law and the use of mental health services. Other provisions are now in preparation. Although there has been an active consultation process between federal and provincial authorities (see: Summary of Views presented to the Department of Justice Consultation Team concerning Mental Disorder in the Criminal Justice System) *the development of legislative provisions remains abstract unless it is matched with service delivery.* Specific legislative provisions have to be seen in the context of the legal *process* in which actions and decisions do not only have a specific, but also a systematic impact. There may be, for example, remand provisions on the pre-trial, trial and pre-sentence level but in practice it would hardly be appropriate to shuttle an accused person back and forth on each issue. At the same time, information gained on examination for bail, e.g., may be highly prejudicial if it is reported at this stage and influences further proceedings.

The proposed Provincial Offences Procedure Act (Bill 74) also makes provisions for the examination of accused persons on an inpatient as well as outpatient basis and The Mental Health Act gives powers to bodies such as the police, the justice of the peace and the courts which may be used in addition to or instead of criminal law powers.

To give some grounding to the analysis and to provide some coherence we propose to examine the various stages of the legal process from police action to post-sentence considerations.

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*Bill C-21, an Act to Amend the Criminal Code, the Canada Evidence Act and the Parole Act, first reading November 21, 1978, Fourth Session, Thirtieth Parliament, 27 Elizabeth II, 1978.

A. *Pre-Trial Issues*

a) *The Police*

It is often stated that the police is a social service agency available 24 hours a day. Since it is common in our society to call the police for all sorts of problems, it is not surprising that they are also involved in situations of dangerous behaviour or where the behaviour of a person becomes unmanageable. The police has a primary peacekeeping and preventive function (Police Act) but can only intervene in situations within the framework of legal powers. Since behaviour associated with mental disorder can also often be seen in terms of a criminal offence, such as creating a disturbance, threats or attempted assaults, criminal law powers may be used even though it is clear from the situation that there is no criminal capacity (mens rea). The road to jail is often chosen instead of the road to hospital if the situation calls for restraint and removal of a mentally disordered person. Police action is not only determined by the law, but also by the availability of resources. If there is no psychiatric facility available and yet a person has to be restrained, where else can the police take him? One example of police discretion are family disputes which not only constitute a large portion of the most serious offences, such as murder, manslaughter and aggravated assaults, but are also a potential source of danger to police themselves. Various police forces have developed styles of intervention to minimize danger by bringing other resources, including mental health resources, to bear on troublesome situations. No change in the criminal law as such is necessary but the LRCC stresses that: "stated policies be developed by police departments in conjunction with the provincial Attorney General's Department to aid in the police screening of the mentally ill." (M.D. in the C.P./p.10) The relevant recommendations are R.4 to R.7, set out in Appendix (I).

The Metropolitan Toronto Police submitted to us their response to the Law Reform Commission of Canada; the Ontario Provincial Police as well as the Ontario Association of Chiefs of Police developed a special brief. They point out that more psychiatric facilities are required and that secure units should be available. They stress the uncertainty that exists between the demands on the police and the ability of mental health facilities to respond to these demands. The Metropolitan Toronto Police also submitted a series of cases in which persons who had come to psychiatric attention had committed subsequent serious offences and the other two briefs give the example of a mentally retarded person who endangered himself by wandering on the highway.

The Ontario Provincial Police, because of their geographic distribution, registered special concern for the transportation of the mentally ill. They recommend that the provincial ambulance service should be responsible for

this task. Transportation is related to the deployment of services and, therefore, will be discussed later in this context.

Because of the mistrust that exists between mental health workers and police forces, the Ontario Provincial Police brief also points out the need for training and cooperative efforts. "Relationships have grown to a 'them' and 'us' type of feeling" (p.8). Specific representation was made in regards to Bill 19,* to remove the word 'serious' from the revised Section 10 of the Mental Health Act (Bill 19, Section 4); to add 'without an order' to 'may take a person in custody' (Section 10 (f)); and that the custodial function should be transferred to a designated hospital member once the patient is safely within the psychiatric facility (Re: Section 25a) These observations were also supported by the Ontario Association of Chiefs of Police.

Most of the points made in the police submissions are also supported by others such as the submission from the Ontario Psychological Association. This association, for example, is also concerned about the provision of secure facilities and the training of forensic staff as well as peace officers.

b) *Pre-Trial Detention and Bail*

If a charge is laid and the accused is held in pre-trial detention a number of issues concerning mental disorder may arise. The first one is the issue of bail. Mental health professionals have become increasingly involved in the determination of this issue and the LRCC states that: "We feel that considering an accused's mental state in the granting of bail is proper and, in some cases, vital." (p.11).

This is based on the consideration that the refusal of bail may result from a mental state of an accused which is not necessarily related to his offence. A person might suffer from intermittent states of confusion which makes his appearance for trial questionable, or he may be in a state of agitation that may be seen as constituting a danger, although his offence is not of this nature. In these cases the Commission recommends the use of provincial legislation. However, as the Ministry of Correctional Services points out in their submission, the use of provincial legislation in the criminal process has led to a great deal of confusion. Although these confusions can be clarified by legislative changes, the public and symbolic confusion which was pointed out in the introduction will remain. It is preferable to make as clear a distinction between criminal and civil powers as possible. This will be discussed further in the next section.

Bill C-21 (Clause 101) now proposes that a court may at any stage in the proceedings either in compelling circumstances or with the consent of the

*Briefs were received prior to royal assent to The Amended Mental Health Act (Nov. 1, 1978). Thus "Bill 19" will be used throughout the text.

accused or his counsel, direct or remand an accused to be examined by a medical practitioner. The limits to such an order is 8 clear days and not withstanding the bail provision under Section 457, (1). This provision would give sufficient flexibility for pre-trial examination to determine issues of bail and diversion as well as issues for trial such as fitness and reduce the need for the 30 and 60 day remand provision (also redrafted as Section 542.1 in Bill C-21).

c) *Prosecutorial Diversion*

It has been widely recognized by now (Schiffer, 1978) that the pre-trial stage is qualitatively as well as quantitatively an extremely important one in the criminal process. Under the Criminal Code the Justice of the Peace already has wide powers before accepting a charge and issuing process. His office is, however, at the present time, rather a routine one. The LRCC has recommended a system of pre-trial discovery to give order and visibility to what is now often seen as "pleas bargaining". Because the mental element plays a role in any offence unless it is one of strict liability, the prosecutor has a discretion, even a duty, to divert cases which are inappropriate for further criminal proceedings.

In order to make these decisions, crown counsel needs assistance from mental health services, and so does defence counsel. The LRCC states: "A prerequisite of the success of such discussions would be the early availability to both sides of a psychiatric report on the accused." (p. 12). Pre-trial considerations for our purposes would involve three possible solutions:

i) The accused is seen as a mental health problem and no further criminal proceedings are indicated.

ii) Although mental health problems are present the criminal process will continue.

iii) The criminal process does or does not continue but without further mental disorder issues.

Ad —i)

It is part of the basic principle of this report to arrive at a clear distinction between criminal and civil authority in the case of mental disorder. If, therefore, the Crown finds that the accused is predominantly a mental problem and that criminal prosecution would not serve a public purpose, then charges should be withdrawn and responsibility and authority shifted to provisions under The Mental Health Act.

Ad —ii)

If the continuation of the criminal process is necessary then the authority over the accused should flow from the criminal law even though further determination of issues concerning mental disorder in

a phychiatric setting are necessary. The present situation of using both criminal and civil law means in the same case should be avoided. Ad —iii)

The case moves outside mental health considerations.

Since Bill C-21 (Clause 101) provides that a person may be *directed* at any stage of the proceedings to be examined rather than the more limited formulation of *remanded* we take it that this includes outpatient examination. The proposed Act to establish a Code of Procedure for Provincial Offences (Bill 74) specifically states the "court or judge may order the defendent to attend at such place or before such person and at or within such time as are specified in the order and submit to an examination for the purpose of determining whether the defendent is, because of mental disorder, unable to conduct his defence" which again gives the judge the discretion as to the nature of the examination (Section 43 (4)).

The concept of diversion, although it raises a host of legal problems for normal offenders, can be seen as less problematic for those whose mental capacity is impaired and for whom other services exist. The Ontario Association for the Mentally Retarded, for instance, in their submission strongly support the concept even though they emphasize that the mentally retarded should be held responsible for their actions in relation to their capacity. It is not so much a question of giving special protection to this group — or others — but of treating them equitably — which is not the case if their condition is not recognized and considered. They often fail to exercise their rights, and they tend to be disadvantaged in penal institutions as well as in regards to release provisions such as temporary absences and parole. The question of capacity cannot be left just to Section 16 of the Code; it must be considered as part of the whole process.

The Ontario Crown Attorney's Association in their submission point out that in the absence of local facilities referrals for persons considered dangerous or escape risk have to be made to the facility at Penetanguishene. They especially regret the closing of the forensic unit of the Hamilton Psychiatric Hospital. For less serious cases in need of "simple assessment" a rotation list of general practitioners and psychiatrists is recommended. Some of the concerns in the legal area (see Appendix VI for summary) should be met by the proposals in Bill C-21 and the proposed Provincial Offences Procedure Act (Bill 74).

Diversion to the mental health system does present problems to the Crown. First, because they are trained and skilled in legal functions they depend on mental health experts for opinions, and secondly, although an accused is mentally disordered, he may not be acceptable to a mental health facility. The Association, therefore, finds the use of the term "mental disorder" by the Law Reform Commission of Canada problematic. No

doubt, in the absence of consultation and examination facilities it is very difficult to arrive at decisions which meet legal standards and contribute to a resolution of community problems.

B. *Trial Issues*

The classical issues at this stage are the issues of fitness and responsibility but mental health professionals become involved in other issues as well for which not only expert testimony and reports but also facilities have to be provided.

1. *The Issues of Fitness*

The LRCC has studied this issue intensively (Study Paper; Working Paper) and issued its recommendations (Appendix I; R.8 to R.25). Even at present, however, legal provisions are wider and more flexible than is evident from practice. Thus, although a trial of the issue can be postponed until "any time up to the opening of the case for the defence" (C.C.C. Section 543(4)), this is rarely — if ever — done.

Since fitness is clearly a matter of criminal law, our main focus here is on the use of mental health services. First, there is a need for remand facilities and, second, for holding facilities if an accused is found to be unfit. Since remands to a psychiatric facility involve many other issues besides fitness they will be treated more fully later. A special problem arrises when an accused is found fit on remand but where there are concerns that a return to jail may again impair his fitness to stand trial. The Criminal Code permits remands only for 30 or 60 days, but trial dates may well be much later. At present, civil commitment is sometimes used to bridge the gap. The purpose of remand is examination and it is therefore only proper that time for this purpose be restricted. There is no reason, however, why an accused should not be able to spend time at a psychiatric facility before and during his trial as a condition of bail.

The more serious problem arises when the accused has been found unfit. Section 543(6) of the Criminal Code specifies that he has to be "kept in custody until the pleasure of the Lieutenant Governor of the Province is known". The LRCC has already expressed that "We consider the LGW inappropriate for *any* disposition" (p. 17) and recommends (R.21) that the disposition of an unfit accused should be made by the trial judge. The authority to hold a person found unfit would then clearly be part of the criminal law and review would be a judicial responsibility. Nevertheless, if the person is to be held in a psychiatric facility or is subject to other psychiatric services this responsibility would remain a provincial one.

In the consultations of the Federal Department of Justice there was wide spread support for the recommendation of the Law Reform Commission of Canada. "Across the country we were told about the undesirable aspects of Section 543, namely, the indeterminacy, the possibility of a return to trial after many years with the consequence of stale or absent evidence, the deleterious effects on mental health that such a return to trial entails and the misuse of fitness as a defence tactic" (p.9). The use of provincial mental health legislation was seen as problematic since "respondents felt that it depended too much on the arbitrary good will and inventiveness of local individuals" (p. 9, 10).

Since fitness is an issue which usually arises early in the proceedings (and is raised as a question often in pre-trial examinations) a fair process depends very much on the relationship between the court and mental health services. If the court is to maintain jurisdiction over those found unfit as recommended by the Law Reform Commission of Canada, then the nature of the control and possible treatment of those temporarily unfit as well as the fate of those permanently unfit will have to be determined by the court on the basis of the nature of the offence and the psychiatric evidence concerning the condition of the offender. This resolution would be preferable to the present position in which there is a rather unstructured interaction between criminal law powers, executive powers and powers flowing from the Mental Health Act.

2. *The Issue of Responsibility*

This is a complex issue and the LRCC could not reach a level of agreement whether the insanity defence should be retained or not, or what other legal mechanisms such as 'diminished responsibility' should replace it. The Commission did state, however, that a finding of "not guilty by reason of insanity" should be made a real acquittal "subject only to a post-acquittal hearing to determine whether the individual should be civilly detained on the basis of his psychiatric dangerousness" (p. 22, also R.12, Appendix I).

Issues concerning responsibility do not only arise in regards to the insanity defence but also in relation to other trial determinations, such as capacity to form required intent, necessary for a given offence; whether the alleged act is consistent with the psychological make-up of a person (as in certain sex offenders); the influence of alcohol and other drugs; the question of automatism, traumatic behaviour and confusional states, and a number of other issues in which the courts depend on the expertise of mental health professionals.

These support services for the court — and they should be seen as such, rather than be left to the Crown and the defence in the battle of experts — are not equally available in the province.

Mental health professionals, unless they have some special training and experience, are not equally comfortable in the court and not of equal assistance to the court since they might vary in their understanding of the legal weight of their contribution.

In our consultations with judges we found that the Supreme Court usually does receive the psychiatric services it demands. The majority of criminal trials, however, are in the provincial courts. The service concerns there are substantial and the lack of adequate facilities in many areas has led to tragic occurrences such as in North Bay and in Hamilton which had led to a further reduction of the availability of mental health services to the courts. This is documented in greater detail in Section 2 of this report.

The consequences of a finding of 'not quilty by reason of insanity' at the present time are the issuance of a Lieutenant Governor's Warrant (L.G.W.) and placement of such persons in custody, usually a mental health facility. They are subject to review by an 'advisory' review board under the Criminal Code. The Law Reform Commission of Canada recommends a mandatory post-acquittal hearing to determine whether the individual should be committed to an institution under provincial legislation (Appendix I, R.12). In this case such persons would be subject to review by the review boards under provincial legislation. There is, at the present time, still a great deal of uncertainty about a proper process for such persons and studies by the Federal Department of Justice are in process. It would be premature to come to any conclusion at this time, except that the province should be closely involved in this development.

C. *Issues of Disposition*

Once the trial is completed and a conviction registered, the question of sentencing arises. The traditional factors determining sentence are consideration of punishment, deterrence and rehabilitation. The LRCC in its report on Dispositions and Sentences in the Criminal Process has recommended the extension of sentencing options available to a judge (Appendix II, table on pages 35 ff.). A number of these recommendations have already been given legislative expression in Bill C-21 and others are under active consideration by the Federal Department of Justice.

There have been serious problems in weighing the various purposes of sentencing especially when issues of the treatment of the offender were involved. As Hogarth documented ("Sentencing as a Human Process", University of Toronto Press, 1971) treatment considerations have often led to longer sentences than punishment considerations. The problem is exacerbated since the judge in the case of a prison sentence has no control over the subsequent fate of the offender and the sentence for the purpose of punish-

ment may well have the same consequences as one ostensibly given on the basis of treatment considerations.

The LRCC has therefore observed that a proper sentencing policy "relegates rehabilitation and treatment to an important but secondary role" (p.23). What it means is that coercion and constraint should rest on considerations of criminal law and not be determined by treatment needs. Within those limits, however, and with the consent of the accused, treatment should be provided to the best possible extent.

Mental disorder raises very different questions at the disposition stage than those raised at trial. These questions may affect a whole range of sentencing options from conditional discharge to imprisonment. Where the sentence is community based, the court retains some control since breach of an order constitutes another offence and is brought back to court. Where the sentence is one of imprisonment, however, the court cannot stipulate any conditions, at best it can only make recommendations to the executive. The LRCC has therefore recommended that the judge be given an option of "hospital orders" after passing a prison sentence so that in fact he will be instrumental in deciding where the sentence is served. The Federal Department of Justice is at present studying the conditions necessary for such sentencing options.

In community based dispositions and sentences the court has greater flexibility in specifying the demands it makes on the offender, either as part of a probation order or in the form of a 'performance contract' as recommended by the Law Reform Commission of Canada. There is also greater flexibility in using general mental health services, although, unless special provisions are made, offenders tend to be underserviced.

To arrive at a disposition which deals with the problem created by the offence, the court does need information to arrive at an appropriate sentence. There is a demand on mental health services in terms of presentence examinations and reports. To be useful, it is not sufficient that a report give an account of the offender's emotional and mental condition; such a report could be supplied by any general mental health service. A meaningful report must contain an assessment of the possible consequences of sanctions on the offender and the community. In order to arrive at such an assessment the mental health service must be familiar with the range of correctional measures which are available and such knowledge is unlikely to exist outside a forensic context. Submissions by groups such as the Elizabeth Fry Society, The Ontario Psychological Association and the Ontario Association for the Mentally Retarded document a number of problems which are exacerbated by the application of ordinary sanctions to vulnerable groups.

D. *Mental Disorder and Correctional Services*

Signs of mental disorder may appear after a person has been sentenced and is under correctional supervision either in the community or in an institution. There are a great many legal provisions not only in the Criminal Code but The Penitentiary Act, The Prisons and Reformatories Act, Correctional Services Act, Parole Act, etc. Community based sentences and prison terms of under two years are a provincial responsibility in any case; but even for those sentenced to two years and over to federal penitentiaries, the provision of mental health services is still a contentious issue. This is now mainly covered by transfer arrangements if and when facilities are available.

In principle it should be stated that if problems of mental disorder arise while a person is on a community based sentence, he should be treated like any other citizen and be subject to conditions under The Mental Health Act. Even there special considerations may arise where the disorder puts the legal status of the offender into jeopardy; as for instance in breach of probation or a parole revocation. For those cases consultation of a specialized service may well be necessary.

The brief by the Probation and Parole Service of the Ministry of Correctional Services strongly expresses the need for community mental health services in their work but also points out the many inadequacies which exist (see Appendix VI). It is argued that "mental health services should be available on the basis of need notwithstanding an individual's criminal status". It is, however, also recognized that this group has limited access to community services. The brief recommends the establishment of referral criteria and processes, liaison and consultation, so that the work of the probation and parole officers can be more meaningfully integrated with that of mental health workers.

A much larger and complex problem is, however, the prison and jail population. The very condition of incarceration may trigger mental disturbances which are difficult to cope with in a prison setting let alone to treat there. Although there is the duty of the superintendent of a correctional institution to either supply or arrange for treatment the Ministry makes it clear in its brief that "assessment", care and treatment of mentally ill inmates will be carried out by the Ministry of Health" (p. 3).

It is important in this context to differentiate between mental health services for the purpose of rehabilitation which clearly are the responsibility of the Ministry of Correctional Services, and mental health services for the care of mentally disordered persons who cannot be treated within the correctional context. This latter group raises serious problems.

On the one hand, it can be argued that treatment for this group does not

flow from the criminal law and should therefore be subject to civil jurisdiction. On the other hand, a person under a prison sentence is subject to restrictions of his personal liberty which flow from the criminal law and therefore are subject to various security measures. Although transfers to hospital are legally provided for, the question of security does make special facilities necessary.

In principle it should be maintained that mentally disordered persons in the criminal justice system should receive the same kind of treatment considerations for mental disorder as other persons in the community. But there are clearly a number of special factors: a) *the need for forensic expertise,* and b) *the need for forensic facilities because of security concerns.* An outline of those needs is attempted in the next chapter.

E. *The Use of Provincial Mental Health Legislation*

Although the Legal Task Force deals in Part I of this report with issues concerning provincial mental health legislation, we have indicated in this section the overlap between criminal law powers and powers flowing from provincial legislation.

Section 10 of the Mental Health Act (R.S.O. 1970, Ch. 269 as amended by 1978, Ch. 50) empowers a peace officer "to take a person in custody to an appropriate place for assessment by a physician" where he observes that this person "(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him" and if in addition in the officer's opinion the person is apparently suffering from mental disorder that will likely result in "(e) serious bodily harm to another person". We are, of course, here in close proximity to the criminal law. We will argue in Section 3 of this Part that although such a power is defensible there have to be appropriate guidelines which clearly distinguish the use and consequences of the two legal powers.

Under Sections 14 and 15 of The Mental Health Act, a judge may order a person charged before him or convicted of an offence to attend or admit to a psychiatric facility for examination. Again, there is an overlap with the remand provisions of the Criminal Code. The use of this section in criminal proceedings has been upheld in the past. This may not be the case, however, once the remand provisions proposed in C-21 are enacted and provisions for provincial offences are included in the Provincial Offences Procedure Act as proposed in Bill 74. Section 18 which now provides for the admission, detention and discharge of a person under the Criminal Code will have to be extended to also cover the Provincial Offences Procedures Act.

The problem of treatment while on remand will however remain. Section 14(3) of The Mental Health Act provides that if a person examined needs treatment, the judge may so order the person to attend. This is not possible

under the Criminal Code and strong opinions exists that it should not be. On the other hand, physicians who receive a patient and see a need for treatment feel impelled by their ethics to supply it. What needs to be clarified and legislatively endorsed is that treatment cannot be given with a view to the criminal process, only on the basis of personal need. For example, a person examined on the issue of fitness should not be 'made fit' to be able to stand trial. On the other hand, if he is psychotic or seriously depressed, the physician should not be barred from supplying relief. Where consent can be and is given, there is no problem. But where informed consent cannot be obtained a special provision is necessary.

This brings us to the function of the review boards. The 'Advisory Review Board' under the Criminal Code has only jurisdiction over warrant of the lieutenant governor cases. The 'Regional Review Board' applies to cases of involuntary patients. There is no review for remand cases since for the purpose of the examination they remain under the jurisdiction of the court. Section 31a(2) of The Mental Health Act provides that if consent to treatment for an involuntary patient cannot be obtained from patient or relative an application can be made to the Regional Review Board. It would be practically impossible to add such a function for remand cases to the Advisory Review Board. Consideration should be given, however, in the re-evaluation of legislation and procedures concerning the Regional Review Board to possibly include questions of treatment for remand cases where patients and relatives are unable to give consent.

II — The Dimensions of Crime and Mental Health Services

According to the Criminal Justice Statistics in Ontario (1977) there were 4,008,032 charges received in Provincial Courts (Criminal Division) in the fiscal year of 1976/77 (Table 3.1). Even though about 1.5 million were under the Highway Traffic Act, about 2 million under various provincial and federal statutes, about 100 thousand under the Liquor Control and License Acts, there were still about 300 thousand charges under the Criminal Code and a further 25 thousand under the Narcotics Control and Food and Drug Acts. We quote these figures to give some appreciation of the Court's volume of work.

Turning to persons involved we find that in 1975 there were about 250 thousand adult males and 31 thousand adult females involved in offences (Table 2.4). Even on simple epidemiological grounds without taking into consideration that mental disorder may be a contributing factor to becoming involved in the criminal process and without counting the stress involved in the process itself, it is clear that there are a significant number of people who will show signs of serious mental disorder.

Concerning jails and correctional institutions, we find that in 1976/77,

about 59 thousand persons were committed to jail for trial and almost 50 thousand after conviction (Table 4.3). About 8 thousand finally ended up in adult institutions (Table 4.4). In 1977 we find another 18 thousand placed on probation (Table 4.8). With the regionalization of parole and the extension of parole to short-term sentences in 1978, no assessment can be made at this time of parole case loads.

The Dimension of Forensic Services

Dr. B. Butler of METFORS undertook a study of Psychiatric Services for the Criminal Justice System in Ontario in 1977 and updated this report in 1978 with the assistance of M.F. Dunbar. He found that not only is there a scarcity of literature for Canada in this area but also that his efforts in obtaining data for Ontario were often dependent on individual impressions and as a result he could only achieve a very incomplete picture of services rendered. In the absence of a good data base, which of course reflects the spottiness of the services themselves, the report has to serve as a basis for a description of services. Thus the following summary account does not pretend to be comprehensive or even complete and should therefore be used with caution. It is, however, the best account we are able to give at this time.

Dr. B. Butler divided the province into seven regions (Appendix III) based in part on catchment areas of psychiatric hospitals and in part on the geographic regions serviced by university medical centres. Because of the different data-keeping efforts and the different definitions of a "forensic case" he had to take a narrow definition to achieve some uniformity. He arrived at the following criteria:

1. The individual was referred to a psychiatric hospital by judicial order, under the Criminal Code or Mental Health Act.
2. The patient was hospitalized on a Lieutenant Governor's Warrant as not guilty by reason of insanity or unfit to stand trial.
3. The individual was remanded to jail for a psychiatric assessment.
4. The individual was transferred to a psychiatric hospital from a correctional facility for treatment.
5. The individual was seen in jail because of a psychiatric problem.

The composite tables of Dr. Butler's findings are given in Appendix III. But because errors tend to be compounded in an overall account when the data are unsystematic, we are following Dr. Butler's account of the various regions.

Region #1

Mental Health Services for forensic patients were provided in this region by: St. Thomas Psychiatric Hospital, the University of Western Ontario, and London Psychiatric Hospital. The only secure facility is a 30-bed female unit which serves all of Ontario. All other facilities admit patients to open wards or carry out the examination in correctional facilities. There have been a total number of 173 forensic patients in the psychiatric hospitals in this region in 1976 (Appendix 4) whereas the following psychiatric contacts have taken place in correctional institutions.

Estimated Psychiatric Contacts in Correctional Institutions — Region 1

Chatham Jail	131 per year
Elgin-Middlesex D.C.	120
Guelph C.C.	2,600
Guelph Jail	156
Kitchener Jail	2
Sarnia Jail	3–4
Stratford Jail	6
Windsor Jail	78

Region #2

This region is served by the Hamilton Psychiatric Hospital which had a forensic unit up until 1977. There is no longer a secure facility available and the number of beds set aside for forensic assessment is 8. The secure facility is still available but not in use because of budgetary constraints. Before the unit closed, in fact, expansion was planned because of service demands. In addition to the 8 assessment beds there were 16 L.G.W. patients on the regular wards.

Most of the psychiatric contacts took place in correctional facilities and this picture is bound to increase further.

Estimated Psychiatric Contacts in Correctional Institutions — Region 2

Brantford Jail	36 per year
Burtch C.C. (Brantford)	36
Hamilton-Wentworth D.C.	360
Niagara D.C.	260

Region #3

Because of the population concentration in the Metropolitan Toronto area this region has the largest number of forensic facilities which we will therefore treat separately.

Whitby Psychiatric Hospital: This hospital did have a forensic unit which is now disbanded and patients are now admitted to the regular wards. The hospital estimates that it does need a secure facility of about 30 beds for forensic as well as other patients who are unmanageable on the regular wards.

From July 1, 1977 to August 31, 1978, 61 persons were seen for assessment remanded through the Courts and another 46 were transferred from local jails or correctional institutions. In addition the hospital cared for 10 L.G.W. patients.

Lakeshore Psychiatric Hospital: This hospital has;* a special 25 bed observation unit for suicidal and aggressive patients which also houses the forensic cases. In 1976, about 40 such cases were referred on Warrants of Remand and in addition admissions came from correctional institutions and L.G.W. patients returning from Penetang.

Queen Street Mental Health Centre: Forensic patients are placed on regular units under the care of a forensic psychiatrist who also does assessments and accepts L.G.W. patients from Penetang on loosened Warrants. In 1977, 31 persons were admitted from the Courts and 8 L.G.W. patients were cared for in the hospital.

Clarke Institute of Psychiatry:

(a) Forensic Service, C.I.P.: The Institute has a 23-bed in-patient facility and extensive out-patient services. In 1977, 146 patients were assessed as in-patients. Although most of these come from the region, the service also accepts referrals from other regions (17 in 1977, but increasing). From January to June of 1978, 213 persons had been referred on an out-patient basis. Although Region #3 has the most extensive forensic services, a great deal of psychiatric work was still carried on in the correctional institutions.

(b) Metropolitan Toronto Forensic Service: This service was established in May, 1977 and from June, 1977 to March, 1978, 372 persons were seen for assessment. The In-patient Unit opened in September of 1977 and assessed 110 patients by the end of March, 1978. Security is provided for the 23-bed In-patient facility as well as for a "Brief Assessment Unit" for persons who are brought to the service from the detention centres. The service has now published its first annual report describing the history of the work it is engaged in and the research efforts that are made.

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*Since the summer of 1978, this unit has been closed.

Estimated Psychiatric Contacts in Correctional Institutions — Region 3

Barrie Jail	30 per year
Brampton A.T.C.	6
Lindsay Jail	10
Maplehurst C.C. & A.T.C.	1,872
Metro Toronto East D.C.	624
Metro Toronto West D.C.	312
Mimico C.C.	520
Ontario Corrections Institution	780
Toronto Jail	208
Vanier Centre for Women	130
Whitby Jail	25–30

Region #4

This region is served by Kingston Psychiatric Hospital which has a forensic unit and a locked ward for difficult and aggresive patients to which forensic patients can be admitted. In 1977, 45 Court ordered patients were assessed, and 15 were transferred from correctional facilities. Total forensic assessments in this year were 85.

Psychiatric work in correctional facilities is presented as follows:

Estimated Psychiatric Contacts in Correctional Institutions — Region 2

Cobourg Jail	2–3 per year
Millbrook C.C.	54
Peterborough Jail	3–4
Quinte D.C.	78

It should also be noted that this region has 5 federal penitentiaries with over 2,000 inmates and a psychiatric facility in Kingston Penitentiary with 160 mentally ill inmates. A new medical facility has been planned for some time. The penitentiaries have also referred inmates to provincial facilities such as Penetang (male) and St. Thomas (female).

Region #5

Facilities in this region include the Brockville Psychiatric Hospital and the Royal Ottawa Hospital.

Brockville Psychiatric Hospital is in the process of setting up a closed unit of 40 beds for forensic patients as well as others who present a management problem. The service plans to concentrate on treatment in addition to assessment.

The Royal Ottawa Hospital has only a 13-bed assessment and treatment unit, although there is a need for at least a 30-bed unit for forensic purposes. Chronic cases and the L.G.W. cases are transferred to Brockville. The hospital does not have secure facilities and therefore many persons must be assessed or treated in the correctional setting.

Estimated Psychiatric Contacts in Correctional Institutions — Region 5

Brockville Jail	6–12 per year
Cornwall Jail	2
L'Original	0
Ottawa-Carleton D.C.	364
Pembroke Jail	0
Perth Jail	1
Rideau C.C. & A.T.C.	988

Region #6

As the map (Appendix III) shows, this is a large area, basically served by North Bay Psychiatric Hospital. Because of the absence of secure facilities the Courts have drastically reduced their referrals. In 1976, 75 persons were referred for examination, and in 1977, only 36.

Even though some services are provided to the correctional facilities, mainly by private psychiatrists, this as well as the next region present special problems of geography and population which will be discussed later.

Estimated Psychiatric Contacts in Correctional Institutions — Region 6

Haileybury Jail	4-5 per year
Monteith C.C.	—
North Bay Jail	20
Parry Sound Jail	1
Sault St. Marie Jail	0
Sudbury Jail	49

Region #7

Lakehead Psychiatric Hospital, serving this region, has no security facilities, nor any special forensic services, although forensic admissions constitute more than 10% of all hospital admissions. Some service is provided to the correctional facilities.

Estimated Psychiatric Contacts in Correctional Institutions — Region 7

Fort Frances Jail	1 per year
Kenora Jail	20-21
Thunder Bay Jail	3-4
Thunder Bay C.C. & A.T.C.	5

should not be more onerous than is necessary for the maintenance of social stability and security.

The police are not only charged with the detection of crime, but with keeping the peace. The Courts, including the Crown and the Defence, are not just expected to follow the letter of the law but to give expression to its spirit. The agencies which administer sentences are not just charged to administer punishment, which every deprivation of liberty entails in any case, but are expected to rehabilitate the offender and to enable him as far as possible to take his place in the community. Even though there are at this time serious questions concerning the relationship between the mental health services and the criminal justice system, questions which arose because of a tendency to use the criminal law as a social regulator beyond its narrowly defined limits, *there can be no question that mental health services should not be denied to people because they are in the criminal justice system.*

We have argued in the first section that criminal law powers and those flowing from mental health legislation should be as clearly separated as possible. We have also argued that because of the special nature of mental health problems in the criminal justice system there is a need for expertise and special facilities. Since the offender comes from the community and will return to the community, general mental health services should be available to him as to any other person. Forensic services, although they have to address themselves to special demands and conditions, should therefore not be entirely separated from other mental health services.

In addition to the need for expertise and security, there is however an added consideration. Cases from the criminal justice system are, to say the least, accepted only with reluctance by general mental health services. The relationship between mental health professionals and legal institutions is not a smooth one and fraught with many difficulties and misunderstandings. Therefore the patients from the criminal justice system tend to be less welcome in general mental health facilities than others. On the other hand, the provision of psychiatric services to criminal justice institutions is equally problematic. Every profession depends, at least to some extent, on the facilities conducive to its work. A police station, a Court, or a jail, are not facilities in which mental health professionals are comfortable. Whatever provisions are made for examination, observation and treatment, a jail is not a hospital and whatever allowances are made, the criminal process can not be equated to an assessment and treatment process.

There are many roles which a forensic service can perform depending on the needs and resources of a given area. Beyond its own capacity for examination, treatment and follow-up, it must be able to provide a consultation service to the police, the Courts, and correctional agencies. This, however,

It is estimated that about 85% of the charges in the northern region are laid against the native Canadians. Serious mental health problems have been stated in many contexts such as alcoholism, suicide and aggression. The needs in this area are too broad to discuss fully in this context. The problem of the native population in the justice system has been of special concern to the Justice Secretariat in Ontario and although various agencies, government and university departments have attempted to provide services, the needs remain as pressing as ever.

Any planning as discussed in the next chapter will have to give special consideration to Regions #6 and #7, not only because of its population composition, but also because of population distribution. Transportation, although a problem in other areas, becomes insurmountable in these areas if it is not planned on a different logistic basis.

Penetanguishene Mental Health Centre, Ontario, has a maximum security hospital facility in the Oak Ridge division of this centre. The facility admits patients on Remand from the Courts (172 in 1977) and has the largest number of L.G.W. patients in the province (130 in 1977). The in-patient population ranges between 260 and 280 but not all are referrals from the criminal justice system. There are also patients who were found to be unmanageable in other psychiatric institutions. Because of the absence of facilities of lesser security, many patients are detained at Oak Ridge who do not need maximum security and could be located closer to their community. There has already been a decline in assessments in 1977 (172 compared to 226 in 1976) most likely due to the opening of METFORS in Toronto. A systematic planning of forensic services could relieve the pressure on the maximum security facility which ideally should serve as a backup facility serving cases that indeed need this kind of security arrangement.

Summary

This outline of mental health services in the criminal justice system in Ontario, as spotty and incomplete as it is, does permit the judgement that the services are unequally distributed, and that in spite of increased demands, the ability to accommodate the forensic patients is in fact decreasing. Dr. Butler's conclusions are given in Appendix III.

Equality before the law is one of the basic principles of justice. Equality is not just a matter of legislation but of the administration of justice itself. The criminal law demands that those found guilty and subject to punishment are rational men. Social justice demands that the effects of the criminal process should be equitable and reason demands that these effects

involves a complexity of administrative relationships which, looking at the history of forensic services, has been and is, one of the most difficult problems which will guide our deliberations in the next section.

III — Conditions for the Development of a Forensic Service Delivery Model

A — Administrative Complexity

The Coroner's Jury in the case of Paul David Reid, a young man who was shot by a police officer in a hostage taking incident in Toronto, found that: "Mr. Reid was excessively transferred from one institution to another from a very early age" and remarked "In general, we believe that there has been a lack of communication between the institutions and the courts as well as among institutions." Paul David Reid had been psychiatrically assessed and his propensities towards dangerous behaviour had been recognized in reports as well as in his behaviour in and out of correctional institutions. (For further statements by Coroner's Juries see Appendix IV)

The term 'Criminal Justice System' hides the fact, which we have repeatedly pointed out, that this 'System' consists of a variety of jurisdictions, competences, administrative arrangements and political accountabilities. The main federal departments involved are Justice and Solicitor General (but also Health and Welfare in regards to drugs, for example, as well as other departments on certain specific issues). On the provincial level the Ministry of the Solicitor General has responsibilities in the police area, Attorney General for courts and prosecution, Correctional Services in the area of execution of sentence; the Provincial Secretariat for Justice has a planning and coordinating function. To repeat again, these are only the major governmental bodies involved in the area of forensic psychiatric services.

We are not addressing this issue of administrative complexity in a critical way — this is far beyond the scope of this report. We note it because, as we have indicated several times before, the primary question which arises in attempting to develop a realistic service delivery model is, *where the responsibility for such a development should rest.*

In the past there has always been the valid assumption that mental health services are the responsibility of the Ministry of Health. It would be unfair and unreasonable, however, to ascribe the full responsibility for the deplorable state of forensic services in this province to this Ministry alone. We have discussed some of the problems in the inter-action between legal and mental health services in the previous sections and it is quite apparent by now that forensic services have aspects which differ significantly from other general mental health services.

In the analysis of the legal process we have made the argument that powers flowing from criminal law and those flowing from mental health legislation should be distinguished as clearly as possible. In discussing the dimensions of crime and mental health services it became abundantly clear that the historical expectation that forensic services should be supplied by general mental health services is bound to be disappointed again and again unless special conditions are met. Historically, on the federal as well as the provincial level, with the exception of some notable special efforts one can observe constant jurisdictional tensions which in the correctional sector for example has led to the decision federally to build psychiatric prison/hospital facilities and on the provincial level to develop G.A.T.U. (Guelph Assessment and Treatment Unit) and O.C.I. (Ontario Correctional Institute). There remain, however, a great deal of uncertainty and some very legitimate concerns even about these developments. The federal decision to build prison hospitals has never found approval in the criminological community and the Brief of the Ministry of Correctional Services makes it quite clear that this Ministry still expects mental health services to be provided by the Ministry of Health.

B — The Range of Needs

We have identified the requirements of the legal process which make a demand on mental health services in the first section. Some of these requirements flow out of statutory commands, others flow out of policy considerations. Even where there is a statutory provision the use of mental health services is, in fact, determined by their availability. Thus, the police has to act within its legal and service mandate, whether mental health services are available or not. The nature, quality and consequences of police actions will, however, differ significantly in a number of cases depending on whether mental health services are available or not. This is equally true for the crown and the courts and even the defence, since, although technical legal requirements may be met, the ability to resolve very real problems influences the most structured and apparently objective legal decision making process. The administration of justice, whether we admit it or not, is not only determined by the legal framework, but equally by available options.

We are not trying to make the assertion that mental health considerations *should* influence the criminal process, only that they *do*. They cannot be eliminated as factors in decisions such as bail, fitness and sentencing.

Forensic services, although they should meet the needs arising from the operation of various components of the criminal justice system can hardly be organized along these lines. In some centres specialization may be possible, but it may, in fact, not even be desirable to think in terms of police,

court and correctional mental health services. On the other hand, mental health services offer very limited usefulness if they are isolated from the criminal justice agencies. Also, effective services cannot only be seen in terms of assessment and treatment needs, but must have two other components: education and research. These latter two should not be seen so much in terms of a formal contribution but as part of an ongoing dynamic of service development. As some of the most important factors in health have been public health measures, the major impact of forensic services may well be in modifying the perceptions of work and the definition of problems in various agencies of the criminal justice system. A policeman who is involved in a family problem with a mental health worker may well increase his competence in handling such situations in the future; a judge may learn to distinguish between the effects of various sexual acts and correctional workers may gain an added understanding of a person's behaviour in a closed situation. Equally, there is an obvious need for mental health workers to learn more about the special demands of the legal process and its limits. Misconceptions and misunderstandings between mental health and criminal justice agencies in the end always have to be absorbed by the offender/patient and the community at large.

C — Organization of Services

Forensic services, by their very definition, are an interface between legal and mental health services. Even from the simplified and summarized account given in this report, it emerges clearly that it is difficult to attach mental health services to one component of the criminal justice system and not very promising to leave them entirely within the framework of general mental health services. Most reports in the past have stressed the importance of relating such services to university departments since well trained professionals are rare in this area and without special supports there is a high 'burn-out rate'. The tension between the criminal justice agencies and mental health services is by no means unique to Ontario or to Canada. Even in a politically unitary system such as in Great Britain these tensions are consistently recorded and have, in fact, become exacerbated by recent developments (Orr, 1978 and Bluglass, 1978). Mental health services have moved to an open door policy and have largely divested themselves of the asylum function. The legal system, on the other hand, has been more and more reluctant to respond to mental health needs. These trends can be clearly observed also in Ontario.

In spite of a current belief that mental as well as criminal problems are largely definitional, they tend not to go away just by a redefinition. These problems are also immune to reports that are not implemented — often in

spite of the provision of funds as is observed at present in England (Bluglass, 1978).

A recent report on forensic psychiatric facilities in England, Denmark, Sweden and Holland by Dr. J.P. Duffy (1978) gives a first hand account of facilities, types of patients and staff patterns as well as the perceived purpose and functioning of such services. Dr. Duffy undertook this study in relation to his Canadian experience and it is, therefore, especially instructive.

From all the evidence it does seem clear now that *no development shows any promise unless it has a specific administrative locus.* British Columbia recognized this a few years ago and established a Forensic Psychiatric Services Commission.

The Commission was established by an act of the Legislature in 1974 and consists of no less than five members appointed by the Lieutenant Governor in Council. The members constitute a corporation with a designated chairman and vice-chairman charged with the following mandate:

Section 1 *Mandate*
Goals and Objectives

Goals *Subsection 1*

a) The Goal of the Forensic Psychiatric Services Commission is to provide an immediate response to referrals from officials of the Justice System; and

b) To provide the highest level of expert and professional care available to persons referred who may be mentally ill.

c) To provide services to certifiably mentally ill persons within the Justice System.

d) To provide treatment service to neurotic persons whose neurosis relates to criminal offences.

Objectives *Subsection 2*

The specific objectives of the Commission are:

a) To provide expert evidence about a referred person's mental health to the Courts.

b) To provide treatment services to persons referred by the Courts and Justice Agencies.

c) To provide consultative services to officials and agencies of the Justice system.

d) To provide information and educational programs for Forensic Psychiatric Services staff and other interested parties.

e) To plan, organize and conduct either alone or with other persons and organizations, research respecting the diagnosis, treatment and care of forensic psychiatric cases. (Policy Manual 1978, pg. 1.14 - 1.15)

The Commission has further spelled out its approach to consultation, assessment, treatment, education and research and has developed its policy on administration and operation in relation to various bodies and institutions.

The various government departments such as Attorney General, Corrections and Welfare are represented on the Commission. The Ministry of Health is charged by Order in Council with the administration of the Forensic Psychiatric Services Commission Act. The Commission has a separate budget of about 5 million dollars.

After many years of substandard service before the Commission came into being, it now has developed an inpatient institute with 130 male and 10 female beds plus a large outpatient clinic in Vancouver and Victoria. In addition, the Commission has now a 24 hour telephone and teleprinter service to provide rapid response. This cut down the number of admissions to inpatient facilities. The Commission also provides a travel clinic to Prince George and arranges transportation through the Sheriff's service. A major part of psychiatric services is provided by private psychiatrists who have shown special interest and ability in the forensic field. Psychologists are also used on a consulting basis and the major administrative load is carried by nurses who are involved throughout the process, including discharge planning.

Of all the models of service delivery which we have examined this does seem to be, by far, the most promising one. British Columbia, like Ontario, has vast regions which are sparsely populated with similar problems of transportation and service delivery. Although there are more regions in Ontario that can become self sufficient in terms of psychiatric services with a full complement of inpatient, outpatient and consultation services other regional services would have to be developed on a travelling basis. Without going into further detail we do recommend that the operation of the British Columbia Forensic Services Commission be considered in detail in the reorganization of forensic services in Ontario.

D — Towards the Development of Forensic Services

There is, at this time in Ontario, everybody and nobody responsible for mental health services in the criminal justice system. Efforts have been made by many agencies but the administrative pattern remains diffuse. The creation of METFORS provides a case study of the difficulties that have to be overcome in a complex arrangement of competences and responsibilities.

Even if there is cooperation finally leading to an actual result, the outcome tends to be specific solutions rather than a service delivery network.

It is all too easy, and should be regarded with some suspicion, to follow up the identification of a problem with the recommendation of creating another agency. And yet, after considering the history, the needs and the present service delivery there cannot be any doubt that the following conditions have to be met before any reasonable and consistent development can take place:

1. The responsibility for mental health services to the criminal justice system has to be clarified and unified.

2. Although responsibility for mental health services for adults rests with the Ministry of Health, forensic services cannot be developed without the active participation of the Ministries of Solicitor General, Attorney General, Correctional Services, Community and Social Services and the Secretariat for Justice.

3. The demands of the criminal justice system on mental health services involve conditions which differ from those of the general mental health services. For instance, an assessment for the purpose of assisting a patient does have very different dimensions from an assessment for the Courts; holding a patient because of concerns of harm for himself and others where the responsibility for change of status or release rests with the mental health institution is very different from holding a person because of a legal command such as a warrant, an order or a sentence. These special conditions, which are often antagonistic to general mental health procedures must be clearly expressed by mental health personnel and understood by patients/offenders.

4. Limited access to mental health services by agencies of the criminal justice system places a burden on those agencies with which they are often badly equipped to deal and for which the criminal law is often a blunt and socially destructive instrument. For instance, police are better equipped to deal with offences such as bank robberies than those that occur within a family crisis — and yet, more homicides are the results of the latter; mentally disordered persons in prisons not only tend to have a rougher time but strain the facilities and staff beyond their limits.

5. In order to be of appropriate assistance to the criminal justice system, mental health personnel have to understand and be able to deal with the special conditions imposed by the criminal law and the criminal process.

6. In the development of new legal options such as hospital orders there has to be a response capacity. Legal development and service development,

therefore, have to be coordinated and provided with an ongoing feedback process.

7. Special social concerns, such as various forms of sexual behaviour, drugs and aggression need to be studied and understood to prevent misconceptions and pseudo-solutions. Forensic services are in a unique situation to provide a context for such studies and these studies, therefore, must be university related. They also provide a unique opportunity for the training of legal, clinical and other personnel such as police, court and correctional officers.
8. Without a full complement of assessment, treatment, teaching and research functions forensic services are not able to maintain a standard of performance, nor are they able to retain quality staff.

We have placed the organizational concerns first because, unless they are resolved, there is not much hope that even the most pressing service needs will be met in an equitable manner. These needs can be summarized as follows:

1. All criminal justice agencies should have a specified access to mental health consultation. The nature of this service will differ for various geographic regions and should, therefore, be developed on a regional basis.
2. There is an urgent need to develop facilities with a reasonable degree of security across the province. The Oak Ridge Division of the Penetanguishene Mental Health Centre should be reserved for those cases for whom maximum security conditions are essential. This facility should also serve largely as a back-up service rather than a primary assessment and treatment facility.

Forensic services, to fulfill their role, should have a mandate to refer cases to the general mental health services whenever this is appropriate. Forensic services should thus provide an interphase between the criminal justice system and the general mental health services. In principle, offenders should receive as far as possible the same services as any other member of the community. It is unfair and inequitable to deprive offenders of these services because of special conditions flowing from their legal status.

In summary, we would like to quote from two reports of the Law Reform Commission of Canada which succinctly describe the concerns which have led to this report:

"We realize that the provision of psychiatric services raises important jurisdictional problems. In some areas of Canada the existing provincial facilities are capable of servicing both the federal penitentiaries and provincial prisons. In others the necessary services can only be provided by the

federal government. Without minimizing the jurisdictional constitutional difficulties, the governing principle must be to provide the necessary access to services as efficiently as possible, irrespective of the source of the service. Whether the tune is federal or provincial, the public purse pays the piper and any unnecessary duplication of services should be avoided." (Mental Disorder in the Criminal Process, p. 28.)

"Although the report is directed toward the Parliament of Canada, it has major implications for the provinces and, indeed, for all those involved in and concerned with the administration of justice. The report is not an end, but a beginning. We sincerely hope that it will be the basis for the formation of a coherent policy of dispositions and sentences in the criminal process. To this end, parliament and the legislatures can provide leadership, but responsibility must be taken by everyone, not only by those engaged in the administration of justice, but by the whole community". (Dispositions and Sentences in the Criminal Process, p. 3.)

E — *Funding*

We have so far not discussed the important question of the funding of such services. The problem is that at the present time services are provided in such a variety of ways that it is impossible to estimate what additional funds are necessary to create a new service system. Most persons who are involved to any extent in the criminal justice system are a burden on the public purse. The difference now between costs in jail or in mental health facilities is minimal and disappears if one considers the special demands of mentally disordered offenders or accused in the jail facilities. Funding, again, is tied in with the diverse administrative arrangements in this area. We would make the assertion that funds are expended in any case but less wisely, appropriately and effectively.

The police, at this time, depend almost entirely on mental health services provided by other agencies. There are, however, a number of hidden — and not so hidden — costs if one considers the involvement of police in family disturbances and in maintaining a peace keeping and protective function in events in which mentally disordered persons are involved. One cost consistently mentioned in police submissions is the cost of transporting mentally disordered persons and although no specific figures could be obtained, that especially in some areas in which there are great distances between facilities, a great deal of staff time can be involved since the means of transportation usually is the ordinary police car.

The courts also have at this time no direct expenditure although the cumbersome process of ensuring an appropriate remand can be time consuming. The Ministry of the Attorney General funds the Metropolitan Toronto Forensic Service. The expenditures for the first 10 months of this service

were $1,012,626. It has been pointed out in various submissions that what was offered through this service for Metropolitan Toronto was also necessary in other centers. On the basis of an estimated 550 to 600 psychiatric examinations conducted by mental health facilities for the courts and taking into consideration that remand periods may be 30 or 60 days, one could estimate an expenditure of one and a half to two million dollars which is absorbed by the general mental health services.

The Ministry of Health operates the Oak Ridge Division of Penetanguishene Mental Health Centre, a maximum security facility with 292 beds. There are about 300 admissions each year and the budget is $5,465,000. A female unit is located at St. Thomas Psychiatric Hospital with 30 beds at the present time and expansion plans for 60 beds. This is considered a medium security unit with a budget of $546,953. The Clarke Institute of Psychiatry, Toronto, has two forensic psychiatric services (in addition to METFORS), one, an adult forensic service with a budget of $847,000 and the other, a family court clinic with a budget of $950,000.

In addition, the Legal Aid Plan of Ontario pays $263,436 for psychiatric services and $27,600 for duty counsel in provincial psychiatric hospitals. Costs for the crown and the defence in retaining psychiatric experts cannot be estimated at the present time. In some cases the cost factor for these services can be very substantial.

The Ministry of Correctional Services provides $400,000 per annum for fee for service for psychiatrists on a contract basis. In addition, it operates G.A.T.U. at Guelph and the Ontario Correctional Institute in Brampton. The per diem rate in jails is now approximately $50.00, but disturbed inmates use a much higher proportion of staff time than others and, therefore, money expended for these persons in the institutions can be estimated as being not much less than if actual psychiatric services were provided.

Capital costs for providing appropriate facilities such as the medium security units we have recommended, would be minimal compared with the operating costs.

The difficulty in obtaining estimates of present funding arrangements bears out the state of organization of forensic psychiatric services. We can only reiterate that unless responsibilities for forensic psychiatric services are assigned to a designated body the dimension of present costs, let alone the cost of improvements will remain anybody's guess. From our enquiries the best estimate we can arrive at would be around ten to fifteen million dollars per annum for present services. This, however, is a totally unreliable estimate.

Conclusions

All through this report we have observed the fragmentation of jurisdiction

and administrative responsibility. Our first recommendation, therefore, is:

1. THAT the Ministry of Health in consultation with the Ministries of the Attorney General, Solicitor General, Correctional Services, Community and Social Services and the Secretariat for Justice clarify the responsibility for mental health services in relation to the administration of justice.

In order to remedy this situation we have come to the conclusion that a focal point, a mechanism or statutory body should be created which is responsible for the delivery of forensic psychiatric services. Such a recommendation needs serious justification since coordinating bodies tend to become another layer of bureaucracy and involve additional expenses without supplying necessary support for line-agencies. It seems to us that neither a coordinating body without service responsibilities, nor a new service agency would be acceptable. We have therefore made the reference to the British Columbia Forensic Psychiatric Services Commission which, although it has developed some facilities where there were none, works in close relationship with the criminal justice agencies and mental health services on a minimal budget. In fact, there is only one full time psychiatrist, the executive director, and other professional services are purchased, involving funds which are now expended in any case (See: Funding). With a 24 hour telephone service, teletype facilities and linkage with the police communication system, the British Columbia Commission has a rapid response capacity, decreasing unnecessary referrals which often involve great transportation and administration costs. In the development of a comparable body in Ontario, the work of the British Columbia Commission should be studied in detail.

2. THAT, because of the complexity of legislation, jurisdiction and administrative procedures, the responsibility for the delivery of psychiatric services be vested in a body, such as a Forensic Psychiatric Services Commission.

3. THAT such a body develop a master plan concerning the needs of the various regions in Ontario in relation to the criminal justice agencies such as the police, the crown and defence, the courts, correctional services and community agencies.

Although there is a sufficient interest in the various professions and educational establishments in forensic psychiatric work, there have only been sporadic attempts to train staff and to provide the kind of information necessary in this field. Again, we are not speaking of developing special institutes, but of providing an incentive to existing institutions such as universities and community colleges. A well organized service delivery system

would in itself be such an incentive since most of the senior professionals are linked to educational institutions.

4. THAT such a plan include in addition to provisions for consultation, outpatient and inpatient examination and treatment, the development of educational and research programs.

That there is a need for secure units in the various areas of the province has been clear for some time and has been stressed by almost every submission that we have received. METFORS is one example of the conversion of an existing facility into a reasonably secure one at moderate costs. The absence of secure facilities has jeopardized forensic work in a number of places as we have outlined in Section 2. It has also placed an undue strain on Penetang, which not only overloads this facility, but involves costly transportation and delays.

5. THAT special consideration be given to the development of secure facilities in the psychiatric hospitals on a regional basis and that special institutions such as Penetanguishene and St. Thomas be reserved for special cases.

Transportation is another problem which has been referred to in various sections of this report. At present the policy is that patients who are in custody because of a criminal proceeding are to be transported by ambulance only if they are non-ambulatory or heavily sedated (The Care and Transportation of the Emotionally Disturbed Patient, Ministry of Health Policy Statement, p. 5). This puts the major burden on the police who have to use their regular patrol cars in most cases. For some areas this can mean that regular policing is seriously diminished for a lengthy period of time. It also has to be clarified when the duty of a police officer ends and is assumed by the hospital since officers often have to wait until admission is decided.

6. THAT a policy be developed concerning the transportation of accused persons or offenders to and from mental health facilities.

Because of the geographic factors and the distribution of population in Northern Ontario to which we have referred in Section 2, service arrangements will have to be made which will differ from those in areas where it is easier to draw on local resources. There are now a number of special arrangements for the provision of general mental health services to isolated communities and a growing concern about the situation of the native population in relation to the criminal justice system.

7. THAT special consideration be given to areas of the province, such as the north, where geography and population demand a different service delivery pattern.

There is now a strong interest in developing legislation on the federal level

in this area as was outlined in Section 1. It is important that there is a unified provincial response to these efforts. Changes in federal law will have an impact on provincial legislative provisions as well as administrative arrangements.

8. THAT consultation concerning the development of federal legislation in criminal law and procedure be coordinated by the body responsible for service delivery and that this body be also charged with assisting in the development of complementary provincial legislation.

The conception of forensic psychiatric services arising out of these recommendations is that they provide an interphase between the criminal justice system and mental health services. They should not function in isolation from either system, nor from the community and its problems. We have stressed in the chapter on the police, for instance, that mental health services which are knowledgeable in the crime field can make a contribution to prevention, especially in sensitive areas such as family disputes, child abuse and neighbourhood tensions as well as in incidents of hostage-taking.

9. THAT forensic psychiatric services provide an interphase between criminal justice agencies and general mental health services with a special emphasis on prevention through their cooperation with criminal justice agencies, especially the police.

Finally, submissions and surveys such as the one by Dr. Butler (Section 2) show that many of the major problems are clear and that the frustration level of those attempting to provide services is at present such that further inquiries without a commitment to a consolidated approach would not be fruitful. There is a justified envy of the services which have been developed in Metropolitan Toronto and other parts of the province feel that they have been sadly neglected.

10. THAT there is already a considerable body of knowledge and positions in the background materials of this report and that further study is not recommended until the responsibility for developments in this area has been consolidated and vested in a designated government agency.

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This committee met with the Legal Task Force on November 28th to discuss the criminal justice system and mental health services.

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APPENDIX I

Law Reform Commission of Canada, 1976.

A REPORT TO PARLIAMENT ON MENTAL DISORDER IN THE CRIMINAL PROCESS

Law Reform Commission of Canada | Commission de réforme du droit du Canada

March 1976

The Honourable S. R. Basford,
Minister of Justice,
Ottawa, Ontario.

Dear Mr. Minister:

In accordance with the provisions of Section 16 of the *Law Reform Commission Act,* we have the honour to submit herewith the report with our recommendations on the studies undertaken by the Commission on mental disorder in the criminal process.

Yours respectfully,

E. Patrick Hartt
Chairman

Antonio Lamer
Vice-Chairman

J. W. Mohr
Commissioner

G. V. La Forest
Commissioner

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VIII. Summary of Recommendations

Rather than set out each recommendation as it appears, we decided to gather together in one section the major recommendations from various parts of the report. These are divided under the headings "Policy" and "Implementation", mentioned earlier.

A. Preliminary Concerns

Policy

R.1 The sections of the Criminal Code dealing with mental disorder should be carefully re-examined in light of recommendations made in this Report with a view to clarifying and clearly articulating the various legal concepts and procedures affecting mental disorder in the criminal law.

R.2 Clear and accurate data are essential to both the rational development of criminal policy toward the mentally ill and the re-ordering of social attitudes toward mentally ill offenders. In this regard the government, through appropriate agencies, should provide information and systems for the evaluation of future changes in procedure and practice.

R.3 The formation of policies to deal with mentally disordered individuals in the criminal process should be in accord with the following general guidelines:

(1) When dealing with a mentally disordered person, the criminal process should be invoked only when no other viable social alternative is available. Implicit in this guideline is the assumption that increased emphasis will be placed on the pre-trial diversion of the mentally ill.

(2) A mentally disordered person is entitled to the same procedural fairness and should benefit from the same protections of personal liberty as any other person. In this regard extreme caution should be exercised before there is any deprivation of personal liberty in the form of a psychiatric examination or treatment. As well, psychiatric treatment of any kind should only be given with the consent of the individual, subject only to the limited exceptions outlined in this report.

(3) In those instances where some form of detention is deemed necessary, it must be subject to review and in no circumstances should it be indeterminate.

B. Pre-Trial Issues

Policy

R.4 Whenever appropriate, the pre-trial screening of mentally disordered accused should be encouraged by the police and prosecutorial authorities.

R.5 As part of their professional formation, police officers and prosecutors should be trained to recognize and deal with the mentally disordered offender, to be knowledgeable of available community resources and means of access to those resources and to encourage the consensual community based solution of marginal cases.

Implementation

R.6 Police and prosecutorial screening of the mentally ill should follow stated policies and be based on known criteria. It should therefore be required that policy directives to prosecutors, police or other officials dealing with the mentally ill be made available to the public. Such screening policies should consider the following criteria:

(1) whether the nature of the apparent disorder is so serious as to warrant taking the individual into custody;

(2) whether there exist, in the community, the necessary facilities to deal with the individual;

(3) whether the nature of the offence and the surrounding circumstances are not so serious as to warrant charging or proceeding to trial;

(4) whether the impact of arrest and charging, or the effect of trial on the accused and his family would be excessive having regard to the harm done.

R.7 Screening policies should be local to take into account community considerations. The Department of Justice, the Department of the Solicitor General and their provincial counterparts, however, should initiate and encourage an exchange of ideas and experiences, and undertake to develop guidelines and model police and prosecutorial procedures for screening of mentally ill persons.

C. The Issues of Fitness and Responsibility

Policy

R.8 An exemption from trial based on an accused's mental inability to participate should be maintained in Canadian criminal procedure.

R.9 The proper rationale of the fitness rule is to promote fairness to the accused by protecting his right to defend himself and by ensuring that he is an appropriate subject for criminal proceedings.

R.10 The present limitation of the fitness rule to mental disorder should be re-examined and the possibility of including other non-mental causes of an inability to participate at trial should be considered.

R.11 Detention of the unfit accused, either for examination or disposition should be regarded as a last resort and procedures not requiring detention must be considered first.

R.12 The verdict "not guilty by reason of insanity", if maintained, should be considered a real acquittal, subject only to a mandatory post-acquittal hearing to determine whether the individual should be committed to an institution under provincial legislation.

Implementation

R.13 The criteria of unfitness should be articulated in the Code.
The following criteria are suggested:
A person is unfit if, due to mental disorder:

(1) he does not understand the nature or object of the proceedings against him, or,

(2) he does not understand the personal import of the proceedings, or,

(3) he is unable to communicate with counsel.

R.14 The Code should specifically exclude lack of recollection alone as a cause of unfitness.

R.15 The Code should specify that the prosecution, the defence or the court may raise the issue of the accused's fitness to stand trial.

R.16 The Code should be amended to make it possible to raise the issue of an accused's fitness to stand trial at any time from arraignment to verdict.

R.17 Subject to the possibility of postponement, the issue of fitness should be determined at trial or, in appropriate circumstances, at preliminary hearings.

R.18 The Code should be amended to allow, in appropriate circumstances, full adjudication of the merits of the charge before the issue of fitness is determined.

R.19 The issue of fitness should be made a question of law to be determined by the presiding judge or magistrate or justice.

R.20 In order to facilitate the postponement procedure suggested in this Report, the jury should be able to deliver a conditional verdict.

R.21 Disposition of the unfit accused should be made by the trial judge on the basis of the following criteria:

(1) the gravity of the offence charged,

(2) the danger the accused represents to himself and society,

(3) the likelihood of the accused regaining sufficient mental capacity to be considered fit,

(4) the recommendations of the medical personnel for treatment which would best facilitate the recovery of the accused.

In the exercise of the above criteria the trial judge should be required to use the least intrusive form of disposition unless there are compelling reasons for doing otherwise.

R.22 A finding of unfitness should not always lead to detention and the Code should provide the trial judge with a range of possible orders, including:

(1) an order releasing the unfit accused forthwith, subject to reindictment and trial if he later becomes fit to stand trial;

(2) an order for treatment as an out-patient;

(3) an order for mandatory hospitalization for a period of up to six months. If at the end of the maximum time set by the order the accused is still unfit, the disposition should be reviewed by the court. It could be renewed or varied, but in cases where the charge is not one for which imprisonment is an appropriate sanction, or where the time the unfit accused has spent in custody is, in the opinion of the judge, approximately the time he would have spent in prison had he been found guilty, the order should be vacated and the accused set at liberty.

R.23 The fitness procedure should be clearly articulated in the Code and be explicit on the following:

(1) the exclusion of the jury,

(2) the presence of the accused,

(3) the reception of expert evidence,

(4) the necessary burden of persuasion.

R.24 Section 544 of the Code (insanity of accused to be discharged for want of prosecution) should be repealed. It is almost never invoked and is incompatible with the above recommendations.

R.25 Section 542 of the Code dealing with the disposition of the accused found not guilty by reason of insanity should be amended to provide only for a mandatory post-acquittal hearing to determine whether there are grounds to detain the accused under the provisions of the relevant provincial mental health legislation.

D. Issues of Disposition

Policy

R.26 The primary concern of any sentence is the determination of a disposition that is fair and just in the circumstances. Treatment, psychiatric or otherwise, plays an important but secondary role and should not affect the length of sentence.

R.27 As a general rule, treatment administered within the context of a just sentence must be consented to by the offender and the receiving institution.

R.28 Due to the complex jurisdictional questions which are often involved, there is a pressing need to encourage consultation between the various levels of government and between the various agencies involved so as to provide the services without costly and unnecessary duplication.

Implementation

R.29 Conditions of psychiatric treatment may form part of a Good Conduct Order, a Reporting Order, a Performance Order or a Residence Order (as outlined in our Report to Parliament) on or as a condition of the present system of probation, but only when:

(1) the offender understands the kind of program to be followed,

(2) he consents to the program, and

(3) the psychiatric or counselling services have agreed to accept the offender for treatment.

R.30 The trial judge should be able, in appropriate circumstances, to order that a portion of the entire term of imprisonment imposed on an offender be spent in a mental hospital. This disposition we call a hospital order should operate according to the procedure outlined in this Report.

R.31 There should be provisions in provincial correctional legislation and the federal *Penitentiaries Act* for the transfer of mentally ill prisoners from prisons to mental institutions. The Uniformity Conference held each year with the provinces and the Department of Justice should ensure that such legislation is in place and is uniform.

R.32 Section 546 of the Criminal Code should be repealed as redundant and unnecessary.

E. The Use of Mental Health Resources in the Criminal Process

Policy

R.33 The role of the mental health expert in the criminal process should be to advise the court on matters outside its own general knowledge or expertise. The mental health expert should not be encouraged to usurp judicial decision making. In particular, mental disorder amounting to criminal irresponsibility and unfitness to stand trial should be reaffirmed as legal, not medical issues to be determined by the judge.

R.34 However, it must also be recognized that the participation of mental health experts in the determination of the above legal issues is essential. Rather than forcing mental health experts into medically meaningless "yes-no" answers to questions on which they are no more expert than anyone else, the procedures should be designed to encourage such experts to give evidence on what they know best, the psychiatric state of the accused.

R.35 Because of the relative scarcity of psychiatric resources in the community, procedures should be designed to use them efficiently.

R.36 As a general principle, there should be no treatment of individuals within the criminal process without consent.

Implementation

R.37 To safeguard against the potential of abuse in the administration of treatment to individuals constrained in some way by the criminal process, the Code should provide that no treatment be undertaken unless:

(1) the treatment is for the individual's personal benefit,

(2) the treatment is established and recognized as likely to be effective for the condition diagnosed,

(3) the treatment does not unreasonably subject the individual to danger to life, limb or mental impairment.

R.38 There should be only two exceptions to the general rule of no treatment without consent. These are:

(1) in emergency situations where treatment is necessary for the immediate preservation of life or protection from serious bodily or psychiatric harm,

(2) when the individual is unable to consent because he is mentally incompetent to do so, but incompetency should be narrowly construed in the manner described in this report.

R.39 The incompetency of an individual within the criminal process should be determined by a board of at least three persons, one of whom is not connected or employed by the institution holding the individual under consideration. Once made, a decision of incompetency should be subject to appeal and periodic review.

R.40 Court remands for examination of mentally disordered accused should be made under the Criminal Code. As well, the Code should contain a variety of possible orders, some involving minimal interference with the individual's freedom.

R.41 The Criminal Code should specifically state that the purpose of such remands is to prepare a psychiatric report. Further, the examination should be linked to the specific expertise sought by the court and the Code should specify when and to whom the reports should be sent.

R.42 The Code should also contain guidelines on the general content of the report. Due to the different kinds of expertise required by the court, it will be necessary to differentiate between reports required before, during and after trial.

R.43 Because of the differences in facilities across the country the detailed report forms and procedures should be worked out by local committees. The Department of Justice, the Department of the Solicitor General and their provincial counterparts should provide leadership in this area by developing model reports and procedures.

R.44 One of the effects of the recommendations made in this report is to abolish the Lieutenant Governor's warrant as a means of disposition of mentally disordered accused or offenders. This has special repercussions on the boards of review established under section 547 of the Criminal Code. A reexamination of the purposes and functions of

these boards should be undertaken to assess their present purpose and function and their future role having regard to recommendations made in this and our other Reports to Parliament.

APPENDIX II

Law Reform Commission of Canada, 1976.

A REPORT

ON

DISPOSITIONS AND SENTENCES

IN THE

CRIMINAL PROCESS

□

GUIDELINES

Law Reform Commission of Canada | Commission de réforme du droit du Canada

January 1976

The Honourable S. R. Basford,
Minister of Justice,
Ottawa, Ontario

Dear Mr. Minister:

In accordance with the provisions of Section 16 of the *Law Reform Commission Act*, we have the honour to submit herewith the report with our recommendations on the studies undertaken by the Commission on dispositions and sentences in the criminal process.

Yours respectfully,

E. Patrick Hartt
Chairman

Antonio Lamer
Vice-Chairman

J. W. Mohr
Commissioner

G. V. La Forest
Commissioner

Commission

Honourable E. Patrick Hartt, Chairman
Honourable Antonio Lamer, Vice-Chairman
Dr. J. W. Mohr, Commissioner
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RANGE OF DISPOSITIONS AND SENTENCES

DISPOSITIONS:

Section In Text	Form	Nature	Rationale
3	*Community:* Crime Prevention	Individuals, families, schools, places of work and communities deal with problems informally, without recourse to the criminal process.	Greater satisfaction results if parties are permitted to settle their own problems, rather than have authorities impose a solution. A sense of responsibility develops when problems are faced by the parties directly concerned within the context of direct relationships. Resort to the criminal process is costly and produces negative effects which at times outweight the severity of the initial problem.
4	*Police:* Screening	Police consider or investigate an incident and decide not to direct it into the criminal process, but to exercise a non-criminal alternative, or, not to pursue the matter further.	The criminal process should be used only as a last resort. Unless alternative dispositions have failed in a particular case in the past, or alternative disposition or resources are not appropriate or acceptable, the criminal process should not be used.
	Caution	Police investigate and decide that a caution or warning is all that is necessary. The caution may be oral or written; in any case it is entered as a disposition.	The caution is widely used in cases of juveniles and less frequently in cases of adults. The police decide that no particular good would be served by invoking the criminal process; nor does the criminal incident disclose the need for conciliation or settlement services. This caution is not to be confused with the police caution used in questioning suspects and taking statements.
5	*The Prosecutor:* Pre-Trial Settlement	The crown prosecutor screens the charges laid and selects those cases that may properly be referred out of the criminal process for a settlement procedure.	The denunciation and stigma attached to being charged are sufficent under the circumstances; in keeping with the principle of using the minimal sanction the case is suitable for a settlement procedure.
	Withdrawal	Before process is issued the Crown may withdraw the charges and inform the Justice of the Peace accordingly. After issuing of process, the Crown may withdraw the charges with the permission of the court.	Procedural.

DISPOSITIONS—*Concluded*

Section In Text	Form	Nature	Rationale
	Stay of Proceedings	In exceptional cases, at any stage before judgment, the Attorney-General may enter a stay of proceedings not subject to judicial control.	Procedural.
6	*The Court:* Dismissal	When proceedings have commenced, the court may dismiss the charge where the prosecution requests a withdrawal or presents no evidence.	Procedural.
	Acquittal	Where the court finds the accused not guilty of the offence charged, it will acquit the accused.	Self-evident.
	Absolute Discharge	No conviction; no conditions.	The circumstances of the offence do not warrant any denunciation and assignment of responsibility beyond the trial itself.
	Conditional Discharge	No conviction; possible conditions include obligation to keep the peace; to be of good behaviour; to make restitution.	Beyond the denunication and assignment of responsibility by the trial, the offender deserves no further denunciation providing he demonstrates his willingness to restore the harm he has done and behave himself.
SENTENCES:			
7	Good Conduct Order	Conviction; conditions attached to the order should be those which assure that the offender keep the peace.	The circumstances of the offence show that more than a conditional discharge is required, but the public interest does not require more than a conviction with the limited restriction to keep the peace.
8	Reporting Order	Conviction; conditions of the order require reporting to a designated person for control purposes.	This is a control and preventive measure to keep a check on the offender's conduct.
9	Residence Order	Conviction; condition: to live at a designated residence or in a given area.	Substantial curtailment of liberty is warranted by the offence, and the offender is in need of control, supervision or support.
10	Performance Contract	Conviction; offender agrees to undertake to meet such conditions and goals re training, treatment, work, counselling or education as are needed and agreed upon; to report to a designated person.	The offence requires restraint on the offender's liberty; the offender is in need of and willing to undertake a specific program to upgrade his social and economic skills.

SENTENCES—*Concluded*

Section In Text	Form	Nature	Rationale
11	Community Service Order	Conviction; agrees to undertake specified tasks for specified number of hours in leisure time.	The offence has been of harm to community generally or the offender is unable to pay fine or make restitution but willing to do work at specified tasks, to the satisfaction of a designated person.
12	Restitution and Compensation Order	Conviction; the offender undertakes to pay restitution to the victim, within the possibility of his means and in accord with the harm done.	The seriousness of the offence would be depreciated were a conviction not entered; offender does not need supervision, control or rehabilitative service but is willing to make restitution to the victim. This does not preclude restitution as a condition of other sanctions.
13	Fines	Conviction; payment of money to the public treasure based on the offender's ability to make such payment and the seriousness of the offence.	The harm done is prejudicial to society generally. The offender does not require isolation, services, or supervision. May be imposed in addition to restitution.
14	Imprisonment	Separation; subject to such conditions and releases as are determined through policy set by the Sentence Supervision board and applied by the prison authorities; the last one-third to be spent in the community under supervision unless there are strong counter indications. The court may maintain jurisdiction over initial part.	The offence is a serious one making separation of the offender from the rest of society necessary. In addition the Crown has shown that the offender is likely to commit further serious acts of violence in the near future if he is not isolated and subjected to control and supervision.
		Denunciation; conditions of the sentence while directed through the Sentence Supervision Board are subject to court control.	The offence is serious and the community would not accept a sentence other than imprisonment as a sufficiently strong statement about the wrongfulness of the offence although the offender is no longer a threat to the community.
		Wilful default.	To be used only where the offender wilfully refuses to pay a fine or fulfil other non-custodial conditions of sentence and no other sanction remains.
15	Hospital Order	Conviction; sentence of Imprisonment to be served in full or in part in a designated hospital.	Offender is in need of treatment, is willing to accept treatment and this treatment can best be provided at a specific hospital.

The report does not deal with the sanction of capital punishment. Much has been said and written on this subject and there is little the Commission can add to the debate. In fact, so much attention is focussed on this sanction that the majority of problems in the administration of criminal justice tends to be neglected. However important the debate may be for the moral tone of this nation, the sanction is of minor importance as a solution to problems of crime. Neither can this sanction be compared with others such as imprisonment since it is final and irrevocable, without hope and future and therefore not subject to policy considerations and objectives after imposition.

Although the report is directed to the Parliament of Canada, it has major implications for the provinces and indeed for all those involved in and concerned with the administration of justice. A report is not an end but a beginning. We sincerely hope that it will be the basis for the formation of a coherent policy of dispositions and sentences in the criminal process. To this end, Parliament and the legislatures can provide leadership but responsibility must be taken by everyone, not only by those engaged in the administration of justice but by the whole community.

Treatment capacity in prisons is necessary in three situations: in emergency situations, in situations where for security reasons, the individual cannot be treated in society, or where the needed services are not available in the community. It is important that prisons have access to the various kinds of treatment mentioned above. Whenever possible, the treatment should be provided from the community as would be the case for any other citizen.

We realize that the provision of psychiatric services raises important jurisdictional problems. In some areas of Canada the existing provincial facilities are capable of serving both the federal penitentiaries and provincial prisons. In others, the necessary services can only be provided by the federal government. Without minimizing the jurisdictional and constitutional difficulties, the governing principle must be to provide the necessary access to services as efficiently as possible, irrespective of the source of the service. Whether the tune is federal or provincial, the public purse pays the piper and any unnecessary duplication of services should be avoided.

Appendix III

Report on Psychiatric Services for the Criminal Justice System in Ontario

Prepared for the Legal Task Force of the Committee on Mental Health Services of the Ontario Council of Health

B. Butler, B.A., M.D., F.R.C.P.(C)–METFORS Psychiatrist
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October 26, 1978

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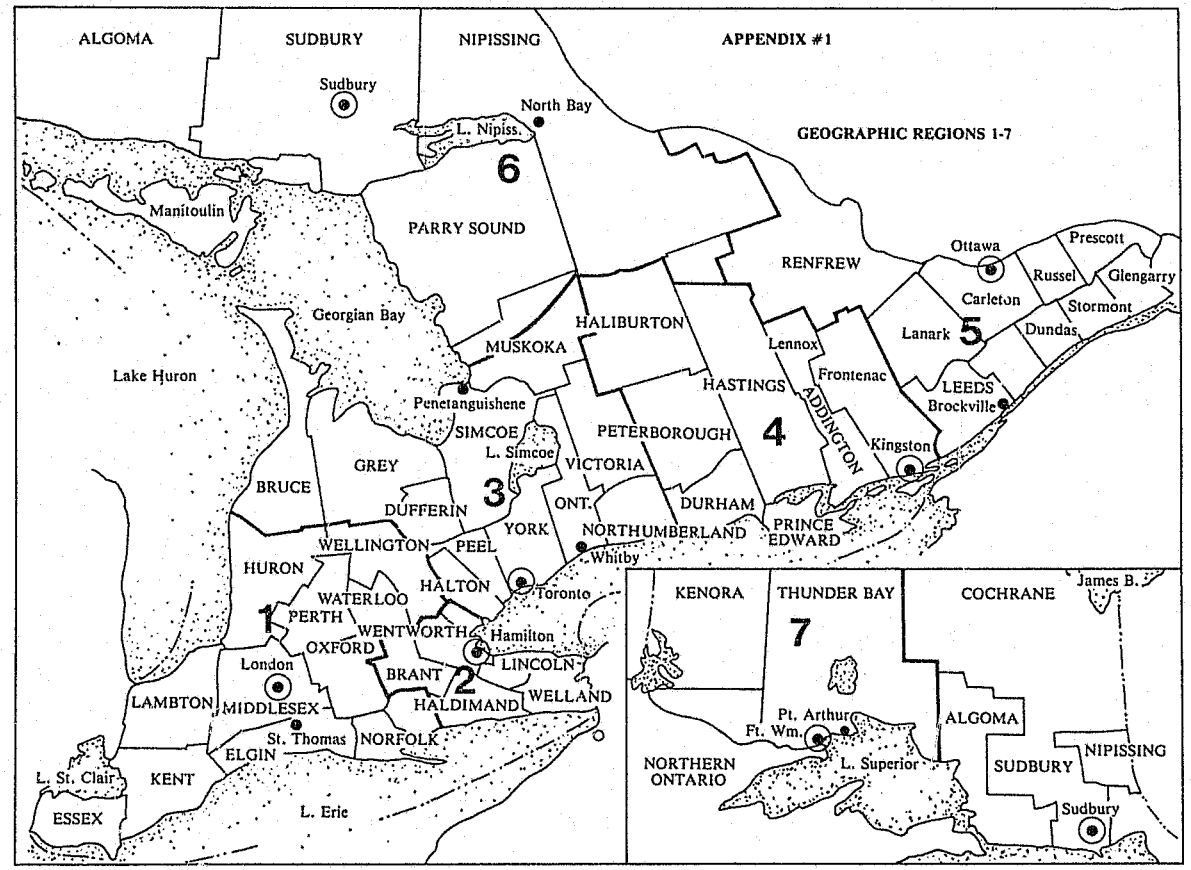
APPENDIX #1
GEOGRAPHIC REGIONS 1-7
ALGOMA
SUDBURY
NIPISSING
Sudbury
North Bay
L. Nipiss.
6
Manitoulin
PARRY SOUND
Georgian Bay
Lake Huron
MUSKOKA
HALIBURTON
Penetanguishene
SIMCOE
L. Simcoe
GREY
BRUCE
3
DUFFERIN
YORK
PEEL
WELLINGTON
HURON
1
WATERLOO
PERTH
OXFORD
London
LAMBTON
MIDDLESEX
St. Thomas
ELGIN
NORFOLK
L. St. Clair
KENT
ESSEX
L. Erie
HALTON
Toronto
WENTWORTH
Hamilton
BRANT
2
LINCOLN
HALDIMAND
WELLAND
VICTORIA
ONT.
DURHAM
NORTHUMBERLAND
Whitby
PETERBOROUGH
4
HASTINGS
ADDINGTON
PRINCE EDWARD
Kingston
RENFREW
Lennox
Frontenac
LEEDS
Brockville
Ottawa
Prescott
Russel
Glengarry
Carleton
Stormont
Lanark
5
Dundas
KENORA
THUNDER BAY
7
COCHRANE
James B.
Pt. Arthur
Ft. Wm.
L. Superior
NORTHERN ONTARIO
ALGOMA
SUDBURY
NIPISSING
Sudbury

CONCLUSION

1. Because of the change in psychiatric hospital policy in Ontario in about 1959 to unlocked wards from locked facilities, most psychiatric hospitals in Ontario do not have the appropriate physical facilities to manage potentially violent patients. This also affects the "forensic" patient, sent from court for assessment or transferred from correctional facilities for treatment.
2. It is difficult to predict the actual "forensic" *needs* of the Ontario Criminal Justice System based on the data we have obtained. Many courts remain without psychiatric consultation. A number of individuals who require psychiatric assessment are not being seen. The opening of METFORS points out the speed with which the courts recognize the usefulness of a psychiatric service which was previously unavailable. It is also true, however, that many individuals who do not require a psychiatric assessment are seen in facilities that provide a "ready" assessment service to the courts.
3. Assessment *and* treatment should be carried out as close to the point of origin of the prisoner as possible to enable contact with his family and his community.
4. Assessment *and* treatment are both more efficient if carried out in the same facility with continuity of care and staff.
5. In response to the question, "In what way do you find existing facilities and services adequate and satisfactory?", the basic response throughout the province has been—"In no way!" People interviewed felt that secure, regional psychiatric facilities were necessary and most felt that treatment facilities were the first priority, assessment facilities secondary.
6. Penetanguishene Mental Health Centre—Oak Ridge Division—is overcrowded. Many patients presently housed in Penetang *could* and *should* be assessed and treated in the local psychiatric hospitals servicing the local communities. Many patients from there could be housed in medium security units. In addition, these units could be used to facilitate movement to an open-ward setting.
7. A substantial and significant amount of forensic in-patient assessment and treatment is presently being done across the province. The vast majority of these cases do not require maximum security facilities and could be handled in medium security facilities. These assessments are being done on general psychiatric wards in the London, St. Thomas, Brockville, North Bay, Thunder Bay, Hamilton and Kingston

Psychiatric Hospitals. These hospitals require separate secure units where forensic patients could be assessed. This would consolidate the existing work, thus facilitating a faster service to the courts, the correctional system and to the patient.

"Forensic beds" are available at the Hamilton Psychiatric Hospital and St. Thomas Psychiatric Hospital (female), and Royal Ottawa Psychiatric Hospital. Assessments are already being done in forensic units in two of these facilities. The need in these facilities is for an expansion for treatment cases, particularly for the Lieutenant-Governor Warrant patients presently housed in Penetang. Brockville is just opening a forensic unit which will in fact have some security and is designed to house this type of transitional patient as well as others.

8. Psychiatric assessment and treatment in secure facilities is not readily available in Ontario. Penetang, Clarke Institute, the Brockville Psychiatric Hospital, the St. Thomas Psychiatric Hospital and Metfors are the only facilities with any kind of security. Large regions of the province, particularly Northern Ontario, have *no* secure facility for psychiatric assessment and treatment. This results in expensive delays in court proceedings, unnecessary hardship for individuals who are acutely mentally ill and costly transfers to the existing secure facilities.

9. Each new forensic unit should be closely affiliated with a university department of psychiatry to ensure high quality service and research and the recruitment of well-trained and highly competent staff.

10. Because of the size of Ontario, distance from some courts to assessment and treatment facilities is enormous. This results in long court delays and enormous expense to the province for transportation and longer involvement with the system. There is no secure assessment or treatment facility in Ontario north of Penetang. This results not only in the delays above but removal of the prisoner from his family (creating problems in assessment and treatment). Regional units would reduce this problem, not only in the north but in all areas of the province, but Central-Southern Ontario where the existing secure facilities are gathered.

11. An additional need that would be met by regional secure psychiatric facilities is to deal with the cultural and language problems of various parts of the province. Not only is the entire northern portion of the province peopled largely by Canadian Indians with a separate and distinct culture but the rest of Ontario has pockets of ethnic groups from French in the east to Slavs in the mining country near Sudbury. A regional centre in these areas should reflect these particular ethnic and language needs.

12. Staffing appears to be easier in psychiatric facilities in hospital settings than in correctional settings. Staff is also more likely to stay in a setting with a varied program of assessment and treatment and not simply one facet. An additional factor to consider in arranging regional secure psychiatric units would be the proximity of a university setting so the opportunity of teaching and peer interaction would be available.

13. The establishment of new psychiatric assessment and treatment units for individuals within the criminal justice system, should be done with the co-operation of the individual psychiatrists actively engaged in forensic psychiatry in the region to be serviced by the new units.

14. A more complete picture of the present forensic services in the Brockville-Ottawa area is necessary to ensure appropriate expansion in this region.

15. The proposed medium security units should provide a treatment facility for the mentally ill within their regional correctional facilities and federal penitentiaries. It would be beneficial to arrange for a sharing of psychiatric staff with Corrections and transfer part of their existing staff to the new units.

16. There are correctional facilities which do not have psychiatric consultation readily available on an ongoing basis. Psychiatric forensic units could provide regular consultation to local correctional institutions, expedite the treatment of the mentally ill offender, and reduce the inter-institution problems which presently exist. (The system in Hamilton with Dr. G. Mercereau and the Hamilton Psychiatric Hospital forensic unit is an example of a workable and productive system).

17. The establishment of a data base for psychiatric patients within the criminal justice system is essential to provide complete assessments for courts, and for expanding the behavioural sciences through research. A system could be developed with the co-operation of new and old forensic facilities and correctional institutions. One proposal was made to have a single card completed on each individual. Such a system would facilitate data collection.

18. There are very few psychiatrists with substantial speciality training in forensic psychiatry. In addition, there are very few psychiatric residents presently being trained in Ontario, who have shown any interest in forensic psychiatry. This must be considered by any planning group in the staffing of new facilities and in providing funds for expanding forensic educational programs.

19. A reasonable ratio of male to female beds for new forensic assessment units is 9:1, based on the sex ratio of the present caseload. This ratio

would be reduced slightly (8:1) if some of the St. Thomas Psychiatric Hospital female population are to be assessed in the new medium security units.

20. The Thunder Bay region had the highest number of 1977 charges/population of the proposed centres for new units. North Bay had the second highest ratio. Both of these regions had more than double the ratio for Ottawa-Carleton, which had the lowest. These ratios should be considered in establishing forensic assessment beds.

21. The federal penitentiaries should provide data regarding the federal parole population presently requiring psychiatric services in Ontario and, if possible, co-operation obtained in sharing regional secure psychiatric units for treatment and assessments.

22. As shown in Appendix #6, court-ordered assessments in the established psychiatric centres and hospitals across Ontario have decreased between 1976 and 1977. Even the Penetang Mental Health Centre, Oak Ridges had a reduction in assessments on remand from courts from 226 in 1976 to only 172 in 1977. Explanations given by various officials centered around lack of security in most centres and the unwillingness of courts to remand for assessment to a facility where none exists. The reduction can also be explained by the opening of Metfors in Toronto. It would appear that the courts clearly will not remand to a non-secure setting when it is possible to remand to a secure and a need has been proven for such units to be distributed more widely in Ontario. The Region #6 figures alone show a fall in assessments in the open-setting North Bay hospital from 75 in 1976 to 36 in 1977.

APPENDIX IV

Recommendations of Coroner's Juries—1976—February 1978

Recommendations of Coroner's Juries 1976-February 1978

— Minimum time for assessment of patients transferred to Don Jail Psychiatric Unit.

— To eliminate remand court requested assessment council out within stated maximum period of time.

— Establishment of Forensic Assessment Centre.

— That local police officers be given every opportunity to review and upgrade their professional capabilities.

— Liberal interpretation of M.H.A. to include prior history in determination of dangerousness.

— New adequate long term facilities to supplement Penetang.

— Formal communications between institutions, agencies and services—(notice to police when release formerly incarcerated person).

— Establish juvenile delinquent institution for intense and continuous psychiatric therapy for those in need of such care.

— Educate lawyers and judges on psychiatric facilities available and proper legal procedures necessary to make use of them.

— Discharge procedures should ensure that the right and safety the public are not sacrificed to protect the rights of the individual.

APPENDIX V

Letter Requesting Briefs

Ontario

Ontario Council
of Health

700 Bay Street
14th floor
Toronto, Ontario
M5G 1Z6
416/965-5031

June 17, 1978

Re: The Criminal Justice System and Mental Health Services

Dear

The Ontario Council of Health was established by Order-in-Council, June 1966, subsequently confirmed by the Department of Health Act 1968/69, and the Ministry of Health Act 1972, as the senior advisory body on health matters to the Minister of Health, and through him to the Government of Ontario. The Council studies, and recommends on, matters which affect the delivery of health care in the Province. The manpower, facilities, and health care patterns required to provide these services efficiently to the people of Ontario are its basic concern.

In 1977, the Minister of Health the Honourable Dennis Timbrell, requested the Council, to undertake a review of mental health services in Ontario and formulate recommendations for eventual consideration of the Council and the Minister of Health. The Minister indicated that issues being considered involve matters of far reaching consequence and that the report could be a major contribution to the health and well-being of the people of Ontario.

The Committee on Mental Health Services was established under the chairmanship of Prof. Abbyann Lynch, Ph.D., of Toronto, with four task forces to undertake specialized aspects of this major study. The task forces are: 1. Legal; 2. Primary Care; 3. Specialized Services; 4. Maintenance and Rehabilitation.

The Committee anticipated that briefs and opinions would be received from all interested groups and individuals both in writing and by oral representations.

Public meetings have been scheduled to be held throughout the province of Ontario, and such meetings began in Toronto on May 11th, 1978.

1. Review of Mental Health Services provided throughout the Province;
2. From the review, to make recommendations for improvement and the provision of services.

The detailed Terms of Reference of the Committee are enclosed.

We are writing you on behalf of the *Legal Task Force* which has been assigned the responsibility to undertake a review and make recommendations with respect to services and facilities designed to provide mental health services for the Criminal Justice System.

The Legal Task Force has agreed to receive written briefs from interested groups and individuals.

We are writing to you to invite you to prepare and submit a brief on the specific matters of mental health services for the administration of criminal justice in Ontario.

We refer to Terms of Reference #2 and #3:

2. To assess and make recommendations concerning psychiatric facilities required for the administration of criminal justice in Ontario, including:
   - —facilities for pre-trial assessment
   - —pre-sentence examination and reports
   - —forensic psychiatry.
3. To consider and make recommendations on changes, if required, in:
   - —The Judicature Act
   - —The Police Act
   - —The Child Welfare Act

and other statutes that will improve the administration of criminal justice regarding:

- —pre-trial assessment
- —pre-sentence reports
- —the powers of judges
- —the powers and immunities of peace officers

—the use of expert witnesses
—the admissibility and compellability of medical records
—the use of Lieutenant-Governor's warrants
—rights of appeal to high courts on decisions on involuntary treatment/committal and incompetency.

You may consider, as an additional guideline for briefs, the recommendations of the Law Reform Commission of Canada as contained in the Commission's Report to Parliament, entitled "Mental Disorder in the Criminal Process", March 1976, insofar as the recommendations may apply to the provincial aspects of the provision of mental health services to the Criminal Justice System.

Groups wishing to submit briefs should indicate in writing by July 7th, 1978, that they intend to do so.

Briefs should be addressed to Mr. B. Crane at the Council address and should be received *by October 6th, 1978.*

We thank you for your interest and look forward to your contribution to these important matters.

Yours sincerely,

R.E. Turner, M.D. F.R.C.P. (C),
Member, Legal Task Force

B.A. Crane, Q.C.,
Chairman, Legal Task Force

Apendix V.

Sample Questions

1. Should psychiatric services be developed and maintained within the Criminal Justice System or should they be developed and maintained by another Ministry such as the Ministry of Health, or by a combination of Ministries such as the Attorney General, Ministry of Health and Ministry of Correctional Services?
2. What department or departments of the provincial government should have responsibility for persons suffering from mental illness or mental retardation but incarcerated in the Criminal Justice System?
3. Is legislation in the field of forensic psychiatric services satisfactory?
4. (a) Under what legislation should these units or programmes be established:
   i) Mental Health Act
   ii) New legislation introduced by Ministry of Health, Ministry of Attorney General, Ministry of Correctional Services.

   (b) What amendments are or may be required in the Criminal Code of Canada to provide referral to such facilities?
5. In what way do you find existing facilities and services adequate and satisfactory?
6. In what way do you find existing facilities and services inadequate and unsatisfactory?
7. Should a court be able to send a remand prisoner for psychiatric assessment without his or her consent?
8. Has a court ever sentenced an inmate directly to a psychiatric institution other than those operated by the Criminal Justice System? Should a court be able to sentence a person directly to a treatment facility other than those operated by the Criminal Justice System? If so, should the sentenced person's consent be required?
9. In your opinion, what is the most suitable environment for treatment of people in correctional facilities suffering from psychiatric problems:
   a) psychiatric hospitals
   b) psychiatric units in general hospitals
   c) psychiatric treatment in correctional facilities.

10. What provisions for mental health services should be provided in the Criminal Justice System for:
    a) The violent offender
    b) The sexual offender
    c) Ethnic groups
    d) Native peoples
    e) Mentally retarded
    f) Children
    g) Adolescents.
11. If you believe that the treatment should be conducted by a psychiatric hospital, do you feel that they should be incorporated into the main stream of patient or that special units be established for this purpose?
12. Comments on procedures and services with respect to those persons emerging from the Criminal Justice System into the community, i.e. the disturbed or deviant person who might enter health care (follow-up).
13. Should each provincial psychiatric hospital have a secure setting or unit to receive persons for brief assessments or for longer assessments on remand?

APPENDIX VI

Submissions and Consultations

Appendix VI

Criminal Justice System and Mental Health Services

Submissions and Consultations

Name	Person	Date of Submission
Ministry of Correctional Services	Mr. G. R. Thompson	May 19, 1978
Department of Psychiatry, U.W.O.	Dr. D. M. Wickware	July 26, 1978
Essex County District Health Council	Mr. F. N. Bagatto	September 26, 1978
Ontario Provincial Police	Mr. H. H. Graham	September 29, 1978
Ontario Psychiatric Association	Dr. G. A. Heasman	October 5, 1978
The Lanark, Leeds & Grenville District Health Council	Mrs. C. C. Tosh	October 5, 1978
Elizabeth Fry Society	Mrs. G. Sandeman	October 6, 1978
Ontario Native Persons	Dr. H. Armstrong	October 10, 1978
Metropolitan Toronto Police	Mr. J. Noble	October 11, 1978
Ontario Association for Mentally Retarded	Mrs. M. McPherson	October 11, October 27, 1978
Ontario Psychological Association	Dr. M. Goodman	October 25, 1978
Law Reform Committee, Provincial Judges' Association (Family Division)	Judge J. D. Karswick	November 2, 1978
Ontario Association of Chiefs of Police	Mr. J. L. Erskine	November 9, 1978
Deputy Solicitor General and Deputy Minister of Justice of Canada	Mr. A. Bissonnette Mr. R. Tasse	November 3, 1978
Ontario Crown Attorney's Association	D. W. Johnson, Pres. L. H. Own, Chairman	November 21, 1978
Metropolitan Toronto Forensic Service	Mr. J. P. Rickaby Mr. M. Phillips Dr. F. Jensen	November 27, 1978
Provincial Secretariat for Justice	Hon. Robert Welch	December 12, 1978
Department of Psychiatry, Division of Forensic Psychiatry University of Toronto	Dr. R. Coulthard	December 15, 1978

(Copies of some submissions may be available on request.)

APPENDIX VII

Public Hearings

Appendix VII

Public Hearings:

The following statements were selected from submissions made at public hearings conducted by the Committee on Mental Health Services across the province in May and June of 1978.

— That section 20(3) [The Mental Health Act] be amended to reflect the policy that an inmate who has been transferred to a psychiatric facility from a jail becomes the responsibility of that psychiatric facility. That this policy be reflected in legislation permitting mentally ill patients to be absent without obtaining leave from a superintendent.

— That the inmate whose mental disorder is not serious make the choice of whether he receives mental health assistance.

— That the officer in charge of the psychiatric facility, when he contemplates a leave of absence for a patient, obtain the approval of the Ministry of Correctional Services prior to authorizing the absence. That greater co-operation between the correctional institution and the psychiatric facility would assist the decision maker.

— That plans for a forensic service for the local judicial and correctional systems be engaged in.

— That the physician-patient privilege receive legislative support.

— The plight of patients detained in the maximum security facilities at Penetang and St. Thomas support the view that the treatment of patients be based on a clinical evaluation and not a judicial determination.

— That, except in extremely rare cases, most patients detained under Warrant of Lieutenant Governor could be more successfully managed and treated in regional psychiatric facilities where appropriate security measures are available.

— That the Government of Ontario – particularly officials from the Ministries of Health, Community and Social Services and the Attorney

Public Hearings–continued

General – consult periodically, on an ongoing basis, with the Ontario Mental Patients' Association, other self-help groups of psychiatric and former psychiatric patients, the Canadian Civil Liberties Association, The Ontario Human Rights Commission and the Ombudsman for Ontario regarding any abuses or violations of these proposed civil and human rights, and any abuses of psychiatric "treatment" in any psychiatric facility or institution in Ontario.

— That there be more insistence on the client's attendance, especially if she is not personally inclined to attend. That the courts determine what mental health services are available, and be empowered to ensure that orders regarding such services are fulfilled on both sides.

— That there be diagnostic and treatment facilities in juvenile court with emphasis on a combined community approach.

— That the Psychiatric Unit at the Metropolitan Toronto Jail be considered a health service and therefore that the Ministry of Health assume responsibility for professional resources comparable to other psychiatric services.

— That Whitby continue to receive patients from Penetang. That the hospital have forensic facilities for court assessments.

— That mental health counselling be provided to incarcerated people in Thunder Bay. That the need for a Forensic Unit be further explored.

— It has been shown recently that mental health intervention in delinquency is unhelpful or possibly even helps promote anti-social behaviour. Such data may suggest that expensive programs be stopped when proven useless. Some form of care will still be required for the delinquent though, and an increase in expenditure of funds on innovative approaches to the problem is clearly needed.

— The Mental Health Act, section 14, empowers a judge to order any person who appears before him to a psychiatric facility for treatment. Presumably this order is sufficient authority for the facility to both hold and treat the person against his/her will. We have been advised by staff of the Ministry of Health that this power is rarely, if ever, used. We believe the powers contained in sections 14–17 constitute an unwarranted and apparently unneeded power which could result in a substantial interference with rights of an individual who came to court to plead guilty to a parking violation. The criminal and civil commitment processes are perfectly adequate to the task.

— Concern has been expressed by psychiatrists as well as others that making acceptance of psychiatric treatment a condition of parole or probation removes the requisite voluntary quality of the person's consent, and may undermine the therapeutic relationship between doctor and patient.

Thus both the voluntariness and the effectiveness of such an approach can be open to question. Because of such conditions in probation or parole orders have, in the past, been considered humane and reasonable courts have not been prepared to regard the person's consent as coerced. We feel the whole area is in need of a thorough re-examination.

— That no persons with mental disorders be incarcerated in jail as they are targets of abuse from other inmates.

— That persons with mental disorders committing crimes have the choice of serving sentences in a jail or psychiatric facility.

— That there be smaller regional maximum security facilities.

— That the Advisory Review process needs to be improved.

Membership of Legal Task Force

Brian A. Crane, Q.C. Chairman	Gowling And Henderson Ottawa
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R. E. Turner, M.D., F.R.C.P.(C)	Psychiatrist-In-Charge & Director Metropolitan Toronto Forensic Service

*For health reasons, Mr. Affleck did not participate actively in most of the Task Force's work.

**Sister Marion Barron, who resigned from the Task Force in June, 1978, was replaced by Mrs. Burwell at that time.

Membership of Committee on Mental Health Services in Toronto

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June, 1979

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J. C. Wilson	Woods, Gordon & Co., Toronto.
W. F. J. Anderson, M.P.H.	Executive Secretary, Ontario Council of Health.

Ontario Council of Health Publications

Reports of the Ontario Council of Health listed below may be obtained from the Ontario Government Bookstore, 880 Bay Street, Toronto, Ontario. M5S 1Z8.

Report on the Activities of the Ontario Council of Health, June 1966 to December 1969.

Summary Volume

Annex A - Regional Organization of Health Services
Annex B - Physical Resources
Annex C - Health Manpower
Annex D - Education of the Health Disciplines
Annex E - Library Services
Annex F - Health Research
Annex G - Health Statistics
Annex H - Health Care Delivery Systems–Highly Specialized Services
–Regional Laboratory Services

1970 Supplements

Supplement No. 1 - Regional Organization of Health Services
Supplement No. 2 - Health Statistics
Supplement No. 3 - Health Manpower
Supplement No. 4 - Library and Information Services
Supplement No. 5 - Health Care Delivery Systems–Community Health Care
Supplement No. 6 - Health Care Delivery Systems–Rehabilitation Services
Supplement No. 7 - Health Care Delivery Systems–Laboratory Systems
Supplement No. 8 - Health Care Delivery Systems–Dental Care Services
Supplement No. 9 - Health Care Delivery Systems–Role of Computers

1971 Reports

1971 Supplement 9A - Role of Computers in the Health Field
1971 Monograph #1 - Future Arrangements for Health Education
1971 Monograph #2 - Perinatal Problems
1971 Monograph #3 - Audiovisual Systems

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2 OF 3

1973 Reports

Report of the Committee on Health Research (Economics of Health Research)
Social Implications of Development in Biomedical Sciences
Cytological Services in Ontario
Mental Health Services Personnel
Proposed Scope of Practice for Chiropodists in Ontario
Scope of Practice and Educational Requirements for Chiropractors in Ontario
A Review of the Report of the Committee on the Community Health Centre Project
A Review of the Ontario Health Insurance Plan
Review of the Ontario Parcost Program

1974 Reports

Acupuncture
Biomedical Engineering and Biophysics
Physician Manpower
Health Services for New Towns and Major Developments or Redevelopments in Existing Communities and in Underserviced Areas

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Nutrition and Dietetic Services

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Evaluation of Primary Health Care Services
An Estimate of the Economic Burden of Ill-Health

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Health Research Priorities for Ontario
Immunization
Hypertension
The Planning Function of District Health Councils

1978 Reports

Medical Record Keeping
Health Care for the Aged

1979 Reports

Report of the Committee on Mental Health Services in Ontario: Agenda for Action
User Charges in Health Services.