
Falling through the Cracks: The Quebec Mental Health System

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The authors, through their experiences as volunteers at a women's shelter, examine the systematic isolation and segregation of the mentally ill and the role of law in continuing this reality. Underlying the current legislation in Quebec is a tension between two rights: liberty and treatment. While the goal of the mental health system is treatment, legislation tends to be very rights-oriented, focussing on protection and control. The current law on involuntary commitment and treatment has adopted a pure danger standard, with the result that treatment is imposed in only the most extreme cases, when individuals are considered a danger to themselves or others.

The present standard fails to account for such factors as emotional and financial stability, and further reinforces the mistaken view that the mentally ill are dangerous. The subjective interpretation that follows from this standard leads to criminalization. Other standards, such as the welfare standard, are also flawed, maintaining inappropriate stigma.

The authors argue for limited involuntary confinement, increasing its efficiency by including a capacity/competency standard. Other options, such as the Ulysses contract, out-patient committals, and stronger community support mechanisms, are suggested as means to combat paternalistic State interference, while at the same time promoting treatment.

Les auteures, s'inspirant de leurs expériences en tant que bénévoles dans un centre d'hébergement pour femmes, étudient l'isolement et la ségrégation systématiques des personnes atteintes de maladie mentale, ainsi que le rôle que joue le droit dans la perpétuation de cet état de choses. Une tension entre deux droits, soit le droit à la liberté et le droit aux soins, sous-tend la législation québécoise actuelle. Le but du système de santé mentale est essentiellement de fournir des soins, alors que la législation, étant plutôt orientée vers les droits, vise la protection et le contrôle. Puisque la loi actuelle portant sur les soins et la garde en établissement sans consentement comprend un test de dangerosité stricte, les soins sont imposés uniquement dans des cas extrêmes, lorsque l'individu présente un danger pour lui-même ou pour autrui.

Le test actuel ne tient pas compte de facteurs tels que la stabilité affective et financière, et renforce la perception erronée que les personnes atteintes de maladie mentale sont dangereuses. L'interprétation subjective qui en résulte mène à la criminalisation. D'autres tests, tels que le test de bien-être, sont également imparfaits, et perpétuent le stigmate.

Les auteures préconisent la garde en établissement sans consentement limitée, et suggèrent d'ajouter un test d'aptitude et de compétence pour améliorer son efficacité. D'autres options, permettant de lutter contre toute ingérence étatique paternaliste, tout en encourageant les soins, sont proposées, telles que le contrat d'Ulysse, la garde de malades en consultation externe, et des meilleurs mécanismes de soutien communautaire.

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Introduction

The law, as a reflection of societal values, has contributed to the marginalization and the isolation of those afflicted with mental illness. The following passage from the judgment of Lamer C.J.C. in *R. v. Swain* is instructive:

The mentally ill have historically been the subjects of abuse, neglect and discrimination in our society. The stigma of mental illness can be very damaging. The intervener ... [Canadian Disability Rights Council] describes the historical treatment of the mentally ill as follows:

For centuries, persons with a mental disability have been systematically isolated, segregated from the mainstream of society, devalued, ridiculed, and excluded from participation in ordinary social and political processes.

The above description is, in my view, unfortunately accurate.¹

The law can also act as an instrument of social change and can be used either to continue the segregation and discrimination of this group or to change the way people view the mentally ill. Thus, the values protected in mental health law and the weight ascribed to such values can have a significant impact on shaping or changing attitudes towards those suffering from mental illness.

The dominant values at stake in mental health law are the individual's right to liberty, enshrined in the *Canadian Charter of Rights and Freedoms*,² the right to inviolability and integrity of the person as articulated in the *Civil Code of Québec* ("C.C.Q."),³ and the *Quebec Charter of Human Rights and Freedoms*,⁴ and the right of the individual to safety, treatment, and relief from suffering.⁵ The tension between the degrees of protection to be afforded each of these rights is a recurring theme in this area of the law. Nowhere is this tug-of-war more evident than among the homeless and indigent.

Part I of this paper provides a brief description of the strong correlation found between the indigent and mental illness. In particular, our discussion deals with indigent women, as our personal experience was gained volunteering with a women's shelter in Montreal. Working with such individuals, we became determined to understand why these women were not being treated, why these women were falling through the cracks.

¹ [1991] 1 S.C.R. 933 at 973, 63 C.C.C. (3d) 481.

² S. 7, Part 1 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter *Charter*].

³ Art. 3.

⁴ R.S.Q. c. C-12 [hereinafter *Quebec Charter*].

⁵ See e.g. M. Bay, "Treatment and the Mental Health Act: A Review Board Perspective" (1991) 12 *Health L. Can.* 11 at 13.

In Part II we conduct a thorough analysis of the present-day mental health law in Quebec. The purpose of this analysis is to investigate, through the current legislative regime, the danger standard, the right to refuse treatment, the role legislation is presently playing within the mental health system, and the role legislation should be playing in the future. At present, the legislation in Quebec is very rights-oriented, and for the most part, only those individuals who voluntarily seek help will be treated. As our empirical observations indicate, it is rarely the case that individuals will voluntarily seek help.

Part III of this paper addresses the future of the mental health system in Quebec. The goal of the mental health system is treatment. One of the major regulatory components of the mental health system is legislation, yet the objective of this legislation is not treatment; it is the protection of individual rights. Consequently, we asked ourselves how legislation can respect civil liberties and at the same time work towards helping the system achieve its goal of treatment. We argue that capacity is the key for ensuring that involuntary confinement remains very limited but also leads to treatment, not mere detention. We determined that the involuntary committal standard should only be applied respecting persons proven incompetent, for only such individuals may be treated against their wishes. This will enable hospitals to remain centres of treatment and not become detention centres. Fortunately, involuntary hospitalization is not the only option available to provide treatment in Quebec's mental health system. There are legislative and other means available that should be explored. These include the Ulysses contract, out-patient committals, and a strong community network. Such endeavours would greatly limit the violation of individual rights while at the same time allowing for more effective treatment.

I. Mental Health and Indigent Women

Through volunteer work at a women's shelter in Montreal, we were able to observe first-hand the overwhelming obstacles indigent women must overcome in coping with the simple tasks of daily life. Moreover, the majority of the women at this shelter suffer from some form of mental illness: paranoid schizophrenia, depression, and obsessive-compulsive disorders are just a few of the illnesses encountered. This is not an uncommon situation. A newswire reported that "Toronto's hostel division estimates close to 80 per cent of the city's homeless women suffer from mental illness ... Women's Residence manager Anabella Wainberg ... [stated] 'More and more, if I see someone who's normal in the shelter, I wonder why she's here.'"⁶

It is very difficult to deal with or analyze a problem that entails the homeless in Canada due to "the lack of consistent and reliable data on both the number and com-

⁶ M. Philp, "Mental Illness Afflicts Many Homeless" *Canadian Press Newswire* (19 October 1997), online: NEXIS (News, WIRES).

position of the homeless population.”⁷ Nonetheless, there have been studies on the correlation of homelessness and mental illness in Quebec. The following are some results of these studies:

Dans une étude intitulée *Traité des problèmes sociaux*, étude codirigée en 1995 par Fernand Dumont, Simon Langlois et Yves Martin, on apprend que, “suivant la définition la plus restrictive, Montréal compterait entre 10 000 et 15 000 personnes sans abri”... Toujours dans cette étude qu’a publiée L’Institut québécois de recherche sur la culture, on peut lire ceci: “La présence des maladies mentales sévères parmi la clientèle itinérante de Montréal est importante: dans l’ensemble, de 40% à 45% souffrent d’une maladie mentale quelconque, dont 10% d’un trouble sévère comme la schizophrénie ou un trouble bipolaire.”⁸

Des études américaines et québécoises (dont celle du Dr. Lamontagne) estiment qu’entre 23% et 50% de ces personnes [les sans-abri], sont aux prises avec de très sérieux problèmes de santé mentale.⁹

Les problèmes de santé mentale sont aussi importants chez les deux sexes. De 27% à 40% (selon l’estimation faible et forte) des personnes interrogées en sont atteintes. Ce sont surtout les plus de 30 ans des deux sexes qui ont de tels problèmes.¹⁰

It is important to note that while these studies concentrate on the specific link between homelessness and mental health, the broader link is between poverty and mental illness. In a 1988 study performed in Quebec, it was concluded that

parmi les individus ayant recours aux services externes de psychiatrie, les personnes sans emploi et les bénéficiaires de l’aide sociale sont surreprésentés. On trouve également parmi les patients un nombre supérieur d’usagers venant des milieux urbains et, par rapport à la population générale, une proportion plus grande de personnes n’ayant pas poursuivi d’études postsecondaires (une caractéristique souvent liée à la pauvreté).¹¹

Thus, the night shelters service the homeless, and the day shelters service the homeless and indigent, but both shelters must confront mental illness on a continuous basis.

⁷ T. O’Reilly-Fleming, *Down and Out in Canada: Homeless Canadians* (Toronto: Canadian Scholars’ Press, 1993) at 11.

⁸ S. Truffaut, “De plus en plus lourd” *Le Devoir* (11 June 1998) A1.

⁹ G. Racine, *Les maisons d’hébergement pour femmes sans abri : un rôle de prévention secondaire en santé mentale* (Quebec: Gouvernement du Québec, Conseil québécois de la recherche sociale, 1990) at 6.

¹⁰ Quebec, Ministère de la Main-d’œuvre et de la Sécurité du revenu, *Les sans-abri au Québec : Étude exploratoire* (Quebec: Ministère de la Main-d’œuvre et de la Sécurité du revenu, 1988) at 117.

¹¹ J.-B. Robichaud et al., *Les liens entre la pauvreté et la santé mentale : de l’exclusion à l’équité* (Montréal: Gaëtan Morin, 1994) at 64.

II. Current Legislative Regime

A. Quebec's Regime for Civil Commitment

1. General Overview

The regime in Quebec governing civil involuntary commitment consists of (i) articles 26-31 of the C.C.Q. ("Confinement in an Institution and Psychiatric Assessment"); (ii) articles 26, 36.2, and 762-784 of the *Code of Civil Procedure* ("C.C.P."); and (iii) *An Act respecting the protection of persons whose mental state presents a danger to themselves or to others*,¹² which came into effect on June 1, 1998, and has replaced the *Mental Patients Protection Act*.¹³ The *Protection Act* emphasizes the primacy of the C.C.Q. provisions in the area of mental health law.¹⁴ The enactment of the *Protection Act* has not given rise to a radical change in this area of the law. The main thrust of the reform has been to harmonize the above-mentioned sources of mental health law, most notably with respect to the procedures relating to involuntary confinement of persons whose mental state poses a danger to themselves or others.¹⁵

The recent legislative reform was based to a large extent on the proposals set out in the *Draft Uniform Mental Health Act*,¹⁶ a document designed to harmonize the legislation in the area of civil commitment across Canada. This initiative (and presumably the legislation modelled after this document) was met with criticism from the psychiatric community. One medical writer was of the opinion that the document was overly legalistic and that the thrust of the *UMHA* was to make it more difficult to hospitalize and thereafter to keep patients in hospital, which will lead to discharging patients under "questionable circumstances that are not dictated by good clinical judgment."¹⁷ Similar sentiments have been expressed by a Montreal social worker involved in crisis intervention. He described the law in Quebec as one of exception, one that is

¹² S.Q. 1997, c. 75 [hereinafter *Protection Act*].

¹³ R.S.Q. c. P-41 [hereinafter *MPPA*].

¹⁴ *Protection Act*, *supra* note 12, s. 1. This section states that the *Protection Act* complements the codal provisions governing confinement and psychiatric assessment.

¹⁵ D. Payette, *Confinement of Persons Whose Mental State Presents a Danger* (Montreal: McCarthy Tétrault, 1998) at 2; A.-M. Veilleux & H. Allard, "Les recours et la représentation du patient psychiatrique selon la nouvelle Loi sur la protection des personnes dont l'état mental présente un danger pour elles-mêmes ou pour autrui" in Barreau du Québec, Service de la formation permanente, *Développements récents en droit de la santé mentale* (1998) (Cowansville, Qc.: Yvon Blais, 1998) 147 at 150 [hereinafter "*Développements récents*"].

¹⁶ Uniform Law Conference of Canada, *Draft Uniform Mental Health Act* (Committee on Mental Health, 1986) [hereinafter *UMHA*].

¹⁷ A.D. Milliken, "The Uniform Mental Health Act: A Clinician's Questions" (1986) 7 *Health L. Can.* 76 at 80.

not focussed on treating the patient and will only serve to hospitalize those in desperate need.¹⁸

One legal commentator stated that the regime in Quebec is focused primarily on the control and protection of and from persons who pose a danger to themselves or others and not on the treatment of such individuals.¹⁹ The following changes in the *Protection Act* provide a strong indication of the legislature's intent to send a strong message that the justification for civil commitment is not based on the need to treat the person affected. The *Protection Act* introduces the term "confinement", which, among other applications discussed below, is used to replace the concept of "close treatment" present in the *MPPA*, thus focussing on control and not treatment. Moreover, the title of the *Protection Act* eliminates reference to mental patients, a term that may have connoted a treatment component.

2. Confinement

a. Preventive Confinement

There are three possible forms of confinement under the new regime. The first, preventive, is regulated under the *Protection Act* and can be invoked by a physician, without the intervention of the court, if the patient's mental state causes him or her to meet the "grave and immediate" standard. Under the *Protection Act*, the police have been given express powers to transport such persons to a hospital facility in certain instances. It should be noted, however, that when a family member, as opposed to a crisis intervention worker, requests that the person be taken to an institution that may hold the person under the preventive requirement, the officer must have "good reason to believe that the mental state of the person concerned presents a grave and immediate danger to himself or to others."²⁰ This requirement adds a measure of protection by ensuring that individuals are not taken against their will for arbitrary reasons.

Section 7 of the *Protection Act* states that a physician and not necessarily a psychiatrist may authorize the preventive confinement, and that a physician cannot hold a person under such confinement for longer than seventy-two hours without obtaining a court order.²¹ No psychiatric examination is to be undertaken during this period. This is supported by the wording of section 7, which states that the confinement is "prior to

¹⁸ Personal communication with a social worker who works at a downtown Centre local de services communautaires providing crisis intervention to itinerant people with mental illnesses.

¹⁹ J.-P. Ménard, "L'impact de la Loi sur la protection des personnes dont l'état mental présente un danger pour elles-mêmes ou pour autrui sur le consentement aux soins" in *Développements récents*, *supra* note 15, 237 at 239. See also Payette, *supra* note 15 at 2.

²⁰ *Protection Act*, *supra* note 12, ss. 6, 8(2).

²¹ S. 7 provides an extension if the period ends on a Saturday or non-judicial day.

psychiatric examination".²² This interpretation is consistent with the first paragraph of article 27 of the C.C.Q., requiring the physician to make an application to the court for an order to confine a person temporarily for the purposes of a psychiatric assessment. Further, the third paragraph of section 7 of the *Protection Act* refers to the expiry of preventive confinement after seventy-two hours unless a "court has ordered an extension of the confinement for psychiatric assessment." While this paragraph refers to assessment and not examination, neither the C.C.Q. nor the *Protection Act* contemplates the conduct of a psychiatric examination for purposes other than as part of a psychiatric assessment bearing on confinement or continued confinement. Moreover, as preventive confinement is based on dangerousness and not treatment, there is no scope for an examination to be performed other than as part of an assessment. Thus, no examination may be commenced until a court order is obtained. For practical purposes, this form of confinement is used in emergency situations, where the time delay involved in obtaining a court order may present serious safety risks to the person affected or others.

b. Temporary Confinement

Once a court order has been obtained, it would appear that a person, once held under preventive confinement, would now fall under the category of being temporarily confined, and the provisions of the C.C.Q. and the C.C.P. would apply equally to those who were initially held under preventive confinement as to those who are admitted to a facility after the issuance of a court order. This period of confinement is regulated primarily by articles 28 and 29 of the C.C.Q. Under these provisions, the person must undergo a psychiatric examination, and if the physician concludes that confinement is not necessary, the person must be released. If the physician concludes that confinement is necessary, a second physician must carry out a separate examination. If this physician determines that the confinement is not warranted, the person must be released. If both physicians concur that confinement is required, authorization of the court must be sought within forty-eight hours (presumably of the date at which the second physician made his or her determination) to confine a patient pursuant to article 30 of the C.C.Q. In any event, a person cannot be held under temporary confinement for the purposes of a psychiatric assessment for longer than seven days.²³

A review of the *Protection Act* and articles 784 and 859(1) of the C.C.P. reveals two avenues from which an individual may contest the temporary confinement. Section 21 of the *Protection Act* gives a person who is dissatisfied with the continuance of confinement or with a decision made under the *Protection Act* the right to contest that decision before the Administrative Tribunal of Québec. While temporary confinement does not appear to be a decision made under the *Protection Act*, it is submitted that the

²² Payette, *supra* note 15 at 15 is of the view that whether an evaluation may be performed is a matter of debate.

²³ According to art. 29 C.C.Q., the report must be filed with the court within seven days of the court order.

change in status from preventive to temporary confinement is continued confinement under the *Protection Act* as contemplated in the third paragraph of section 7, thus giving rise to the application of section 21. Nothing in the new regime alters the person's right to appeal the court order authorizing the psychiatric assessment as outlined in the above-mentioned articles of the C.C.P. While this may be more of a theoretical than a practical concern with respect to temporary confinement, it is important to note that this situation may arise in dealing with contestations of continued confinement that have been authorized by a court pursuant to article 30 of the C.C.Q. It remains to be seen how this jurisdictional issue will be resolved.

c. Court-Authorized Confinement

Pursuant to article 30 of the C.C.Q., a court will not authorize confinement without two psychiatric assessments recommending such a course of action. When a court order is granted, the judgment must set the length of the term of confinement. However, subsection 12(1) of the *Protection Act* requires the release of the person if, in the opinion of the attending physician, confinement is no longer justified. This determination is made without regard to the term outlined in the judgment. It is the absence of dangerousness that will precipitate this release, irrespective of whether the physician is of the opinion that the person may benefit from continued treatment.

The *Protection Act*, at section 10, requires periodic examinations to be performed to evaluate the continuing need for confinement. The first such evaluation is to be made twenty-one days following the court order, even if the court order has stipulated a longer term of confinement. Subsequent reviews, if necessary, must be performed every three months thereafter.

In reviewing the new provisions of the *Protection Act* and the C.C.Q., some commentators are of the opinion that reading these provisions together raises a possible interpretation problem: a court order is no longer required to continue the confinement past the terms authorized in the original judgment.²⁴ Such an interpretation appears to go against the spirit of the new regime, which is intended to enhance and protect individual rights in the face of involuntary committal. To get around such possible arguments, they argue that the examination as required by section 10 is one that is authorized by the court and pursuant to section 4 must be delivered to the court. Such an interpretation would result in the court authorizing all renewals, thus ensuring that this important review mechanism is not lost when dealing with confinement renewal.²⁵ It would seem incongruous to impose at the initial stage the rigorous standard

²⁴ Veilleux & Allard, *supra* note 15 at 161. The authors argue that art. 30 deals solely with confinement pursuant to a psychiatric assessment, which is interpreted to mean two examinations; the *Protection Act*, *supra* note 12, s. 10, however, states that only one examination is needed to renew confinement, thereby precluding extensions of confinement from the application of art. 30 and the necessity of obtaining a court order.

²⁵ *Ibid.* at 162.

of court review of the recommendation to confine, but then to drop this safeguard at the time of renewal, when judicial review is equally if not more important in protecting the liberty interests of the person affected.

d. Conclusion

The legislation governing confinement is not designed to be a mental health policy but a means of control and protection when people's mental state poses a physical safety risk to themselves or others. It is not designed to catch those slipping through the cracks. Moreover, it is designed to ensure that limitations to liberties arise in narrowly defined circumstances, and that the deprivation of freedom is not conducted in an arbitrary manner and lasts only as long as the conditions justifying its imposition are present.

As the danger standard is the sole criterion used in Quebec to justify involuntary confinement, a detailed analysis of this standard is necessary to ascertain if it does in fact attain the goal of minimal deprivation of liberty. Further, the formulation of the danger standard in other provinces and the use of other standards, such as the welfare standard, will be examined to determine if there are more desirable alternatives to the standard currently applied in Quebec.

B. Involuntary Civil Commitment Standards

1. Introduction

Robertson has observed that "beginning approximately in the 1940's, the scope of civil commitment was significantly expanded by the introduction of the 'welfare test'."²⁶ Consequently, the need for treatment became the goal of legislation. As a result, people "could be hospitalized and treated on a compulsory basis if this would protect or promote their best interests and welfare."²⁷ By the late 1970s, the general view was that both society and legislation gave considerable power to the medical community, often to the detriment of the patient's rights. As a result of this recognition, all Canadian provinces strove to adopt new legislation that emphasized protection of civil liberties over beneficial medical treatment. This marked a return to the danger standard, used in the nineteenth and early twentieth centuries, when the concept of dangerousness played a large role in involuntary hospitalization.²⁸ Upon a closer analysis of the change, it became apparent that while the courts in certain

²⁶ G.B. Robertson, *Mental Disability and the Law in Canada* (Scarborough: Carswell, 1994) at 386.

²⁷ *Ibid.*

²⁸ *Ibid.* at 385.

provinces did interpret these acts restrictively,²⁹ others simply treated the change as a reformulation of the welfare standard.³⁰

Various questions arise in determining the appropriate scope of involuntary civil commitment. For instance, in deciding between the narrow standard of protection from danger and the wider standard of need for treatment, a balance must be struck between two conflicting powers of the state: the police power and the *parens patriae* power. A second problem arises in defining the notion of danger. That is, should it be limited to physical violence or extended to include financial deterioration and the inability or unwillingness to provide oneself with the necessities of life?

2. The Danger Standard in Quebec

a. Legislation

In the *Protection Act*, there are two danger standards: where a person is confined without a court order (preventive confinement) and where a person is confined with a court order. The former danger standard is more stringent, since there is no court involvement at all. Rather, the individual is confined solely on the assessment of the physician. In the *Protection Act*, if the patient's mental state presents a grave and immediate danger to that patient or others, owing to mental health, section 7 comes into play:

A physician practising in such an institution may, notwithstanding the absence of consent, place a person under preventive confinement for not more than seventy-two hours in a facility maintained by the institution, without the authorization of the Court and prior to psychiatric examination, *if he is of the opinion that the mental state of the person presents a grave and immediate danger to himself or to others.*³¹

The same danger standard is articulated in section 8 with respect to the police power to take an individual against that individual's will to an institution.

The danger standard articulated in the *Protection Act* for confinement by court order is found in section 1. It states:

²⁹ See *M. v. Alberta* (1985), 63 A.R. 14 (Q.B.). The court held that the legislative concept of "danger" was meant to address serious risk of physical harm and not emotional or mental harm. The danger standard applied was very narrow—it was a pure danger standard.

³⁰ Robertson, *supra* note 26 at 395. See also *Re Producers and the Mental Health Act* (1984), 5 D.L.R. (4th) 577, 8 C.R.R. 142 (P.E.I.S.C.) [hereinafter *Re Mental Health* cited to D.L.R.]. The P.E.I. Supreme Court interpreted the notion of "safety" to address not only physical injury but also "mental or psychiatric symptoms as well as the provision of creature comfort in appropriately congenial physical surroundings" (at 589). Hence the legislation did not result in a pure danger standard. There was an implicit welfare standard as well.

³¹ *Protection Act*, *supra* note 12, s. 7 [emphasis added].

The provisions of this Act complement the provisions of the Civil Code of Québec concerning the confinement in a health and social services institution of persons *whose mental state presents a danger to themselves or to others*, and the provisions concerning the psychiatric assessment carried out to determine the necessity for such confinement.³²

This danger standard is wider in scope, since a court order is required. Confinement of the individual is not based solely on the discretionary power invested in a physician; rather, the court adds another step in the process that must be satisfied before an individual can be confined against his or her will. An individual confined under court order will be confined for a minimum of twenty-one days before a review and under temporary confinement for a maximum of seven days.

Consequently, the language used in Quebec is “danger to himself or others” and “danger that is grave and immediate to himself or others.” The word danger, however, is very ambiguous. There is no definition of this concept in either the *Protection Act* or the C.C.Q. Moreover, because the *Protection Act* and the C.C.Q. itself are so recent, case law provides little authoritative guidance. It is not yet known how the courts will interpret the danger standards quoted above.

It is worth noting, however, that the *MPPA*,³³ the predecessor of the *Protection Act*, also had two danger standards. Upon examination of the *MPPA*, it becomes evident that there is no real difference between its danger standards and those articulated in the *Protection Act*. Certain writers appear to be of the opinion that the *Protection Act* made no substantive changes to the danger standard. Thus, despite the legislative changes, case law pertaining to the *MPPA*'s danger standards may well be a useful guide as to how the courts will interpret the danger standards in force today.

b. Case Law

While there is virtually no case law relating to the preventive confinement danger standard of the *MPPA*, the case law is abundant with respect to section 11 of the *MPPA*, which articulates the close-treatment danger standard which is analogous to section 1 of the *Protection Act*. The Commission des affaires sociales (“CAS”) has faced the issue of maintaining the close treatment of an individual on many occasions. The CAS is asked by the legislation (previously the *MPPA* and now the *Protection Act*) to answer the following question: Might the mental condition of the individual endanger his or her health or security or the health or security of others? To provide an adequate response, the CAS must in turn then ask: What is health and security? Is it solely the individual's physical health and security? Or does it include the individual's emotional and mental health? Does it include financial security or marital security? If the CAS interprets the danger standard as being concerned with only the physical elements of violence or injury, then it is our submission that Quebec is a pure

³² *Ibid.*, s. 1 [emphasis added].

³³ *Supra* note 13.

danger standard jurisdiction. If the CAS interprets the danger standard more widely, Quebec is a mixed jurisdiction including both a danger and a welfare component.

In *Protection du malade mental—1*³⁴ the CAS determined that due to the physical violence against his mother in the past, the present day threats against his mother, and his reaction of self-mutilation in stressful situations, the appellant's close treatment should be maintained. This is a perfect example of a pure danger standard: danger of physical violence to others and physical injury to self. Another strong example of the pure danger standard is found in *Protection du malade mental—4*.³⁵ Here the CAS maintained the order for close treatment against an individual who was a repeat pedophile offender. The CAS held that this individual posed a great danger to the health and security of others.

The CAS, in *Protection du malade mental—1*,³⁶ again maintained the close treatment. The patient, upon arrival, demonstrated psychotic behaviour and suffered from delirium and paranoia. He was improving with his medication treatment. However, in the past, when he was released from hospital, he refused to take his medication and, as a result, there was a *rapid* deterioration in his improved behaviour and he became very menacing. Moreover, despite the improvement from the medication, he was still suffering from very active delirium. Consequently, the CAS concluded that the patient did presently pose a danger to others.

In *Protection du malade mental—6*³⁷ the CAS held that despite the fact that the patient exhibited obsessive and rigid personality traits and paranoia tendencies, and had an interest in articles regarding violence as a solution to problems, his mental state did not presently pose a risk to society. It was quite evident that the patient required treatment, but the CAS was not willing to confine him to close treatment unless he posed a present risk to society or to himself. The risk that the CAS appears to be referring to is the risk of immediate physical violence, harm, or injury, hence a pure danger standard.

The question that must now be addressed is whether there is a welfare element in this danger standard. In *Protection du malade mental—2*³⁸ the CAS released the appellant even though her psychiatrist was concerned because the patient was not capable of organizing her life and that the patient could not afford lodging. The CAS held, "La lois n'impose pas la cure fermée pour assurer ou consolider le traitement ou pour soustraire le patient aux contraintes socio-économiques de la vie en société. L'état de dangerosité est le seul critère retenu par la loi."³⁹ This case demonstrates that financial

³⁴ [1992] C.A.S. 239.

³⁵ [1997] C.A.S. 271.

³⁶ [1990] C.A.S. 243.

³⁷ [1992] C.A.S. 937.

³⁸ [1992] C.A.S. 243.

³⁹ *Ibid.* at 245.

insecurity and inability to organize one's life do not permit the CAS to continue close treatment.⁴⁰

In *Protection du malade mental—2*⁴¹ the CAS held that the appellant, although suffering from mental illness, should be released despite the concerns that she would not eat well, would not be taken back home by her family, and had a tendency to exercise poor judgment that could put her at risk. Here it is evident that security pertains to the absence of imminent physical harm, not security in the sense of food, clothing, and lodging. Moreover, the term "health" does not seem to include mental or emotional well-being; rather, it is concerned with the physical health of the individual. The CAS did not feel that the fact that the patient would not eat well was sufficient to constitute an endangerment to the health of the patient. Consequently, it is reasonable to conclude that the endangerment to the physical health has to be a serious one, such as self-mutilation, and the danger must be likely to occur in the immediate future.

The CAS held in *Protection du malade mental—2*⁴² that the appellant, who suffered from bipolar depression, should be kept under close treatment because his lithium medication had not yet been stabilized. This could be interpreted as a need for treatment/welfare-based decision. However, this is not clear, since a minimum standard of medical care would dictate that a patient remain hospitalized until his or her level of medication is regulated.

Based on the above analysis of the interpretation of section 11 by the CAS, the standard established in Quebec is one of danger in the sense of physical injury or physical harm to oneself or others. Quebec does not share the interpretation expressed in *Re Mental Health*, where the notion of safety was held to include "such things as the alleviation of distressing physical, mental or psychiatric symptoms as well as the provision of creature comfort in appropriately congenial physical surroundings."⁴³ In each of the Quebec cases noted above, the patient was suffering from mental illness. All patients were in need of treatment. Nonetheless, the CAS was not willing to confine the individuals any longer if they did not pose an immediate danger to the health or security of themselves or others. Health and security means physical health, not the mental and emotional health of the individual. Indeed, the mental health of each patient was suffering, but that is not what the CAS is investigating. "Security" means security of the physical body, not security of financial status, of marital status, or of housing status. Moreover, the CAS appears to be looking for a serious endangerment to the physical health and physical security of oneself or others in the immediate future, not something that may result over time. The danger standard for close treatment is very narrow. It should be noted that this analysis is based on the case law of the CAS that was published. Many decisions of the CAS have not been published. Nonetheless, the con-

⁴⁰ See also *Protection du malade mental—5*, [1992] C.A.S. 632.

⁴¹ [1982] C.A.S. 290.

⁴² [1991] C.A.S. 935.

⁴³ *Supra* note 30 at 589.

clusions of this analysis have been confirmed by interviews with psychiatrists and social workers who deal with this issue daily.

Therefore, since section 11 of the *MPPA* has been interpreted narrowly by the CAS, it is probable that the new danger standards articulated in the *Protection Act* will be interpreted in the same fashion. That the CAS has incorporated the "immediate danger" element of preventive confinement in cases dealing with the broader close-treatment danger standard is a strong indicator that the CAS desires to confine individuals under only the most pressing of circumstances. Hence, the design of the legislation, as noted above, does attain its goal that limitations to liberties arise in narrowly defined circumstances.

The result of such a standard is that the fundamental rights of these individuals are rarely, if at all, violated. Another result of such a standard is that only those individuals who, due to their mental state, are blatantly dangerous persons are ever confined and thus have the potential to be treated.

3. The Danger Standard in Ontario

a. Legislation

The *Mental Health Act*⁴⁴ provides that a person may be admitted as an involuntary patient in the following circumstances:

15(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 or herself;

(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 her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

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 will likely 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.⁴⁵

⁴⁴ R.S.O. 1990, c. M.7.

The legislation is extremely demanding (although an amendment process is underway to make it less so). It is much more restrictive than that of Quebec or Alberta. A physician may detain an individual for seventy-two hours under section 15. After that time, the patient must be released unless the attending physician, as per paragraph 20(1)(c), feels that the patient is suffering from a mental disorder of a nature or quality that will likely result in (d), (e), or (f) noted above. If a patient is readmitted under paragraph 20(1)(c), the minimum length of time the patient can be detained is two weeks. Moreover, subsection 20(2) requires that the physician who confines an individual pursuant to section 15 cannot be the same physician who readmits the patient under paragraph 20(1)(c). As in Quebec, there is a two-step process involved in detaining an individual for a long duration.

The danger standard in Ontario is, semantically, very rigorous. The question remains whether the courts are equally demanding in interpreting this legislation.

b. Case Law

In *G.(G.) v. Swamy*,⁴⁶ “the patient was severely delusional and believed, amongst other things, that she could communicate with people ... by means of mental telepathy.”⁴⁷ The patient wanted to be released, but due to her history, it was believed that she would stop taking her medication if she were discharged from the hospital. The court’s medical evidence suggested that this would happen “in a matter of weeks”, resulting in a serious deterioration in her condition, whereby she would probably then be a danger to herself and perhaps to others. The court held that “the patient’s discharge from the psychiatric hospital would likely result in imminent and serious physical impairment.”⁴⁸ Here, it appears that imminent can include “in a matter of weeks”. This is a very broad interpretation.

In another 1986 case, *Foran v. O’Doherty*,⁴⁹ the Review Board held that the patient, suffering from schizophrenia, should be committed because he had a “history of aimless wandering on the streets, an occasional contact with marijuana, an inability to handle money and a slovenly lifestyle.”⁵⁰ Fitzgerald J. reversed the decision of the Review Board. He noted that “[t]he whole scheme of the review process under the

⁴⁵ *Ibid.*, s. 15(1) [emphasis added]. Amendments are being made to the *Mental Health Act* by Bill 68, *An Act, in memory of Brian Smith, to amend the Mental Health Act and the Health Care Consent Act, 1996*, 1st Sess., 37th Leg., Ontario, 2000 (1st reading 25 April 2000) [hereinafter Bill 68]. Para. (f) of s. 15(1) is being amended by the striking out of “imminent and” at the beginning. S. (1.1) is being added to s. 15 to the effect that a physician will have more bases permitting him or her to make application for a psychiatric assessment.

⁴⁶ (1986), 36 A.C.W.S. (2d) 247 (Ont. Dist. Ct.) [hereinafter *Swamy*].

⁴⁷ As quoted in Robertson, *supra* note 26 at 392.

⁴⁸ *Ibid.*

⁴⁹ [1986] O.J. No. 2146 (Dist. Ct.), online: QL (OJRE).

⁵⁰ *Ibid.* at 3-4.

Mental Health Act is to ensure that patients do not become prisoners of the system."⁵¹ The court, while it did indicate that continued hospitalization would be beneficial, concluded that the medical evidence was insufficient to conclude that the patient's release would result in "imminent and serious" physical harm.⁵²

Nonetheless, the interpretation in *Swamy* was confirmed in 1989 by *Subotic v. Ropchand*.⁵³ Here the patient's mental state had, from lack of food and medication, progressively diminished. She suffered from paranoid schizophrenia and when out of the hospital became reclusive and tended to smoke in bed. The hospital staff stabilized her and she was accepting her medication. Due to her history of not taking her medication, McGarry J. articulated that he felt that he could not ignore her past refusals to take her medication and her past inability to feed herself properly. He stated that the proper analogy for "imminent" is "impending". He concluded that he had no doubt that her release would not be in her best interest, as serious physical impairment would be impending. This is a very different holding than that which was found in *Protection du malade mental—1*,⁵⁴ where the patient's close treatment was maintained because the refusal to take one's medication would result in a "rapid deterioration" not simply deterioration "in a matter of weeks", and *Protection du malade mental—2*,⁵⁵ where the patient's inability to feed herself was not a sufficient concern to continue to commit her under close treatment.

The term "likely" has also been the subject of some confusion. In *Azhar v. Anderson*,⁵⁶ the patient suffered from paranoid schizophrenia. He believed that he was being devoured by cobras and heard voices that told him to kill his brother's children. Here Locke J. held that the patient should not be released. He struck down the appellant's arguments that the nature of his mental state was not "likely" to result in serious bodily harm to himself or to another person. The appellant argued that "likely" means "highly probable". However, Locke J. interpreted "likely" to mean "probable".⁵⁷ With respect to serious bodily harm, he concluded that there was "a likelihood that it *could* happen."⁵⁸ As Gerald Robertson points out, "[T]he judge's conclusion that there was a likelihood that an attack on the children *could* happen seems inconsistent with his view that the statute requires the bodily harm to be 'probable.'"⁵⁹ The broader interpretation of the term "likely" has been confirmed in a 1989 decision of Doyle J. In

⁵¹ *Ibid.* at 5.

⁵² *Ibid.* at 7. Fitzgerald J. stated, "Beneficial as it might be for the patient to remain in the hospital, I cannot find convincing evidence that he is, if released, likely to sustain imminent and serious physical impairment as a result. If he is to continue to remain it must be on a voluntary basis" (*ibid.*).

⁵³ (14 July 1989), Elgin 701/89 (Ont. Dist. Ct.) [hereinafter *Ropchand*].

⁵⁴ *Supra* note 36.

⁵⁵ *Supra* note 37.

⁵⁶ (1985), 33 A.C.W.S. (2d) 521 (Ont. Dist. Ct.).

⁵⁷ As quoted in Robertson, *supra* note 26 at 394.

⁵⁸ *Supra* note 56.

⁵⁹ *Supra* note 26 at 394.

Mack v. Royal Ottawa Hospital,⁶⁰ the appellant had a chronic psychotic disorder. Doyle J. upheld the Review Board decision that the patient should remain at the institutional facility. He concluded that he believed there was "a serious problem here and a very strong possibility [leading] to the conclusion that ... there would likely be serious bodily harm if this person was not kept in a particular institution."⁶¹ This is broader than the requirement that something must be probable. The Ontario District Court decisions indicate a preference for a broader interpretation of the word "likely".⁶²

In summary, while Ontario's legislation is semantically stricter, in practice the courts are interpreting the legislation in broader terms. In reviewing the above-noted case law, it would appear that the courts of Ontario have put a welfare twist on the danger standard. Cases like *Swamy*⁶³ and *Roopchand*⁶⁴ indicate that the courts are not only determining if the patients/appellants are dangerous to themselves or others. Rather, they are also investigating the patients' eating and hygiene habits. Moreover, courts do not require that the danger be immediate but are willing to look further into the future in assessing an individual's potential impending dangerousness. Consequently, it is submitted that Ontario is a jurisdiction that has a mixed standard, but tends to lean more towards the welfare standard.

C. Critique of Involuntary Committal Standards

As noted above, the present day legal system offers two tools to involuntarily commit individuals suffering from mental illness: the danger standard and the welfare standard. The legal doctrine supporting the danger standard is the doctrine of police power, that being the power of the State to protect society from harm, whereas the legal doctrine supporting the welfare standard is the *parens patriae* power, that being the State's power to help those who cannot help themselves. The return to the danger standard in several jurisdictions is a response to the criticism that the welfare standard had been too paternalistic. Nonetheless, it is essential that neither standard be blindly accepted. Rather, one must investigate the benefits and costs of each of these standards.

1. The Danger Standard

Proponents of the danger standard argue that this standard is the best means to respect civil liberties. They seize upon the philosophy of John Stuart Mill that "the only purpose for which power can be rightfully exercised over any member of a civilised

⁶⁰ (1989), Ottawa 30176/89 (Dist. Ct.).

⁶¹ As quoted in R. Chandrasena, "The Ontario Mental Health Act: A Review of Court Decisions on Involuntary Committal" (1991) 11 Health L. Can. 97 at 98-99.

⁶² *Ibid.* at 99.

⁶³ *Supra* note 46.

⁶⁴ *Supra* note 53.

community, against his will, is to prevent harm to others.”⁶⁵ The police power is the only way to respect such a philosophy. They also argue that the danger standard is a more objective standard and provides less discretionary power to the medical profession than the welfare standard, and consequently there is greater consistency in involuntary commitment decisions.

The danger standard established in most jurisdictions is a mix of both the police power “danger to others” and the *parens patriae* power “danger to self”. That this standard concentrates on “danger” rather than “best interest” appears to give it a more narrow focus than the welfare standard. It is from this narrowness that the danger standard derives its status as the standard that respects civil liberties. Nonetheless, there are several indicia that the danger standard is quite flawed.

a. Stigma

While the danger standard may respect the civil liberties of those individuals suffering from mental illness, at the same time it reinforces the historical, mistaken belief that mental illness is equated with dangerousness. This is a grave error, for there appears to be little, if any, correlation between mental disorder and violence: “The most frequent outcome of studies trying to correlate the two is that the level of violence among people with mental disorders is the same as, or less than, the level of violence in the general public.”⁶⁶ The only other group within society that is subject to a danger standard is those individuals charged with a criminal offence. The danger standard for the mentally ill serves as a preventive measure because the medical profession believes they will be dangerous. There is no strong evidence supporting such a belief. It is based on the intuition of the doctors. As Carla McKague has noted,

If we are justified in applying preventive detention to the apparently violent mentally disordered person, why do we hesitate to use it in the case of the apparently violent person without a mental disorder? Why would most of us consider it wrong to lock up the members of a motorcycle gang, much as they might frighten us, before they have committed an offence?⁶⁷

Consequently, not only does the danger standard state that mental illness equals danger, it also appears to state that those suffering from mental illness are potentially more dangerous than the general public. The danger standard continues to provide so-

⁶⁵ J.S. Mill, “On Liberty” in R.B. McCallum, ed., *On Liberty and Considerations on Representative Government* (Oxford: Basil Blackwell, 1946) 1 at 8.

⁶⁶ C. McKague, “Involuntary Hospitalization: Are New Mental Health Laws Necessary? A Patients’ Rights Perspective” (1988) 9 *Health L. Can.* 15 at 15. See also J. Brennan, “Mentally Ill Aggressiveness—Popular Delusion or Reality” (1964) 120 *Am. J. Psy’try* 1181; D. Hastings, “Follow-up Results in Psychiatric Illness” (1958) 114 *Am. J. Psychiatry* 1057; J. Rappeport & G. Lassen, “Dangerousness—Arrest Rate Comparisons of Discharged Patients and the General Population” (1965) 8 *Am. J. Psychiatry* 776.

⁶⁷ McKague, *ibid.*

ciety with misinformation that only reinforces and adds to the stigma already endured by individuals suffering from mental illness.

b. Vagueness

While proponents of the danger standard argue that the concept of danger replaces the total subjectivity of psychiatric labels with a higher degree of certainty and objectivity, the above analysis of the various danger standards in Canada does not appear to support this view. The interpretation of the danger standard varies from province to province. Moreover, even within each jurisdiction, the way in which it is interpreted can also vary, depending on the judge ruling on the matter. The fact is that "best interests" is very subjective and asks the physician or psychiatrist to impose on the patient what he or she feels is best. "Danger", like "best interests", has no precise definition or accurate determination.

c. Predictability

Even if the danger standard could be constructed to avoid vagueness, it is still open to criticism because it cannot be predicted accurately. The predictability of dangerousness has been a highly contested question.⁶⁸ This doubt was best summarized by Steadman and Cocozza when they stated, "Whether magic or science, the prediction of dangerousness by psychiatrists represents an excellent example of professionals who have exceeded their areas of expertise for whom society's confidence in their ability is empirically unjustified."⁶⁹

A serious error that psychiatrists make in predicting dangerousness is the selection of false positives. A false positive is someone who is confined but does not, in fact, become dangerous. The problem is one of over-prediction. Studies have shown that predictive methods used yield sixty to seventy percent false positives, resulting in at least two persons being mistakenly confined for every one that does become dangerous.⁷⁰ Other studies have brought the ratio up to as high as twenty to one.⁷¹

⁶⁸ See e.g. C.J. Frederick, ed., *Dangerous Behavior: A Problem in Law and Mental Health* (Rockville, Md.: U.S. Dept. Of Health, Education & Welfare, 1978); H.J. Steadman, "Predicting Dangerousness Among the Mentally Ill: Art, Magic and Science" (1983) 6 Int'l J. L. & Psychiatry 381; S.J. Pfohl, "From Whom Will We be Protected? Comparative Approaches to the Assessment of Dangerousness" (1979) 2 Int'l J. L. & Psychiatry 55; T.W. Harding & H. Adserballe, "Assessments of Dangerousness: Observations in Six Countries; A Summary of Results From a WHO Coordinated Study" (1983) 6 Int'l J. L. & Psychiatry 391; H.J. Steadman, "The Right Not to Be a False Positive: Problems in the Application of the Dangerousness Standard" (1980) 52 Psychiatric Q. 84 [hereinafter "The Right Not to Be a False Positive"].

⁶⁹ J.J. Cocozza & H.J. Steadman, "Prediction in Psychiatry: An Example of Misplaced Confidence in Experts" (1977) 25 Soc. Prob. 265 at 275.

⁷⁰ B. Rubin, "Prediction of Dangerousness in Mentally Ill Criminals" (1972) 27 Arch. Gen. Psychiatry 397 at 398.

H.J. Steadman concluded that “[r]ather than asking what evidence is there that psychiatrists, or other clinicians, cannot accurately predict dangerous behavior, what evidence is there that they *can*? When the question is phrased in this manner, the answer is unequivocal. *There is none.*”⁷¹ If the danger standard is the legal system’s response to the desire for protection of civil liberties, and the central role of that response is highly controversial, it is doubtful that the danger standard can be regarded as a just and reliable response to this need.

d. Criminalization

While the danger standard has been applauded for its limited inclusiveness, there is a price that is paid for its narrowly defined parameters. That price is the criminalization of the mentally ill. It has been observed in studies that “arrests would take place when persons were not sufficiently mentally disordered to be admitted by the hospital, but were too public in their deviance to be ignored.”⁷² Consequently, while the danger standard gives the mentally ill the right to be delusional and not confined in a mental institution, this does not eradicate the likelihood that they will, nonetheless, be confined to jails. Where should these people be confined if they are mentally ill, not dangerous, but their behaviour exceeds the community’s tolerance? Most people, even supporters of the danger standard, would probably prefer that the mentally ill be placed in hospital, for there is something repugnant about the thought of punishing someone for something that is, due to illness, beyond his or her control.

e. Revolving Door Syndrome

Another result of the narrowly defined parameters of the danger standard is the revolving door syndrome. The revolving door symbolizes that in many cases, the patient, who is involuntarily committed, falls into a cyclical pattern of confinement and release within the mental health system. Take the following example. One day, Mrs. Y, a paranoid schizophrenic, goes out and buys a gun and says she is going to shoot the next alien she sees, since they have been chasing her for years. This is a situation where she would most likely be preventively confined in Quebec under section 7 of the *Protection Act*. Mrs. Y. allows the doctors to examine her and she also consents to receiving treatment. After the seventy-two hour confinement, Mrs. Y is much calmer and she has agreed to continue with her medication. Mrs. Y is no longer posing an immediate danger to herself or others. She is released. After a couple of days, Mrs. Y is feeling so good she decides she does not need her medication anymore. Two weeks later, the police find Mrs. Y wandering the streets with a knife, threatening to kill her-

⁷¹ J.J. Cocozza & H.J. Steadman, “We Can’t Predict Who is Dangerous” (1975) 8:8 *Psychol. Today* 32 at 35.

⁷² “The Right Not To Be A False Positive”, *supra* note 68 at 96.

⁷³ L.A. Teplin & N.S. Pruett, “Police as Streetcorner Psychiatrist: Managing the Mentally Ill” (1992) 15 *Int’l J. L. & Psychiatry* 139 at 147.

self because she cannot stop the voices. Mrs. Y is admitted again for another seventy-two hours and the cycle continues.

The aim of the danger standard is to prevent harm, and it does achieve that goal for seventy-two hours. But in most cases, after that period, the individual has calmed down and cannot be considered dangerous, and therefore can no longer be confined. Some would consequently argue that the danger standard deals only with the symptoms of the problem but not with the problem itself.

2. The Welfare Standard

The *parens patriae* doctrine has an extremely broad jurisdiction. It was described in *E. (Mrs.) v. Eve* as follows: "The *parens patriae* jurisdiction is, as I have said, founded on necessity, namely the need to act for the protection of those who cannot care for themselves. The courts have frequently stated that it is to be exercised in the 'best interest' of the protected person, or again, for his or her 'benefit' or 'welfare'."⁷⁴ This is the foundation upon which the welfare standard is based. The principle of helping others is a predominant one in the Canadian political and legal system. For example, consider the vast range of social programs designed to help the unemployed, the poor, and the physically or mentally challenged. Proponents of the welfare standard argue that it is society's responsibility to help those who cannot help themselves. Through the welfare standard, people who need treatment are at least within the confines of an institution that will be able to give them treatment if they consent. Moreover, the availability of food and shelter will raise the standard of living for many of the patients. Proponents argue that, unlike the situation under the danger standard, there is no falling through the cracks.

Nonetheless, like the danger standard, the welfare standard has many flaws. They are discussed briefly below.

a. Stigma

The welfare standard maintains and possibly adds to the stigma surrounding mental illness. Being institutionalized only heightens this stigma. Individuals, after they have been institutionalized, often find it difficult to find employment and accommodation. Moreover, many of their family members and friends treat them differently following the confinement. Society still fails to recognize that mental illness is an illness like any other.

b. Vagueness

As noted above, "best interests" is exceptionally broad. It is an extremely subjective notion. Consequently, an individual can be confined involuntarily based solely on

⁷⁴ [1986] 2 S.C.R. 388 at 426, 31 D.L.R. (4th) 1.

the subjective decision of a physician or psychiatrist. There is nothing concrete or determinative directing the decision of these professionals.

Parens patriae grants huge discretionary power. This discretionary power is often the impetus behind criticisms of the paternalism it tends to embody. There are several examples demonstrating the abuse which has resulted from such authority. They include the "depatterning" experiments conducted by Dr. Ewen Cameron at the Allan Memorial Institute in Montreal between 1950 and 1965,⁷⁵ and the case of the "Duplessis Children", which took place between 1939 and 1961.⁷⁶

c. Civil Liberties

The major reason behind the shift from the welfare standard to the danger standard is that the welfare standard did not respect the rights of individuals. The welfare standard has often been viewed as involving an excess of State-authorized interference in an individual's life. Too much deference was given to the medical community and little respect was given to the individual. The welfare standard created a huge dichotomy between mental illness and physical illness. Those suffering from the latter were permitted to make their own decisions despite their illness. Those afflicted with the former, once labelled mentally ill, were at the mercy of the medical profession. Given that strong individual rights have been entrenched in all areas of the law, it is unlikely that a standard which is not compatible with or does not respect patient's rights will or should form a part of the future direction of the law.

3. Conclusion

While the welfare standard does possess the respectable desire to "do good" like many other social programs in Canada, it is understandable why there was a revolution leading to the adaptation of the danger standard. The welfare standard was in direct violation of civil liberties, and it granted too much discretionary power to the medical profession. But as noted above, the danger standard also presents problems. Hence, attempts must be made to develop standards for involuntary committal that protect individual liberties, yet do not abandon these individuals to their illnesses. Moreover, in developing the future course of the law in the area of mental health, we must examine whether there are alternatives to involuntary committal that may be more successful in balancing these often conflicting objectives.

⁷⁵ Dr. Cameron performed experiments in which he administered electroshock treatments to patients who were heavily sedated for approximately ten days. See *e.g. Morrow v. Royal Victoria Hospital* (1973), [1974] S.C.R. 501, 42 D.L.R. (3d) 233.

⁷⁶ Serious abuses of the Quebec mental health laws caused the institutionalization of orphans and other children, as reported in A. Picard, "'Duplessis Children' Fight to End the Shame" *The Globe and Mail* (12 September 1992) A1. This tragedy has recently been in the news again as the victims of this abuse are requesting compensation from the Quebec government.

Before analyzing the direction that the law should be taking in the future, we will first examine one of the most significant advances in the area of recognition of the rights of the psychiatric patient, the right to refuse treatment. Any reform in the law must include the recognition of this right.

D. The Right to Refuse Treatment

This area of the law is permeated by the tension between the legal and medical views. The right to self-determination is at conflict with the view, generally ascribed to health care professionals and families of the mentally ill, that these individuals are too ill to know what is good for them, and refusals of treatment by involuntarily confined patients should be overruled irrespective of whether this decision represents the competent wishes of the patient. While the controversy in this area is framed in terms of these opposing views, it is important to remember that these are not competing interests held by different groups of individuals, but two sets of conflicting interests held by each individual.⁷⁷

The law in Quebec is focussed primarily on protecting and fostering the rights of the patient, as opposed to promoting a treatment-based approach to mental health law. Yet it is important to remember that the psychiatric profession plays a significant role in determining whether a patient can in fact exercise this right, as it is this group that determines if the patient is competent to consent to or to refuse treatment.

It has long been recognized that a major factor precipitating de-institutionalization has been the introduction of psychotropic medications, sometimes referred to as "major drugs".⁷⁸ These drugs control the symptoms manifested by acute psychotic individuals. In addition, they have been credited with lengthening the intervals between psychotic episodes and lessening the duration of these episodes.⁷⁹ Thus, the use of these drugs has allowed certain patients to lead "normal" lives within the community. Moreover, some writers maintain that the use of such drugs makes those suffering from mental illness more responsive to other forms of non-drug therapy, such as psychotherapy.⁸⁰

The growing use of these medications in treating mental illness has given rise to both medical and legal issues, the analysis of which will be the focus of this next section. The most serious medical problem associated with the use of these drugs is their

⁷⁷ Bay, *supra* note 5 at 13.

⁷⁸ D. Rochefort, *From Poorhouses to Homelessness: Policy Analysis and Mental Health Care* (Westport, Conn.: Auburn House, 1993) at 38.

⁷⁹ S. Gelman, "Mental Hospital Drugs, Professionalism, and the Constitution" (1984) 72 *Georgetown L.J.* 1725 at 1741.

⁸⁰ A.D. Brooks, "The Constitutional Right to Refuse Antipsychotic Medications" (1980) 8 *Bull. Am. Acad. Psychiatry & L.* 179 at 183.

side effects, which range from minor and temporary to serious and permanent.⁸¹ The legal question that arises is to what extent do we wish to define and extend this right as it applies to those involuntarily confined. The issues concerning the right to refuse treatment are also central to the debate over whether there should be legislation authorizing compulsory out-patient committal, which will be discussed below in Part III.C.

1. Drug Therapy: Benefits and Side Effects

While many clinicians agree that the introduction of psychotropic drugs has increased the quality of life for many people suffering from mental illness, these drugs do not cure the illness; they merely mask or inhibit the symptoms. One medical commentator has made the following statement describing the operation and effects of psychotropic drugs: "[A]gents that perform a chemical lobotomy ... The drugs do not cure a disorder but instead flatten the emotions, produce disinterest or apathy and enforce docility."⁸² Furthermore, there is controversy within the medical community as to the nature and extent of the benefits derived from the use of such drugs. Some studies indicate that the use of psychotropic drugs is beneficial to the treatment of acute schizophrenia, whereas other studies have challenged this claim.⁸³ Still other studies have indicated that these drugs do not appear to be effective in terms of preventing progressive deterioration of schizophrenics.⁸⁴

As previously mentioned, a significant disadvantage to the use of such drugs is the side effects suffered by those who take these medications over a prolonged period. Weatherhead classifies the side effects into two broad categories: movement or neuromuscular disorders and non-movement disorders. A few examples of the latter category are cardiovascular effects, such as severe drops in blood pressure and dizziness, and gastrointestinal effects, namely nausea and vomiting.⁸⁵ The more serious and enduring side effects, however, are the former, the most prevalent one being tardive dyskinesia. This disorder normally appears after prolonged use of antipsychotic drugs and is generally thought to be untreatable and irreversible. It may present itself in the form of involuntary movements of the tongue, mouth, or cheeks; similarly it may cause bizarre, involuntary movements of the torso or limbs. Further, continued use of

⁸¹ R. Weatherhead, "Psychotropic Drug Treatment Refusal by Competent Psychiatric Patients" (1988) 47 U.T. Fac. L. Rev. 101 at 105-6. See also C. Gendreau, *Le Droit du patient psychiatrique de consentir à un traitement : élaboration d'une norme internationale* (Montreal: Thémis, 1996) at 39-40.

⁸² P. Breggin, "Brain Damage, Dementia and Persistent Cognitive Dysfunction Associated with Neuroleptic Drugs: Evidence, Etiology, Implications" (1990) 11:3-4 J. Mind & Behav. 425 at 426.

⁸³ S. Beyer, "Madness and Medicine: The Forcible Administration of Psychotropic Drugs" [1980] Wisc. L. Rev. 497 at 539-40.

⁸⁴ Gelman, *supra* note 79 at 1749.

⁸⁵ K. Temple, "The Right to Refuse Treatment" (1986) 14 J. Psychiatry & L. 375 at 386.

these drugs can affect respiration, swallowing, and speech.⁸⁶ Breggin also states that there is research indicating that the use of these drugs may affect certain higher brain and mental functions.⁸⁷ While clinical studies on the prevalence of these side effects among long-time users yield various results, the incidence of these side effects is not insignificant.⁸⁸

The effects of refusal to consent to medication among involuntarily committed patients include delayed recovery, increased hospital stays, and increased use of physical or chemical restraints in those cases where the refusal to submit to treatment precipitates aggressive or violent behaviour on the part of the patient.⁸⁹ Trimnell expresses the frustration felt by clinicians at having to restrain patients, sometimes repeatedly, when such action usually has no impact on their condition. Moreover, Trimnell believes that if the severely psychotic patient could be medicated adequately for a short time, the patient and clinician(s) would be able to come up with some form of mutually agreeable treatment.⁹⁰

2. Clinical Views on the Right to Refuse Treatment

A recognized right to refuse treatment among competent, involuntarily hospitalized patients is a source of concern for many psychiatrists and other mental health care professionals. It is often cited as an example of the adverse affect that the increased intervention of the law in the mental health domain has had on the welfare of the mentally ill patient. The role of health care professionals when dealing with an involuntary patient who has refused treatment becomes that of the State's delegate as an agent of social control and protection. They are unable to treat the illness that precipitated the need for the hospitalization and often feel relegated to watching these institutionalized patients "rotting with their rights on".⁹¹ This position is clearly articulated in the following passage: "[T]o commit someone involuntarily to a mental institution without treatment for the illness that is the underlying basis for such con-

⁸⁶ Breggin, *supra* note 82 at 427.

⁸⁷ *Ibid.* at 429ff.

⁸⁸ Brooks, *supra* note 80 at 186 suggests that the rate of tardive dyskinesia in some mentally ill populations ranges from 25-50% of those who use anti-psychotic medications for prolonged periods. Breggin, *supra* note 82 at 428 cites various APA studies which indicate that the rate of incidence of tardive dyskinesia in routine treatment (several months up to two years) is between 10% and 20% among those with more than minimal mental illness. Studies of elderly nursing home patients indicated that 41% developed the disease over a period of only 24 months and none fully recovered.

⁸⁹ J. Trimnell, "The Need to Treat" (1988) 8 Health L. Can. 102 at 102-103.

⁹⁰ *Ibid.* at 103.

⁹¹ P.S. Appelbaum & T.G. Gutheil, "'Rotting With Their Rights On': Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients" (1979) 7 Bull. Am. Acad. Psychiatry & L. 306.

finement would be tantamount to warehousing him or her, that is, to confining without hope of reversing the process that resulted in the confinement.”⁹²

These statements are strong arguments in support of a medical model that focuses on the welfare of the patient. Yet the lack of consensus over the long-term benefit of prolonged use of such drugs, the powerful nature of these drugs, and the serious side effects that these drugs may produce are also factors that must be considered and are often glossed over by clinicians. Moreover, an approach to mental health law that ignores a patient’s right to self-determination does not necessarily promote the welfare of the patient. The assumption that the patient is not capable of knowing whether treatment is in his or her best interests may have an adverse effect on the individual. Removing this element of control from the person’s life can be damaging both emotionally and in terms of self-esteem to these already-vulnerable individuals.

3. Analysis of the Law

The right of the patient to determine what can and cannot be done to his or her body, which includes the right to refuse treatment, exists in medical law in both Quebec and Ontario.⁹³ This right is protected under the doctrine of informed consent, and is articulated in the C.C.Q. as follows:

Every person is inviolable and is entitled to the integrity of his person.

Except in cases provided for by law, no one may interfere with his person without his free and enlightened consent.⁹⁴

Further, article 11 of the C.C.Q. provides that no person shall be made to undergo care, treatment, or any other act except with his or her consent. The second paragraph of article 11, however, states that if the person is incapable of giving or refusing consent to care, a person authorized by law or by mandate given in anticipation of his or her incapacity may do so in his or her place. Article 15 provides a hierarchy of persons authorized to give consent in the case of the patient’s incapacity. Thus, a finding of incapacity does not obviate the need for consent; it merely means that the consent must be obtained from a substitute authorized by law or mandate.

The right to refuse treatment protects the patient’s right to make decisions that are against his or her best interests, or stated otherwise, the right to make unreasonable or

⁹² T.G. Gutheil, “The Right To Refuse Treatment: Paradox, Pendulum and the Quality of Care” (1986) 4 *Behav. Sci. & L.* 265 at 267-68.

⁹³ The Common Law position is articulated in *Malette v. Shulman* (1990), 72 O.R. (2d) 417, 67 D.L.R. (4th) 321 (C.A.) [hereinafter *Malette* cited to O.R.].

⁹⁴ Art. 10. The exception provided for emergency in art. 13 will not be examined. The exceptions to consent dealing with involuntary confinement and psychiatric evaluation in art. 26ff. have been examined in Part II.A, above.

irrational decisions.⁹⁵ To force a competent individual to submit to treatment for his or her own good is viewed as paternalistic and runs counter to a person's right to life, liberty, and security of the person as articulated in section 7 of the *Charter*. The seminal decision by the Ontario Court of Appeal in *Fleming v. Reid*⁹⁶ has elevated the competent refusal of treatment to the level of a constitutional right. Moreover, this decision is significant in the area of mental health law, as it dealt with the refusal to consent to treatment by an involuntary patient. The following statement articulates the right to refuse treatment and makes clear that the doctrine of informed consent applies equally to psychiatric patients:

These traditional common law principles extend to mentally competent patients in psychiatric facilities. They, like competent adults generally, are entitled to control the course of their medical treatment. Their right of self-determination is not forfeited when they enter a psychiatric facility. They may, if they wish, reject their doctor's psychiatric advice and refuse to take psychotropic drugs, just as patients suffering from other forms of illness may reject their doctor's advice and refuse, for instance, to take insulin ... The fact that these patients, whether voluntarily or involuntarily, are hospitalized in a mental institution in order to obtain care and treatment for a mental disorder does not necessarily render them incompetent to make psychiatric treatment decisions.⁹⁷

While this articulation is taken from an Ontario decision, it nonetheless also captures the Quebec position taken with respect to the right to refuse treatment and the right of informed consent as it applies to the psychiatric patient.⁹⁸

4. Capacity and the Right to Refuse Treatment

The degree to which the psychiatric patient's bodily integrity is protected by the right to refuse treatment turns on whether the patient is found to have the capacity to make such a decision. As stated above, a person is free to make decisions that may not be in that person's best interests. Yet the notions of paternalism that are rejected when dealing with consent to treatment for physical illness may nonetheless come to the

⁹⁵ See *Malette*, *supra* note 93 at 424. In the Civil Law this position is articulated in *Manoir de la Pointe Bleue v. Corbeil*, [1992] R.J.Q. 712 (Sup. Ct.), and *Nancy B. v. Hôtel-Dieu de Québec*, [1992] R.J.Q. 361 (Sup. Ct.).

⁹⁶ (1991), 4 O.R. (3d) 74, 82 D.L.R. (4th) 298 (C.A.) [hereinafter *Fleming* cited to O.R.]. In this case, the appellant psychiatric patients were incapable at the time of treatment of consenting to the proposed treatment with neuroleptic drugs. The substitute decision-maker refused to consent to the treatment, based on the prior competent wishes expressed by the patients. These decisions were overridden by the Review Board, which granted treatment orders pursuant to the *Mental Health Act*, R.S.O. 1980, c. 262, s. 35ff. The Court held that the provisions operated to deprive the appellants of their right to security of the person as guaranteed under s. 7 of the *Charter* and could not be justified under s. 1.

⁹⁷ *Fleming*, *ibid.* at 86. This position has been codified in the *Health Care Consent Act, 1996*, S.O. 1996, c. 2 [hereinafter *Health Care Consent Act*].

⁹⁸ See arts. 10, 11 C.C.Q.; Ménard, *supra* note 19 at 239, 241, where he states that this applies in all circumstances, even when dealing with those subject to involuntary confinement in an establishment.

fore when dealing with psychiatric patients, especially when determining capacity to consent to treatment. Thus, to protect these fundamental rights, it is imperative that the approach taken in determining both the level of capacity needed to consent to psychiatric treatment and the criteria used in making such assessments seek to maximize the occasions whereby the patient can exercise his or her own free will, rather than having decisions imposed by substitutes.

5. Functional Approach to Capacity

In Quebec law, the determination of capacity to consent to treatment is a question of fact and is based on the patient's ability to make the decision at hand.⁹⁹ This determination is not based on the patient's legal status. Thus, that one is under a regime of protection is of no relevance to the issue of capacity to consent to treatment. Delisle J.A. in *Institut Philippe-Pinel v. Gharavy* made the following statements concerning the determination of capacity: "[L]'aptitude à consentir à des soins médicaux donnés est soumise à une évaluation particulière qui, si la personne concernée est sous le coup d'une régime de protection, peut être différente de l'évaluation dont a fait l'objet la raison pour laquelle un tel régime lui a été ouvert ..."¹⁰⁰ The judge also said, "Il peut fort bien arriver qu'une personne soit incapable d'administrer ses biens, tout en étant parfaitement consciente de ses besoins de santé."¹⁰¹

This functional approach to capacity affords additional protection to the individual rights of the psychiatric patient. Prior to this change in 1994 with the coming into force of the C.C.Q., one who was unable to manage his or her property and placed under public curatorship was automatically deemed incapable to consent to medical treatment. It was not unheard of in such instances for doctors to have someone placed under public curatorship to override the patient's refusal to submit to treatment.¹⁰²

Article 16, which requires court authorization of decisions made by a substitute where the incapable person categorically refuses to receive treatment to which that substitute has assented (with the exception of hygienic care or an emergency), exemplifies the functional approach taken to capacity in the C.C.Q. While such a provision does not guarantee that treatment will not be imposed on the refusing patient, it places the onus on an interested party to convince the court both that the finding of incapacity to consent is well-founded, and second, that the proposed treatment is in fact nec-

⁹⁹ Ménard, *ibid.* at 241. See also M. Somerville, "Changes in Mental Health Legislation as Indicators of Changing Values and Policies" in M. Roth & R. Bluglass, eds., *Psychiatry, Human Rights and the Law* (Cambridge: Cambridge University Press, 1985) 156 at 168-69. This functional approach is also taken in Ontario and is reflected in *Fleming, supra* note 96 at 86 and in the *Substitute Decisions Act, 1992*, S.O. 1992, c. 30 [hereinafter *Substitute Decisions Act*].

¹⁰⁰ [1994] R.J.Q. 2523 at 2529 (C.A.) [hereinafter *Gharavy*].

¹⁰¹ *Ibid.* at 2532.

¹⁰² D. Morrison, "Consentement éclairé et capacité en pratique clinique psychiatrique ou opinion : le consentement éclairé s'applique-t-il en psychiatrie?" in P. Migneault & J. O'Neil, eds., *Informed Consent and Capacity in Psychiatry: Clinical and Legal Aspects* (Verdun, Qc.: Douglas, 1988) 5 at 11.

essary. This independent review mechanism reinforces the primacy of the patient's right to inviolability and bodily integrity as articulated in article 10 of the C.C.Q.

The adoption of the functional approach, in addition to maximizing the opportunity for the individual to make his or her own choices, also fosters the view that discrimination and de-personalization of those suffering from mental illness is not to be tolerated.

6. Determination of Criteria Used to Assess Capacity

The importance of the criteria used to assess competence is articulated by LeBel J. in *Institut Philippe-Pinel v. Blais*, where she makes the following comments:

Le respect de l'inviolabilité et de l'intégrité de la personne humaine exige que le critère utilisé pour déterminer si une personne est ou non apte à refuser son consentement à un traitement soit assez strict pour que le recours à un tiers décideur, qu'il s'agisse d'un mandataire ou du tribunal, ne devienne pas une technique pour priver une personne de son droit de refuser un traitement recommandé par ses médecins traitants.¹⁰³

The law does not specifically provide the criteria necessary to determine if the patient has the requisite capacity to consent to or to refuse treatment. If the standard to be met is too stringent, the inevitable result is that most psychiatric patients will not meet the test and will be denied the right to choose. Conversely, if the bar is set too low, individuals who cannot appreciate the consequences of the decision at hand will be held to be capable, even though in such instances it would be more appropriate for a substitute to determine whether to consent to treatment. Upholding a decision to refuse treatment in the case of an individual who is only marginally capable denies the patient the opportunity to receive potentially beneficial treatment. Even the strongest proponents of a right to refuse treatment would not advocate extending this right to those who cannot appreciate the consequences of their actions. The right to refuse treatment respects the right to make irrational decisions, yet this is not the same as respecting choices made by one who does not have the cognitive ability to make a decision, rational or otherwise. A proper balance between these two extremes must be sought in determining appropriate criteria for use in assessing competency to make treatment decisions.

In *Gharavy*, the court used the same criteria for assessing capacity to consent to medical treatment. The criteria adopted focus on the patient's ability to understand his or her illness, the nature and purpose of the proposed treatment, the risks involved in undergoing the treatment and in refusing treatment, and whether his or her ability to consent is affected by the illness.¹⁰⁴ These criteria provide useful broad guidelines but fail to provide much direction as to how they should be applied in a given situation. Nor is there any indication as to the proper weight to be given to each criterion. It is

¹⁰³ [1991] R.J.Q.1969 at 1973-74 (Sup. Ct.).

¹⁰⁴ *Gharavy*, *supra* note 100 at 2434-35. These are the criteria found in the *Hospitals Act*, R.S.N.S. 1989, c. 208, s. 52(2), as cited by the Court of Appeal.

necessary to have well-articulated criteria to ensure that these assessments are not conducted in an arbitrary manner and that there is a certain degree of consistency of application. Otherwise, there is the risk that these determinations will be totally subjective assessments based on the values of the assessor and not the person being assessed. This will result in a very narrow scope of application for the right to refuse treatment.

Of particular significance in the assessment of capacity to consent or refuse treatment is the degree to which the psychiatrist takes into account the refusal itself as evidence of incapacity. In cases where the person is delusional and denies that he or she has an illness, the refusal of treatment is consistent with a finding of incapacity based on the above-mentioned criteria. Yet in other instances, there is the risk that an assessment that focusses on the refusal alone may tend to overlook the reasons underlying the refusal, such as the desire to avoid side effects of drug therapy. Viewing the mere refusal of treatment as evidence of the patient's denial of illness and hence incapability is another manifestation of the paternalism still present in this area of the law. Moreover, such applications of the criteria tend to undermine the right to refuse treatment. This position was articulated by Steinberg J.A. in his dissenting opinion in *Gharavy*: "[T]he incapacity of the Respondent to consent is attributed to a denial of his condition, and that denial is inferred from the refusal to undergo the treatment. If pushed to extremes, this reasoning deprives the individual of the very right to refuse treatment conferred by Article 10 of the *Civil Code of Québec*."¹⁰⁵

The role of the psychiatrist in assessing capacity is to determine if the patient has the cognitive ability to make the decision, not to evaluate the rationality of the effect of such a decision. By focussing on the effect of the decision and not on the patient's ability to make such a decision, the patient is more likely to be found to have capacity when he or she is agreeing to the proposed treatment than when he or she has chosen to go against the plan proposed by the psychiatrist. Such an approach tends to deny the right to refuse treatment to those who are competent to make treatment decisions and find competent those who may not be capable of giving consent. In neither case has free and enlightened consent been obtained.

7. Conclusion

It is important to note that the right of the competent psychiatric patient to refuse treatment sends a strong message that these patients should not be treated differently from those hospitalized for physical illness. Thus, the protection and promotion of the individual rights of those suffering from mental illnesses goes a long way towards changing people's perceptions of mental illness. As the distinctions between those suffering from physical and mental illness are broken down, we hope that the stigma attached to those afflicted will lessen.

¹⁰⁵ *Ibid.* at 2542.

While it is true that those suffering from mental illness have special interests and needs, they nonetheless want the same things as everyone else: a home, a job, friends, and a support system comprised of those who have similar life experiences.¹⁰⁶ Empowering this group by ensuring mental health laws have a strong patient-rights base paves the way for advocacy groups to promote the special interests of the mentally ill in mental health policy development. If the law focusses too strongly on the medical or treatment model, the voice of the group affected by these laws may not be heard.

The right to refuse treatment need not be seen as adverse to the welfare of the patient. On the contrary, such a right gives the individual options, which may make him or her feel less helpless at the hands of a psychiatrist. Forcing one to do something against one's will, even if it is in one's best interests, cannot be positive for the doctor-patient relationship. This sort of treatment environment will not necessarily lead to continued use of medication by the patient once he or she is released from the hospital. Pat Capponi, in explaining what finally drove her to stay on medication after bouts of refusal, emphasized the importance of finding a doctor who listened to her and with whom she could negotiate a treatment plan.¹⁰⁷ She stressed the importance of being treated as an intelligent individual who could make treatment choices. A mutually determined plan stands a better chance of being followed than one that is imposed unilaterally on the patient. This can only be achieved if the right to choose is firmly entrenched in the law.

III. Future Legislative Options

It is important to understand the purpose of the mental health system in Quebec. There appear to be two options: protection of the public from dangerous mentally ill individuals and treatment of mentally disordered persons. If the purpose is to detain dangerous individuals, "[T]here is no need to connect that dangerousness to mental disorder. That purpose would be best attained by simply authorizing the detention of individuals who are predictably dangerous regardless of whether they are mentally disordered or not."¹⁰⁸ Consequently, the logical conclusion must be that the purpose of the mental health system is the treatment and care of the mentally ill. This is so not only in Quebec, but throughout the rest of Canada as well.

The mental health system is comprised of many components. One major component is legislation. While the purpose of the mental health system is treatment, the

¹⁰⁶ This observation was made by Pat Capponi, Toronto writer and one who has been hospitalized for mental illness, in an interview with Michael Enright on the CBC Radio national programme "This Morning" on the topic of involuntary treatment legislation (2 November 1998).

¹⁰⁷ *Ibid.*

¹⁰⁸ M. Kingma, *Mental Health Law: A Critique of the "Dangerousness" Criterion for Civil Commitment and Some Recommendations for Change* (LL.M. Thesis, Dalhousie University 1995) at 8 [unpublished]. Kingma, on this point, argues that the purpose of mental health legislation is treatment. This is not our conclusion. In Quebec, the legislative purpose is detention, not treatment. We would, however, conclude that the purpose of Quebec's mental health system is treatment.

Quebec mental health legislation does not appear to be in sync with this objective. The goal of Quebec's legislation is protection. The result of having these inconsistent goals or purposes is that involuntary confinement remains very limited but, at the same time, it does not lead to treatment. Rather, it results in mere detention. As Stone and Stromberg noted, "When a patient exercises this right [to refuse treatment], the cruelest paradox in civil commitment results: a mentally ill patient is deprived of his liberty but cannot be treated. This stalemate converts suffering mental patients into warehoused items, converts psychiatrists into jailers, and converts civil commitment into a charade."¹⁰⁹ How can this charade be addressed? One answer lies in capacity.

A. *The Role of Capacity*

Mental health legislation began with the belief that mental illness automatically included incapacity.¹¹⁰ It has been observed that "capacity is now recognized as being distinct from mental disorder".¹¹¹ Consequently, to be involuntarily committed one should be found to be (i) suffering from a mental illness, (ii) dangerous, and (iii) incapable. We will refer to these three components as the capacity standard. Only then should an individual be committed involuntarily. There will be no issue of hospitalization as a form of detention. Involuntary hospitalization would then serve the purpose of treatment.

There is a reasonable concern that incorporating a capacity test would grant the same discretionary power to the medical profession as did the welfare test. However, as noted by Robertson, there are difficulties in determining capacity, but that should not undermine the importance of a capacity test.¹¹² To protect individuals from such vast discretionary power, it is imperative that the criteria developed for determining capacity be well defined, as was discussed in Part II.D. In this instance, the need for objectivity is even more crucial since we are dealing with deprivations of individual liberty, both in terms of involuntary confinement and of forced treatment.

Legislation incorporating an involuntary civil commitment standard based on a well-defined capacity test could prove to be a strong and viable alternative to replace the present "danger to self" component of the danger standard.¹¹³ However, one issue remains: there may be some individuals who suffer from mental illness and are dangerous, but capable. Kingma has observed that "[a]lthough the concern for dangerous but capable individuals is arguably small, it exists nonetheless, and makes the elimination of the 'danger to others' criterion an unlikely possibility."¹¹⁴ While it was noted

¹⁰⁹ A.A. Stone & C.D. Stromberg, "A Model State Law on Civil Commitment of the Mentally Ill" in American Psychiatric Association, *Issues in Forensic Psychiatry* (Washington, D.C.: American Psychiatric Association, 1984) 59 at 66.

¹¹⁰ Kingma, *supra* note 108 at 208.

¹¹¹ *Ibid.* at 209.

¹¹² *Supra* note 26 at 396.

¹¹³ Kingma, *supra* note 108 at 219.

¹¹⁴ *Ibid.* at 212-13.

above that the most frequent outcome of research is that there is little, if no, correlation between danger and mental illness, there have been, nonetheless, some studies that appear to indicate some correlation, and consequently, such findings, however limited they may be, should not be ignored.¹¹⁵ Confinement for the protection of others has been a well-accepted principle. This was the philosophy of Mill and is essentially the sole justification for the “danger to others” component. Involuntary confinement of a capable individual, however, cannot be viewed as treatment if the individual refuses treatment. Despite the flaws noted in this “danger to others” component, the fact remains that while this standard is not the best, it is all that is available. Until it can be proven with the utmost of certainty that there is no correlation between mental disorder and dangerousness, then the “danger to others” component should prevail, unless a more successful method finds sufficient scientific and social support.¹¹⁶

Replacing all welfare standards and “danger to self” standards with the capacity standard would be a positive step in ensuring respect for civil liberties, combatting paternalistic interference by the State, and achieving the mental health system’s goal of treatment. It would be an improvement since it takes a major step in addressing that the right to refuse treatment exists and that capacity is an element separate from mental illness.

The capacity standard and the “danger to others” standard will continue to limit the cases of involuntary confinement. Fortunately, involuntary hospitalization is not the only means available to address mental illness. There are other mechanisms available to address the shortcomings of the mental health system. They include the following: i) Ulysses contracts; ii) out-patient committals; and iii) community services.

B. Ulysses Contracts

A Ulysses contract¹¹⁷ is a means whereby mentally ill patients can ensure that they get treatment during an acute phase of their illness, notwithstanding that, at this time, due to illness, they may in fact resist the treatment needed to stabilize the condition. The use of such instruments is a recognition or admission that the decisions made when the illness has intensified are not the decisions that one would make when the illness is under control. The act of creating a Ulysses contract is a conscious choice on

¹¹⁵ See J. Monahan, “Mental Disorder and Violent Behavior: Perceptions and Evidence” (1992) 47 *Am. Psychol.* 511 at 514-18. Monahan concluded that there may be “a relationship between mental disorder and violent behavior, one that cannot be fobbed off as chance or explained away by other factors that may cause them both” (at 511).

¹¹⁶ Kingma, *supra* note 108 at 220.

¹¹⁷ A. Macklin, “Bound to Freedom: The Ulysses Contract and the Psychiatric Will” (1987) 45 *U.T. Fac. L. Rev.* 37 at 39. Macklin states that such a contract is a device through which individuals anticipate the impact of mental illness on their willingness to accept help and attempt to inoculate themselves against it. Further, she states that such contracts are appropriate for those whose illnesses are characterized by periods of “normalcy” alternating with bouts of severe psychosis.

the part of the patients to let the healthy self and not the ill self determine what is in their best interests.

Such instruments allow patients who suffer from a psychotic disorder such as schizophrenia, manic depression, or depression, while competent, to outline in legally binding form the nature of treatment that they will undergo when the illness progresses to an acute phase and they may not be able to make competent treatment decisions. The traditional articulation of the contract is one that is entered into between the patient and the doctor and would normally outline the deterioration that would trigger the coming into effect of the contract provisions. In addition, the contract would stipulate the range of treatment that the doctor would be authorized to effect.¹¹⁸ The terms of such a contract would include not only drug treatments but also the authorization of hospitalization if such action were in the person's best interests. In these instances unwilling patients, who do not meet the danger standard and thus could not be involuntarily confined, will be hospitalized based on their competent wishes as set out in a Ulysses contract. In addition, this form of contract could be used by the patients to outline the forms of medication that they will agree to take and those that they would refuse to take during this period. The advantage of such contracts is that during the illness, the treatment decisions being authorized by the substitute decision-maker are those previously agreed to by the patient. Through private ordering, the patients anticipate the illness and restrict their autonomy and liberty to give way to the need to be treated. The use of such contracts allows the individual and not the State to balance these competing interests, resulting in an outcome that is acceptable to the patient.

Ontario consent legislation gives effect to a form of Ulysses contract. Under the legislation, patients can bind their wishes by executing, when competent, a power of attorney for personal care in compliance with the *Substitute Decisions Act*,¹¹⁹ rather than entering into a contract with the treating psychiatrist. The power of attorney for personal care will grant the attorney the right to make decisions on behalf of the grantor should the person become incapable, and it would normally include instructions as to how these decisions are carried out.¹²⁰ These forms of Ulysses contracts provide a level of protection to the patient more than the above-mentioned contract with the psychiatrist, as the treatment decisions are not simply effected by the physician but must be agreed to by the substitute decision-maker. Any decisions over which the attorney has authority must be made in accordance with the known wishes of the patient or, in the absence of such known wishes, in the best interests of the patient.¹²¹

Moreover, if properly drafted, this power of attorney for personal care will contain provisions that prevent the grantor from trying to block the attorney's decisions when he or she later becomes incapable. The special types of inclusions needed to

¹¹⁸ *Ibid.* at 39-40.

¹¹⁹ *Supra* note 99.

¹²⁰ *Ibid.*, ss. 46(1)-46(8).

¹²¹ *Health Care Consent Act*, *supra* note 97, Sch. A., ss. 21(1), 21(2).

make the power of attorney for personal care an effective "Ulysses contract" are expressly provided for in the *Substitute Decisions Act* as follows:

1. Section 50(2)2 allows the power of attorney for personal care to contain a provision authorizing the attorney to use the force reasonable and necessary in the circumstances to take the grantor to any place for care or treatment, to admit the person to that place, and to detain and restrain the grantor in that place during the care or treatment.

2. Section 50(2)3 allows a power of attorney for personal care to contain the grantor's waiver of the right to apply to the Consent and Capacity Board for a review of a finding of incapacity under the following sections of the *Health Care Consent Act*.¹²²

a. section 32, which deals with a finding of incapacity with respect to treatment; and

b. section 50, which deals with incapacity with respect to a finding of incapacity with respect to the person's admission to a care facility.

Subsection 24(2) of the *Health Care Consent Act* reinforces that an attorney for personal care may admit the grantor to a psychiatric facility for treatment, notwithstanding that the patient objects to the admission. However, it is important to note that such action may only be taken if the patient is incapable (thereby necessitating an assessment at the time of admission) and if the power to admit is expressly provided for in the document and in accordance with section 50 of the *Substitute Decisions Act*.

1. The Application of Ulysses Contracts in Quebec

At first glance, it does not appear that there should be any impediments in the law of Quebec to effecting a valid Ulysses contract in the same manner as that outlined above under the laws of Ontario. Articles 2166 to 2174 of the C.C.Q. outline special rules governing the mandate given in anticipation of the mandator's incapacity. Article 2166 stipulates that a mandate can be used in anticipation of the mandator's incapacity to care for himself. Article 11 (in the chapter on integrity of the person) authorizes the mandatary to give consent to "treatment or any other act" if the person concerned is incapable of granting such consent. While the mechanism exists whereby the patient may plan for future illness and authorize the mandatary to hospitalize the patient and consent to various forms of drug treatment, there is no mechanism available by which the mandator may make the provisions in this act unassailable.

Article 16 requires the court to authorize any treatment that is categorically refused by a person incapable of giving consent to treatment. In such instances, the mandatary must justify before the court the necessity and benefits of treatment decisions that may in fact have been expressly provided for in the mandate. While this is

¹²² *Ibid.*

not to say that the court will not authorize such decisions, the introduction of such a procedure will delay the treatment. This has the effect of frustrating one of the main purposes of planning in advance for managing psychotic episodes, which is ensuring that the patient gets the care needed before a serious deterioration in condition. Furthermore, while article 26 authorizes a mandatary to provide consent to admission to a psychiatric establishment, confinement is only valid if the mandator does not object.

The provisions in the C.C.Q., such as those mentioned above, serve to protect the psychiatric patient's right to autonomy, and there should not be any changes to the general regime that would weaken these rights. However, in those cases where competent patients freely decided to bind their autonomy by the use of a mandate in anticipation of incapacity, the law should recognize and accommodate these prior capable wishes. This could be effected by modifications to the narrower regime of such mandates, while leaving the general regime intact.

C. Out-Patient Committal

Out-patient committal has recently generated interest as an alternative to involuntary committal. Such legislation is viewed by its proponents as the only humane solution to the current abandonment or dumping of chronically mentally ill persons. They submit that the alternative to such legislation is "continued homelessness, distraught families, dangerousness [and] violence ..."¹²³ This option is not without its detractors and, as previously indicated, the tensions in this area are once more between the individual's right to autonomy and the fact that treatment may be beneficial to the individual.

It does not appear that the legislators in Quebec are inclined, at least in the near future, to introduce the use of compulsory community treatment into existing mental health legislation; it is, however, an alternative that is growing in popularity in other provinces. Saskatchewan has adopted legislative provisions allowing for out-patient committal, referred to as "community treatment orders".¹²⁴ Furthermore, in Ontario, a government bill¹²⁵ has been introduced and it proposes changes to the *Mental Health Act* to allow for community treatment orders similar to those in Saskatchewan.

This alternative to institutionalization has many benefits in terms of patient treatment. By allowing the patient to obtain treatment in the community, the negative effects of marginalization and isolation that are common among patients who are detained involuntarily may be eliminated. Further, community treatment is viewed by

¹²³ F. Boudreau & P. Lambert, "Compulsory Community Treatment ? II. The Collision of Views and Complexities Involved: Is It 'The Best Possible Alternative?'" (1993) 12:1 Can. J. Comm. Mental Health 79 at 85.

¹²⁴ *The Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, as am. by S.S. 1993, c. 59, s. 13, adding ss. 24.1-24.7.

¹²⁵ Bill 68, *supra* note 45.

some commentators as filling the gaps in treatment that de-institutionalization has precipitated.¹²⁶

This option has also been cited by some of its proponents as being the least restrictive alternative. While allowing the patient to live in the community is certainly less intrusive than involuntary in-patient committal, it can hardly be said to be less invasive than allowing the patient the choice of voluntarily seeking treatment in the community.¹²⁷

The competent wishes of an involuntarily committed patient have attained constitutional protection. Thus, any out-patient committal legislation must recognize this right, which in effect limits its application to those who are held to be incapable of making treatment decisions for themselves. The Saskatchewan legislation¹²⁸ limits the application of this option to those individuals who meet this criterion. Bill 68 stipulates that a community treatment order may be issued by a physician if the patient or the substitute decision-maker consents to the treatment plan that forms part of the community treatment order. Thus, the agreement could not be made without the competent patient's consent.¹²⁹ In the case of incompetent individuals, it is the substitute who will decide if such treatment is in the best interests of the person affected and it would appear that it could be done against that person's objections.

If such legislation were enacted in Quebec, a competent patient who refused treatment would be forced to remain hospitalized. Yet a patient who is deemed incompetent to make treatment decisions and whose substitute decision-maker decided that such treatment was in the patient's best interests might remain in the community, notwithstanding that both patients had met the "danger to self" standard. Such inconsistent results are problematic. The difficulty lies not necessarily with the notion of out-patient committal, but with the use of the danger standard as the sole criterion for justifying committal. One solution lies in redefining the criterion for in-patient committal to include a finding of incapacity as was noted above in Part III.A. The solution with respect to those meeting the "danger to others" standard is less straightforward.

While the use of mandatory community treatment orders avoids abandoning those chronically ill patients to their illnesses, care must be taken to ensure that in providing for such options the net is not cast too wide. Such orders should not be viewed as a means of extending the ambit of forced treatment, but should be viewed as an alternative in a clearly defined set of circumstances. Thus, the development of specific criteria under which out-patient committal will be applied is of primary importance.

Out-patient committal does not present an overall solution to the problems encountered in the area of mental health. However, it may provide a partial solution to

¹²⁶ See J. Geller, "Rights, Wrongs and the Dilemma of Coerced Community Treatment" (1986) 143 *Am. J. Psychiatry* 1259 at 1259.

¹²⁷ Boudreau & Lambert, *supra* note 123 at 82.

¹²⁸ *The Mental Health Services Act*, *supra* note 124, s. 24.3(1)(a)(v).

¹²⁹ Bill 68, *supra* note 45, s. 14.

that small group of chronically ill patients who are repeat users of mental health facilities. If out-patient commitment is to be considered as an option to in-patient confinement, mental health care providers must be able to deliver the program effectively. Adequate resources must be allocated to the implementation of a system that will be adequately staffed to handle the increased patient load. In addition, the following are issues that must be addressed if such an alternative were to be implemented.

There must be a system in place to monitor the patient's progress and to evaluate the ongoing need for continued compulsory treatment. To this end, the orders should be for a relatively short duration. The objective of such an alternative should be to get the individual stabilized. The therapeutic goal would be to move toward the adoption of a voluntary treatment plan. If this is not possible, the order must last only as long as the patient meets the defined criteria. Once the individual fails to satisfy the criteria, to minimize the limitation to individual autonomy inherent in such orders, the imposition of treatment should come to an end.¹³⁰

The system must also monitor compliance with the treatment order. Thus, appropriate courses of action must be developed to deal with situations where a patient fails to comply with the terms of the order.¹³¹ Will the penalty for non-compliance be involuntary in-patient committal or forced injections? Is there some other effective alternative? Moreover, who will monitor compliance and who will enforce the sanctions or consequences of non-compliance? All of these issues must be addressed and incorporated into out-patient committal legislation.

Finally, the treatment must be accessible to the patient. Such a system will be doomed from the outset if the patient does not have easy access to the treatment. A patient who is on welfare and must travel for miles to obtain costly medication will not be predisposed to following such a treatment order.

It is important to remember that out-patient committal is an alternative available to help alleviate some of the suffering caused by those afflicted with mental illness. Drug treatment is not the only form of assistance that those suffering from mental illness require. Pat Capponi argues that an approach to mental health legislation that focusses too strongly on the medical model may mean that legislators will lose sight of the social issues that need to be addressed when dealing with those suffering from mental illness, such as the need to provide housing, jobs, and resources for the development of support networks.¹³² Thus, the quality of life of those suffering from mental illness cannot be improved unless a strong community network is established.

¹³⁰ See *The Mental Health Services Act*, *supra* note 124, s. 24.5(3), dealing with revocation of such orders. For Ontario, see Bill 68, *ibid.*

¹³¹ See *The Mental Health Services Act*, *ibid.*, s. 24.6, dealing with the failure to comply with such orders. For Ontario, see Bill 68, *ibid.*

¹³² *Supra* note 106.

D. Community Network

The intended results of de-institutionalization do not appear to have materialized. The goal of de-institutionalization was to get people out of the obscure wards of the institutions and into the welcome arms of the community. The problem is that the community was not equipped to accept these individuals. A strong, interconnected community network was not established before the patients were removed from the hospitals. Consequently, it is not known if the original plan of the drafters was a good one, since it was not implemented as it was formulated. Therefore, the option of community services and support should be explored to its fullest before condemning de-institutionalization.

De-institutionalization is a respectable endeavour, as it recognizes that involuntary confinement is a direct violation of civil liberties. Provision of community services is a logical complement to a plan for de-institutionalization. To ensure adequate and effective community services, governments must make a full-time commitment to ensuring the viability of such programs, which entails three major factors: contribution, coordination, and continuity. These elements, however, are currently missing.

Governments need to contribute more financial resources to these community services. The community services available today are struggling on the limited funds they are given to keep up with the demand for their services. Long waiting lists are the norm. In the future, the government of Quebec needs to recognize and acknowledge the existence of those individuals roaming the streets, alone and receiving little, if any, assistance.

Coordination is another feature missing from the community services currently available. Many health-care workers do not know the range of services that may be of use to their patients. Consequently, they are unable to provide options to their patients once they have exhausted the services available to them in their own organization. Coordination must become a primary goal. The ultimate objective must be a true system of care that results in constant communication among different types of agencies (e.g., psychiatric, social, vocational and housing), rather than a loose network of services.¹³³

Moreover, continuity of care is essential to ending the revolving door cycle. It would be ideal if every individual had one person who would be responsible for his or her treatment or care. If it is not possible to have one person who would follow the individual, then it is essential that the transition from one person to another be thorough and understood by the patient. Too often, the community services take a patient only through the first few steps on the road of recovery that in many cases is a road of innumerable steps. Again, due to the lack of coordination between services, the onus is on individuals to make their own way to the next stage of the recovery process. Thus,

¹³³ J.A. Talbott & H.R. Lamb, "Summary and Recommendations" in H.R. Lamb, ed., *The Homeless Mentally Ill* (Washington, D.C.: American Psychiatric Association, 1984) 1 at 5-6.

there is the risk that these next steps will never be made, whereas if there were adequate support and follow-up from a health-care or social-services professional, the individuals would stand a greater chance of going the full distance on the road to recovery.

The philosophy of de-institutionalization has yet to realize its full potential. It requires the establishment of a strong network of community services that runs smoothly, is adequately funded, and meets the needs of its users. Community-based mental health services and organizations are essential elements of a strong, accessible, and effective mental health system.

Conclusion

Mental health law in Quebec places heavy emphasis on protecting the individual's right to autonomy and self-determination. This stance has arisen partly in response to the abuses suffered by many psychiatric patients in the developing years of psychiatry. Moreover, this trend is in keeping with the primacy that we as a society place on individual freedoms. In the area of mental health law, the era of paternalism has given way to the era of empowerment. The strong emphasis on individual rights in this area of the law is an important means of breaking down the barriers that many individuals suffering from mental illness feel exist between them and the rest of society.

The standard for involuntary confinement in Quebec is that of pure danger. While this strict criterion ensures that individual liberty is infringed only in a narrow set of circumstances, it also means that only those who are desperately ill fall within these parameters. This strong focus on the rights of individuals, to the exclusion of their treatment needs, gives these individuals the "right to be delusional". Along with this "right" comes the right to be isolated and maybe even homeless. Is this really fostering the right to autonomy and self-determination? It is through the use of one's mind that one's free will is expressed. Thus, when it is one's brain that is diseased, is it the disease or the individual making the choice? Perhaps it is only when the disease is treated and under control that one is expressing one's true will. Thus, as we have argued, strong individual rights are needed to enhance patient welfare; however, providing treatment to those too ill to seek it themselves may also enhance individual autonomy.

Mental health laws need to reflect in a more balanced fashion the individuals' right to self-determination and right to relief from suffering. The starting point must be to re-evaluate the criteria for involuntary confinement. Dangerousness as the sole criterion tends to be both under- and over-inclusive. It is under-inclusive when it sets the standard of danger to be immediate or imminent harm, yet it is over-inclusive when such a standard would justify the confinement of competent individuals who do not pose a danger to themselves or others. Thus, one solution to the over-inclusiveness lies in developing standards that incorporate incapacity as a criterion for involuntary committal. The problem of under-inclusiveness is best addressed by legislative options designed to enhance the opportunity for the patient to receive treatment outside of the institutional setting.

Out-patient committal may be a means of ensuring that the chronically mentally ill who are in and out of hospitals get the treatment they need, without entirely depriving them of their liberty in the process. Similarly, the use of Ulysses contracts is a means whereby individuals can plan in advance to get the required treatment once the illness overcomes them. Such solutions are by no means all-encompassing. There is still a large population of those suffering from mental illness who fall between the cracks. A strong, coordinated network of community mental health services must be developed to fill these gaps. This requires a modification to mental health policy and a commitment of resources to ensure that adequate support mechanisms are available in the community to fill the void that de-institutionalization has created.

The law alone cannot solve all the problems encountered by those suffering from mental illness. There must be financial resources committed to improving their social conditions. This means ensuring that these individuals have affordable housing, job training, jobs, and resources for the development of adequate support networks. It is only when their medical and social needs are adequately addressed that those suffering from mental illness will be able to transcend the circumstances in which they find themselves.
