

Involuntary Detention and Involuntary Treatment Through the Lens of Sections 7 and 15 of the *Canadian Charter of Rights and Freedoms*¹

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I. INTRODUCTION

In Canada, civil mental health laws fall within provincial and territorial legislative jurisdictions. Within these 13 jurisdictions, there are significant differences between civil mental health statutes, particularly with respect to involuntary detention criteria and the legal tests for the capacity to consent and refuse treatment.² Nevertheless, in all Canadian jurisdictions, civil mental health legislation authorizes the non-criminal detention of persons with mental disabilities,³ in psychiatric facilities,

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² Halsbury's Laws of Canada (online), *Mental Health*, "Psychiatric Assessments and Admission Procedures: Legislative Framework: Saskatchewan (V.3.(10)) at HMN-104 "Voluntary Admissions".

³ We acknowledge that there are many terms used to describe mental disabilities, and that there is no consensus within legal and disability communities about the appropriate terminology. Given the legal analysis that is the focus of this paper, we use the legal term "mental disabilities" to describe persons who are recipients or former recipients of civil mental health and/or addiction services.

against their will and without their consent. Involuntary detention “has been described as ‘the most significant deprivation of liberty without judicial process that is sanctioned by our society.’”⁴ Involuntary detention and involuntary treatment are inextricably linked: in a number of Canadian jurisdictions, involuntary detention may deprive persons with mental disabilities of the right to refuse psychiatric treatment in certain circumstances.

Disability rights advocates have long rejected legal frameworks that provide for involuntary detention and involuntary treatment, on the basis of mental disability, as a violation of fundamental human rights. This is reflected in a number of international human rights treaties, including the *Convention on the Rights of Persons with Disabilities* (CRPD). The CRPD is a treaty that was created “to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.”⁵ The United Nations Office of the High Commissioner for Human Rights has explained that involuntary treatment and compulsory care regimes within domestic mental health legislation violate multiple rights articulated in the CRPD:

Mental health legislation is unjustly discriminatory against people with psychosocial disability because it systematically uses mental disorder as criteria to limit legal capacity, a view echoed by the CRPD Committee. The proposition of applying supported decision making to mental health legislation is therefore problematic, given that principles of non-discrimination and equality underpin supported decision-making. Particular sections of the CRPD will create ongoing challenges to the operation of mental health legislation: in particular, Article 14, as relates to detention (‘the existence of a disability shall in no case justify a deprivation of liberty’); Article 17, as relates to involuntary treatment (‘(e)very person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others’), and 25, and, again, Article 12, as relates to restrictions on legal capacity on the basis of a disability.⁶

⁴ Raj Anand, “Involuntary Civil Commitment in Ontario: The Need to Curtail the Abuses in Psychiatry” (1979) 57:2 Can Bar Rev 250 at 251 cited in Isabel Grant & Peter J Carver, “*PS v Ontario*: Rethinking the Role of the *Charter* in Civil Commitment” (2016) 53:3 Osgoode Hall LJ 999 at 1001.

⁵ *Convention on the Rights of Persons with Disabilities*, A Res 61/106, UNGAOR, 61st Sess, Supp No 49 (2006) 2 at 4, art 1, online (pdf): <treaties.un.org/doc/Publication/CTC/Ch_IV_15.pdf> [perma.cc/22JM-C6JK] [CRPD].

⁶ Piers Gooding, “Supported Decision-Making: A Rights-Based Disability Concept and Its Implications for Mental Health Law” (2013) 20:3 Psychiatry, Psychology & L 431 at 440. See also United Nations General Assembly, OHCHR, Tenth session Agenda item

In Canada, persons with mental disabilities who are subjected to involuntary detention and treatment are vulnerable to violations of their *Charter*-protected rights, including the section 7 rights to life, liberty, and security of the person, because they are physically detained and deprived of the right to refuse treatment. Their section 15 rights to equality may also be violated, given that Canadian mental health laws subject only persons labelled with mental disabilities to involuntary detention and treatment. Despite the hope that the *Canadian Charter of Rights and Freedoms*⁷ would serve to ensure greater recognition of the liberty and equality interests at stake within civil mental health law, scholars argue that this has not been fully realized.⁸

In this paper, we apply a *Charter* analysis to involuntary detention and involuntary treatment provisions in select Canadian jurisdictions. Specifically, we examine these provisions through the lens of the *Charter*'s sections 7 and 15 rights.⁹ Our *Charter* analysis is informed by the rights

2, “Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General: Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities” Distr. GENERAL A/HRC/10/48 26 January 2009; Tina Minkowitz, “The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions” (2007) 34:2 *Syracuse J Intl L & Com* 405 at 405–28; Tina Minkowitz, “Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities” in Bernadette McSherry & Penelope Weller, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford, UK: Hart, 2010) 151 at 151–77.

⁷ Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

⁸ Grant & Carver, *supra* note 4.

⁹ We conducted extensive research and searches of all scholarly analyses of mental health law and the *Charter*, the *Convention on the Rights of Persons with Disabilities*, and supported decision-making in the mental health law context. Research was conducted in the Law Libraries databases, HeinOnline, ProQuest, SSRN, QuickLaw, CanLII, the Canadian Legal Literature Database, Google Scholar, and Google. We also searched for articles and books written by seminal authors writing on the topic, including Terry Carney, Sheila Wildeman, Anna Nilsson, Piers Gooding, Archie Kaiser, Tina Minkowitz, Anna Arstein-Kerslake, Steven Hoffman, and Michael Perlin. Further, we researched Canadian federal, provincial and territorial legislation and jurisprudence focusing on specific key words including: “legal capacity”, “supported decision-making”, “substitute decision-making”, “best interests”, “mental health law”, and the “CRPD.” Further, we reviewed research conducted by the Law Commissions within various provinces, NGOs, legal clinics, the Government of Canada, and the United Nations to provide

articulated in the CRPD. The CRPD was signed by Canada on March 30, 2007 and ratified on March 11, 2010.¹⁰ Article 4(1)(a) of the CRPD requires state parties to use “all appropriate legislative, administrative and other measures”¹¹ to implement the rights contained therein. The Supreme Court of Canada has recognized that international human rights treaties, such as the CRPD, are a “relevant and persuasive factor in *Charter* interpretation”¹² and directed that Canadian laws should be interpreted and applied in a manner that is consistent with Canada’s international human rights obligations.¹³ Consequently, any *Charter* analysis of Canadian mental health legislation must consider the implications of the CRPD.

The CRPD includes, in its general principles (Article 3), individual autonomy and the freedom to make one’s own choices. Article 12 of the CRPD recognizes that persons with disabilities are entitled to the right to “enjoy legal capacity on an equal basis with others.”¹⁴ Article 12 also requires states that are party to the CRPD to implement supported decision-making regimes, which do not remove decision-making rights based on disability or a functional test of a person’s ability to make decisions. Instead, these regimes provide access to supports to enable persons with disabilities to exercise their decision-making rights on an equal basis as others.¹⁵ It is important to note that Canada reserved the right to allow both supported and substitute-decision-making arrangements in “appropriate circumstances”, which are subject to proper safeguards including review by

insights and context. We are grateful to subject matter experts in Alberta, British Columbia, Ontario, and Yukon for sharing their expertise and time with us.

¹⁰ CRPD, *supra* note 5.

¹¹ *Ibid*, art 4(1)(a). Lana Kerzner, “Paving the way to Full Realization of the CRPD’s Rights to Legal Capacity and Supported Decision-Making: A Canadian Perspective” at 19, online (pdf): *National Resource Center for Supported Decision Making* online: <citizenship.sites.olt.ubc.ca/files/2014/07/> [perma.cc/6ZVB-YCXT].

¹² *Reference re Public Service Employee Relations Act (Alberta)*, [1987] 1 SCR 313 at 349, 38 DLR (4th) 161, Dickson CJC dissenting.

¹³ *R v Hape*, 2007 SCC 26 at para 35.

¹⁴ CRPD, *supra* note 5, art 12.

¹⁵ A fulsome description of Article 12, supported decision-making, and its implication for Canadian law and policy is beyond the scope of this paper. For a detailed analysis of these topics, refer to Michael Bach, Lana Kerzner, Ruby Dhand, Kerri Joffe, Faisal Bhabha and Brendan Pooran, “Implementing Equal Access to Legal Capacity in Canada: Experience, Evidence and Legal Imperative” (Toronto: IRIS – Institute for Research and Development on Inclusion and Society, 2019).

an independent tribunal.¹⁶ This is inconsistent with Article 12 and the CRPD Committee's General Comment that Article 12 requires states to implement only supported decision-making regimes.¹⁷

In the *Charter* analysis that follows, we draw upon Article 12 of the CRPD and argue that one way in which Canadian mental health laws violate the *Charter* is by prohibiting involuntarily detained persons from accessing supports for decision-making. A determining element of any *Charter* claim is the purpose of the impugned legislative provision or state action. We, therefore, begin Part II with an examination of the purposes of mental health legislation in various jurisdictions. We highlight mental health provisions from the following jurisdictions: British Columbia, Alberta, New Brunswick, Nova Scotia, Saskatchewan, and Newfoundland and Labrador because they exemplify some of the challenges that mental health legislation poses for *Charter* analyses. Next, we review key *Charter* jurisprudence on involuntary detention and involuntary treatment laws. We also consider the role of less intrusive treatment options in *Charter* jurisprudence. In Part III, we provide a section 7 analysis of involuntary treatment provisions in British Columbia, Alberta, and New Brunswick - three jurisdictions which reveal some of the most extreme ways that civil mental health laws interfere with *Charter* rights. Part IV analyzes how civil mental health laws violate substantive equality rights, thereby amplifying their interference with *Charter* rights. Part V concludes with a summary of our findings and recommendations.

¹⁶ *Convention on the Rights of Persons with Disabilities: Declarations and Reservations*, A/RES/61/106, UNOR, 2006, 3, online: <treaties.un.org/pages/ViewDetails.aspx?src=IND&mtdsg_no=IV15&chapter=4&clang=_en#EndDec> [perma.cc/M27U-NEU5]. See also Krista James & Laura Watts, *Understanding the Lived Experiences of Supported Decision Making in Canada: Legal Capacity, Decision-Making and Guardianship* (March 2014) online (pdf): *Law Commission of Ontario* <www.lco-cdo.org/wp-content/uploads/2014/03/capacity-guardianship-commissioned-paper-cce1.pdf> [perma.cc/24AW-AQ4S].

¹⁷ Committee on the Rights of Persons with Disabilities, *General Comment No 1 Article 12: Equal Recognition Before the Law*, CPRDOR, 11th Sess, UN Doc CPRD/C/GC/1 (2014) 1, online: <www.ohchr.org/en/hrbodies/crpd/pages/gc.aspx> [perma.cc/FYH2-8R2D]; Amita Dhandu, "Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?" (2007) 34:2 *Syracuse J Intl L & Com* 429.

II. BALANCING AUTONOMY AND PROTECTION IN CIVIL MENTAL HEALTH LAW

A. Contested Purposes of Mental Health Legislation

The purposes of mental health legislation are contested and evolving territory.¹⁸ Despite the coercive nature of involuntary detention and involuntary treatment provisions, mental health legislation is often interpreted by Canadian courts as being ‘protective’¹⁹ and ‘remedial’.²⁰ This interpretation is typically grounded in the *parens patriae* role of the state, which courts have described as “founded on necessity, namely the [state’s] need to act for the protection of those who cannot care for themselves.”²¹ The objectives of mental health legislation have also been characterized as protecting public safety (sometimes referred to as “police powers”) and improving the treatment of persons with mental disabilities.²² In *Thompson v Ontario (Attorney General)*,²³ the Court of Appeal for Ontario found that Ontario mental health laws combine these two purposes into a single statute.²⁴

¹⁸ Sophie Nunnolley, "Involuntary Hospitalization and Treatment: Themes and Controversies" in Jennifer A Chandler & Colleen M Flood, eds, *Law & Mind: Canadian Mental Health Law and Policy* (Markham, ON: LexisNexis Canada, 2016) 113 at 113–38 [Nunnolley, “Themes and Controversies”]; Michael L. Perlin and Eva Szeli, “Mental Health Law and Human Rights: Evolution and Contemporary Challenges” (2008) New York Law School Legal Studies Research Paper No 07/08-28, online: SSRN <papers.ssrn.com/> [perma.cc/UGY2-4M9G]; Geoffrey Reaume, “Understanding Critical Disability Studies” (2014) 186:16 CMAJ 1248 at 1248–49.

¹⁹ *Ontario (Public Trustee) v Brika* 1987, 61 OR (2d) 58 at 5, 1987 CarswellOnt 1013 (ONSC) mentioned in Tess C Sheldon, Karen R Spector & Mercedes Perez, “Re-Centering Equality: The Interplay Between Sections 7 and 15 of the Charter in Challenges to Psychiatric Detention” (2016) 35:2 NJCL 193 at 203–04; Michael L Perlin, “Chimes of Freedom: International Human Rights and Institutional Mental Disability Law” (2002) 21:3 NY L School J Intl & Comparative L 423 at 427.

²⁰ Sheldon, Spector & Perez, *supra* note 19 at 203; Michael L Perlin, “International Human Rights and Comparative Mental Disability Law: The Role of Institutional Psychiatry in the Suppression of Political Dissent” (2006) 39:3 Israel LR 69 at 74.

²¹ *E (Mrs) v Eve*, [1986] 2 SCR 388 at 51, 31 DLR (4th) 1. The rationale was to be used for one’s “best interest.”

²² *Thompson v Ontario (Attorney General)*, 2016 ONCA 676 at para 8 [Thompson 2016].

²³ *Ibid.*

²⁴ *Ibid.*

While the purposes of most mental health statutes are characterized as treatment, protection, or both, mental health jurisprudence also recognizes the need to balance treatment-based and police power purposes with principles of autonomy, specifically the right to medical self-determination. For example, in *Starson v Swayze*,²⁵ the Supreme Court of Canada found that “[u]nwarranted findings of incapacity severely infringe upon a person’s right to self-determination. Nevertheless, in some instances the well-being of patients who lack the capacity to make medical decisions depends upon state intervention... [t]he [Health Care Consent] Act aims to balance these competing interests of liberty and welfare.”²⁶ In *L (AJ) v Kingston Psychiatric Hospital*²⁷ the Court of Appeal for Ontario found that “[t]he *Mental Health Act* attempts *inter alia* to balance the needs and rights of often vulnerable people with the community’s interest in ensuring that mentally ill persons receive adequate treatment.”²⁸

Such balancing is also reflected in the express purpose provisions of some mental health statutes. For example, Nova Scotia’s *Involuntary Psychiatric Treatment Act* states that its purpose is to ensure that mental health is addressed in accordance with guiding principles that include, “each person has the right to make treatment decisions to the extent of the person’s capacity to do so; treatment must be offered in the least restrictive manner and environment with the goal of having the person live in the community or return home as soon as possible; and treatment should promote self-determination and self-reliance.”²⁹

The review of key jurisprudence above demonstrates how Canadian courts have and continue to grapple with the purposes of mental health legislation and the appropriate balance between protecting and treating persons with mental disabilities through coercive state practices (including involuntary detention criteria, involuntary treatment, lack of procedural safeguards, and intrusive treatment options), on the one hand, and upholding their rights to medical self-determination, on the other.

²⁵ 2003 SCC 32 [*Starson*].

²⁶ *Ibid* at para 75. Although *Starson* was not a constitutional case, it has had significant implications for the understanding of capacity law within the involuntary mental health care context.

²⁷ 2000 CarswellOnt 3428, 136 OAC 334.

²⁸ *Ibid* at para 17.

²⁹ *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, ss 2(b)–(c), (e).

B. Significant *Charter* Challenges to Involuntary Detention and Involuntary Treatment

Involuntary detention occurs when a person meets the involuntary admission criteria in the relevant provincial or territorial mental health statute. In all jurisdictions, involuntary admission procedures refer to five criteria for which a person with a mental disability can be involuntarily detained: mental disorder, harm, need for treatment, incapacity to consent to treatment, and unsuitability for voluntary admission.³⁰

In 1988, the Manitoba Court of Appeal addressed the constitutionality of Manitoba's involuntary admission provisions in *Thwaites v Health Sciences Psychiatric Facility*.³¹ At issue was the broad involuntary detention criteria in subsection 9(1) of the *Mental Health Act*, which provided for involuntary detention if the physician had examined the person and believed that “the person should be confined as a patient at a psychiatric facility”.³² Justice Philip found that Manitoba's involuntary admission provisions, described as “paternalistic legislation with the purpose and effect of imposing the will of the majority on an individual for his or her own good”, were in violation of section 9 of the *Charter*.³³ Section 9 of the *Charter* provides that “[e]veryone has the right not to be arbitrarily detained or imprisoned.”³⁴ The Court grappled with the extent to which the involuntary admission provisions were rationally connected to the objectives of the legislation. In finding a *Charter* violation, Justice Philip stated:

Firstly, I have concluded that the provisions have not been carefully chosen to achieve their objective; that they are arbitrary and unfair for the reasons set out above. Secondly, I do not think it can be said that, in the absence of a "dangerousness" or like standard, the provisions impair as little as possible on the right of a person "not to be arbitrarily detained." Finally, when compared with other legislation, including the amendments to the Act which have been passed but not proclaimed, the provisions strike the wrong balance between the liberty of the individual and the interests of the community. In the absence of objective standards, the possibility of compulsory examination and detention hangs over the heads of all persons suffering from a mental disorder, regardless of the nature of

³⁰ Nunnolley, “Themes and Controversies”, *supra* note 18 at 113, 122. See generally Halsbury's Laws of Canada (online), *Mental Health*.

³¹ [1988] 3 WWR 217, 48 DLR (4th) 338 [*Thwaites*].

³² *Ibid* at 8 [emphasis in original].

³³ *Ibid* at 4, 24.

³⁴ *Charter*, *supra* note 7, s 9.

the disorder, and the availability and suitability of alternative and less restrictive forms of treatment.³⁵

As a result of the *Thwaites* decision, the Manitoba *Mental Health Act* was amended to include dangerousness in the harm criteria (“likely to cause serious harm to themselves or others or to suffer substantial mental or physical deterioration”), when assessing whether a person meets the admission requirements for involuntary detention.³⁶ Sophie Nunnelly argues that the Court in *Thwaites* “failed to indicate any functional means of distinguishing the category of persons for whom it is permissible to consider the health or harm consequences of non-treatment from persons permitted to refuse treatment ‘regardless of the results’ (A.C. 2009, para. 45).”³⁷

In *McCorkell v Riverview Hospital*,³⁸ the constitutionality of British Columbia’s involuntary detention criteria (as they were at the time) was unsuccessfully challenged.³⁹ Joseph McCorkell was detained involuntarily in 1991, after being diagnosed with bi-polar disorder and chronic alcoholism.⁴⁰ The basis of the *Charter* challenge was that the involuntary detention criteria, which provided that a person could be involuntarily detained if they require “care, supervision or control for his own protection or welfare or for the protection of others”⁴¹ were vague and overbroad, contrary to section 7 of the *Charter*.⁴² Section 7 provides that “[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental

³⁵ *Thwaites*, *supra* note 31 at 23–24 [emphasis in original].

³⁶ *Ibid* at 25. These provisions were later upheld in another *Charter* challenge. See *Bobbie v Health Sciences Centre* 1988, 56 Man R (2d) 208, [1989] 2 WWR 153.

³⁷ Sophie Nunnelly, “Coercive Care in Civil Mental Health Law: An Autonomy Lens” (2014) Comparative Program on Health and Society Working Paper Series 2014-2015, online (pdf): <munkschool.utoronto.ca/cphs/wp-content/uploads/2016/08/1858-Nunnelly-Proof-R1-FINAL.pdf> [perma.cc/535Q-2A57] [Nunnelly, “Coercive Care in Civil Mental Health Law”].

³⁸ [1993] 8 WWR 169, 104 DLR (4th) 391 [McCorkell]. The case was brought forward as a test case by the Community Legal Assistance Society (CLAS). It was argued that the BC MHA’s involuntary detention criteria denied McCorkell his liberty in violation of section 7 of the *Charter* and resulted in arbitrary detention, as per section 9 of the *Charter*.

³⁹ *Ibid*.

⁴⁰ *Ibid*.

⁴¹ *Mental Health Act*, RSBC 1979, c 256, s 24(1).

⁴² *McCorkell*, *supra* note 38 at 2.

justice.”⁴³ It was argued that this lower harm criteria was vague because the legislation provided no criteria for the review of involuntary detention and such detention should only be justified on the dangerousness criteria.⁴⁴

Relying on the *parens patriae* purpose of the legislation, Justice Donald upheld the lower harm criteria as follows:

Unlike incarceration in the criminal justice system, involuntary committal is primarily directed to the benefit of the individual so that they will regain their health... [and] [i]n determining the fairness of the balance, I take into account my perception that Canadians want to live in a society that helps and protects the mentally ill and that they accept the burden of care which has always been part of our tradition.⁴⁵

It is evident that the Court in *McCorkell* favoured the state’s *parens patriae* role over the principle of autonomy and the right to self-determination. In contrast to the Courts in *Thwaites* and *McCorkell*, the Court of Appeal for Ontario, in *Fleming v Reid*,⁴⁶ recognized the importance of legal safeguards to promote the right to self-determination and the autonomy principle.⁴⁷ In considering the constitutionality of involuntary treatment orders, the Court of Appeal found that the provisions in the Ontario *Mental Health Act* that empowered the Ontario Review Board to authorize treatment of the patient, contrary to the individual’s capable treatment refusal expressed through their substitute decision-maker (treatment refusal override), violated section 7 of the *Charter*.⁴⁸ The Court of Appeal found that these provisions deprived the appellant of his rights to liberty and security of the person, thereby affirming the “supremacy of prior capable wishes.”⁴⁹ The Court found as follows:

A legislative scheme that permits the competent wishes of a psychiatric patient to be overridden, and which allows a patient’s right to personal autonomy and self-determination to be defeated, without affording a hearing as to why the substitute consent giver’s decision to refuse consent based on the patient’s wishes should not be honoured, in my opinion, violates the ‘basic tenets of our legal system’ and cannot be in accordance with the principles of fundamental justice.⁵⁰

⁴³ *Charter*, *supra* note 7, s 7.

⁴⁴ *McCorkell*, *supra* note 38 at 2, 47.

⁴⁵ *Ibid* at 49–50.

⁴⁶ (1991), 4 OR (3d) 74, 82 DLR (4th) 298 (ONCA) [*Fleming*].

⁴⁷ *Ibid* at 37.

⁴⁸ *Ibid* at 36–38.

⁴⁹ *Ibid*. See generally Halsbury’s Laws of Canada (online), *Mental Health*.

⁵⁰ *Fleming*, *supra* note 46 at 32.

In describing the importance of informed consent vis-à-vis the right to refuse treatment, Justice Robins stated as follows:

The right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent. With very limited exceptions, every person's body is considered inviolate, and, accordingly, every competent adult has the right to be free from unwanted medical treatment. The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination.⁵¹

In applying the autonomy principle, the Court found:

Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as persons of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection, than that of competent persons suffering from physical ailments.⁵²

Provisions of British Columbia's *Mental Health Act* are presently the subject of a *Charter* challenge in *MacLaren v British Columbia (Attorney General)*.⁵³ Relying on the decision in *Fleming*, the Council of Canadians with Disabilities is challenging British Columbia's deemed consent provisions (explained in more detail later in this paper), which deprive involuntarily detained persons with mental disabilities of the right to refuse psychiatric treatment.⁵⁴

In *PS v Ontario*,⁵⁵ the Court of Appeal for Ontario addressed the extent to which liberty and autonomy can be infringed through coercive involuntary detention practices. PS was involuntarily detained for 19 years

⁵¹ *Ibid* at 17-18.

⁵² *Ibid* at 20.

⁵³ 2018 BCSC 1753.

⁵⁴ *Ibid* at paras 16, 18. It is important to note that the British Columbia Supreme Court denied public interest standing to the Council of Canadians with Disabilities, in an attempt to prevent them from bringing this case forward. The organization is presently appealing this decision. The appeal was successful and the Court of Appeal for British Columbia "set aside the order dismissing the action and remit the CCD's application for public interest standing to the Supreme Court of British Columbia for fresh consideration." See *Council of Canadians with Disabilities v British Columbia (Attorney General)*, 2020 BCCA 241. Also, see *Canadian Council with Disabilities v. Attorney General, Amended Notice of Civil Claim*, Vancouver Registry, No. S-167325 (BC SC) [CCD]; Community Legal Assistance Society, News Release, "Charter Challenge of Forced Psychiatric Treatment Filed in BC Supreme Court" (13 September 2016), online: <clasbc.net/charter-challenge> [perma.cc/HRD8-RM8S] [CLAS, "Charter Challenge"].

⁵⁵ 2014 ONCA 900 [PS].

without appropriate procedural safeguards and disability accommodation for his pre-lingual deafness.⁵⁶ The Court found that people with mental disabilities who are involuntarily detained for six months or longer must be provided procedural safeguards – consisting of review board oversight of the conditions and services of their detention.⁵⁷ The Court found that involuntary detention is “close or analogous to criminal proceedings” – detention of persons who are found NCRMD⁵⁸ under the Criminal Code⁵⁹ – and “that the provisions of the MHA dealing with involuntary committal violate s. 7 of the *Charter* by allowing for indeterminate detention without procedural protection of the liberty interests of long-term patients.”⁶⁰ The Court used the heading “interplay between s. 15 and s. 7” to support the conclusion that “s. 15(1) violations increased the gravity of the s. 7 violations.”⁶¹ The lack of disability accommodations “decreased PS’s prospects for timely community reintegration.”⁶²

The reasoning in *PS* provided the basis for a constitutional challenge to Alberta’s *Mental Health Act*. *JH v Alberta*⁶³ challenged the constitutionality of sections 2, 4(1), 4(2), 7(1), 8(1), and 8(3) of the *Alberta Mental Health Act*. These sections of the *Mental Health Act* were found to infringe sections 7 and 9 of the *Charter* and were therefore struck down.⁶⁴ This case involves JH, who argues that his continued detention (nine months) was contrary to his *Charter*-protected liberty interests, given the lack of appropriate review board oversight, procedural safeguards, and justification provided by the lower harm criteria within Alberta’s *Mental Health Act*.⁶⁵ Recognizing the importance of the right to medical self-determination, the Court of Queen’s Bench of Alberta stated as follows:

In JH’s case, unfortunately, most of the provisions about how to legally treat someone without consent under the *MHA* were ignored. His competency was not properly addressed and certified until well into his stay (in March 2015), notice to

⁵⁶ *Ibid.*

⁵⁷ *Ibid* at paras 126–29, 202.

⁵⁸ NCRMD refers to not criminally responsible by reason of mental disorder.

⁵⁹ *PS*, *supra* note 55 at paras 80–81.

⁶⁰ *Ibid* at para 3.

⁶¹ *Ibid* at para 178.

⁶² *Ibid* at para 179.

⁶³ *JH v Alberta Health Services*, 2019 ABQB 540 [*JH* 2019]; *JH v Alberta Health Services*, 2017 ABQB 477 (CanLII) [*JH* 2017].

⁶⁴ *JH* 2019, *supra* note 63.

⁶⁵ *Ibid.* See *JH* 2017, *supra* note 63, in which the Court ruled in favour of JH proceeding with the *Charter* challenge.

any substitute decision maker was not made until April 2015, notice was not given about his right to appeal his competency finding until March of 2015, and despite this, he was treated without his consent. Accordingly, not only were his rights under the *MHA* breached, his right to security of the person pursuant to s. 7 were also breached.⁶⁶

In *Thompson*,⁶⁷ the Court of Appeal for Ontario found that the lower harm criteria for involuntary admission did not violate the *Charter*. The Court of Appeal in *Thompson* dismissed a *Charter* challenge to Ontario's expanded involuntary admission criteria (called the Box B criteria) and a new community treatment order regime.⁶⁸ The admission criterion were expanded from "apparently suffering from mental disorder that would likely result in serious bodily harm to another person or to themselves (the 'Box A' criteria)" to also include the likelihood of "substantial mental or physical deterioration of the person or serious physical impairment of the person" (the 'Box B' criteria).⁶⁹

Although the Court recognized the manner in which involuntary detention interferes with section 7 rights to liberty and security of the person, it ultimately found that the provisions were consistent with the purposes of the legislation which were public safety and improved treatment.⁷⁰ The assessment criteria and community treatment order provisions were found to be consistent with their dual purposes because they were applied in an individualized manner and persons subject to them had access to procedural and substantive safeguards.⁷¹ Thus, the Court found the expanded "Box B criteria" and the new Community Treatment Order provisions within the *Mental Health Act* did not violate sections 7, 9, 10, 12, and 15 of the *Charter*. Interestingly, the Court did not engage in a full section 15 analysis and briefly stated that the new provisions do not create "invalid stereotypes" about mental disability because they "give[s] priority to the patient's views and require[s] an individualized assessment of the patient's capacity to make treatment decisions before the patient's views can be overridden."⁷²

⁶⁶ *JH* 2019, *supra* note 63 at para 109 [emphasis in original].

⁶⁷ *Thompson* 2016, *supra* note 22.

⁶⁸ *Ibid* at paras 3, 63–67.

⁶⁹ *Ibid* at paras 7–8.

⁷⁰ *Ibid* at paras 46, 51.

⁷¹ *Ibid* at para 51.

⁷² *Ibid* at para 67.

C. Questioning the Established Purposes of Mental Health Laws

While courts continue to grapple with characterizing the purposes of mental health statutes and balancing protection, treatment, public safety, and autonomy, scholars have questioned the very validity of the established purposes of mental health laws.⁷³ The treatment-based purpose has been critiqued for failing to consider the actual punitive and coercive effects that are often experienced by persons who are involuntarily detained and/or involuntarily treated.⁷⁴ The police power purpose has been critiqued as discriminatory as a result of its implicit linking of mental disability with violence and danger. Such links raise concerns about whether mental health legislation is based upon erroneous, discriminatory, and harmful oppressive stereotypes that criminalize mental disabilities.⁷⁵

Moreover, there is a growing body of evidence to support the argument that often, involuntary treatment does not yield its intended therapeutic benefits, thereby bringing into question the validity of the treatment purpose.⁷⁶ This has been reflected in the jurisprudence that addresses the lack of less restrictive treatment options for persons with mental disabilities. For example, in *JH v Alberta Health Services*,⁷⁷ the Alberta Court of Queen's Bench grappled with whether JH met the involuntary detention criteria set out in Alberta's *Mental Health Act*. The evidence of one of the physicians who assessed JH was that, "...without adequate supports in the community he is at risk to deteriorate and suffer serious physical impairment."⁷⁸ The

⁷³ Sheldon, Spector & Perez, *supra* note 19 at 223; Nunnelle, "Coercive Care in Civil Mental Health Law", *supra* note 37; Simon N Verdun-Jones & Michelle S Lawrence, "The Charter Right to Refuse Psychiatric Treatment: A Comparative Analysis of the Laws of Ontario and British Columbia Concerning the Right of Mental-Health Patients to Refuse Psychiatric Treatment" (2013) 46:2 UBC L Rev 489 at 489-90.

⁷⁴ Sheldon, Spector & Perez, *supra* note 19 at 223.

⁷⁵ See e.g. in *Thompson* 2016, *supra* note 22 at para 7. Belobaba J (the application judge) found that if Ontario's mental health legislation had a singular purpose of public safety, specifically to protect the public from persons with mental disabilities who are prone to violence, the legislation would not have withstood Charter scrutiny because there is "no meaningful correlation between mental illness and violence" (see *Thompson* 2016, *supra* note 22 at para 50).

⁷⁶ *Ibid.*

⁷⁷ *JH* 2019, *supra* note 63; *JH* 2017, *supra* note 63.

⁷⁸ *JH v Alberta Health Services*, 2015 ABQB 314 [*JH* 2015] at para 10. See also *JH* 2019, *supra* note 63.

physician gave evidence that he would not have kept JH involuntarily detained if “community supports” were in place; however, it, “...was not his job to seek out those supports.”⁷⁹

In a similar vein, the appellants in *Thompson* adduced evidence discounting the effectiveness of involuntary treatment and demonstrating its negative impact on dignity and recovery.⁸⁰ Although competing evidence was provided in support of the treatment regime at stake, Justice Belobaba nevertheless suggested that “[t]here is... a significant disagreement about the efficacy of a community treatment regime that is based on coercion”⁸¹ and that a strong case had been made “for a government review of the impact and effectiveness of the Box B and CTO provisions.”⁸² Similarly, in *Thwaites*, the Manitoba Court of Appeal was attentive to the need to carefully design the legislative standards so that persons with mental disabilities would not be involuntarily detained if alternative and less restrictive forms of treatment were available.⁸³

Collectively, the analyses of these cases demonstrate that some courts have been attentive to the possibility of decreasing intrusions into the autonomy of persons with mental disabilities who are involuntarily detained by using less restrictive and coercive, community-based treatment options. In addition, access to decision-making supports and tools may offer another alternative to decrease state interferences with autonomy. These Courts have implied that using less restrictive treatment options is imperative where *Charter*-protected liberty interests and the right to medical self-determination are at stake.

In the section that follows, we provide a section 7 analysis of involuntary treatment provisions in three jurisdictions: British Columbia, Alberta, and New Brunswick. The analysis draws upon the jurisprudential tensions inherent in characterizing the purposes of mental health statutes and

⁷⁹ *Ibid* at para 10. In analyzing the *JH* decision, Lorian Hardcastle has argued, “It is concerning that patients are involuntarily hospitalized merely because there are insufficient community supports. Several cases raise constitutional arguments where the liberty of individuals with mental illnesses is jeopardized due to resource constraints.” See Lorian Hardcastle, “Is Alberta’s Mental Health Act Sufficiently Protecting Patients?”, Case Comment on *JH v Alberta Health Services* (18 September 2017), online (pdf): <ablawg.ca/wp-content/uploads.pdf> [perma.cc/PJ6W-VSGH]. See also *JH* 2019, *supra* note 63.

⁸⁰ *Thompson v Ontario (Attorney General)*, 2013 ONSC 5392 [*Thompson* 2013].

⁸¹ *Ibid* at para 89.

⁸² *Ibid* at para 128.

⁸³ *Thwaites*, *supra* note 31.

balancing protection, treatment, public safety, and autonomy. The following section further explores the manner in which prohibiting access to supports in decision-making violates *Charter*-protected liberty interests and the right to medical self-determination.

III. SECTION 7 AND INVOLUNTARY TREATMENT IN BRITISH COLUMBIA, ALBERTA, AND NEW BRUNSWICK

Jurisdictions in Canada differ in regard to whether persons with mental disabilities who are involuntarily detained are permitted to exercise their rights to medical self-determination. In many jurisdictions, the rights of involuntarily detained patients to consent or refuse psychiatric treatment are regulated by mental health statutes as well as health care consent legislation, including “advance health care directives, substitute decision-making legislation, long term care facility legislation and/or hospital legislation.”⁸⁴ Persons with mental disabilities may be involuntarily detained but retain their capacity with respect to treatment decisions in Ontario,⁸⁵ Manitoba,⁸⁶ Prince Edward Island,⁸⁷ Northwest Territories,⁸⁸ and Nunavut.⁸⁹ In Saskatchewan,⁹⁰ Nova Scotia,⁹¹ and Newfoundland and Labrador,⁹² people who are assessed to have the capacity to make treatment decisions cannot be involuntarily detained. In Alberta, British Columbia, and New Brunswick, persons with mental disabilities may lose their capacity to make treatment decisions in certain circumstances, once they are involuntarily detained. In this section, we argue that British Columbia’s “deemed consent” provisions and the “treatment refusal override” provisions in Alberta and New Brunswick reveal some of the most extreme

⁸⁴ Halsbury’s Laws of Canada (online), *Mental Health*.

⁸⁵ *Health Care Consent Act*, SO 1996, c 2, Sched A, s 25(2) [HCCA ON].

⁸⁶ *Mental Health Act*, RSM, c 36, CCSM c M110.

⁸⁷ *Consent to Treatment and Health Care Directives Act*, RSPEI 1996, c C-17.2.

⁸⁸ *Personal Directives Act*, SNWT 2005, c 16.

⁸⁹ *Mental Health Act*, RSNWT 1988, c M-10, s 8(1).

⁹⁰ *Mental Health Services Act*, RSS 1986, c M-13.1, s 24(2)(a)(ii) [MHSA].

⁹¹ *Involuntary Psychiatric Treatment Act*, RSNS 2005, c 42, s 17(e) [IPTA].

⁹² *Mental Health Care and Treatment Act*, SNL 2006, c M-9.1 ss 17(1)(b)(ii)(C), 28 [MHCTA].

ways that civil mental health laws interfere with the *Charter*-protected right to liberty.⁹³

A. British Columbia's Deemed Consent Provisions

In British Columbia, a person who is involuntarily detained under the *Mental Health Act*⁹⁴ is deemed to consent to any treatment that is authorized by the director of the facility. Subsection 31(1) of the *Mental Health Act* provides that:

If a patient is detained in a designated facility under section 22, 28, 29, 30 or 42 or is released on leave or is transferred to an approved home under section 37 or 38, treatment authorized by the director is deemed to be given with the consent of the patient.⁹⁵

Although British Columbia's *Health Care (Consent) and Care Facility (Admission) Act*⁹⁶ provides for the presumption of capacity for "giving, refusing or revoking consent to health care,"⁹⁷ this presumption does not apply to involuntary patients under the *Mental Health Act*.⁹⁸ British Columbia is the only jurisdiction in Canada which allows psychiatric treatment on the basis of deemed consent. The combined effect of these deemed consent provisions is that psychiatric treatment is compulsory for all involuntary patients, without regard for their capacity to give or refuse consent to treatment.

The only guidelines interpreting the deemed consent provisions are in the 2005 Government Guide to the *Mental Health Act*,⁹⁹ which states that "[w]here a patient is capable but refuses to sign the form, or where the patient is incapable, the form is given to the director or designate... [and] [i]t is strongly recommended that wherever possible, the person signing Form 5 as the director or designate should be someone other than the

⁹³ Given the lack of mental health services available in the Yukon, people with mental disabilities who are involuntarily detained are often transferred to Alberta or British Columbia. To this extent, the impugned provisions are also relevant to persons in the Yukon. See *Mental Health Act*, RSY 2002, c 150, s 24.

⁹⁴ *Mental Health Act*, RSBC 1996, c 288, s 31 [*Mental Health Act BC*].

⁹⁵ *Ibid*, s 31(1).

⁹⁶ *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181 [*HCCFA*].

⁹⁷ *Ibid*, s 3(1)(a).

⁹⁸ *Ibid*, ss 2(a)-(c).

⁹⁹ British Columbia, Ministry of Health, *Guide to the Mental Health Act* (Guide), 2005 Edition (Victoria: Ministry of Health, 4 April 2005) at 19, online (pdf): <www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf> [perma.cc/3HFC-XD3M].

treating physician.”¹⁰⁰ These guidelines are troubling because they suggest that the treating physician should not sign the form. Also, despite the Guide’s reference to a “capacity assessment”, there is no legal requirement in the *Mental Health Act* or its regulations for physicians to assess involuntary patients’ capacity to give or refuse treatment.¹⁰¹ Further, there is no legal requirement that the Consent for Treatment form be completed prior to administering the treatment and the legislation does not stipulate who should sign the form or for how long the form is valid. Empirical data suggests that, in practice, physicians often did not attempt to obtain consent to treat involuntary patients and the forms were “rarely” signed by involuntary patients.¹⁰² Consequently, the effect of the deemed consent provisions is that even people who are capable, with respect to treatment, are stripped of their right to medical self-determination if they are involuntarily detained.

In British Columbia, people with mental disabilities who are involuntarily detained have no legal mechanism to review their deemed consent to treatment, whether before a review board or otherwise.¹⁰³ However, there is an option to “request a second medical opinion on the appropriateness of the treatment” in subsection 31(2) of the *Mental Health Act*.¹⁰⁴ These requests should be made to the director, who “must consider whether changes should be made in the authorized treatment for the patient and authorize changes the director considers should be made.”¹⁰⁵ The empirical evidence suggests that “this role is again delegated and the second medical opinion is simply delivered to the treating physician.”¹⁰⁶ Thus, the “second opinion” provisions are arguably ineffective and do not provide an appropriate procedural or substantive oversight mechanism for the deemed consent provisions.

¹⁰⁰ *Ibid.*

¹⁰¹ Laura Johnston, “Operating in Darkness: BC’s Mental Health Act Detention System” (2017) at 85–86, online (pdf): *Community Legal Assistance Society* <d3n8a8pro7vhmx.cloudfront.net/clastest/pages/1794/attachments/original/152727872/CLAS_Operating_in_Darkness_November_2017.pdf?1527278723> [perma.cc/4BJX-65HE].

¹⁰² *Ibid.* at 89.

¹⁰³ *Mental Health Act* BC, *supra* note 94, s 31(2). This subsection of the Act states that “[a] patient to whom subsection (1) applies, or a person on the patient’s behalf, may request a second medical opinion on the appropriateness of the treatment authorized by the director once” in each certification period.

¹⁰⁴ *Ibid.*

¹⁰⁵ *Ibid.*, s 31(3).

¹⁰⁶ Johnston, *supra* note 101 at 91.

B. Treatment Refusal Override Provisions in Alberta and New Brunswick

Included in mental health legislation in a number of other Canadian jurisdictions are powers known as treatment refusal override provisions. In Alberta and New Brunswick, involuntarily detained patients can refuse treatment but, subject to certain procedural safeguards, their refusal can be overridden, and they can be forced to undergo psychiatric treatment.¹⁰⁷

Section 29 of Alberta's *Mental Health Act*¹⁰⁸ provides that the board of a hospital, a person in charge of the facility, or the attending physician may apply to a review panel for an order directing that treatment may be administered to a patient who is mentally capable of making treatment decisions and refuses treatment, or to a patient who is not capable of making treatment decisions but whose substitute decision-maker has refused treatment.¹⁰⁹ In effect, an involuntarily detained patient's capable treatment refusal can be overridden by a review board decision that the refused treatment is in the patient's "best interest".¹¹⁰

In New Brunswick, an involuntarily detained patient's capable treatment refusal can be overridden by order of a tribunal. Before making such an order, the tribunal must find that the "refusal does not constitute reliable and informed instructions based on the person's knowledge of the effect of the treatment[,]...the treatment is in the best interests of the person, and...without the treatment, the person would continue to be detained...with no reasonable prospect of discharge."¹¹¹ New Brunswick's *Mental Health Act* sets out the criteria against which the tribunal must assess whether overriding a capable person's treatment refusal is in their best interests.¹¹² If the tribunal refuses to make an order overriding a patient's

¹⁰⁷ *Mental Health Act*, RSNB 1973, c M-10, s 8.11(3) [*Mental Health Act NB*]; *Mental Health Act*, RSA 2000, c M-13, ss 28-29 [*Mental Health Act AB*].

¹⁰⁸ *Mental Health Act AB*, *supra* note 107, s 29.

¹⁰⁹ *Ibid.*

¹¹⁰ *Mental Health Act AB*, *supra* note 107, ss 29(3)(i)-(iv). The Act sets out factors against which the review board must assess best interests, including: "whether the mental condition of the patient will be or is likely to be improved by the treatment; whether the patient's condition will deteriorate or is likely to deteriorate without the treatment; whether the anticipated benefit from the treatment outweighs the risk of harm to the patient; [and] whether the treatment is the least restrictive and least intrusive treatment that meets the requirements."

¹¹¹ *Mental Health Act NB*, *supra* note 107, ss 8.11(3)(b)-(d).

¹¹² *Mental Health Act NB*, *supra* note 107, ss 8.11(4)(a)-(d). These subsections of the Act state that "In forming an opinion under subsection (1), (2) or (3) as to the best interests

treatment refusal, a physician may apply to a review board for such an order.¹¹³ The review board must consider essentially the same issues as the tribunal before making such an order.¹¹⁴

C. Do Involuntary Treatment Provisions in British Columbia, Alberta, and New Brunswick Interfere with the Section 7 Right to Liberty?

Section 7 of the *Charter* provides that everyone has the right not to be deprived of liberty and security of the person, “except in accordance with the principles of fundamental justice.”¹¹⁵ The right to liberty protects an individual’s personal autonomy. A violation occurs when state action, in purpose or effect, interferes with a person’s physical liberty or fundamental personal decisions.¹¹⁶

British Columbia’s deemed consent provisions are a particularly stark violation of the section 7 rights to liberty and security of the person. The deemed consent provisions, in concert with the relevant provisions of the *HCCFA*,¹¹⁷ interfere with the right to liberty by removing a capable person’s decision-making rights regarding consent to psychiatric treatment during their detention as an involuntary patient. A decision about whether to receive psychiatric treatment, which may include electroconvulsive shock treatment (ECT) or psychotropic drugs that carry serious psychological and physical side effects, is, no doubt, a fundamental personal decision. In *Fleming*, the Court of Appeal for Ontario found that “[f]ew medical

of a person, the tribunal shall have regard to (a) whether or not the mental condition of the person will be or is likely to be substantially improved by routine clinical medical treatment, (b) whether or not the mental condition of the person will improve or is likely to improve without routine clinical medical treatment, (c) whether or not the anticipated benefit from the routine clinical medical treatment outweighs the risk of harm to the person, and (d) whether or not routine clinical medical treatment is the least restrictive and least intrusive treatment that meets the requirements of paragraphs (a), (b) and (c).”

¹¹³ *Ibid*, s 30.1(1).

¹¹⁴ *Ibid*, s 30.1(6.2).

¹¹⁵ *Charter*, *supra* note 7, s 7.

¹¹⁶ *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519 at 10, 104 DLR (4th) 342 [Rodriguez]. The SCC found that the right to security of the person encompasses “a notion of personal autonomy involving, at the very least, control over one’s bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress.”

¹¹⁷ *Supra* note 96.

procedures can be more intrusive than the forcible injection of powerful mind-altering drugs.”¹¹⁸ British Columbia law removes the rights of involuntarily detained persons to make these fundamental personal decisions, even when they meet the legal test for capacity to do so. Stripping an involuntarily detained person of their right to medical self-determination plainly interferes with their liberty and fundamental personal decisions.

A similar analysis applies to persons whose capable treatment refusal is overridden, as permitted by mental health statutes in Alberta and New Brunswick. The laws in these jurisdictions permit a physician or other designated person to administer psychiatric treatment despite the person’s capable refusal, thereby interfering with involuntarily detained patients’ physical liberty. In these circumstances, involuntarily detained persons are stripped of their right to medical self-determination. For instance, in *JH v Alberta Health Services*,¹¹⁹ the Court recognized how the treatment refusal override provisions in Alberta were contrary to *Fleming* and *Carter* as follows:

The *MHA* is outdated since the decisions of *Fleming* and *Carter* which have recognized the individual’s rights to self determination in medical treatment decisions. In particular, s. 29 ultimately allows a competent patient’s treatment decisions (and even their substitute decision maker’s decision if incompetent) to be overridden by a Review Panel if the treatment was found to be in a patient’s best interest. Most Canadian jurisdictions require consent for treatment by either a competent patient or his or her substitute decision maker. Notably, the *Criminal Code* s 672.55(1) also requires that an NCR patient not be subjected to psychiatric treatment unless they consent and the Review Board “considers the condition to be reasonable and necessary in the interests of the accuse.”¹²⁰

A key difference between the deemed consent provisions in British Columbia and the treatment refusal override provisions in Alberta and New Brunswick is the presence of procedural safeguards in the latter. This is addressed in the discussion below on the principles of fundamental justice. The right to liberty is infringed even for persons who do not meet the legal test for capacity to consent to health care decisions. In British Columbia, the *Health Care (Consent) and Care Facility (Admission) Act*¹²¹ provides that substitute decision-makers are not authorized to consent to mental health admission or treatment on behalf of persons found to lack capacity to make

¹¹⁸ *Fleming*, *supra* note 46 at 23.

¹¹⁹ *JH* 2019, *supra* note 63.

¹²⁰ *Ibid* at paras 260–61 [emphasis in original].

¹²¹ *Supra* note 96.

their own decisions.¹²² Under the *Representation Agreement Act*, persons may not authorize a representative to refuse consent to involuntary admission or treatment based on mental disability.¹²³

These provisions interfere with incapable persons' decision-making rights regarding consent to psychiatric treatment by removing access to their personally appointed substitute or supported decision-maker. Access to a personally appointed substitute or supported decision-maker is important for ensuring that people are able to exercise their decision-making rights as fully as possible. In circumstances where a person is found to be incapable of making their own decisions, personally appointed substitutes or supported decision-makers can make decisions in accordance with the person's wishes, will, and preferences. That access to personally appointed substitutes or supported decision-makers that can enhance a person's decision-making autonomy has been judicially recognized in specific contexts and jurisdictions. For example, when interpreting the purpose of Ontario's *Health Care Consent Act*, in the context of consent to admission to a long-term care facility, the Ontario Superior Court found that "the purposes of the *H.C.C.A.*... make it clear that the autonomy of persons... is to be enhanced by both allowing those persons to have a representative of their choice assisting with the decision and for there to be a significant role for supportive family members in making those decisions."¹²⁴ By removing access to personally appointed substitutes and supported decision-makers, British Columbia's deemed consent provisions remove the rights of involuntarily detained persons to make fundamental personal decisions through their personally appointed substitutes or supported decision-makers, thereby interfering with their section 7 rights to liberty.

D. Do Involuntary Treatment Provisions in British Columbia, Alberta, and New Brunswick Interfere with the Right to Security of the Person?

The section 7 right to security of the person is violated when state action, in purpose or effect, interferes with physical or psychological

¹²² *Ibid*, ss 2(a)-(c).

¹²³ *Representation Agreement Act*, RSBC 1996, c 405, ss 11(1)(a)-(b) [RAA].

¹²⁴ *S(J) v Evans*, 2016 ONSC 914 at para 21 [*Evans*]. The Court made these observations in relation to interpreting the purposes of Ontario's *Health Care Consent Act*, as set out in s 1 of that legislation (*HCCA ON*, *supra* note 85, s 1).

integrity. In *Rodriguez*,¹²⁵ the Court emphasized that the ability to make fundamental life choices is a component of security of the person, in the sense that it includes the right to make choices concerning one's own body, control over one's physical and psychological integrity, and basic human dignity.¹²⁶

In the case of involuntary patients who meet the legal test for the capacity to consent to health care decisions, British Columbia's deemed consent provisions interfere with security of the person by permitting the administration of non-consensual psychiatric treatment, non-consensual physical touching, and threatened use of physical restraints.¹²⁷ The provisions further interfere with security of the person by removing patients' rights to make choices regarding their physical and psychological integrity.¹²⁸ The same is true for involuntary patients who do not meet the legal test for capacity to consent to health care decisions, in the sense that the law removes their right to make choices regarding their physical or psychological integrity through their personally appointed substitutes or supported decision-makers.

Similarly, the treatment refusal override provisions in Alberta strip incapable involuntary patients of their right to consent or refuse treatment via their substitute decision-maker. A similar situation was found to violate section 7 of the *Charter* in the 1991 Ontario decision of *Fleming. v Reid*.¹²⁹ In that case, the Court of Appeal for Ontario found that the provisions then in force in Ontario's *Mental Health Act*, which empowered the Ontario Review Board to authorize treatment of incapable involuntarily detained patients, were contrary to the individual's capable refusal, as expressed through their substitute decision-maker.¹³⁰ As such, the provisions were found to be contrary to section 7 of the *Charter* because they deprived patients of their rights to security of the person.¹³¹ The Court found that the common law right to bodily integrity and personal autonomy is deeply entrenched in Canadian law "and deserving of the highest order of

¹²⁵ *Supra* note 116.

¹²⁶ *Ibid* at paras 587-89.

¹²⁷ *CCD*, *supra* note 54.

¹²⁸ *Ibid*.

¹²⁹ *Fleming*, *supra* note 46.

¹³⁰ *Ibid* at 36.

¹³¹ *Ibid*. Ontario's *Mental Health Act* has since been amended to remove the treatment refusal override power.

protection.”¹³² Forcing involuntarily detained patients to submit to psychiatric treatment by overriding their previously expressed capable wishes to refuse treatment, as articulated by their substitute decision-makers, was a clear violation of the right to security of the person. The treatment refusal override provisions in Alberta violate the section 7 right to security of the person for the same reasons articulated in the *Fleming* decision.

E. Do Involuntary Treatment Provisions in British Columbia, Alberta, and New Brunswick Interfere with Liberty and Security of the Person in a Manner that Accords with the Principles of Fundamental Justice?

Section 7 of the *Charter* provides that everyone has the right not to be deprived of liberty and security of the person, “except in accordance with the principles of fundamental justice.”¹³³ A law or state action violates the principles of fundamental justice if it contravenes the basic tenets of our legal system.¹³⁴ A law can violate the principles of fundamental justice because it is vague, arbitrary, overbroad, or grossly disproportionate. Each of these principles is grounded in the concept of proportionality, focusing the analysis on whether the state has pursued its policy objectives in a manner that is appropriately proportionate.¹³⁵ In *Bedford*, the Supreme Court of Canada clarified that a law is arbitrary if there is no direct connection between the purpose of the law and the impugned effect on the individual, or if the law is inconsistent with its purpose.¹³⁶ In *Carter*, the Supreme Court described an arbitrary law as “one that is not capable of fulfilling its objectives. It exacts a constitutional price in terms of rights, without furthering the public good that is said to be the object of the law.”¹³⁷

A law will be overbroad if it includes some conduct that bears no relation to its purpose or if it is broader than needed to attain its purpose.¹³⁸

¹³² *Fleming*, *supra* note 46 at 22–23.

¹³³ *Charter*, *supra* note 7, s 7.

¹³⁴ *Re BC Motor Vehicle Act*, [1985] 2 SCR 486, 24 DLR (4th) 536.

¹³⁵ *Canada (Attorney General) v Bedford*, 2013 SCC 72 at para 120 [*Bedford*].

¹³⁶ *Ibid* at para 111. See also *Carter v Canada (Attorney General)*, 2015 SCC 5 at para 83 [*Carter*].

¹³⁷ *Carter*, *supra* note 136 at para 83. Access to medical assistance in dying for people with mental health disabilities, as per to the *Carter* decision, is highly contested amongst the disability communities. It is the beyond the scope of this paper to address this analysis.

¹³⁸ *Bedford*, *supra* note 135 at paras 112–13.

A law is grossly disproportionate if the state action or impugned provision is so extreme that it is disproportionate to any legitimate government interest.¹³⁹ Given the analytical focus on proportionality, a key step in determining whether a law violates the principles of fundamental justice is to understand the law's purpose.

1. British Columbia's Deemed Consent Provisions

British Columbia's *Mental Health Act* has no express purpose provision. In *McCorkell*, the British Columbia Supreme Court found that the purpose of the *Mental Health Act* was to ensure "the treatment of the mentally disordered who need protection and care in a provincial psychiatric hospital."¹⁴⁰

Assuming that this is the sole purpose of the legislation, the deemed consent provisions are arbitrary because they do not fulfill their objective of treating persons with mental disabilities to protect and care for them. Academic literature and empirical studies provide evidence that involuntary psychiatric treatment can be harmful for patients and often does not achieve its intended therapeutic benefits.¹⁴¹ In *Thompson v. Ontario*, the Ontario Superior Court reviewed a large body of evidence and acknowledged that involuntary treatment may cause more harm to patients than good.¹⁴² Thus, while the deemed consent provisions allow for treatment, in many instances the treatment will not be protective or caring and may actually worsen the patient's mental health. The provisions are, therefore, arbitrary in the sense that they do not further the public good to which the law is directed.

The deemed consent provisions are overbroad because they effectively render involuntary patients who are mentally capable of consenting to health care decisions incapable of doing so by permitting the director of a facility to consent to treatment, even if the patient capably refuses such treatment. Capable patients are rendered incapable of consenting to or refusing psychiatric treatment without any meaningful assessment of their legal capacity.¹⁴³ Forcing treatment on persons with mental disabilities who

¹³⁹ *R v Malmo-Levine; R v Caine*, 2003 SCC 74 at para 143.

¹⁴⁰ *McCorkell*, *supra* note 38 at 42.

¹⁴¹ *Thompson* 2013, *supra* note 80 at paras 89-90; Sheldon, Spector & Perez, *supra* note 19 at 223.

¹⁴² *Thompson* 2013, *supra* note 80 at paras 89-90.

¹⁴³ *Johnston*, *supra* note 101 at 89. Also, refer to previous section of this article, which discusses that there is no legal requirement for physicians to assess patient's capacity to consent to treatment and empirical evidence shows that physicians rarely do so.

are capable violates the recognized legal principle of medical self-determination, expressed as the right to refuse medical treatment.¹⁴⁴ The Supreme Court of Canada has affirmed this right and commented on the appropriate balancing between medical self-determination and the state's interest in treating persons judged to need medical intervention:

A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor's opinion, it is the patient who has the final say on whether to undergo the treatment...The doctrine of informed consent is plainly intended to ensure the freedom of individuals to make choices concerning their medical care...[and] the interest in the freedom to reject, or refuse to consent to, intrusions of her bodily integrity – outweighs the interest of the state in the preservation of life and health and the protection of the integrity of the medical profession.¹⁴⁵

Such balancing, which protects the right to refuse medical treatment to a greater degree than the state's interest in treating persons that are judged to need medical intervention, is generally applicable in the context of health care consent. However, scholars have argued that a similar approach is often not followed in the context of involuntary treatment under mental health legislation.¹⁴⁶ There is no principled reason why such balancing should not apply, regardless of the context.¹⁴⁷ Capable patients have the right to give or refuse consent to medical treatment, even where serious risks or consequences may result. Stripping capable patients of this right in the mental health context goes further than needed to attain the legislative purpose of treating those who need protection or care and it is, therefore, overbroad.

In the case of incapable involuntary patients, the deemed consent provisions remove their rights to consent or refuse treatment through their personally appointed substitutes or supported decision-makers. Substitutes or supported decision-makers can give or refuse consent in a manner that accords more closely with the patient's right to medical self-determination than the deemed consent provided by a physician. By removing this option,

¹⁴⁴ Verdun-Jones & Lawrence, *supra* note 73 at 490.

¹⁴⁵ *AC v Manitoba (Director of Child & Family Services)*, 2009 SCC 30 at para 41, citing *Malette v Shulman* 1990, 72 OR (2d) 417 at 424, 426, 429-30, 67 DLR (4th) 321.

¹⁴⁶ Nunnelley, "Coercive Care in Civil Mental Health Law", *supra* note 37 at 8.

¹⁴⁷ For a fuller discussion of this issue, see the later analysis in Part IV, applying a s 15 *Charter* analysis.

the deemed consent provisions intrude on the patient's right to self-determination more than necessary to achieve their objective, rendering them overbroad.

The above analysis demonstrates that there are strong arguments in favour of the deemed consent provisions violating the section 7 rights to liberty and security of the person, in a manner that does not accord with the principles of fundamental justice. This analysis assumes the traditional interpretation of the singular purpose of British Columbia's *Mental Health Act* as treating those in need of care and protection.

An even stronger argument emerges if the analysis starts from an understanding that the *Mental Health Act* ought to embody the dual purposes of treatment and safeguarding medical self-determination to the greatest extent possible. Accepting these dual purposes, it is clear that the Law is arbitrary because it effectively renders involuntary patients who are mentally capable of consenting to health care decisions incapable of doing so by permitting the director of a facility to consent to treatment, even if the patient themselves refuses such treatment. This stripping of the fundamental right to medical self-determination clearly would not respect the second purpose of the Act. Nor would it appropriately balance the dual purposes of the Act.

In the case of incapable involuntary patients, the law removes their rights to consent or refuse treatment through their personally appointed substitute or supported decision-makers. However, a less restrictive course of action is available. Permitting incapable involuntary patients to exercise their decision-making rights through their personally appointed substitutes or supporters is less restrictive of these patients' liberty interests. Admittedly, a less restrictive approach would lead to some involuntarily detained persons with mental disabilities refusing psychiatric treatment and/or being involuntarily detained for a longer period. For some of these persons, not getting treatment will lead to deterioration in their mental and physical well-being. Despite this impact, it must be remembered that treatment is not, in this analysis, the sole purpose of the legislation. Rather, the legislation must balance the dual purposes of treatment and safeguarding medical self-determination. Achieving an appropriate balance of these purposes will necessarily mean that some involuntarily detained persons may refuse treatment.

As described above, Canadian common law and jurisprudence has long accepted that for capable persons, the right to refuse medical treatment

must be protected to a greater degree than the state's interest in treating them, even where refusing medical treatment may lead to poor health outcomes. This principle ought to be extended to incapable persons who can exercise their medical self-determination through their personally appointed substitute or supported decision-maker. By employing an overly restrictive approach to decision-making capacity, the deemed consent provisions are broader than needed to attain their dual purposes of treating and protecting persons with mental disabilities and safeguarding their medical self-determination. The provisions are arbitrary because they do not appropriately balance the dual purposes of the Act. By stripping incapable patients of their access to personally appointed substitute or supported decision-makers, the provisions allow for treatment of these individuals, but fail to safeguard their liberty to the greatest extent possible.

2. Treatment Refusal Override Provisions in Alberta and New Brunswick

A similar analysis applies to the ways in which the treatment refusal override provisions in Alberta and New Brunswick fail to meet the principles of fundamental justice. The mental health statutes that include treatment refusal override provisions have various purposes, which reflect the traditional treatment and protection purposes of mental health legislation. New Brunswick's *Mental Health Act* states that the purposes of the Act are: "(a) to protect persons from dangerous behaviour caused by a serious mental illness, (b) to provide treatment for persons suffering from a serious mental illness that is likely to result in dangerous behaviour, and (c) to provide when necessary for such involuntary custody, detention, restraint, observation, examination, assessment, care and treatment as are the least restrictive and intrusive for the achievement of the purposes set out in paragraphs (a) and (b)."¹⁴⁸ Alberta's *Mental Health Act* contains no express purpose provision. Like the deemed consent provisions, the treatment refusal override provisions are arbitrary because, to the extent that involuntary treatment may have poor health outcomes for patients, the provisions do not achieve their purposes of treating and caring for persons with mental disabilities.

An important difference between the deemed consent provisions and the treatment refusal override provisions is the extent to which they provide for procedural safeguards when removing involuntarily detained persons' decision-making rights. British Columbia's *Mental Health Act* provides for

¹⁴⁸ *Mental Health Act* NB, *supra* note 107, ss 1.1(a)-(c).

very limited procedural safeguards. Namely, involuntarily detained persons who are deemed to consent to treatment may request a second medical opinion as to the appropriateness of the treatment authorized.¹⁴⁹ More robust procedural safeguards are provided for in respect of the treatment refusal override provisions. In Alberta and New Brunswick, treatment cannot be given until an administrative tribunal or court holds a hearing and determines that such treatment meets the relevant statutory requirements. Involuntarily detained persons have participatory rights in these proceedings.¹⁵⁰

Canadian jurisprudence has found that long-term, involuntary detention without these kinds of procedural safeguards violates section 7 in a manner that does not accord with the principles of fundamental justice. In *PS*, the Court of Appeal for Ontario found that people with mental disabilities who are involuntarily detained for six months or longer must be provided with procedural safeguards – consisting of review board oversight of the conditions and services of the detention.¹⁵¹ The Court held “that the provisions of the MHA dealing with involuntary committal violate s. 7 of the *Charter* by allowing for indeterminate detention without procedural protection of the liberty interests of long-term patients.”¹⁵² Although *PS* was a challenge to involuntary detention provisions, the reasoning in the decision is also applicable to challenges to involuntary treatment provisions. *PS* implies that Canadian courts will treat the presence of adequate procedural safeguards as sufficient protection for the liberty interests of involuntarily detained patients who are found incapable of consenting to

¹⁴⁹ *Mental Health Act BC*, *supra* note 85, s 31(2).

¹⁵⁰ *Mental Health Act AB*, *supra* note 98, s 40; *Mental Health Act NB*, *supra* note 98, s 7.6(5). Also, s 30.1(1) of the *Mental Health Act NB*, *supra* note 98 states that “If a tribunal refuses to make an order under section 8.11 authorizing the giving of routine clinical medical treatment without consent, the attending psychiatrist may file an application on a form provided by the Minister with the chairman of the review board having jurisdiction for an inquiry into whether routine clinical medical treatment should be given to an involuntary patient without consent.”

¹⁵¹ *Supra* note 55 at paras 126–29, 202.

¹⁵² *Ibid* at para 3. This reasoning in *PS* is the basis for an upcoming section 7–10 *Charter* challenge to Alberta’s *Mental Health Act* in *JH v Alberta*. This case involves *JH*, who argues that his continued detention (nine months) was contrary to his liberty protected interests under the *Charter* given the lack of appropriate review board oversight, procedural safeguards and justification provided by the lower harm threshold within Alberta’s *Mental Health Act*. See *JH 2017*, *supra* note 63, in which the Court ruled in favor of *JH* proceeding with the *Charter* challenge.

psychiatric treatment. Put another way, the presence of adequate procedural safeguards may mean that the treatment refusal override provisions in Alberta and New Brunswick survive *Charter* scrutiny.

Contrary to *PS*, the presence of procedural safeguards does not, in practice, guarantee that involuntarily detained persons will have access to a fair process within which to assert their rights to medical self-determination. Often, involuntarily detained persons appear before administrative tribunals or courts without legal representation or rights information and with little understanding of the *Charter* arguments that can be made.¹⁵³ Conversely, medical practitioners or psychiatric institutions are typically represented by experienced lawyers. The processes are adversarial and legally complex.¹⁵⁴ In these contexts, involuntarily detained persons are at a significant power imbalance, and access to procedural safeguards does not necessarily bring about access to justice.

Furthermore, an argument can be made that access to an administrative, court, or tribunal proceeding is not the only procedural safeguard needed in the context of involuntary treatment. Rather, access to a personally appointed substitute or supported decision-maker, who can make decisions in accordance with a person's wishes, will, and preferences, is a decision-making safeguard which must be in place to protect the right to medical self-determination to the greatest extent possible. Access to these decision-making safeguards would ensure that decisions about treatment could be made by substitutes or supporters who could do so in accordance with the involuntarily detained person's wishes, will, and preferences. Without such access, involuntary treatment provisions fail to interfere with liberty interests in the least restrictive way possible. Viewed through this approach, the treatment refusal override provisions do not respect the principles of fundamental justice. By overriding the decision of a substitute or supported decision-maker, the treatment refusal override provisions do not provide for meaningful access to decision-making safeguards.

¹⁵³ Johnston, *supra* note 101 at 97–105. See generally Lorne Sossin, “Access to Administrative Justice and Other Worries” in Colleen M Flood & Lorne M Sossin, eds, *Administrative Law in Context*, 2nd ed (Toronto: Emond Montgomery Publications, 2013) 211 at 211–22.

¹⁵⁴ Johnston, *supra* note 101 at 97–105.

F. Section 1: Do Involuntary Treatment Provisions in British Columbia, Alberta, and New Brunswick Interfere with Liberty and Security of the Person in a Manner That is Justified in a Free and Democratic Society?

Section 1 of the *Charter* provides that the rights and freedoms guaranteed therein are “subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”¹⁵⁵ If the involuntary treatment and involuntary detention provisions described above were found to infringe any *Charter* rights, the state would have an opportunity to justify those infringements, pursuant to section 1.

In *R v Oakes*,¹⁵⁶ the Supreme Court set out the framework for a section 1 analysis. The *Oakes* test considers whether the objective of the impugned law or state action is sufficiently important and whether the measures adopted to achieve the objective are proportional.¹⁵⁷ Proportionality is analyzed with reference to three criteria: (1) the measures adopted must be rationally connected to the objective; (2) the means should impair as little as possible the right or freedom in question; and (3) there must be proportionality between the objective and the effects of the measures which are responsible for limiting the *Charter* right or freedom.¹⁵⁸ These criteria are similar to the concepts of arbitrariness, overbreadth, and gross disproportionality that are the subject of the section 7 inquiry into whether an infringement accords with the principles of fundamental justice. As explained by Hasan, “arbitrariness is analogous to ‘rational connection’; overbreadth is analogous to ‘minimal impairment’; and gross disproportionality is analogous to the weighing of salutary versus deleterious effects.”¹⁵⁹

Given the parallels between the analytical frameworks under section 1 and section 7’s principles of fundamental justice, it is not hard to imagine that similar arguments may be relevant under section 1 as we have been put forward above in relation to section 7. Further, to the extent that community-based mental health services and supports are available, it could

¹⁵⁵ *Charter*, *supra* note 7, s 1.

¹⁵⁶ [1986] 1 SCR 103, 1986 CanLII 46 [*Oakes*].

¹⁵⁷ *Ibid* at 138–39.

¹⁵⁸ *Ibid* at 138–40.

¹⁵⁹ Nader R Hasan, “Three Theories of ‘Principles of Fundamental Justice’” (Paper delivered at Osgoode’s Annual Constitutional Cases Conference, 2013), (2013) 63:14 SCLR 339 at 369.

be argued that involuntary detention is not a minimal impairment of the right to liberty or security of the person. In addition, it could be argued that stripping persons with mental disabilities who are involuntarily detained of access to existing decision-making supports and tools fails to minimally impair their rights to medical self-determination, on an equal basis as others.

IV. INVOLUNTARY TREATMENT, INVOLUNTARY DETENTION, AND SECTION 15

Civil mental health law has significant and broad implications for the interpretation of the substantive equality provisions under section 15 of the *Charter*. However, there is a notable absence of section 15 jurisprudence in the civil mental health law context, as the jurisprudence focuses primarily on section 7.¹⁶⁰ This is troubling given the history of systemic discrimination and inequality faced by people with mental disabilities. We argue that *Charter* claims in civil mental health cases should be analyzed using section 15 and section 7 lenses. Applying both lenses will elucidate the compounding and intersecting nature of discrimination and liberty claims and enable the development of jurisprudence recognizing how the principle of substantive equality must be incorporated into the principles of fundamental justice. It would also further demonstrate the challenges of balancing civil mental health law's treatment-based and police power purposes with principles of equality and the right to medical self-determination.

In *PS v Ontario*, the Ontario Court of Appeal recognized the “[i]nterplay between s. 15 and s. 7” of the *Charter*, emphasizing how “s. 15(1) violations increased the gravity of the s. 7 violations.”¹⁶¹ Further, Sheldon, Perez, and Spector suggest that “a person’s lived reality may be distorted by discretely pleading either s. 7 or 15, given the intersecting nature of liberty and equality in the context of psychiatric detention.”¹⁶² We support this assertion and acknowledge how, unlike in other health care contexts, persons with mental disabilities disproportionately experience

¹⁶⁰ Sheldon, Spector & Perez, *supra* note 19 at 223; Nunnolley, “Coercive Care in Civil Mental Health Law”, *supra* note 37 at 8; Verdun-Jones & Lawrence, *supra* note 73 at 490.

¹⁶¹ *PS*, *supra* note 55 at para 178.

¹⁶² Sheldon, Spector & Perez, *supra* note 19 at 195.

discrimination and the coercive impacts of involuntary detention and compulsory treatment, as a result of being labelled “a person with a mental disability” and “incapable”.¹⁶³

Section 15(1), the *Charter’s* equality rights provision, states that:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.¹⁶⁴

The section 15 test is based on the Supreme Court of Canada’s decisions in *R v Kapp*¹⁶⁵ and later in *Withler v Canada (Attorney General)*¹⁶⁶ and *Quebec (Attorney General) v A*.¹⁶⁷ The two-part test analyzes whether: “(1) the law creates a distinction based on an enumerated or analogous ground; and (2) whether the distinction creates a disadvantage by perpetuating prejudice or stereotyping”.¹⁶⁸

Applying a section 15 *Charter* analysis to involuntary detention and treatment provisions, we argue that civil mental health laws violate substantive equality rights in at least two ways. First, the involuntary detention and treatment provisions in British Columbia,¹⁶⁹ Saskatchewan,¹⁷⁰ Nova Scotia,¹⁷¹ and Newfoundland and Labrador¹⁷² are discriminatory because they create a standard of capacity to consent to treatment, which applies only in the civil mental health context and is different than the standard used in other health care contexts. Second, provisions in British Columbia,¹⁷³ Alberta,¹⁷⁴ and Newfoundland and

¹⁶³ Michael Perlin & Meghan Gallagher, “The Pain I Rise Above’: How International Human Rights Can Best Realize the Needs of Persons with Trauma-Related Mental Disabilities” (2017) New York Law School Research Paper No 3021044, online: SSRN <papers.ssrn.com/sol3/papers.cfm?abstract_id=3021044> [perma.cc/84NT-UWZ9].

¹⁶⁴ *Charter*, *supra* note 7, s 15(1).

¹⁶⁵ 2008 SCC 41 [*Kapp*].

¹⁶⁶ 2011 SCC 12 [*Withler*].

¹⁶⁷ 2013 SCC 5 [*Quebec v A*].

¹⁶⁸ *Kapp*, *supra* note 165 at para 17.

¹⁶⁹ *Mental Health Act BC*, *supra* note 94, s 31; *HCCFA*, *supra* note 96, ss 2(a)–(c); *RAA*, *supra* note 123, ss 11(1)(a)–(b).

¹⁷⁰ *MHSA*, *supra* note 90, s 24(2)(a)(ii).

¹⁷¹ *IPTA*, *supra* note 91, s 17(e).

¹⁷² *MHCTA*, *supra* note 92, s 17(1)(b)(ii).

¹⁷³ *Mental Health Act BC*, *supra* note 94, s 31; *RAA*, *supra* note 123, s 11(1)(a).

¹⁷⁴ *Adult Guardianship and Trusteeship Regulation*, Alta Reg 219/2009, s 23 [AGTR]; *Adult Guardianship and Trusteeship Act*, SA 2008, c A-4.2, s 88(2) [AGTA].

Labrador¹⁷⁵ prohibit persons with mental disabilities who are involuntarily detained from accessing decision-making supports and tools in those provinces.¹⁷⁶ The analysis reveals how the substantive equality rights of persons with mental disabilities intersect with their rights to liberty, autonomy, and the right to medical self-determination, pursuant to the principles of fundamental justice.

A. Do Laws That Establish a Higher Standard of Capacity Create a Distinction Based on an Enumerated Ground?

In Newfoundland and Labrador, Nova Scotia, and Saskatchewan, involuntary admission criteria impose a more rigorous capacity standard in the civil mental health context than the capacity standard applicable to other health care contexts.¹⁷⁷ Mental health legislation in these provinces requires that, “the patient must also be unable to fully appreciate the nature and consequences of the mental disorder or to make an informed decision regarding his or her need for treatment or care and supervision in order to be involuntarily detained.”¹⁷⁸ In other (non-involuntary detention) contexts in these provinces, the standard for capacity to consent to health care treatment is “understand information relevant to the decision and... appreciate the consequences of making a decision.”¹⁷⁹ The additional requirement to fully appreciate the nature and consequences of the decision, applicable in the involuntary detention context, arguably sets a more rigorous standard for capacity than the requirement to merely appreciate the consequences of making a decision, applicable in the general health care treatment context.

¹⁷⁵ *Advance Health Care Directives Act*, SNL 1995, c A-4.1, s 2(b)(ii) [AHCDA].

¹⁷⁶ *Mental Health Act BC*, *supra* note 94, s 31; *RAA*, *supra* note 123, ss 11(1)(a)-(b); *AGTR*, *supra* note 174, s 23; *AGTA*, *supra* note 174, s 88(2); *AHCDA*, *supra* note 175, s 2(b)(ii).

¹⁷⁷ In contrast, Ontario has the same capacity threshold in the civil mental health context as in other health care contexts. Ontario’s *Health Care Consent Act* applies in both contexts. See *HCCA ON*, *supra* note 85, s 4(1) [emphasis added] which states as follows: “A person is capable with respect to a treatment, admission to or confining in a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission, confining or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.”

¹⁷⁸ Refer to *MHCTA*, *supra* note 92, s 17(1)(b)(ii)(B); *IPTA*, *supra* note 91, s 17(e); *MHSA*, *supra* note 90, s 24(2)(a)(ii).

¹⁷⁹ *AHCDA*, *supra* note 175, s 14.

The situation is slightly different in British Columbia. As described previously in this paper, the British Columbia *Mental Health Act* does not create a different standard of capacity, but rather requires no finding of incapacity at any point during the involuntary admission process. Specifically, persons with mental disabilities who are involuntarily detained and are capable of making treatment decisions are unable to refuse treatment due to the deemed consent provisions. Deemed consent occurs only in the involuntary detention context. In other health care contexts in British Columbia, consent to treatment is required.¹⁸⁰ To the extent that it establishes a different requirement with respect to the capacity to consent to treatment, the *Mental Health Act* in British Columbia, like the mental health statutes in Newfoundland and Labrador, Nova Scotia, and Saskatchewan, creates a different standard of capacity to consent to treatment than the standard otherwise required in other health care contexts. These different standards apply only to persons with mental disabilities who are involuntarily detained.

By creating a different standard of capacity applicable only to those who are involuntarily detained, the laws in these provinces create a distinction based on the enumerated ground of mental disability. As described earlier, “mental disorder” is one of the criteria for involuntary admission in all jurisdictions in Canada. A person must meet the definition of mental disorder in order to be involuntarily detained. Since the different standard of capacity applies only within the context of involuntary detention, it necessarily applies only to persons who have mental disabilities.

In *Starson*¹⁸¹ and *Fleming*,¹⁸² the Courts affirmed the importance of equally applying the same medical decision-making principles in the involuntary psychiatric context. In *Starson*, the Supreme Court of Canada recognized that the medical decision-making principles in a general health care context should apply equally to persons with mental disabilities who are involuntarily detained.¹⁸³ Citing *Fleming*, the Supreme Court in *Starson* stated as follows:

¹⁸⁰ HCCFA, *supra* note 96, s 3.

¹⁸¹ *Supra* note 25. Although *Starson* was not a constitutional case, it has had significant implications for the understanding of capacity law within the involuntary psychiatric care context.

¹⁸² *Supra* note 46.

¹⁸³ Nunnolley, “Coercive Care in Civil Mental Health Law”, *supra* note 37; Verdun-Jones & Lawrence, *supra* note 73 at 490.

The right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy. This right is equally important in the context of treatment for mental illness: see *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (Ont. C.A.), per Robins J.A., at p. 88.¹⁸⁴

The creation of different standards of capacity for involuntarily detained patients in British Columbia, Saskatchewan, Nova Scotia, and Newfoundland and Labrador runs contrary to the *Starson* and *Fleming* decisions. Persons with mental disabilities who are involuntarily detained are subject to different and higher standards of capacity to consent to medical treatment than non-disabled persons or disabled persons who are not involuntarily detained. This distinction results in a deprivation of the right to substantive equality and the right to medical self-determination and fewer substantive and protective safeguards for persons with mental disabilities vis-à-vis persons in other health care contexts.

B. Do Laws that Remove Access to Decision-Making Supports and Tools Create a Distinction Based on an Enumerated Ground?

In British Columbia, the *Representation Agreement Act* specifically prohibits involuntarily detained persons from accessing decision-making supports and tools available under that Act.¹⁸⁵ Similarly, in Alberta, the *Adult Guardianship and Trusteeship Act* prohibits involuntarily detained persons from accessing decision-making supports and tools available under that statute.¹⁸⁶ In Newfoundland and Labrador, the *Advance Health Care Directives Act* does not apply to health care decisions made in the involuntary detention context.¹⁸⁷

Like the provisions that establish a different standard of capacity, the removal of access to decision-making supports and tools is a distinction that results in a deprivation of the right to medical self-determination and a lack of substantive (decision-making) safeguards for people with mental disabilities vis-à-vis patients in other health care contexts. The discriminatory nature of depriving only people with mental disabilities from

¹⁸⁴ *Starson*, *supra* note 25 at para 75.

¹⁸⁵ *Mental Health Act BC*, *supra* note 94, s 31; *RAA*, *supra* note 123, ss 11(1)(a)-(b); *AHCDA*, *supra* note 175, s 2(b)(ii).

¹⁸⁶ *AGTR*, *supra* note 174, s 23; *AGTA*, *supra* note 174, s 88(2).

¹⁸⁷ *AHCDA*, *supra* note 175, s 2(b)(ii).

accessing decision-making supports and tools has been articulated as follows:

The exclusion of family members and friends from psychiatric treatment decisions contributes to the isolation of individuals with mental disabilities and discounts the valuable role that personal support networks play in recovery. The prohibition on *Mental Health Act* detainees using planning tools like Representation Agreements means individuals with mental health problems are not permitted to put a legal plan in place to prevent or ameliorate future mental health crises.¹⁸⁸

C. Are These Provisions an Ameliorative Program Under Section 15(2) of the *Charter*?

Once a distinction has been identified under section 15(1), the state may shield the provisions from further *Charter* scrutiny by demonstrating that they can be protected by section 15(2) if “(1) the program has an ameliorative or remedial purpose; and (2) the program targets a disadvantaged group identified by the enumerated or analogous grounds.”¹⁸⁹

The state will likely argue that the purpose of these involuntary detention and treatment provisions is remedial – to protect persons with mental disabilities who are in need of treatment. However, in applying the section 15(2) test in *R v Music Explosion Ltd*,¹⁹⁰ the Manitoba Court of Appeal found that, “a restriction was not a conferral of special benefits but simply a colourable attempt to discriminate.”¹⁹¹ The Supreme Court, in *R v Kapp*, affirmed this approach, suggesting that laws designed to restrict or punish behaviour do not qualify for protection under section 15(2).¹⁹²

This principle is applicable to the provisions at issue here. The provisions in Newfoundland and Labrador, Nova Scotia, and Saskatchewan that establish a higher standard of capacity have the effect of restricting the medical decision-making rights of involuntarily detained persons to a greater degree than persons who are not involuntarily detained. Similarly,

¹⁸⁸ Johnston, *supra* note 101 at 85. This section 15(1) argument has been put forward by the Canadians for Disabilities and the Community Legal Assistance Society in their *Charter* challenge of the deemed consent provisions in BC’s *Mental Health Act*. See CCD, *supra* note 54; CLAS, “Charter Challenge”, *supra* note 54.

¹⁸⁹ *Kapp*, *supra* note 165 at para 41.

¹⁹⁰ (1990), 68 Man R (2d) 203, 11 WCB (2d) 33 [*Music Explosion*].

¹⁹¹ Jacquelyn Shaw, “One Step Forward, Two Steps Back: a Charter Analysis of s. 39 of Nova Scotia’s *Involuntary Psychiatric Treatment Act*” (2009) 4:2 JEMH 1 at 1-11; *Ibid* at 575.

¹⁹² *Kapp*, *supra* note 165 at para 54.

the deemed consent provisions in British Columbia restrict the medical decision-making rights of involuntarily detained patients by effectively removing their capacity to consent to or refuse treatment. The provisions in British Columbia and Alberta that prevent involuntarily detained persons from accessing decision-making supports and tools restrict their ability to plan and express their wishes, will and preferences through their supported decision-makers. Each of these provisions restricts or deprives persons with mental disabilities who are involuntarily detained of their rights to medical self-determination. The provisions are not remedial in nature. Rather, they are discriminatory, punitive, and coercive measures that apply only to involuntarily detained persons with mental disabilities. Therefore, following the Courts' guidance in *Music Explosion* and *Kapp*, the provisions at issue cannot be shielded by section 15(2) because they violate the substantive equality rights of persons with mental disabilities.

D. Do the Distinctions Created by These Laws Lead to Disadvantage by Perpetuating Prejudice or Stereotyping?

Once a distinction has been established, the second part of the section 15 test is whether that distinction creates a disadvantage by perpetuating prejudice or stereotyping.

In *Withler*, the Supreme Court explained that section 15(1) should consider “the actual impact of the impugned law, taking full account of social, political, economic and historical factors concerning the group. The result may be to reveal differential treatment as discriminatory because of prejudicial impact or negative stereotyping.”¹⁹³

Persons with mental disabilities who are involuntarily detained are particularly vulnerable to negative stereotyping. As the Supreme Court articulated in *R v Swain*, “[t]here is no question but that the mentally ill in our society have suffered from historical disadvantage, have been negatively stereotyped and are generally subject to social prejudice.”¹⁹⁴

The imposition of a different standard of capacity in Newfoundland and Labrador, Nova Scotia, Saskatchewan, and British Columbia, and the lack of access to decision-making supports and tools in British Columbia, Alberta, and Newfoundland and Labrador result in involuntarily detained

¹⁹³ *Withler*, *supra* note 166 at para 39.

¹⁹⁴ *R v Swain*, [1991] 1 SCR 933 at 49–50, 193, 4 OR (3d) 383.

persons being stripped of their right to substantive equality and the right medical self-determination.

The provisions at issue reinforce the negative stereotype that having a mental disability necessarily means that a person cannot make decisions about their health care treatment. This is a long-held prejudice, as explained by the Supreme Court in *Starson*:

The tendency to conflate mental illness with lack of capacity, which occurs to an even greater extent when involuntary commitment is involved, has deep historical roots, and even though changes have occurred in the law over the past twenty years, attitudes and beliefs have been slow to change. For this reason it is particularly important that autonomy and self-determination be given priority when assessing individuals in this group.¹⁹⁵

In a 2013 review of Nova Scotia's civil mental health legislation, Justice LaForest and Professor Lahey more particularly identified the discriminatory nature of the higher capacity standard in that province:

The difference appears to be discriminatory using the criteria that the courts use under section 15 to distinguish differences in treatment from *discriminatory* differences in treatment. Specifically, the difference may reinforce and perpetuate stereotypes and prejudices. The stereotype it may reinforce and perpetuate is that lack of capacity and mental health are synonymous. The prejudice it may reinforce and perpetuate is the prejudice that people with mental illness cannot be trusted and respected to make decisions about their own health and medical treatment even when they have the level of capacity that would allow others to make those decisions.¹⁹⁶

In *Fleming*, the Court of Appeal warned that:

Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as person of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection, than that of competent persons suffering from physical ailments.¹⁹⁷

The provisions at issue discriminate against persons with mental disabilities by reinforcing negative historical stereotypes that they cannot make their own decisions about their treatment. In so doing, the provisions treat involuntarily detained persons with mental disabilities as entitled to

¹⁹⁵ *Starson*, *supra* note 25 at para 77.

¹⁹⁶ Honourable Justice Gérard V La Forest & William Lahey, "Report of the Independent Panel to Review the Involuntary Psychiatric Treatment Act and Community Treatment Orders" (2013) at 64, online (pdf): <novascotia.ca/dhw/mental-health/reports/IPTA-Review-2013.pdf> [perma.cc/7X8J-C6VR] [emphasis in original].

¹⁹⁷ *Fleming*, *supra* note 46 at 20.

less equality, autonomy, and dignity, with respect to their health care decisions, than persons who are not involuntarily detained.

V. CONCLUSION

In this paper, we analyzed involuntary detention and involuntary treatment provisions in select jurisdictions in Canada, through the lens of the *Charter's* sections 7 and 15 rights. We argued that British Columbia's deemed consent provisions and the treatment refusal override provisions in Alberta and New Brunswick violate the section 7 rights to liberty and security of the person, in a manner that does not accord with the principles of fundamental justice. In Part IV, we applied a section 15 *Charter* analysis to highlight the discriminatory and coercive impact of the interference with the rights to substantive equality and medical self-determination in the civil mental health law context. We analyzed how the involuntary admission criteria in British Columbia, Saskatchewan, Newfoundland and Labrador, and Nova Scotia violate section 15 of the *Charter* by imposing a different and more rigorous standard of capacity to consent to treatment that applies only in the context of involuntary detention. Further, we have argued that provisions in British Columbia, Alberta, and Newfoundland and Labrador violate section 15 by prohibiting involuntarily detained persons from accessing decision-making supports and tools that are otherwise available to persons who are not involuntarily detained. We contend that these provisions are not remedial and instead result in undermining the substantive equality rights of persons with mental disabilities experiencing involuntary detention and treatment.

As discussed throughout this paper, at the heart of most of the *Charter* cases that challenge mental health laws is the need to appropriately balance the state's interest in protecting and treating persons with mental disabilities with their fundamental rights to autonomy and medical self-determination. Often, governments and courts have given greater weight to protection and treatment and have used these purposes to justify significant, coercive state interferences with liberty, security of the person, and substantive equality. However, the right to medical self-determination is a fundamental and abiding principle of Canadian legal tradition. It is reflected in Canadian legislation and common law. In *Carter*,¹⁹⁸ the Supreme Court of Canada

¹⁹⁸ *Supra* note 136.

summarized the principle of autonomy in the context of medical decisions as follows:

The law has long protected patient autonomy in medical decision-making. In *Manitoba (Director of Child and Family Services) v. C. (A.)*, 2009 SCC 30, [2009] 2 S.C.R. 181 (S.C.C.), a majority of this Court, per Abella J. (the dissent not disagreeing on this point), endorsed the “tenacious relevance in our legal system of the principle that competent individuals are – and should be – free to make decisions about their bodily integrity” (para. 39). This right to “decide one’s own fate” entitles adults to direct the course of their own medical care (para. 40): it is this principle that underlies the concept of “informed consent” and is protected by s. 7’s guarantee of liberty and security of the person (para. 100; see also *R. v. Parker* (2000), 49 O.R. (3d) 481 (Ont. C.A.)).¹⁹⁹

At its heart, the right to medical self-determination is an expression of the dignity of each human being. In describing the connection between the right to medical self-determination and section 7 of the *Charter*, the Court of Appeal for Ontario found in *Fleming* that “the common law right to determine what shall be done with one’s own body and the constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of each individual, can be treated as coextensive.”²⁰⁰

Given the fundamental and abiding importance of autonomy in medical decision-making, we propose that this principle should be reflected in the purpose of all mental health legislation, not just those statutes which expressly include such purpose. Non-discrimination and substantive equality demand that autonomy is no less applicable to persons with mental disabilities than persons who are not disabled, even in the context of involuntary detention. In order to give effect to the principle of autonomy, all mental health legislation in Canada ought to be interpreted to include, as one of its purposes, safeguarding medical self-determination to the greatest extent possible. This does not preclude mental health acts from setting out other purposes, including treatment and/or protection, as discussed above. However, where such purposes are expressly stated in the statute or interpreted to be present by a court, they ought to be balanced with the purpose of protecting medical self-determination to the greatest extent possible. This approach is in keeping with the common law and Canadian legal principles articulated above. It is also consistent with Canada’s international legal obligations, including those articulated in the

¹⁹⁹ *Ibid* at para 67.

²⁰⁰ *Supra* note 46 at 23.

CRPD. By including autonomy in all mental health statutes, we can achieve greater substantive equality for people with mental disabilities.

Secondly, we propose that all civil mental health and decision-making statutes must recognize the supremacy of prior capable wishes, whether through advanced directives, access to personally appointed substitute decision-makers, or access to other decision-making supports and tools. People with mental disabilities must have access to these supports and tools on an equal basis as others, in accordance with their rights under sections 7 and 15 of the *Charter* and the *CRPD*. As we highlighted in our *Charter* analysis, provinces and territories must ensure that the same legal test of capacity to consent to treatment applies in the mental health context, as in other health care contexts, to ensure substantive equality and prevent further deprivations of liberty.

Lastly, concerted and coordinated efforts must be focused on developing non-coercive, community-based mental health services and supports. This includes the development of community-based supports for decision-making. As the courts have recognized, community-based mental health services and supports result in fewer liberty deprivations and less discrimination against persons with mental disabilities.