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PS v Ontario: Rethinking the Role of the Charter in Civil Commitment

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“PS v Ontario: Rethinking The Role of the *Charter* in Civil Commitment”
Isabel Grant*
Peter J. Carver**

Abstract: In *PS v Ontario*, a five Justice panel of the Ontario Court of Appeal struck down the wording of the province’s *Mental Health Act* that authorized the involuntary committal of psychiatric patients for a period exceeding six months. This extraordinary order sought to remedy the fundamental injustice of not providing tribunal review of treatment and discharge planning decisions for long-term patients. The authors explore how the judgment can invigorate the important liberty interests at stake in civil commitment, and bridge the gap that has grown between civil and forensic mental health law. As the flaws identified by the Ontario Court appear in legislation across Canada, the article considers the implications for all common law jurisdictions.

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I. Introduction

Civil commitment regimes in every province and territory in Canada allow the state to detain individuals with a mental illness without their consent, usually on the basis that that individual presents a threat to themselves or to others, or is at risk of serious physical or mental deterioration.¹ Such detentions must be renewed periodically and while there are limits on each

* Professor, Peter A. Allard School of Law, University of British Columbia The authors would like to thank Heather Burley and Kayla Strong for their diligent research and editing assistance on this paper. We would also like to thank the anonymous reviewers of this article who made a number of helpful suggestions. We dedicate this article to the late Professor Judith Mosoff who died in December 2015. Professor Mosoff worked tirelessly, first as a lawyer and then as an academic, to improve the lives of persons with disabilities in Canada. Both authors have been inspired by her insights into mental health law, and by her friendship.

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¹ See for example: *Mental Health Act*, RSBC 1996, c 288, s 22(3)(c)(ii); *Mental Health Act*, RSA 2000, c M-13, s 2; *Mental Health Services Act*, SS 1984-85-86, c M-13.1, s 24(2)(a)(iii); *Mental Health Act*, SM 1998, c 36, s 17(1)(b)(i); *Mental Health Act*, RSO 1990, c M.7, s 20(1.1); *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, s 17; *Mental Health Act*, RSNB 1973, c M-10, s 8.1(1); *Mental Health Care and Treatment Act*, SNL 2006, c M-9.1, s 17(1)(b)(ii)(A); *Mental Health Act*, SPEI 1994, c 39, s 13(1); *Mental Health Act*, RSY 2002, c 150, s 13(1); *Mental Health Act*, RSNWT 1988, c. M-10, s 13; *Mental Health Act (Nunavut)*, RSNWT 1988, c M-10, s 14. Note: In

renewable period of detention, no jurisdiction has imposed a limit on the overall length of time an individual may be detained. Every province and territory has a tribunal to which a civilly committed individual may apply to have his or her detention reviewed.²

Civil commitment has been described as “the most significant deprivation of liberty without judicial process that is sanctioned by our society.”³ Some advocates hoped that the *Canadian Charter of Rights and Freedoms* would serve as the catalyst for the reform of civil commitment laws and for a greater recognition of the liberty interests involved but, with a few exceptions, the *Charter* has not lived up to its billing.⁴ Professor Kaiser has called for a reassessment of coercive hospitalization and treatment as the centrepiece of mental health law given Canada’s ratification of the *Convention on the Rights of Persons with Disabilities*.⁵ To date, neither courts nor legislatures have picked up on this call to action.

Quebec a physician may place a person under preventive confinement for up to 72 hours without authorization of the court and prior to psychiatric examination if he is of the opinion that the person presents a grave and immediate danger to himself and others: *An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others*, CQLR c P-38.001, s 7 [“the *Protection Act*”]. With respect to deterioration, Ontario requires “serious physical impairment” to the individual (s. 20 (5)(a)(iii)) whereas British Columbia, by contrast, requires “substantial physical or mental deterioration” (s. 22(3)(c)(ii)).

² *Mental Health Act*, RSBC 1996, c 288, s 25; *Mental Health Act*, RSA 2000, c M-13, s 41; *Mental Health Services Act*, SS 1984-85-86, c M-13.1, s 34(8); *Mental Health Act*, SM 1998, c 36, s 56(1); *Mental Health RSO Act*, 1990, c M.7, s 39(1); *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, s 68; *Mental Health Care and Treatment Act*, SNL 2006, c M-9.1, s 64(1)(a); *Mental Health Act*, SPEI 1994, c 39, s 28(1); *Mental Health Act*, RSY 2002, c 150, s 30(1). Note: NWT and Nunavut do not have a review tribunal and instead decisions on detention are made by a territorial judge. In Quebec, appeals are heard before the Tribunal Administratif du Québec: *The Protection Act*, *supra* note 1, s 21. In New Brunswick the tribunal reviews applications submitted by reviewing physicians for involuntary admission and then determines whether to confirm in writing an order for that person to be admitted as an involuntary patient: *Mental Health Act*, RSNB 1973, c M-10, s 8.1(1).

³ Raj Anand, “Involuntary Civil Commitment in Ontario: The Need to Curtail the Abuses of Psychiatry” (1979) 57 *Can Bar Rev* 250 at 251.

⁴ H Archibald Kaiser, “Canadian Mental Health Law: the Slow Process of Redirecting the Ship of State” (2009) 17 *Health L J* 139 at 148-149. One notable exception is the decision in *Fleming v Reid*, [1991] 4 OR (3d) 74, 82 DLR (4th) 298 where the Ontario Court of Appeal found that the existing treatment regime for persons deemed incompetent to consent to treatment violated section 7 of the *Charter* because it failed to consider previously expressed wishes made by the individual when competent.

⁵ *Convention on the Rights of Person with Disabilities*, 13 December 2006, 189 UNTS 137 [CRPD]; While the CRPD does not explicitly address involuntary hospitalization and treatment, Kaiser argues that some provisions bring the coercive nature of provincial Mental Health Acts into question. For example, he refers to article 17: “Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.” H Archibald Kaiser, “Law and Psychiatry in the Age of the *Convention on the Rights of Persons with Disabilities (CRPD)*” in Richard D Schneider & Hy Bloom, eds, *Law and mental disorder: a comprehensive and*

There are three aspects of the civil commitment process that attract *Charter* scrutiny. First, the *Charter* has been used to challenge the criteria by which the commitment decision is made, usually by physicians. With one notable exception, judges have shown deference to legislators and to physicians in assessing the criteria for civil commitment.⁶ Second, the *Charter* can be used to challenge the statutory regime for nonconsensual treatment that may accompany civil commitment depending on the particular legislative regime in force in the province.⁷ Finally, the procedures and powers of the review tribunal that exists in almost every jurisdiction to review civil commitment may be subject to a *Charter* challenge. It is this last stage that is the focus of this paper.

practical approach (Toronto: Irwin Law, 2013) 1333 at 1345 [Kaiser, “Law and Psychiatry”]. The Court of Appeal in *PS* does not refer to the *CRPD*. Kaiser concludes, at 1345, that “[t]he *CRPD* demands no less than a *tabula rasa* study of the entire current system of Canadian involuntary measures, which are so firmly anchored in the now displaced or at least repositioned medical model.” See also H Archibald Kaiser, “The Convention on the Rights of Persons with Disabilities: Beginning to Examine the Implications for Canadian Lawyers’ Professional Responsibilities (2012) 20:2 Health Law Review 26. The *PS* Court does not refer to the *CRPD* which has not garnered the attention of courts in Canada.

⁶ See *McCorkell v Riverview Hospital (Director)*, [1993] BCJ No 1518, 104 DLR (4th) 391 [*McCorkell*] where Justice Donald rejected a *Charter* challenge to the BC civil commitment criteria. For a more detailed discussion of *McCorkell*, see text at footnote 69. See also *Refre Procedures and Mental Health Act* (1984), 5 DLR (4th) 577, 8 CRR 142, (sub nom *Re Jenkins*) 45 Nfld & PEIR 131, 132 APR 131 (PEICA) where the PEI Court of Appeal upheld the impugned legislation, finding that the provision on involuntary commitment did not constitute prohibited discrimination on the basis of mental disability under s 15(1) and that restrictions owing to the infirmity of people with mental disabilities were reasonable limits within s 1. Further, since involuntary patients under the Act may have the validity of their detention determined by habeus corpus, there was no violation of s 10.

Thompson and Empowerment Council v. Ontario, 2013 ONSC 5392. *Thwaites v Health Sciences Centre Psychiatric Facility*, [1988] 3 WWR 217 [*Thwaites*], was an early exception to this where the Manitoba Court of Appeal held that committal criteria failed to sufficiently define the persons who could be subject to committal and the circumstances under which they could be compulsorily detained. The standard at issue in *Thwaites* was extremely all-encompassing as the legislation provided that a person could be admitted as a compulsory patient if a qualified medical practitioner thought the person “should be admitted as a patient at a psychiatric facility”. After the *Thwaites* decision, the government responded by amending the legislation to provide for an objective “dangerousness” test to be met prior to certifying involuntary admission. The legislation also provided a more specific definition of “mental disorder” and “mental retardation”. This amended legislation was upheld in *Bobbie v Health Sciences Centre*, [1988] MJ No 485, [1989] 56 Man R (2d) 208 (MBQB).

⁷ In a landmark Ontario Court of Appeal decision, that Court struck down the provisions of Ontario’s *Mental Health Act* that allowed the best interests of an incompetent individual to override his or her previously expressed competent wishes about treatment. See *Fleming v Reid*, *supra* note 4. This decision has not been used to invalidate much more invasive compulsory treatment regimes in provinces like British Columbia and Newfoundland: *Mental Health Act*, RSBC 1996, c 288, s 31(1); *Mental Health Care and Treatment Act*, SNL 2006, c M-9.1, s 35(1).

This paper addresses a groundbreaking decision of the Ontario Court of Appeal which has required the Ontario government to revise significantly its civil commitment review tribunal and has the potential to prompt changes to the role of civil commitment review tribunals across Canada. In *PS v Ontario*,⁸ a five person bench of the Court of Appeal unanimously concluded that the civil commitment legislation in Ontario violated section 7 of the *Charter* because it provided for long term commitment without adequate procedural protections to protect the liberty interest of the person committed. The Court held that an individual could not be civilly committed beyond six months because the Consent and Capacity Review Board (the “CCB”), the tribunal that reviews commitment decisions in Ontario, did not have any jurisdiction to monitor and ensure that the appellant was receiving appropriate treatment and being held in conditions that were minimally restrictive of his liberty. In this paper, we argue that the Court’s decision is broad enough to apply across Canada to all jurisdictions which have civil mental health tribunals and has the potential to change radically the landscape of civil commitment review tribunals in Canada. We also examine the Ontario government’s response to the *PS* decision and argue that, while the response will improve the plight of persons detained for more than six months, its narrow scope is likely to lead to further litigation around the protections given to those detained for shorter periods of time.⁹

II. *PS v Ontario* and Its National Scope

A. The Facts

⁸ 2014 ONCA 900, [2014] 379 DLR (4th) 191 [*PS*].

⁹ When we refer to commitment of greater than six months in *PS*, we are actually referring to commitments that are longer than six months and two weeks, which is the actual time allowed for by the Ontario Court of Appeal's remedy. See text accompanying note 49.

After serving a sentence of 45 months in Kingston Penitentiary for sexual assault against a 12 year-old boy, during which time he received no treatment or therapy,¹⁰ PS was civilly committed under Ontario's *Mental Health Act*. He remained committed at the Oak Ridge division of Penetanguishene Mental Health Centre (now called the Waypoint Centre for Mental Health Care) for 19 years in circumstances that even his doctors conceded constituted mere warehousing.¹¹ The appellant was deaf and had very limited ability to speak or understand spoken language. He communicated using a version of Signed English and some American Sign Language.¹² PS spent his entire time in a maximum security wing at Waypoint Hearing after hearing by the CCB concluded that, while he met the conditions of civil commitment, he did not require placement in maximum security. The CCB also found repeatedly that Waypoint did not have treatment programs suitable for someone with his limited communication skills. Year after year, medium security facilities declined to accept the appellant as an inpatient.¹³ PS was 56 years old at the time of the hearing.

B. The Practice of 'Psychiatric Gating'

Why had PS been detained for such an extraordinarily long period of time? He was subject to a practice that is commonly referred to as psychiatric "gating."¹⁴ Gating is a colloquial term used to describe the practice of civilly committing a person, who is identified as dangerous, at or near the end of a sentence of imprisonment.¹⁵ In effect, "gating" represents the use of civil

¹⁰ *PS*, *supra* note 8 at para 7.

¹¹ *Ibid* at para 61.

¹² *Ibid* at para 6.

¹³ *Ibid* at para 9.

¹⁴ Yukimi Henry, "Psychiatric Gating: Questioning the Civil Committal of Convicted Sex Offenders" (2001) 59 UT Fac L Rev 229; Andres Hannah-Suarez, "Psychiatric Gating of Sexual Offenders under Ontario's Mental Health Act: Illegality, Charter Conflicts and Abuse of Process" (2005-2006) 37 Ottawa L Rev 71.

¹⁵ In several US states, "gating" has been accomplished by the passage of statutes authorizing the civil commitment of sexual offenders to psychiatric treatment facilities. In June, 2015, a Federal District Court Judge in Minnesota

commitment to continue to detain someone who can no longer be held by the criminal justice system, but is thought to present a danger to the public. It is used almost exclusively for sex offenders, whose sexual deviance can be labelled as a form of mental illness in order to satisfy the legal requirements of civil commitment. The Ontario Court of Appeal upheld this practice in 1995 in *Starnaman v Penetanguishene Mental Health Centre*¹⁶ as long as the individual meets the requirements for commitment prescribed by the *Mental Health Act*. The Court of Appeal in *Starnaman* rejected arguments that gating is an inappropriate use of the civil commitment system to augment the dangerous offender regime set out in the *Criminal Code*, and held that it was not contrary to section 7 of the *Charter*. Gating is controversial in part because serious doubts exist with respect to whether effective treatment regimes exist for personality disorders and disorders such as pedophilia. In other words, persons committed to hospital for personality and sexual disorders have little realistic opportunity of having a diagnosed condition remediated to the point of no longer meeting the civil commitment requirements.¹⁷ Thus, individuals who are “gated” may easily be warehoused as long-term detainees of psychiatric facilities. While the decision in *PS* is not limited to those who have been “gated”, and applies to anyone detained involuntarily for more than six months, “gated” individuals are likely to become long term detainees.

We have not been able to find any gating cases outside of Ontario. While this may be explained by different protocols and policies by health systems and practitioners in the other

ruled the civil commitment of sexual offenders at the end of their criminal sentences to be unconstitutional. *Karsjens et al v Jenson et al*, Civ No 11-3659 (D Minn. 2015) (Frank J, June 17, 2015).

¹⁶ *Starnaman v Penetanguishene Mental Health Centre*, [1995] 24 OR (3d) 701,100 CCC (3d) 190. The Ontario Divisional Court reached a similar result in *Penetanguishene Mental Health Centre v Stock*, [1994] 116 DLR (4th) 550, 1994 CanLII 7506 (Ont Gen Div).

¹⁷ Professor Kaiser describes the intractable problem created by those who present a danger based on a personality disorder yet who are found to be criminally responsible: “The very nature of a personality disorder compared to psychosis virtually guarantees that there will be conflict and uncertainty at every level of the accused's experience with the criminal justice and mental health care systems.” H Archibald Kaiser, “*R v Knoblauch: A Mishap at the often ambiguous crossroads between the criminal justice and the mental healthcare systems*” (2001) 37 CR (5th) 401 at 404.

provinces, it would also seem to be explained by the varying committal criteria used in jurisdictions around the country. Several jurisdictions incorporate into those criteria the requirement that the mental illness or disorder need treatment or be treatable by psychiatric care.¹⁸ Ontario has no such requirement.¹⁹ The Court of Appeal sat five justices in *PS* because it thought that the constitutionality of psychiatric gating, upheld in *Starnaman*, might need to be reconsidered. In fact, the Court decided to focus on all long term detainees and did not address the constitutionality of gating.

C. Jurisdiction of the Consent and Capacity Board

The *PS* case deals with the decision-making authority of Ontario's CCB, an administrative tribunal whose extensive jurisdiction in health care matters is unique among Canadian provinces. The CCB serves as a review tribunal for those who have been civilly committed to psychiatric facilities in Ontario, but it has several other functions as well. The CCB has decision-making authority with respect to reviews of medical determinations of incapacity to consent to treatment,²⁰ the appointment of a representative to consent to treatment,²¹ the review of appointments of substitute decision-makers for incapable individuals, applications by substitute decision-makers to depart from the prior wishes of a person made during a period of capability,²² and review of consent given to the admission of incapable individuals to hospital facilities,²³ all in addition to its review of civil commitment to psychiatric facilities and commitment to community treatment orders ("CTOs") under the Ontario *Mental Health Act*. The

¹⁸ See for example *Mental Health Act*, RSBC 1996, c 288, s 22(3)(c); *Mental Health Services Act*, SS 1984-85-86, c M-13.1, s 24(2)(a)(i); and *Mental Health Act*, SM 1998, c 36, s 17(1)(b)(ii).

¹⁹ *Mental Health Act*, RSO 1990, c M.7, s 20(5).

²⁰ *Health Care Consent Act, 1996*, SO 1996, c 2, Sch A, s 32.

²¹ *Ibid*, s 33.

²² *Ibid*, s 36.

²³ *Ibid*, s 34.

CCB has no counterpart in the rest of Canada²⁴ where, generally speaking, civil mental health review tribunals have jurisdiction only to review civil commitment and, in some provinces, to review CTOs and applications by hospitals to override treatment refusals.²⁵ Given its various roles, the CCB is a large tribunal, with an extensive jurisprudence.²⁶ Prior to the changes prompted by the *PS* decision, the CCB had a narrowly defined jurisdiction to review civil commitment in Ontario, thus making it analogous to other provincial tribunals. It could order that the involuntary detention continue or it could order that the involuntary status be rescinded and the individual released. In 2010, the Ontario legislature gave the CCB the jurisdiction to order that an involuntary patient be transferred to another facility at certain points after at least nine months of civil commitment.²⁷

D. The Decision

Superior Court of Justice

PS brought a *habeas corpus* application to the Ontario Superior Court of Justice seeking, among other things, a declaration that his rights had been violated under section 7 of the *Charter*. Justice McCarthy held that the decision in *Starnaman* had “conclusively” determined that the *Mental Health Act* does not offend against the procedural component of the principles of

²⁴ With the exception of the Yukon’s Capability and Consent Board, empowered under that Territory’s *Care Consent Act*, SY 2003, c 21, Sch B for purposes similar to the CCB in Ontario.

²⁵ In the Northwest Territories and Nunavut, reviews of involuntary admission are conducted by the Supreme Court of the Northwest Territories, and the Nunavut Court of Justice, respectively: See *Mental Health Act*, RSNWT 1988, c M-10, s 26. Both Courts have the authority to “make any other order the judge considers appropriate” in addition to confirming or canceling the certificates of admission – see s 28(2)(c).

²⁶ In the 2014-2015 year, the CCB had 123 members, divided roughly equally between lawyers, psychiatrists and members of the public. The Board convened 3,586 hearings. See “Annual Report of the CCB for 2014-2015 on the CCB website at <http://www.ccboard.on.ca/scripts/english/index.asp>. Reasons for decisions of the CCB are found in CANLII.

²⁷ *Mental Health Act*, RSO 1990, c M.7, s 39.2.

fundamental justice.²⁸ He found that PS had been properly admitted and that the CCB had regularly reviewed his involuntary status.²⁹ Justice McCarthy found that, although PS was detained in a maximum security facility that was excessive for his needs, he enjoyed “uncommon” freedoms and privileges that were often tailored to his individual needs.³⁰ In rejecting the argument that PS’s security interests were infringed, he found that PS had not suffered “any serious state imposed psychological harm or stress.”³¹ He also went on to reject PS’s argument that Waypoint’s failure to retain deafness experts to assist in his assessments and treatment left him unable to meaningfully participate in his rehabilitation, thereby lengthening his detention. Instead, Justice McCarthy found that the record was “replete with treatments and opportunities afforded to the Appellant.”³² He concluded his section 7 analysis by rejecting the argument that PS had merely been warehoused, and found that the evidence indicated that he has enjoyed a variety of opportunities and freedoms, transfer options had been explored, and that PS’s own failure to take action to initiate a transfer had contributed to his remaining at Waypoint.³³ Accordingly, he held that the impugned provisions of the *Mental Health Act* and the actions of Waypoint had not infringed section 7 of the *Charter*.³⁴

PS also based his challenge to his continued involuntary detention and the conditions of his hospitalization on section 15(1) of the *Charter*, citing discrimination on the grounds of physical disability, *i.e.*, deafness. He presented evidence demonstrating that, throughout his 19 years of involuntary committal, therapeutic interactions with him had generally been carried out without the provision of ASL interpreters. McCarthy J. concluded that the Supreme Court of

²⁸ *S v Her Majesty the Queen*, 2013 ONSC 2970 at para 43 [*S v the Queen*].

²⁹ *Ibid* at para 45.

³⁰ *Ibid* at para 69.

³¹ *Ibid* at para 72.

³² *Ibid* at para 76.

³³ *Ibid* at para 86.

³⁴ *Ibid* at para 103.

Canada's seminal ruling in *Eldridge v BC*,³⁵ in which the Court said that equality required public hospitals to provide interpreters for deaf patients as part of delivering medical services, applied to PS's circumstances. However, Justice McCarthy interpreted the *Eldridge* principle as requiring interpretation only for "significant therapeutic interventions", which he believed had occurred on four specified occasions, prior to 2006. On none of those occasions, he noted, were the breaches "intentional."³⁶ At worst, PS was simply in an inappropriate facility for his needs. Justice McCarthy found no violations of section 15(1) since that time, and made no declaration with respect to section 15(1). PS appealed this decision to the Ontario Court of Appeal.

The Ontario Court of Appeal

With respect to the section 7 issue, the Court of Appeal began by making a distinction between those individuals who are civilly committed for less than six months (roughly 98%), and those who are civilly committed for more than six months (roughly 2%).³⁷ Relying on these statistics, the Court held that the focus of the CCB is on short-term committal and whether the patient meets the criteria for commitment.³⁸ However, when that commitment extends beyond six months, the *Charter* requires that the Board have additional powers to deal with those commitments.³⁹

The Ontario Court of Appeal acknowledged the significant deprivation of liberty involved in civil commitment. Even where protection of the public requires detention, "the state cannot detain people for significant periods of time without providing them with a fair

³⁵ [1997] 3 SCR 3.

³⁶ *S v the Queen*, *supra* note 28 at para 100.

³⁷ *PS*, *supra* note 8 at para 26.

³⁸ *Ibid* at para 193.

³⁹ *Ibid* at paras 128, 129, 197.

procedural process.”⁴⁰ The Court acknowledged that the greater the impact on the liberty of the individual the greater the need for procedural protections and that “factual situations which are closer or analogous to criminal proceedings will merit greater vigilance by the courts.”⁴¹ This finding was particularly significant because it enabled the Court to rely heavily on jurisprudence involving various provincial *Criminal Code* Review Boards where concerns around the liberty interests of the accused have been much more front and centre than in the civil commitment context. *Criminal Code* Review Boards have the power to impose conditions that relate to the provision of medical services and treatment and, by analogy, so must tribunals that review civil commitment:

In sum, the case law suggests that in the non-punitive detention context, s. 7 requires the body reviewing detention to have the procedures and powers necessary to render a decision that is minimally restrictive on liberty in light of the circumstances necessitating the detention.⁴²

By failing to give the CCB the necessary tools to protect the liberty interests of long term involuntary detainees, the *Mental Health Act* fails to ensure that “the liberty interest of the [detained individual is] built into the statutory framework.”⁴³ Specifically, the Court held that the Board lacks the jurisdiction “to supervise security level, privileges, therapy and treatment of long-term detainees and to craft orders that would ensure an appropriate balance between public protection and the protection of detainees’ liberty interests.”⁴⁴

The Court rejected the argument that the new jurisdiction to transfer patients under section 39.2 was sufficient to uphold the legislation under section 7. The Board had no authority

⁴⁰ *Ibid* at para 78 citing *R v Kobzar*, 2012 ONCA 326 at para 57.

⁴¹ *Ibid* at para 79 citing *Dehghani v Canada (Minister of Employment & Immigration)*, [1993] 1 SCR 1053 at 1077, 101 DLR (4th) 654.

⁴² *Ibid* at para 92.

⁴³ *Ibid* at para 115 citing *Penetanguishene Mental Health Centre v Ontario (Attorney General)*, 2004 SCC 20 at para 53, [2004] 1 SCR 498.

⁴⁴ *Ibid* at para 115.

to order that the individual be transferred to a different level of security within a detaining institution, to transfer the individual to another hospital with conditions, or to increase access to the community or order conditions to prepare for gradual release.⁴⁵ The *Mental Health Act* must provide the Board with sufficient flexibility to ensure that individuals are not subjected to overly restrictive or prolonged detentions and to make sure that the individual's treatment is moving them towards reintegration into society. The Court of Appeal envisaged a review mechanism that would allow the Board to examine basic questions as to "where and how a person is detained and how they are discharged into the community."⁴⁶ One example of the inadequacy of the Board's powers was the fact that the *Mental Health Act* did not give the CCB the power to issue a community treatment order as an alternative to detention for an individual certified as an involuntary patient.⁴⁷

The Court crafted a simple but elegant remedy in this case, pursuant to section 52(1) of the *Constitution Act*, 1982. Rather than invalidating the civil commitment regime, it focused on the provisions that provided for renewals beyond six months. By severing the words "or subsequent", renewals beyond six months are disallowed.⁴⁸ Section 20(4) provided as follows:

An involuntary patient may be detained, restrained, observed and examined in a psychiatric facility,

(a) for not more than two weeks under a certificate of involuntary admission; and

(b) for not more than,

(i) one additional month under a first certificate of renewal,

(ii) two additional months under a second certificate of renewal, and

⁴⁵ *Ibid* at para 126.

⁴⁶ *Ibid* at para 127.

⁴⁷ *Ibid* at para 127. As will be discussed below this is one deficiency identified by the Court of Appeal that was not addressed in the Ontario government's amendments. See Part III B, below.

⁴⁸ *Ibid* at para 202.

(iii) three additional months under a third ~~or subsequent~~ certificate of renewal, ...⁴⁹

Because the Board only had jurisdiction to order a transfer after approximately 9 months, the Court held that the transfer provision would no longer be applicable because individuals could not be committed for nine months. The Court left for another day whether problems of the kind encountered in this case could arise in short-term civil commitment.⁵⁰ The Court suspended the operation of its remedy for a period of 12 months so that the Ontario government could consider how to review its legislative regime.⁵¹

With respect to the equality rights claim, again the Court of Appeal unanimously found in PS's favour. The Court of Appeal rejected the "significant intervention" test as being too narrow for this form of discrimination. The Court stated that properly interpreted, *Eldridge* had established a threshold of "effective communication", and that in the context of civil commitment, this had a particularly strong content. Justice Sharpe described the implications as follows:⁵²

I note here that s. 15(1) does not require "24/7" interpretation services for all aspects of daily living, but in the context of involuntary detention, it certainly does require a degree of accommodation beyond the context of significant therapeutic services and interactions. In *Eldridge*, the court held, at para. 82, that the "'effective communication' standard is a flexible one, and will take into consideration such factors as the complexity and importance of the information to be communicated, the context in which the communications will take place and the number of people involved." The means for effective communication does not have to be provided at all times and in every situation.

However, statutorily-mandated detention renders detainees entirely dependent upon the hospital, whether privately or publicly operated, for essential services and treatment. In my view, in the context of detention, the flexible *Eldridge* standard of "effective communication" mandates the regular provision of communication through deaf

⁴⁹ The Court apparently overlooked the fact that the remedy ordered here actually allows for commitment beyond six months since there is the initial two weeks, followed by one month, an additional two months, and finally three more months which makes for a total of six months and two weeks.

⁵⁰ *PS*, *supra* note 8 at para 204.

⁵¹ *Ibid* at para 206.

⁵² *Ibid* at paras 147-148.

appropriate services in order to ensure that the detainees' basic and fundamental personal needs are being fully understood and consistently addressed.

The Court went on to say that the applications judge had erred by finding violations of PS's section 15 rights only on isolated occasions, in the face of evidence that hospital authorities had relied for years on written communication with PS despite being aware that he was functionally illiterate and required ASL interpretation for comprehension. The Court made a particular point of noting the importance of using interpreters for effective communication of requests for consent to treatment, something the facilities had consistently failed to do.

With respect to its ruling that PS's equality rights had been consistently and unjustifiably violated over a period of years, the Court made an order for declaratory relief as follows, pursuant to the remedial power in section 24(1) of the *Charter*:⁵³

- (1) that the appellant's s. 15(1) rights have been violated, and
- (2) setting out in general terms the nature and extent of his entitlement under s. 15(1), namely, that Ontario and Waypoint are required to provide the necessary and appropriate communication services that will ensure: (i) that the appellant's basic and fundamental personal needs as a detainee are fully understood and addressed, and (ii) that the appellant is able to communicate effectively to access the therapeutic, treatment and other programs offered to hearing detainees.

PS represents the most fulsome elaboration by a Canadian appellate court of the *Eldridge* principles with respect to access to equal public services by deaf persons, and indeed by persons with disabilities generally.

E. National Significance of *PS v Ontario*

Given that *PS* has binding force only in Ontario, why should academics and lawyers outside Ontario still take heed of this important decision? While the mental health regime in Ontario is unique, features of Ontario's legislation germane to the reasoning in *PS* are common

⁵³ *Ibid* at para 207.

to most provincial and territorial mental health statutes.⁵⁴ In other words, the shortcomings identified by the Ontario Court of Appeal in *PS* exist across the country. Every province and territory provides for civil commitment which can last longer than six months.⁵⁵ For example, in British Columbia, an individual can be detained for one month, renewed for a second month, then three months followed by an unlimited number of six-month renewals.⁵⁶ Nova Scotia is similar except no single renewal is for more than three months.⁵⁷ None of these jurisdictions puts a limit on how long a person can be detained. Some provinces provide a role for the tribunal in reviewing treatment decisions⁵⁸ while others limit their review tribunals to reviewing the status of civil commitment and release.⁵⁹ In British Columbia, for example, the civil review tribunal only has the jurisdiction to review detention, although this extends to those on extended leave.⁶⁰ Unlike in Ontario, the BC statute gives the review panel no jurisdiction whatsoever regarding treatment which, for those with involuntary status, can be imposed without consent.⁶¹ Further, no provincial mental health legislation in Canada provides the kind of jurisdiction envisaged by the

⁵⁴ We confine our general remarks to Canada's common law jurisdictions. Mental health law in Quebec has distinct features owing both to its civil law system and the role of an omnibus administrative tribunal, the Administrative Tribunal of Quebec. Civil mental health law in Quebec is governed by provisions of that province's Civil Code, the Code of Civil Procedure, and the *Protection Act*, *supra* note 1. Beyond an initial 72 hour period of hospital confinement, a person is subject to involuntary admission only by virtue of a court order, and for a period specified by the court (subject to renewal). The individual may seek a review of the order of confinement before the Administrative Tribunal of Quebec (the "ATQ"), the tribunal that conducts administrative reviews across many areas of public governance in Quebec. The ATQ also acts as the forensic review board in Quebec for purposes of Part XX.1 ("Mental Disorder") of the Criminal Code.

⁵⁵ *Mental Health Act*, RSBC 1996, c 288, s 24(1)(c); *Mental Health Act*, RSA 2000, c M-13, s 8(3)(c); *Mental Health Services Act*, SS 1984-85-86, c M-13.1, ss 23(7), 24.1; *Mental Health Act*, SM 1998, c 36, s 21(4); *Mental Health Act*, RSO 1990, c M7, s 20(4)(b)(iii); *Civil Code of Québec*, SQ 1991, c 64, s 30.1; *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, s 22; *Mental Health Act*, RSNB 1973, c M-10, s 13(1)(c); *Mental Health Care and Treatment Act*, SN 2006, c M-9.1, s 31(1)(c); *Mental Health Act*, SPEI 1994, c 39, ss 16(3)(b), 16(3)(c); *Mental Health Act*, RSY 2002, c 150, s 16(1); *Mental Health Act*, RSNWT 1988, c M-10, s 23.2(1); *Mental Health Act (Nunavut)*, RSNWT 1988, c M-10, s 23.2(1).

⁵⁶ *Mental Health Act*, RSBC 1996, c 288, s 24(1).

⁵⁷ *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, s 22.

⁵⁸ *Mental Health Act*, SM 1998, c 36, s 30(5); *Mental Health Act*, SPEI 1994, c 39, s 24(4).

⁵⁹ See, for example, British Columbia (*Mental Health Act*, RSBC 1996, c 288, s 25(2)) and Saskatchewan (*Mental Health Services Act*, SS 1984-85-86, c M-13.1, s 34(8)).

⁶⁰ *Mental Health Act*, RSBC 1996, c 288, ss 25(2), 39(1).

⁶¹ *Ibid* s 31.

Ontario Court of Appeal in *PS* to supervise the conditions of long-term commitment. Nor does any provincial review tribunal, outside of Ontario, have the authority to transfer the patient to another facility, although PEI and the Yukon provide for review of a physician's transfer decision,⁶² and New Brunswick requires the review tribunal to approve transfers to another jurisdiction.⁶³ The changes following *PS* in Ontario mean that Ontario is the only province in Canada that provides significant procedural protections to long-term civilly committed individuals.

We have seen small steps towards expanding the jurisdiction of review tribunals in some provinces. Nova Scotia, for example, allows the Review Board to review community treatment orders.⁶⁴ In general, when the Review Board is considering an application to review detention or a community treatment order, it may make "such recommendations to the chief executive officer as it sees fit respecting the treatment or care of a patient."⁶⁵ However, the statute stops short of giving the Board the jurisdiction to make orders regarding treatment or other conditions of detention as the chief executive officer is not required to implement any of the recommendations made by the tribunal.⁶⁶ Prince Edward Island has a unique provision guaranteeing certain communication rights on the part of the patient and the tribunal can review denial of those rights.⁶⁷ Despite these exceptions, no province outside Ontario has the kinds of powers required as a matter of constitutional law by the *PS* Court. No province has for example, the power to order transfers to lower levels of custody, the power to release an individual on conditions or on a community treatment order rather than prolonging detention, the power to scrutinize the

⁶² *Mental Health Act*, SPEI 1994, c 39, 28(1)(g); *Mental Health Act*, RSY 2002, c 150, s 24(2).

⁶³ *Mental Health Act*, RSNB 1973, c M-10, s 27. New Brunswick has a somewhat unique regime in which a physician must apply to the review board in order to have a person admitted to a psychiatric facility although the person may be detained and treated pending the tribunal's decision.

⁶⁴ *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, ss 58, 76(2)(f).

⁶⁵ *Ibid*, s 68(2).

⁶⁶ *Ibid*.

⁶⁷ *Mental Health Act*, RSPEI 1988, c M-6.1, ss 33(2), 28(1)(h).

freedom of movement within the facility and its surrounding community, and the power to scrutinize treatment plans to ensure that the individual is making progress towards reintegration into the community. *PS* provides important ammunition for challenging all these shortcomings in provincial and territorial regimes.

III. Commentary

In this commentary, we wish to outline the significance of the ruling in *PS* for enhanced administrative supervision of the civil mental health system in Ontario, and for the systems in all common law provinces. We focus on the systemic section 7 issue, rather than on the individualized section 15 claim which was unique to *PS*.

We begin by demonstrating that the most significant aspect of the Court's decision was its reliance on the *Criminal Code* Review Board jurisprudence. We then move on to examine the response to *PS* recently enacted by the Ontario government and demonstrate that, while the changes are progressive and important for long-term detainees, the response stops short of fully vindicating section 7 liberty interests and may even raise its own section 15 concerns for persons civilly committed for shorter periods of time. Finally, we speculate on a broader role for administrative tribunals in the mental health field generated by the Court of Appeal's reasoning. Specifically, we raise the possibility of according review responsibility to tribunals with respect to important liberty interests of civilly committed individuals, which are put in jeopardy by ongoing use in psychiatric hospitals of measures such as physical restraint and seclusion. In turn, this leads us to a brief consideration of an issue raised but not resolved in *PS* – the jurisdiction of mental health review tribunals to address and remedy breaches of a civilly committed individual's *Charter* rights. In our view, a move in the direction of an increased role for

independent review tribunals in mental health, especially in the areas of discharge planning and conditions and levels of hospital security, is overdue. Such broad jurisdiction responds more appropriately to the constitutional interests of liberty and security of person of individuals involuntarily detained in psychiatric facilities across Canada.

A. Reliance on the Criminal Code Review Board Model

In 1991, Professor Isabel Grant wrote about the importance of recognizing the coercive nature of civil commitment through analogizing to the deprivations of liberty involved in the criminal justice system.⁶⁸ In *PS*, the Ontario Court of Appeal takes a step in that direction by relying heavily on the jurisprudence under the *Criminal Code* Review Board thus revitalizing the judicial understanding of civil commitment. In our view this is the most significant implication of the decision. The Court's reliance on case law dealing with the *Criminal Code* Review Board, a tribunal established in each province under the *Criminal Code* to make decisions regarding persons found not criminally responsible by reason of mental disorder ("NCRMD") or unfit to stand trial, enables the Court to recognize the serious deprivation of liberty involved in civil commitment. This is in complete contrast to the approach taken by Justice Donald in the BC Supreme Court in an earlier *Charter* challenge to the criteria justifying civil commitment. In *McCorkell*, Justice Donald applied a much more paternalistic approach to civil commitment to justify the lack of procedural protections on the basis that the system is aimed at helping people

⁶⁸ Isabel Grant, "Mental Health Law and the Courts" (1991) 29 Osgoode Hall L J 747. Grant's paper was written before the creation of the *Criminal Code* Review Board and thus the author focused on criminal law more broadly. Since that time, the Supreme Court of Canada has differentiated the *Criminal Code* Review Board from the criminal trial process more broadly because of its inquisitorial nature. *Winko v Forensic Psychiatric Institute*, [1999] 2 SCR 625, 175 DLR (4th) 193 [*Winko*]. However the *PS* court focuses its analysis on the connection between the *Criminal Code* Review Board and mental health tribunals.

who are sick. The analogy to criminal law procedural protections was not relevant to the civil commitment context because of these different rationales:

It is necessary at this point to repeat what I said earlier concerning the use of criminal cases to decide a mental health matter: the objects and purposes of criminal law and mental health legislation are so different that cases in one area will be of little guidance in the other. A protective statute and a penal statute operate in dramatically dissimilar contexts. Strict and narrow criteria for the detention of persons in a criminal law context reflect our society's notions of fundamental justice for an accused person and protection of the public is a foremost consideration. But in the field of mental health, the same criteria would defeat the purpose of the legislation which is to help seriously mentally ill people in need of protection.⁶⁹

The Court failed to recognize that even a statute with a “protective” *purpose* can have the same *effect* on the individual as a punitive statute and thus should trigger the same liberty interests.⁷⁰

Two years prior to *McCorkell*, the law concerning the criminal or forensic psychiatry system had been sent on a striking new trajectory. In *R v Swain*,⁷¹ the Supreme Court of Canada ruled that the *Criminal Code* provisions that provided for immediate and indefinite detention of a person found to have been NCRMD at the time of committing an offence, without assessment of their mental condition at the time of disposition, unjustifiably infringed both sections 7 and 9 of the *Charter*. The Court's decision in *Swain* effectively endorsed a package of reform measures that were enacted shortly thereafter as Section XX.1 of the *Criminal Code*, the “Mental Disorder” provisions. Central to the reform package was the empowering of Review Boards, to be constituted at the provincial level, for the purpose of supervising the progress of NCRMD detainees in the forensic psychiatric hospital system. These Boards have authority to rule on

⁶⁹ *McCorkell*, *supra* note 6 at para 63.

⁷⁰ See for example: *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143, 56 DLR (4th) 1; *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 44, [2011] 3 SCR 134.

⁷¹ [1991] 1 SCR 933, 5 CR (4th) 253.

issues of discharge, conditions of discharge, security levels within hospital custody, and treatment planning.

In *PS*, the Ontario Court of Appeal revisited and relied on the reasoning of *Swain*. In particular, the Court found that the Supreme Court's understanding of the *procedural* aspects of fundamental justice in circumstances where the state acts to detain individuals were applicable to civil committal, at least so far as it relates to long-term involuntary patients. The Court of Appeal cited the Supreme Court of Canada's 2007 decision in *Charkaoui v. Canada*⁷² concerning the statutory scheme for detaining and deporting non-citizens believed to pose national security threats to Canada, quoting in particular the Supreme Court's statement that section 7 requires that detention for an extended period "must be accompanied by a meaningful process of review that takes into account the context and circumstances of the individual case."⁷³

In the 25 years following *Swain*, Canadian courts have recognized forensic Review Boards as having an important role in protecting the liberty interests of NCR accused and those found unfit to stand trial. In fact, it was as a result of a decision in the context of the Ontario Review Board that the *Charter* jurisdiction of Canadian administrative tribunals in general was confirmed. In *R v Conway*⁷⁴ the Supreme Court of Canada ruled that the Review Board had jurisdiction to decide issues of law, and thus had *Charter* jurisdiction. The Court described the broad role of the Review Board in these terms:

The Board is a quasi-judicial body with significant authority over a vulnerable population. It is unquestionably authorized to decide questions of law. It was established by, and operates under, Part XXI of the *Criminal Code* as a specialized statutory tribunal with ongoing supervisory jurisdiction over the treatment, assessment, detention and discharge of those accused who have been

⁷² 2007 SCC 9, [2007] 1 SCR 350.

⁷³ *Ibid* at para 107.

⁷⁴ 2010 SCC 22, [2010] 1 SCR 765 [*Conway*].

found not criminally responsible by reason of mental disorder (“NCR patient”).⁷⁵

Criminal Code Review Boards regularly assess the levels of custody in which an individual is detained and the level of privileges an individual is allowed to experience. By contrast, civil tribunals rarely have any jurisdiction to assess whether the hospitalization is doing anything positive for the individual or moving him or her closer to discharge. *PS* provided a stark demonstration of the impact of the lack of a similar jurisdiction on the civil mental health side in Ontario. Year after year the CCB told the medical staff that *PS* did not need maximum security and yet year after year he continued to be detained, untreated, in maximum security: an unconstitutional deprivation of liberty that the CCB was powerless to address. It took a case about psychiatric gating, arising out of the criminal justice system, to get the Court to explicitly acknowledge the connection between coercive deprivations of liberty in the criminal system and coercive deprivations of liberty through civil commitment.

The *Criminal Code* Review Board’s powers with respect to scrutinizing treatment decisions are not explicitly given to the Review Board in the *Criminal Code*, but rather are inferred from the Board’s broad jurisdiction to make decisions about the risk the accused presents to the community and to reintegrate the accused.⁷⁶ The supervisory power given to the Review Board was not inevitable but rather the result of deliberate choices by the courts. For

⁷⁵ *Ibid* at para 84 (*per* Abella J). Note that in *Conway*, the Supreme Court ruled that even though the Ontario Review Board had *Charter* jurisdiction and was a “court of competent jurisdiction” for purposes of section 24(1), its remedial authority under that provision was limited to the orders it was authorized to make by its parent statute, i.e., the *Criminal Code*. This is a further limitation on the scope of tribunal jurisdiction in *Charter* matters that complicates the field.

⁷⁶ It is important to acknowledge that Parliament has made significant revisions to the disposition provisions that are applied by the *Criminal Code* Review Board, most significantly removing the requirements that the board impose the least restrictive option when imposing a disposition. Now the board is instructed to give priority to the safety of the public and the accused’s liberty interest has been given less weight. This is particularly problematic given the Supreme Court of Canada’s reliance on the least restrictive requirement to uphold the disposition provisions under the *Charter* in *Winko*, *supra* note 68. It remains to be seen how this change will affect the scope of the Board’s jurisdiction. For further discussion, see Lisa Grantham, “Bill C-14: A Step Backwards for the Rights of Mentally Disordered Offenders in the Canadian Criminal Justice System”, (2014) 19 Appeal 63.

example, in *Mazzei v British Columbia (Director of Adult Forensic Psychiatric Services)*,⁷⁷ the Court upheld the BC Review Board's order that the treating hospital develop a comprehensive treatment plan for the patient and "undertake assertive efforts to enroll the accused in a culturally appropriate treatment program."⁷⁸ While *Mazzei* made clear that it was not the job of the Review Board to prescribe specific treatments, the Court held that "Review Boards have the power to bind hospital authorities and to impose binding conditions regarding or supervising (but not prescribing or imposing) medical treatment for an NCR accused."⁷⁹ The role of the Board is to make sure that there is an appropriate treatment plan in place that is moving the individual towards reintegration in the community.⁸⁰

The fact that the Court of Appeal was willing to consider the *Criminal Code* Review Board jurisprudence opens the door to a much higher level of scrutiny of the individual's liberty interests. We argue that the forensic model is the most appropriate model for common law jurisdictions for ensuring adequate protection of liberty. The power of the Review Board to, for example, ensure that the individual has an appropriate treatment plan has not impeded physicians in treating individuals found not criminally responsible or unfit. Rather, this jurisdiction has served as a check on the unfettered powers of the treating psychiatrists and hospital administrators. Counsel for Ontario in *PS* had argued that the Supreme Court's decision in *R v*

⁷⁷ 2006 SCC 7, [2006] 1 SCR 326 [*Mazzei*].

⁷⁸ *Ibid* at para 4.

⁷⁹ *Ibid* at para 7.

⁸⁰ We are not suggesting that the plight of individuals detained in the forensic system is ideal by any means nor that an expansive approach to Review Board jurisdiction has been a panacea for all the problems of the forensic system. See for example, H Archibald Kaiser, "Conway: A Bittersweet Victory for Not Criminally Responsible Accused" (2010) 75 CR (6th) 241 at 241 [Kaiser, "Conway: A Bittersweet Victory"]. Kaiser notes that "some accused face huge obstacles in obtaining the kind of treatment they desire, and the promise of eventual liberty and reintegration remains unfulfilled for them." Kaiser laments the long periods of detention that the courts appear to be willing to tolerate in the forensic context and the refusal to consider proportionality as a limiting factor. Conway himself had spent 26 years in custody. H Archibald Kaiser, "Mazzei: Constrained Progress in Construing Review Board Powers", (2006) 36 CR (6th) 37.

Conception,⁸¹ which recognized a forensic hospital's limited right to refuse to accept a patient referred to it under the *Criminal Code*, supported the idea that hospital personnel have plenary authority over treatment decision-making. Justice Sharpe rejected this argument:

Conception certainly does not detract from the long line of authority discussed above as to the need for ongoing supervisory review of the treatment of NCR accused and those found unfit to stand trial: see *Mazzei*, at paras. 40-41, and *Penetanguishene*, at para. 67. Nor does it stand for the proposition advanced by Ontario that by conferring discretion on health care professionals, a statute such as the *MHA* can somehow avoid the need for an effective review mechanism.⁸²

In our view, the decision in *PS* was made possible by the recognition that significant deprivations of liberty by the state in the civil commitment context are analogous to those in the forensic context where someone is being detained in the absence of a criminal conviction. In other words, the Court recognized the coercive nature of civil commitment regardless of whether it is being used for the so-called benefit of the individual or the state. The notion that an individual who has been civilly committed has fewer liberty interests flowing from the detention, as compared to someone in the forensic system, simply because they have not been charged with a crime cannot be justified.

B. The Ontario Government's Response to *PS*

The Amendments

Ontario had a number of options open to it in response to the decision in *PS*. It could have simply done nothing and allowed the suspended declaration of invalidity to take effect thus prohibiting civil commitment beyond six months. Doing nothing was likely an unpopular option with the government because it would raise the possibility that individuals who were identified

⁸¹ 2014 SCC 60, [2014] 3 SCR No 82.

⁸² *PS*, *supra* note 8 at para 121.

as dangerous, but who had been detained longer than six months, would have to be at a minimum decertified as soon as the declaration of invalidity took effect. Ontario could also have extended the CCB powers for all civilly committed individuals or, alternatively, for all individuals in a psychiatric facility for more than six months, whether voluntary or involuntary. This would have been a more expensive, and we will argue preferable, solution and one that would have gone beyond the strict requirements of *PS*.

Instead the Ontario government designed a solution that applied specifically to those who were committed for periods longer than the six months allowed by *PS*. Section 20(1.1) of the *Mental Health Act* now provides for a new mechanism, a “certificate of continuation”, which provides for the continued detention of those who have reached the maximum number of three “certificates of renewal” of civil commitment under s. 20(4), adding up to six months detention following an initial period of two weeks. The criteria for a certificate of continuation are the same as those for civil commitment. Certificates of continuation authorize detention for a further period of three months, and can be renewed an indefinite number of times. With respect to each certificate of continuation or renewal, the person concerned or someone on his or her behalf can apply to the CCB for an inquiry as to whether committal criteria continue to be met. As with certificates of renewal, the Board may rescind a certificate of continuation should it find that committal criteria are not met.⁸³ The statute also provides that an application for review shall be deemed to be made by a patient on the completion of a first certificate of continuation, and every fourth such certificate thereafter.⁸⁴

⁸³ *Mental Health Act*, RSO 1990, c M.7, ss 41(3) and (4).

⁸⁴ *Ibid*, s 39(4). Section 39(5) provides that a patient cannot waive deemed applications.

The centerpiece of the amendments is found in new section 41.1(2) of the *Mental Health Act*. It states that should the Board confirm a certificate of continuation, the patient or someone on his or her behalf may request the Board to make one or more of the following orders.⁸⁵

1. Transfer the patient to another psychiatric facility,... but only if the patient does not object.
2. Place the patient on a leave of absence for a designated period on the advice of a physician ...
3. Direct the officer in charge of the psychiatric facility to provide the patient with a different security level or different privileges within or outside the psychiatric facility.
4. Direct the officer in charge of the psychiatric facility to allow the patient to be provided with supervised or unsupervised access to the community.
5. Direct the officer in charge of the psychiatric facility to provide the patient with vocational, interpretation or rehabilitative services.

The Board may make any or all of these five orders on its own motion, even where not requested to do so, but is expressly barred from making any other order. Section 42(2) lists the parties to a hearing on a certificate of continuation, including the Minister should he or she wish to appear, and parties may seek a variance of the Board's orders during a continuation period on the basis of a change "in material circumstances." Barring such a change, a patient is limited to making only one application under section 41.1(2) every 12 months.⁸⁶

The CCB is required to impose the order that is the least restrictive given the circumstances justifying detention.⁸⁷ Apart from this statement, however, the amendments reflect a remarkable caution about trusting the CCB to exercise its new discretionary powers in a responsible fashion. The CCB must consider the safety of the public, the ability of the facility to

⁸⁵ *Ibid*, s 41.1(2).

⁸⁶ *Ibid*, s 39(7).

⁸⁷ *Ibid*, s 41.1(3). This is particularly striking given that the Harper government amended the *Criminal Code* provisions dealing with the *Criminal Code* review board such that the board no longer is required to grant the least restrictive disposition. See: *Criminal Code*, RSC 1985, c C-46 s 672.54, as amended by SC 2014, c 6, s 9.

manage and provide care for the individual, the mental condition of the individual, reintegration into society and any other needs of the individual. The Board has no jurisdiction to require a physician to provide treatment⁸⁸ although the Board can order an independent assessment of the individual's "mental condition or his or her vocational, interpretation or rehabilitative needs."⁸⁹ The officer in charge of the facility is given the authority to act contrary to an order of the CCB if there is a risk of serious bodily harm to the individual or anyone else⁹⁰ although this power is temporary and the officer in charge must apply to the CCB within seven days to cancel or vary its order Ontario has not given its tribunal the power to issue a community treatment order as an alternative to detention, a power specifically found to be lacking by the *PS* Court.⁹¹

Assessing Ontario's Response

In our view, the amendments meet in a narrow fashion the constitutional problems identified by the Court with respect to section 7 of the *Charter*. The Legislature has granted authority to the CCB that gives it a form of supervisory role in treatment planning for long-term patients. In so doing, Ontario has further distinguished its mental health legislation from that of other provinces in the area of protection of patients' rights. Ontario stands out as a leader when it comes to protecting the liberty interests of long-term detainees. However, the amendments are couched in terms that limit the positive impact they might otherwise have. We have two primary concerns. First, the government has failed to address the fact that the line between involuntary and voluntary "patients" is not always a clear one and manipulation of this distinction could

⁸⁸ *Ibid*, s 41.1(4).

⁸⁹ *Ibid*, s 41.1(8).

⁹⁰ *Ibid*, s 41.2(1).

⁹¹ *PS*, *supra* note 8 at para 127.

undermine the new protections granted. Second, we have serious concerns about limiting the scope of procedural protections to those who are detained for longer than six months.

It is widely believed by mental health law advocates that there is considerable manipulation of an individual's status as a voluntary or involuntary "patient" in psychiatric facilities. Decertifying an individual may be a technique used to render a legal dispute moot and, in the context of these new provisions, could potentially be used to deny access to the enhanced powers of the CCB that accompany a certificate of continuation. In *PS* specifically, the applicant lost his access to the CCB because he was decertified and made "voluntary" even though he was told he would be certified as involuntary if he tried to leave the facility. This problem can arise even in the absence of deliberate manipulation of the system. An individual's mental state may vary over time justifying periods of decertification to a voluntary status. Many individuals, like *PS*, may have their status changed more than once during a hospitalization; others may have brief periods in the community over the course of what is otherwise a long-term hospitalization. This potential for movement between two statuses raises important concerns. Will even a brief period of decertification after civil commitment trigger the civil commitment process again, thus allowing the certificate of continuation mechanism to be avoided? The Ontario Court of Appeal explicitly ruled out the possibility that an individual could be decertified before six months and then immediately recertified to start the clock running again:

Needless to say, it would not be acceptable to circumvent the time-limited duration of a committal by simply restarting the process with a new certificate of involuntary admission upon the expiry of the three-month period contemplated by s. 20(4)(b)(iii).⁹²

⁹² *Ibid* at para 203.

While the *PS* Court indicated that this was not an appropriate way to respond to *PS*, there is nothing in the statute that prevents such status changes. Given that any one individual may go back and forth between the two different statuses, it would be desirable to have some mechanism to review the circumstances of anyone who has been hospitalized for more than six months, regardless of their status.⁹³ Given that the incidence of long-term psychiatric hospitalizations has decreased significantly in recent decades, the safeguard should not be prohibitively expensive.

While Ontario has improved the plight of long-term detainees, it has not closed the door to further litigation on the procedures for review of civil commitments of less than six months. In our view, limiting amendments to long-term involuntary commitment will only create uncertainty and put an undue onus on persons who are civilly committed for shorter periods of time to litigate the scope of their liberty and security interests. The Court's use of a six-month cutoff period (or to put it another way, its restricting the ruling to "long-term committals" defined as 6 months) is open to criticism as arbitrary. The Court arrived at this time period through analyzing statistics, which demonstrated that 98% of patients are released before six months and only 2% are detained beyond six months.⁹⁴ The Ontario government's response draws a clear line at the six-month cutoff. However, it is not entirely clear why these percentages are relevant to the cut off point for protecting the liberty interests of an individual. The fact that only a small number of people are detained beyond six months has no coherent connection to the liberty interests of the majority released before six months. Would it be appropriate to detain an individual in maximum security where he or she does not need that level of custody for five months, or even one month? Is it acceptable to deny civilly committed

⁹³ In the committee hearings about Bill 122, advocacy groups expressed concern about individuals who are being held "voluntarily" yet who face the threat of civil commitment. Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, 41st Parl, 1st Sess, No 125 (25 November 2015) at 772-773 (J Meadus) and 775-776 (K Spector).

⁹⁴ *PS*, *supra* note 8 at para 26.

persons appropriate treatment tailored to their disability for three months? When one considers the revolving door syndrome, and the fact that people who are detained for short periods may well be readmitted subsequently, many individuals may spend long periods of time civilly committed without any effective mechanism of review of the conditions of that detention.⁹⁵ The Court leaves these questions for another day given that PS had been detained for 19 years. However the Court's rationale applies just as persuasively to review tribunals that are considering shorter-term commitments and reviewing patients who are on extended leave or released on CTO's. We can think of no other context where deprivations of liberty are allowed to continue unchecked for up to six months before a full panoply of section 7 rights take effect.⁹⁶ While the *PS* Court recognized that by limiting its analysis to long-term detention, it opened the door to future challenges about whether the failure to have an administrative tribunal with a broad-based supervisory role is constitutional for shorter periods of commitment. There are two arguments against extending the CCB jurisdiction to all civil commitments. First, because the numbers of short-term commitments is much larger, the cost would correspondingly increase. We do not feel this is an acceptable reason for denying the vindication of section 7 rights. The second argument against extending jurisdiction to this group of individuals is that it might

⁹⁵ We note here the more robust view of the Supreme Court of Canada when describing the appropriate supervisory role of a Nova Scotia Provincial Court judge in the context of the continuing supervision of a "protection order" for a vulnerable adult, authorized by that province's *Adult Protection Act* RSNS 1989, c. 2:

The significance of independent judicial review of state action when a vulnerable adult has been deprived, at the instigation of the state, of the right to function autonomously, cannot be overstated. The court's statutorily assigned supervisory role emerges from the adult's vulnerability. The corollary of a judicial determination that an adult is in need of protection is a corresponding limitation on that adult's autonomous decision making and liberty. It is the function of the court to monitor the scope of that limitation. The legislation must, therefore, be interpreted in a way which acknowledges the intrusiveness of the determination and offers muscular protection from state intervention incompatible with the adult's welfare.

JJ v Nova Scotia (Minister of Health), 2005 SCC 12, at para 23 (per Abella J.).

⁹⁶ In the very different context of security certificates under the *Immigration and Refugee Protection Act* SC 2001, c. 27, the Supreme Court of Canada rejected an argument by the federal government that sought to justify the denial of detention review for foreign nationals for a period of six months, finding such a delay to violate fundamental justice in section 7. See *Charkaoui et al v Canada, (Citizenship and Immigration)*, 2007 SCC 9, at paras 91-92.

unduly interfere with treatment goals of the treating physician for shorter-term commitments. We believe this problem can be minimized by, for example, limiting the number of times an individual could access the extended powers of the CCB, just as Ontario has already done for long-term commitments.

Given that the distinction between those detained longer than six months and those detained for shorter periods is somewhat arbitrary, we are also concerned that in limiting its solution to long-term detainees, Ontario may have exposed its statute to possible challenge under section 15 of the *Charter*, the equality rights provision. Ontario's decision to establish a new set of powers for the CCB with respect to individuals subject to continuation certificates creates a "benefit" or, more aptly, a "protection of the law" that is denied to those on shorter periods of commitment. This statutory distinction arguably discriminates on grounds of disability in violation of section 15(1) of the *Charter*. This is ironic given the strong equality rights thrust that underpinned the facts in *PS*, and that was vindicated in the Court of Appeal's striking judgment on the section 15(1) issue. The equality rights issue as it concerns long-term and short-term commitments is of a different nature. Whereas the issue in an *Eldridge*-type case deals with the failure of public authorities to accommodate the needs of a disadvantaged group in order for them to participate in equal benefit and protection of the law—what is often referred to as "adverse effect discrimination"—the limiting of access to the new powers of the CCB to long-term commitments is more an instance of "direct discrimination." The distinction in law is clear on the face of the statute, and is drawn between different groups of persons with mental disabilities, based on legal status while hospitalized and length of stay in a psychiatric facility. Jurisprudence on section 15(1) is clear that discrimination claims can be based on differential treatment in law between sub-groups sharing the same overall enumerated or analogous

characteristic.⁹⁷ The more difficult question in a section 15(1) challenge to the denial of access to the protections afforded by section 41.1(2) of the *Act* would be whether the distinction is discriminatory in the sense of compounding disadvantages experienced by that person, through prejudice, stereotyping or otherwise.⁹⁸ While the government would presumably argue that the additional protections afforded to those subject to continuation certificates correspond to a need for enhanced supervision of treatment planning past the point of diagnosis and early application of therapeutic interventions, this position might be less persuasive with respect to individuals with a history of frequent or multiple recent involuntary committals. This is especially true when considering the newly added power of the CCB to order the director of a facility to provide a person with “vocational, interpretation or rehabilitative services.” It should be noted that this power speaks most directly to the equality rights interest raised by the *PS* case, and can be seen as a means of ensuring that those interests must not be neglected. The fact that these protections are needed for long-term commitments does not inevitably lead to the conclusion that they are unnecessary for commitments of less than six months.

This discussion of the equality problem in the amended Ontario legislation is not intended to suggest that a section 15 challenge to this otherwise important reform legislation is imminent or would be straightforward. But nor can the government rely on the *PS* decision to insulate its distinction between short and long-term commitments. The Ontario Court of Appeal does not mandate such a distinction in its decision. Rather, it was confronted by a man who had been civilly committed for 19 years and did not need to address short-term commitments. It thus limited its judgment based on the six-month cutoff period. It explicitly leaves open the

⁹⁷ *Nova Scotia (Workers' Compensation Board) v Martin*; *Nova Scotia (Workers' Compensation Board) v Laseur*, 2003 SCC 54, [2003] 2 SCR 504 [*Martin*]; *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004 SCC 78, [2004] 3 SCR 657; *Corbiere v Canada (Minister of Indian and Northern Affairs)*, [1999] 2 SCR 203, 173 DLR (4th) 1.

⁹⁸ *Quebec (Attorney General) v A*, 2013 SCC 5, [2013] 1 SCR 61, per Abella J writing for a majority on this point.

possibility that further protections are necessary for short-term commitments. It held that longer-term commitments require more, it did not hold that short-term commitments do not.

IV. Moving Beyond *PS*

A. Restraint and Seclusion Within Psychiatric Facilities

The conclusion in *PS* that long-term civil commitment requires tribunal review of treatment and discharge planning implicitly raises the question of whether there are other section 7 liberty interests in civil commitment that call for enhanced administrative oversight and review. In our view, there is at least one other area that comes distinctly within the ambit, that of the use of “disciplinary” or behaviour control measures within the hospital setting, particularly the use of physical restraint and seclusion. These are issues which have come under increasing scrutiny in Canada and elsewhere, both in prison and hospital settings. In Canada, the 2013 coroner’s inquest into the death by self-strangulation of Ashley Smith, a young woman with a history of mental health issues who while held in the corrections system was subject to extended periods in solitary confinement, resulted in jury recommendations going to strict limits being placed on the use of seclusion.⁹⁹ Two *Charter* challenges to solitary confinement in the prison context have also been initiated, one in BC and one in Ontario.¹⁰⁰ The UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has concluded that even short periods of seclusion for people with mental disabilities may constitute torture and ill-

⁹⁹ For the response by the federal Corrections Canada to the inquest report, see “Response to the Coroner’s Inquest Touching the Death of Ashley Smith” Ottawa, December 2014, online at: <http://www.csc-scc.gc.ca/publications/005007-9011-eng.shtml#4.0> (accessed August 22, 2015).

¹⁰⁰ See: John Ivison, “Group launching legal challenge to limit use of solitary confinement in Canadian prisons”, *National Post* (19 January 2015) online: National Post <<http://news.nationalpost.com/news/canada/group-launching-legal-challenge-to-limit-use-of-solitary-confinement-in-canadian-prisons>>. Sean Fine, “Ontario government sued for putting youth in solitary confinement”, *Globe and Mail* (4 November 2015) online: Globe and Mail <<http://www.theglobeandmail.com/news/national/ontario-faces-lawsuit-for-putting-young-offenders-in-solitary-confinement/article27107663/>>.

treatment.¹⁰¹ The Special Rapporteur also notes that there can be no therapeutic justification for the prolonged use of restraints.¹⁰²

The use of restraint and seclusion in psychiatric hospital facilities is a well-known phenomenon. The measures continue to be used in Canadian psychiatric facilities, including in Ontario.¹⁰³ While subject to government and hospital policies and protocols, concerns have long been expressed that the mechanisms for enforcing compliance with policies are informal and uneven.¹⁰⁴ If additional powers are to be given to mental health tribunals, it would seem appropriate to include the ability to review and report on, and direct changes with respect to the use of these highly invasive, and largely unreviewable, measures.

B. Charter Jurisdiction of Mental Health Tribunals

The discussion of restraint and seclusion leads to an issue that was raised before the Court of Appeal in *PS*: whether the tribunal should be given jurisdiction to grant section 24(1) *Charter* remedies. An intervener in *PS v Ontario*, the Mental Health Legal Committee, sought to

¹⁰¹ UN General Assembly, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UNGAOR, 23rd Sess, UN Doc A/HRC/22/53 (1 February 2013) at para 63 <http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf> accessed 31 January 2016. The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment. Any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment and it is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions.

¹⁰² UN General Assembly, *Torture and other cruel, inhuman or degrading treatment or punishment: note | by the Secretary-General*, UNGAOR, 63rd Sess, UN Doc A/63/175 (28 July 2008) at paras 55-56 <<http://www.refworld.org/docid/48db99e82.html>> accessed 31 January 2016. The Special Rapporteur notes that there can be no therapeutic justification for the prolonged use of restraints, which may amount to torture or ill-treatment. The Special Rapporteur also notes that prolonged solitary confinement and seclusion of persons may constitute torture or ill treatment.

¹⁰³ Tina M Mah, John P Hirdes, George Heckman, and Paul Stolee, “Use of control interventions in adult in-patient mental health services.” (2015) 28 *Healthcare Management Forum* 139.

¹⁰⁴ H Archibald Kaiser, “Restraint and Seclusion in Canadian Mental Health Facilities: Assessing the Prospects for Improved Access to Justice”, (2001) 19 *Windsor Access to Justice* 391. For a recent discussion of the constitutional implications of the use of restraint and seclusion in the US, see Jeremy Weltman, Roderick MacLeish and Jacquelyn Bumbaca, “Deference Does Not Equal Abdication: Application of Youngberg to Prolonged Seclusion and Restraint of the Mentally Ill”, (2015) 26 *Stanford Law & Policy Review* 239.

have the Court of Appeal order that the CCB be given this jurisdiction. The Court declined to make such an order, in part because it would involve overruling an earlier decision of the Divisional Court.¹⁰⁵

The idea of extending *Charter* jurisdiction to civil mental health tribunals is an intriguing one. Section 24(1) authorizes a “court of competent jurisdiction” to order such remedies “as the court considers appropriate and just in the circumstances” to address the breach of an individual’s *Charter* rights by state action. The Supreme Court of Canada has stated on several occasions that section 24(1) contemplates the power to order creative remedies, responding to the wide range of circumstances in which an individual may have his or her rights infringed by statutory delegates (but not by legislation).¹⁰⁶ The appeal of recognizing section 24(1) jurisdiction in a civil mental health tribunal like the CCB is that it would permit a flexible response to those situations in which civilly committed individual’s *Charter* rights, including section 7 liberty interests, were compromised. It would obviate the need for statutory definition, and anticipation, of the myriad circumstances in which this might occur, including such circumstances as the over-reliance on restraint and seclusion measures.¹⁰⁷

This begs the question of how civil mental health tribunals might come to possess section 24(1) powers. It is clear that civil mental health tribunals will be presumed to be “courts of competent jurisdiction” for purposes of section 24(1) provided that they have jurisdiction over

¹⁰⁵ *Ontario (AG) v Jane Patient*, (2005) 250 DLR (4th) 697 [*Jane Patient*].

¹⁰⁶ See for example, *Doucet-Boudreau v Nova Scotia (Minister of Education)*, 2003 SCC 62, [2003] 3 SCR 3 and *Vancouver (City) v Ward*, 2010 SCC 27, [2010] 2 SCR 28.

¹⁰⁷ For an excellent discussion of the *Charter* jurisdiction of civil and forensic mental health review tribunals prior to *PS v Ontario*, see Joaquin Zuckerberg, “Jurisdiction of Mental Health Tribunals to Provide Positive Remedies: Application, Challenges and Prospects” (2011) 57:2 McGill LJ 267. Zuckerberg concludes that despite the broadening of *Charter* jurisdiction of administrative tribunals, in general, promised by *Martin* and *Conway*, nothing had significantly changed with respect to civil mental health tribunals. He notes that civil mental health tribunals in Canada generally lack the jurisdiction to make rulings about ongoing treatment and supervision matters that are granted to forensic review boards under the *Criminal Code*. “Rather”, he states, “their jurisdiction is generally restricted to confirming decisions to civilly commit a person and findings of incapacity to consent to medical treatment.” This underlies the ruling in *Jane Patient*, *supra* note 106.

issues of law.¹⁰⁸ That presumption could be rebutted by express legislative withdrawal of *Charter* jurisdiction, or by a clear implication of such intent derived from statutory limits on a tribunal's role and logistical functioning.¹⁰⁹ The legislatures of Alberta and British Columbia have enacted blanket provisions withdrawing *Charter* jurisdiction for most tribunals within their jurisdiction, including civil mental health tribunals.¹¹⁰ Ontario has also withdrawn *Charter* jurisdiction from the CCB with respect to civil commitment and CTO reviews.¹¹¹ It would appear then that these tribunals are precluded from having the power to order section 24(1) remedies so long as the legislature maintains its prohibition.¹¹² However, there is an issue as to whether this denial of *Charter* jurisdiction to civil mental health tribunals is constitutional, and therefore whether a challenge to that statutory withdrawal could instead provide tribunals with section 24(1) jurisdiction.

In *Martin*, the Supreme Court of Canada based its finding of a rebuttable presumption that tribunals with jurisdiction generally over issues of law have *Charter* jurisdiction on the logic of section 52(1) of the *Constitution Act, 1982*. Section 52(1) states that any law which is inconsistent with the Constitution is invalid and of no force or effect. The Court stated that this means that statutory decision-makers who have the authority to interpret and apply law must refuse to enforce a law they deem unconstitutional. This is inconsistent with the idea that legislators have *carte blanche* to decide whether any particular tribunal has *Charter* jurisdiction

¹⁰⁸ *Conway*, *supra* note 74 at para 78.

¹⁰⁹ *Martin*, *supra* note 98.

¹¹⁰ *Administrative Procedures and Jurisdiction Act*, RSA 2000, c A-3, s 11, and *Designation of Constitutional Decision Makers Regulation*, AB Reg 69/2006; and *Administrative Tribunals Act*, SBC 2004, c 45, ss 44, 45, and *Mental Health Act*, RSBC 1996, c 288, s 24.2.

¹¹¹ See s 70.1 of the *Health Care Consent Act*, SO 1996, c 2, Sched A, which was enacted pursuant to SO 2006, c 19, Sched L, s 2.

¹¹² Professor Kaiser has argued that the logic of *Conway* extends to provincial mental health tribunals. He argues that the availability of the *Charter* “should provide enhanced access to justice in settings where it has been difficult to invoke the protection of the law, let alone the *Charter*. These tribunals vitally affect the dignity, liberty and living conditions of institutionalized persons. Before *Conway*, the exercise of discretion by clinicians and administrators was virtually invisible and unchallengeable...” Kaiser, “*Conway*: A Bittersweet Victory”, *supra* note 80 at 243.

(or constitutional jurisdiction generally), irrespective of the tribunal's place in the legal system, its importance with respect to access to justice, and the breadth of its role in interpreting law. Justice Gonthier, writing for the Court in *Martin*, appeared to acknowledge this problem in the following passage:

I refrain, however, from expressing any opinion as to the constitutionality of a provision that would place procedural barriers in the way of claimants seeking to assert their rights in a timely and effective manner, for instance by removing *Charter* jurisdiction from a tribunal without providing an effective alternative administrative route for *Charter* claims.¹¹³

The reference to an “effective alternative administrative route” appears not to include recourse to superior courts on constitutional matters, which is otherwise always available. As noted by Justice Sharpe in *PS*, individuals detained in psychiatric facilities face particular challenges in asserting their rights and in accessing the courts.

In a second and related submission, Ontario argues that where a patient wishes to challenge a committal on grounds that fall outside the powers of the CCB, there are alternate procedures available to fill any perceived gap. The patient can initiate proceedings in the Superior Court, resort to internal complaint procedures within the hospital, complain about doctors and nurses to the appropriate professional colleges or invoke the process established by the *Human Rights Code*, R.S.O. 1990, c. H.19, with respect to complaints about a failure to accommodate a disability.

If we were to accept this submission, the appellant, a person who suffers from a mental disorder and a serious disability and who is held in a maximum security institution, would have to initiate proceedings in two or more different tribunals. This solution is fatally flawed; it is legally inadequate and practically unworkable. It would be prohibitively costly, very slow, seriously inconvenient and almost certainly ineffective.¹¹⁴

While Justice Sharpe was directing his comments to the absence of an administrative mechanism to raise issues related to overall treatment planning, access to a forum to pursue *Charter* rights

¹¹³ *Martin*, *supra* note 98 at para 44.

¹¹⁴ *PS*, *supra* note 8 at paras 118-119.

encounters the same barriers for individuals confined in a psychiatric facility. A constitutional challenge might well be available with respect to the denial of *Charter* jurisdiction to mental health tribunals, or to any other administrative agency with supervisory authority over psychiatric facilities, if those entities do not provide “effective alternative administrative” routes. The arena in which these tribunals and agencies operate is one in which *Charter* rights, particularly section 7 rights, are implicated on a regular basis. The populations whose rights are at risk of infringement are particularly vulnerable, and have limited means to access other avenues for recourse as well as legal counsel. Therefore, it might be that the CCB and other review tribunals are precisely the kind of entities that should be able to rule on and remediate individual *Charter* breaches.

V. Conclusion

The decision in *PS* has the potential to prompt amendments to civil commitment statutes across Canada since no mental health statute currently meets the criteria that the Court of Appeal has prescribed. We would hope that provincial legislatures would treat this decision as a message that it is time to move towards treating civilly committed individuals as rights holders, entitled to the same procedural protections as other individuals detained by the state. However, if past experience is any indication, doing nothing is the most likely response by most provincial legislators, as the rights of civilly detained individuals have never been given priority. Failure to respond proactively to *PS* would put the onus on those detained in psychiatric facilities to initiate *Charter* challenges to bring about reform. There has been a dearth of litigation regarding mental health tribunals outside of Ontario. Even the refusal to allow competent civilly committed individuals to decline treatment in British Columbia and Newfoundland, a denial that raises

serious *Charter* concerns¹¹⁵ have not yet been subject to a *Charter* challenge despite the compelling reasoning of the Ontario Court of Appeal in *Fleming v Reid*.¹¹⁶ There are huge institutional barriers to having these matters litigated, not the least of which is a profound lack of funding as well as difficulties with mootness where potential plaintiffs are decertified or released before their cases are heard by a court.¹¹⁷

As a result of the *PS* decision, the legislative scheme for long-term detainees in Ontario has changed for the better. However, the government chose reforms that would give rights to the smallest possible number of civilly committed individuals and left open the possibility of manipulating the regime by decertifying individuals for a short period of time. A better option for all committals would be to develop a civil mental health tribunal with a role and structure similar to that which now exists in forensic psychiatric systems across this country. The tribunal should have explicit *Charter* jurisdiction, and detained individuals should be guaranteed the right to paid counsel. Ontario's recognition of the need for a tribunal role in protecting the liberty interests of involuntarily long-term detained individuals should serve as a beacon to that evolution.

¹¹⁵ Simon Verdun-Jones & Michelle 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 UBC L Rev 2.

¹¹⁶ The Ontario Court of Appeal in its landmark decision in *Fleming v Reid*, *supra* note 4, put significant constraints on the province with respect to limiting prior expressed wishes of a competent individual regarding psychiatric treatment.

¹¹⁷ This in fact happened in *PS* with the appellant's involuntary status allowed to lapse and the CCB thus losing jurisdiction over his detention. The appellant argued unsuccessfully that he would be recertified if he attempted to leave and thus that the Board should have taken jurisdiction. Because this is such a common practice, courts are sometimes willing to decide moot cases in this context. See, for example, *McCorkell*, *supra* note 6.