Available online at www.sciencedirect.com
ScienceDirect
International Journal of Law and Psychiatry 30 (2007) 512–529
INTERNATIONAL JOURNAL OF LAW AND PSYCHIATRY

International human rights for mentally ill persons: The Ontario experience☆

Joaquin Zuckerberg *

Faculty of Law, University of Toronto, Canada

Abstract

This article is part of a working project which assesses Ontario's mental health legislation and practice vis-à-vis international human rights standards. The paper focuses on procedural safeguards provided by the major international human rights instruments in the field of mental health law such as the UN Principles for the Protection of Persons with Mental Illness (MI Principles) and the European Convention on Human Rights as interpreted by the European Human Rights Court. In analysing Ontario's compliance with international standards, the paper will explore some problems arising from the implementation of the legislation with which the author is familiar with from his experience as counsel for the Consent and Capacity Board. The paper aims to generate discussion for potential reforms in domestic legal systems and to provide a methodology to be used as a tool to assess similar mental health legislation in other local contexts.

1. Introduction

Ontario's mental health legislation includes a number of legal safeguards designed to protect the rights of the mentally ill. This study analyses the main *procedural* safeguards dealing with mentally incapable persons and involuntarily detained patients and compares them with human rights standards established by international human rights documents. Conditions of confinement and substantial right to health are not less important principles defined in several international human rights instruments[1] but are outside the scope of this study. Equally, this article does not cover the criminal procedures dealing with mentally ill persons detained in the course of criminal proceedings or investigations against them.

☆ Any views or opinions expressed in the article are those of the author and do not represent the views of the Consent and Capacity Board.

* Consent and Capacity Board, Toronto, Ontario, Canada. Tel.: +1 416 212 6826; fax: +1 416 327 4207.
E-mail address: joaquin.zuckerberg@ontario.ca.

[1] See on this issue General Comment No 14 (2000)(E/C.12/2000/4) on the right to the highest attainable standard of health established by article 12 of the International Covenant on Economic, Social and Cultural Rights, adopted by the Committee on Economic, Social and Cultural Rights at its twenty-second session in April/May 2000, para 11. This includes access to: "adequate sanitation, an adequate supply of safe food, nutrition, housing, healthy occupational and environmental conditions, and access to health-related education and information, including sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels."

0160-2527/$ - see front matter © 2007 Elsevier Inc. All rights reserved.
doi:10.1016/j.ijlp.2007.09.005

Beginning with the Universal Declaration on Human Rights,[2] there are several documents dealing directly or indirectly with people with disabilities.[3] These documents, although valuable as evidence of the growing interest of the international community in the protection of the rights of the mentally ill, are rarely used in domestic or international litigation involving people with mental disabilities.[4] When they are, they make reference to procedural safeguards and due process protections in ambiguous and general terms.[5] This article will focus on the most detailed international instruments concerning procedural requirements,[6] including the International Covenant on Civil and Political Rights (ICCPR),[7] the International Covenant on Economic, Social and Cultural Rights (ICESCR)[8] and the UN Principles for the Protection of Persons with Mental Illness (the "MI Principles").[9] The MI Principles may, in certain cases, provide fewer protections than existing international human rights conventions. In those instances, this paper refers to the rights established in the appropriate convention, as a treaty takes precedence over a standard.[10] The value of non-binding documents such as the MI Principles is that they fill the gap created by the lack of specific domestic convention or law on a point (or when existing law provides fewer protections). Where such a gap exists, "governments should look to human rights standards as a non-binding but persuasive source of authority as to what international human rights law requires."[11]

The Convention for the Protection of Human Rights and Fundamental Freedoms[12] (the 'European Convention') as interpreted by the European Court of Human Rights (the 'ECHR') is, although regional in coverage, another useful tool because it is perhaps the most developed body of international law dealing with the rights of the mentally ill.[13] In fact, jurisprudence of the ECHR reflected at relatively early stages its concern with the existence of special procedural safeguards to protect the rights of the mentally ill.[14] Although not referred to in this study, mention must also be made of the Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities.[15] This Convention is a relatively new and significantly less utilized international instrument than the European Convention.[16]

It is expected that the discussion of Ontario's experience will provide a useful framework to generate discussion for potential reforms in other domestic legal systems and provide a methodology to be used as a guideline for the advocate and for the government official as a tool to assess similar mental legislation in other local contexts. The value of this paper lies in contributing to successful human rights advocacy for the mentally ill, which seeks the incorporation of

[2] UN GA Res 217 A (III), UN Doc A/810 (10 December 1948) art I.

[3] See for example the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993).

[4] Stanley S. Herr, § 119–121 (2003).

[5] See for example International League of Societies for the Mentally Handicapped (1968); and UN Declaration of the Rights of Mentally Retarded Persons (1971).

[6] International customary law, legal principles so widely accepted as binding that they need not even be written legal principles, may be another source of law concerning procedural safeguards. However, there is no consensus as to the obligations of governments regarding the rights of people with mental disabilities is a relatively new area of international law. Eric Rosenthal and Clarence J. Sundram, (2002).

[7] G.A. Res. 2200A(XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), entered into force Mar. 23, 1976. The U.N. has also appointed a Special Rapporteur on Human Rights and Disability.

[8] G.A. Res. 2200A (XXI) (1966).

[9] Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1992) [hereinafter the MI Principles]. "While the MI Principles were drafted primarily to define the rights of people with psychiatric disabilities, they provide rights to 'all persons who are admitted to a mental health facility'[CESC General Comment 14, Definitions, s (f)].

[10] Principle 25 of the MI Principles provides that "there shall be no restriction upon or derogation from any existing rights of patients, including rights recognized in applicable international or domestic law, on the pretext that these Principles do not recognize such rights or that they recognize them to a lesser extent."

[11] E. Rosenthal and C. J. Sundram (2004).

[12] *European Convention for the Protection of Human Rights and Fundamental Freedoms*.

[13] ECHR jurisprudence has also been used as a valuable instrument in the development of other regional human rights systems such as the Inter-American one.

[14] *Winterwerp v. The Netherlands (1979) 2 EHHR 387* and *Herczegfalvy v. Austria* (1992) 14 EHRR. The Council of Europe has produced as well a series of Recommendations related to the protection of psychiatric patients. For a brief overview see Johan Legemaate, § 75–91 (2003).

[15] AG/RES 1608 (XXIX-0/99).

[16] The I-A Convention is still not binding on a number of members of the Organization of American States which have not ratified it, including Canada. However, the Inter-American Commission and Court often cite EHRC jurisprudence and the Court has referred to the MI Principles at least in one occasion. The Inter-American system has thus far dealt with only one case involving a mentally ill person. This was done in the context of conditions of confinement. In *Victor Rosario Congo v. Ecuador*, Case 11.427, Inter-Am. C.H.R. 63/99, para. 54 (1999). The Inter-American Commission found Ecuador in violation of Article 5 of the American Convention, which guarantees humane treatment and of the right to life guaranteed in Article 4(1). The language used by the drafters of the Inter-American Convention has been criticized for its potential for weakening existing human rights law. Eric Rosenthal and Clarence J. Sundram, *op. cit.* 4 §§ 474–75.

human rights principles into domestic law and into the discourse of people who apply human rights principles in different legal and non-legal settings.[17]

Ontario's experience discloses a high rate of compliance with international human rights standards. It also shows that well-developed legislation in a domestic jurisdiction may succeed in achieving even greater protection for human rights than the international instruments currently available. This somewhat paradoxical phenomenon in the area of mental health is arguably the result of the early stages of development of international human rights standards concerning the mentally ill vis-à-vis the relatively well-developed legislation of a number of domestic jurisdictions, including Ontario.

2. Incorporation of international law

In assessing compliance, it is worth mentioning that ratified international conventions, such as the ICCPR, are of no force or effect within the Canadian legal system until incorporated into domestic law. The effect of a treaty that is not expressly implemented through domestic legislation is unclear. International law appears merely to constitute one of many sources of guidance to Canadian courts in interpreting statutes. International conventions can be taken into consideration in interpreting legislation whose meaning is not settled and clear.[18]

3. Overview of Ontario mental health legislation

The Consent and Capacity Board (the "Board") is an independent body created by the provincial government of Ontario.[19] It conducts hearings under the *Mental Health Act* (MHA),[20] the *Health Care Consent Act* (HCCA),[21] the *Personal Health Information Protection Act* (PHIPA)[22] and the *Substitute Decisions Act* (SDA).[23] The Board has a wide range of authority.[24] This study focuses on the Board's authority to review involuntary status, findings of incapacity to make treatment decisions, and findings of incapacity to manage a person's property and assesses compliance with international procedural standards.

For purposes of assessing Ontario's legal framework, this article traces in chronological order how legal safeguards come into play when the mentally ill come into contact with the health system. The analysis below describes the preliminary steps that give rise to a hearing before the CCB and all the subsequent steps until the final disposition of a case.

4. Preliminary stages prior to the involvement of the consent and capacity board

4.1. Decision-making standards to be used for involuntary admission

Different international legal bodies have addressed the need for objective medical expertise in ordering the civil committal of an individual. Article 9(1) of the ICCPR reads as follows: "Everyone has the right to liberty and security of person. No one shall be subjected to *arbitrary* arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law (emphasis mine)." Regional conventions present similar[25] or more elaborate[26] provisions.

---

[17] Stanley S. Herr, *op. cit.* 4 § 119–121.

[18] *Baker v. Canada (Minister of Citizenship and Immigration)*, [2003] 1 S.C.C. 722, paras. 69–71. The minority in *Baker* rejected even this limited use of unincorporated international conventions as a guiding principle for domestic legislation (para. 79).

[19] Health care is a provincial jurisdiction in Canada.

[20] R.S.O. 1990, c. M.7.

[21] S.O. 1996, c. 2, Sch A.

[22] S.O. 2004, c. 3, Sch. A.

[23] S.O. 1992, c. 30.

[24] The Board's multifaceted jurisdiction includes the following: review of capacity to consent to treatment, admission to a care facility or personal assistance service; consideration of the appointment of a representative to make decisions for an incapable person; consideration of a request to amend or terminate the appointment of a representative; review of a decision to admit an incapable person to a hospital, psychiatric facility, nursing home or home for the aged for the purpose of treatment; consideration of a request from a substitute decision maker for directions regarding wishes; consideration of a request from a substitute decision maker for authority to depart from prior capable wishes; review of a substitute decision maker's compliance with the rules for substitute decision making; review of involuntary status (civil committal); review of a community treatment order; review of a finding of incapacity to manage property and review of a finding of incapacity to consent to the collection, use or disclosure of personal health information.

[25] Article 7 of the *American Convention on Human Rights*; and Article 6 of the *African Charter on Human and Peoples' Rights*.

[26] Article 5 of the European Convention.

According to *General Comment No. 8*, Article 9(1) "is applicable to all deprivations of liberty, whether in criminal cases or in other cases such as, for example, *mental illness*, vagrancy, drug addiction, educational purposes, immigration control, etc.".[27] Article 9(1) thus covers all cases of administrative detention, including the type of involuntary committal dealt with by Ontario's MHA.

The UN Human Rights Committee has indicated that a nine-year civil committal of a person based on the opinion of three psychiatrists and which is periodically reviewed is not "arbitrary" and does not violate Article 9(1) of the ICCPR.[28] A person may be admitted involuntarily to a mental health facility or have his or her status changed from voluntary to involuntary patient so long as this is done by a qualified mental health practitioner.[29] Equally, the ECHR has required "objective medical expertise" to commit a person involuntarily.[30] The European Commission of Human Rights has accepted that medical evidence may come from a general practitioner rather than a psychiatrist.[31]

International standards refer not only to the qualifications of persons who make a determination of mental illness but to the diagnosis as well. A mental health institution may involuntarily admit a person only if she has a mental illness diagnosed under internationally accepted medical standards.[32] Thus, domestic legislation will also need to incorporate standardized diagnostic systems.

The MHA provides that only a "physician" can issue a certificate of involuntary admission.[33] A physician is defined as a "legally qualified practitioner."[34] To define "mental disorder" under the MHA, physicians and the Board generally use the Diagnostic and Statistical Manual of the American Psychiatric Association,[35] the main diagnostic reference of mental health professionals in North America.[36]

The MI Principles provide two grounds for civil committal:

(a) Dangerousness: serious *likelihood* of *immediate* or *imminent* harm to that person *because of a mental illness*;[37] or
(b) Best interest: that the release of the person will result in serious deterioration in his or her condition or will prevent the giving of appropriate treatment. In this case, "a second mental health practitioner, independent of the first, should be consulted where possible".[38]

As with the MI Principles, the grounds for involuntary detention set up under the MHA also require a link between dangerousness and mental illness. The MHA[39] also establishes two grounds to detain a person; however some distinctions are worth noting.

Section 20 (5) of the MHA is the first ground for civil committal. It specifies the only categories of pre-requisites that existed in the legislation prior to December 1, 2000, which continue to apply today. The patient must be suffering from a mental disorder "of a nature and quality that will *likely* result in *serious* bodily harm to the patient *or another person*", or alternatively, which will *likely* result in serious physical impairment of the patient.[40]

Board panels have defined "likelihood" as more than a mere probability. The legislation does not specify whether this is a long-term or short-term probability, and "likelihood" might therefore be invoked in either case. "Physical impairment" refers to unintentional self-harm through an inability to care for oneself. It includes both physical

[27] Human Rights Committee, United Nations Compilation of General Comments, p. 117, para. 1.
[28] *A. v. New Zealand*, Communication No. 754/1997 (Views adopted on 15 July 1999), p. 254, para. 7.2.
[29] Principle 16(1). See also in the European context, *Rakevich v. Russia*, [2003] ECHR 558.
[30] *X. v. the United Kingdom*, judgment of 5 November 1981, Series A, No. 46, p. 18, para. 40. Principle 16(1).
[31] *Schuurs v. the Netherlands*, App. No 10518/83, 41 Dec., & Rep.186, 188–189, 1985, European Commission of Human Rights, Council of Europe.
[32] Principles 4(1) and 16(1).
[33] MHA, ss. 15 and 20.
[34] MHA, s. 1.
[35] American Psychiatric Association, Diagnostic and Statistical Manual Disorders, DSM-IV (1994).
[36] The International Classification of Diseases is another well-recognized diagnostic system. World Health Organization, ICD-10 Classification of Mental and Disorders: Clinical Descriptions and Diagnostic Guidelines (1993).
[37] The EHRC has interpreted Article 5 of the European Convention to require a link between mental disorder and compulsory treatment as well. Johan Legemaate, *op. cit.* 14 § 78.
[38] Principle 16(1).
[39] MHA, s. 20(1.1.) and 20(5).
[40] MHA, s. 20(5)(a)(ii) and (iii).

impairment of the patient by his or her own acts and acting out "in such an aggressive and obnoxious way that [the patient] will invite harm at the hands of other people."[41]

Note that s. 20(5) sets a higher threshold than the MI principles, as the "harm" must be *serious*.[42] The Board has in the past rescinded certificates of involuntary admission because the harm alleged to ensue if the patient were the patient released did not amount to serious harm. However, the MHA does not require that the harm be "immediate" or "imminent." An earlier version of the MHA included a requirement that the serious physical impairment be imminent, however that condition was removed from the current legislation.

Nevertheless, the MHA does not establish a required time period within which the likely serious bodily harm or physical impairment must occur. The Board has held that the *event* (e.g. harm, impairment, etc.) must happen within a reasonable time after discharge and that likelihood includes an element of proximity.[43] The temporal element is therefore flexible.[44]

Section 20(1.1) is the second ground under the MHA. It prescribes an alternative pre-requisite for involuntary detention that, under limited conditions, may allow such detention where there is evidence of a *likelihood* of *serious* bodily harm, *substantial* physical or mental deterioration, or physical impairment.[45] Substantial physical or mental deterioration is an additional ground under this section. This arguably corresponds to the meaning of "serious deterioration" under the MI Principles.

The conditions necessary for a physician to rely on Section 20(1.1) include that the patient "is suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;" "has shown clinical improvement as a result of the treatment"; and "has been found incapable of consenting to his or her treatment and the consent of his or her substitute decision-maker has been obtained."[46] In other words, Section 20(1.1) may only be met if the patient can be treated and is not capable of consenting to such treatment.

Unlike under the MI Principles, a physician's decision to commit a person under the MHA must be reviewed by an "officer in charge", irrespective of which grounds for detention are used.[47] However, the review by the "officer in charge" can be delegated and has been interpreted by the Board to be a clerical or proof-reading function which may not need a medically qualified person.[48]

International standards do not require that treatment be carried out while a person is detained in a health facility, nor does the MHA require that treatment be administered when a person is held involuntarily. Under Section 20(5) of the MHA discussed above, a patient may be capable with respect to treatment. The basis for civil committal under Section 20(1.1.) only requires that the patient may be treated. The section does not require that the patient actually be treated. Section 20(5) and 20(1.1.) of the MHA incorporate a security component, namely the protection of the patient and other members of society. Thus, psychiatric facilities are sometimes left to fulfill a custodial, rather than a therapeutic role. This is not inconsistent with case law which has in fact stated that the MHA is consistent with s. 7 (right to liberty) under the Canadian *Charter of Rights*,[49] as the legislation is designed to protect persons who pose a danger to themselves or to others.[50] Whether psychiatric facilities are the best equipped institutions to fulfil this custodial role is a question which is outside the scope of this article.

---

[41] *Levinkas v. Hutson*, April 6, 1989 (Ont. Dist. Ct.), unreported. The Board has historically treated this category as covering the patient who is likely to wander out into harsh weather conditions without appropriate clothing on a cold winter day or patient's who, as a result of his or her mental disorder, will neglect or refuse essential medical care. This latter category also covers the patient who, as a result of his or her mental disorder, is likely to be so provocative or socially inappropriate that he or she are likely to cause other people to assault them and cause serious bodily harm. See for example HA 05-6183.

[42] MHA, s. 20(5).

[43] See for example PE-04-3270,3310; TO-03-0804; TO-01-894 ,895; and HA-04-1939.

[44] See for example the Board's Reasons for Decisions in HA-05-6183.

[45] S. 20(1.1.) was incorporated when the MHA was amended under *Brian's Law*, Mental Health Legislative Reform, 2000.

[46] MHA, s. 20(1.1.).

[47] MHA, s. 20(8).

[48] See for example TO-02-1167; TB-03-0089, 0090; TO-03-1454.

[49] Canadian Charter of Rights and Freedoms, Part I of the Constitution Act.

[50] *Penetanguishene Mental Health Centre v. Stock*, [1994] O.J. No. 1545 at para. 11 (Gen. Div.), *McCorkell v. Director of Riverview Hospital Review Panel* (1993), 104 D.L.R. (4th) 391 at para. 63 (B.C.S.C.); *Clark v. Clark* (1982), 40 O.R. (2d) 383 (Co. Ct.). *C.B. v. Sawadsky*, [2005] O.J. No. 3682.

4.2. Detention for assessment purposes

International standards prescribe that an involuntary admission shall initially be for a short period for observation and preliminary treatment pending review of the admission or retention by the review body.[51] In Ontario, a physician may issue an application for psychiatric assessment under the MHA after the examination of a person.[52] The application gives a psychiatric facility the authority to detain a person and to restrain, observe and examine him or her in the facility for not more than 72 h.[53] The attending physician, after observing and examining a person who is the subject of this application may admit the person as an involuntary patient[54] for an initial period of 2 weeks.[55] The certificate of involuntary admission may be subsequently renewed.

4.3. Authorized place of detention

Additionally, the MI Principles establish that "[a] mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law".[56] The MHA prescribes that a person can only be detained in a "psychiatric facility" designated by the Ministry of Health and Long-Term Care.[57] To be designated by the Ministry, a psychiatric facility must offer a number of essential medical services as prescribed by the legislation.[58]

4.4. Least restrictive means

International standards prescribe that an involuntary admission can only be justified if "appropriate treatment…can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative";[59] or as the last resort.[60] A physician in Ontario may commit a person only if the person is "not suitable for admission or continuation as an informal or voluntary patient".[61] A physician may therefore have to look at the kind of potential dangerousness involved to determine if the patient is suitable as a voluntary patient. Therefore, a patient in Ontario may be certified because of the likelihood of a dangerous situation even though potentially "least restrictive" or "last resort" alternatives which do not require admission to a psychiatric facility (such as community treatment orders) may be available.

4.5. Treatment

Article 12 of the ICESCR establishes 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. For further elaboration of the ICESCR's requirements, General Comment 14, adopted by the Committee on Economic, Social and Cultural Rights states as follows:

> The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference such as the right to be free from torture, *non-consensual* treatment and *experimentation*. By contrast, the entitlements include the right

[51] Principle 16(2).
[52] MHA, ss. 15(1) and 15(1.1). The grounds enumerated under these two sections are similar to the ones dealing with the issuance of a certificate of involuntary admission and require that the physician must be "of the opinion that the patient". This is an objective criteria. However, a physician need only have "reasonable cause to believe" that the application for assessment will prevent harm or is in the best interest of the patient. This is arguably a subjective criteria. In any case, several Board decisions have established that the Board does not have statutory authority to review the detention of a person under an application for assessment. For a recent example see TO-05-7474, 7475, 7476.
[53] MHA, s. 15(5)(b).
[54] MHA s. 20(1)(c).
[55] MHA s. 20(4).
[56] Principle 16(3).
[57] MHA, s. 1.
[58] General-R.R.O. 1990, Reg. 741.
[59] MI Principle 16(1)(b).
[60] EHRC, art. 5.
[61] S. 20(1.1)(f) and 20(5)(b). There is no similar provision for applications for assessment under the MHA. However, the authority to detain a person under a Form 1 application is limited to a 72 h period.

to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health. [62][italics mine]

General Comment 14 then recognizes the MI Principles as a guide to State obligations under the Convention. The MI Principles establish the general principle that no treatment may be carried out without "informed consent".[63] The exceptions to this general principle are five:

1. (a) The person is an involuntary patient;
   (b) The person is found incapable by an "independent authority" (not defined by the MI Principles) or the patient unreasonably withholds consent having regard to his/her own safety or safety of others; and
   (c) An "independent authority" finds this is in best interest of the patient's health needs.[64]
2. There is consent from a substitute decision-maker.[65]
3. Treatment is necessary to prevent immediate or imminent harm.[66] The ECHR has held that such an emergency measure must only be for a short duration.[67]
4. Treatment is necessary for a major medical or surgical procedure and this decision has been independently reviewed.[68]
5. It is part of a clinical trial and experimental treatment and it has been reviewed by "independent review body".[69]

In contrast to the vaguely defined concept of "informed consent" found in the MI Principles, there is a clear definition in the HCCA.[70] This very detailed statutory definition and some decisions by Canadian courts[71] create a better standard of protection in Ontario.

In connection to the exceptions prescribed at the international level, a number of observations are worth mentioning with respect to Ontario:

1. Involuntary admission and involuntary medical treatment are treated separately under Ontario legislation.[72] Thus, a physician in Ontario cannot override a patient's decision to refuse consent even if she or he is an involuntary patient.[73] Nor can the physician treat a patient if she or he "unreasonable [sic] withholds consent having regard to his/her own safety or safety of others" as per the MI Principles. *Capacity*, rather than *reasonableness* is the legal test in Ontario.[74]

   A finding of incapacity to make a treatment decision can be reviewed by the Board. That finding must be based on the legal test prescribed by the legislation.[75] As stated before, this is a finding which is independent from the

[62] General Comment No 14 (2000)(E/C.12/2000/4) on the right to the highest attainable standard of health (art 12 of the ICESCR), para 8.
[63] Principle 11(1).
[64] Principle 11(6).
[65] Principle 11(7).
[66] Principle 11(8).
[67] *X. v. the United Kingdom*, judgment of 5 November 1981, Series A, No. 46, p. 18, paras. 44-46., where the ECHR assessed whether the interests of the protection of the public prevail over the individual's right to liberty to the extent of justifying an emergency confinement in the absence of the usual guarantees implied in article 5(1)(e) of the European Convention.
[68] Principle 11(13).
[69] Principle 11(15).
[70] HCCA, s. 11.
[71] *Reibl v. Hughes* [1980] 2 S.C.R. 880; *Ciarlariello v. Schacter* [1993] 2 S.C.R. 119.
[72] A number of jurisdictions combine involuntary admission and involuntary medical treatment. See for example Portugal's Mental Health Law No. 36, 1998 and Mental Health Ordinance for Pakistan, 2001, quoted in World Health Organization, (2005).
[73] *Fleming v. Reid* (1991) 4 O.R. (3d) 74 (C.A). This is in contrast this with the legislation in the Provinces of British Columbia, Saskatchewan and Newfoundland, where all patients who meet the criteria for involuntary status can also be treated involuntary. In Alberta, New Brunswick and PEI, physicians can apply to their review boards to override a decision made by a capable patient.
[74] *Re Koch* (1997) 33 O.R. (3d) 485, p. 521. The legal separation between treatment and hospitalization in several provincial legislations, including Ontario, may unintentionally have a negative effect in a patient's civil liberties. An involuntary patient who is found capable to make treatment decisions patients may eventually accept treatment after being subject to forms of coercion such as bargaining, inducements of hospital privileges and pestering. Siegfried Kasper et. al., Prospective Study of patient's refusal of antipsychotic medication under a physician discretion review procedure, 483–488, 485–486 (1997); Mona Gupta, *op. cit.* 14 § 172.
[75] HCCA, s. 4(1).

involuntary admission of the patient. The 'best interests' of the patient are irrelevant to the legal test for capacity.[76] The legislation presumes a person capable and places the onus of proving incapacity on the health practitioner who made the finding. Although not addressed by international instruments, the existence of this presumption limits the beneficent intervention of the state in the decision-making of patients.[77]

2. The HCCA provides a statutory scheme which ensures that a person found incapable to make a decision concerning treatment always has a substitute decision maker.[78] That means a physician can always treat a patient found incapable, irrespective of whether the patient is in the community or detained on an involuntary basis. The only difference between the two is that treatment can only be forced on an involuntary patient.[79]
3. There are also 'emergency' provisions under Ontario legislation.[80] Use of those provisions is limited to when the individual "is experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm".[81] The wording of the emergency provision also contains an element of immediacy ("experiencing" and "promptly"), but only "serious" and "bodily" harm will meet the requirements of the emergency provision. Finally, emergency treatment may *only* be administered if no effective communication with the patient is possible and there is no reason to believe that the person does not want the treatment.[82]
   Overall, the HCCA appears to incorporate more restrictions than the MI Principles to the use of the emergency provisions. The HCCA also provides that emergency treatment of an incapable person may be continued "only for as long as is reasonably necessary to obtain the substitute decision maker's "consent or refusal to consent, to the continuation of treatment".[83]
4. Ontario legislation does not contain a "major medical or surgical procedure" exception as do the MI Principles.
5. The MI Principles enumerate non-therapeutic experimentation as one of the exceptions which may override treatment of a capable person without his or her consent. Ontario mental health legislation does not have a similar exception.[84] This is in accordance with Article 7 of the ICCPR which altogether prohibits clinical and experimental research without informed consent.[85]

The MI Principles prohibit psychosurgery and other intrusive and irreversible treatments for mental illness on involuntary patients, *unless* permitted by law and where an "independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient".[86] The MHA provides better substantial protections by banning psychosurgery altogether.[87] Therefore, a person who has been found incapable can apply to the Board to review a decision concerning *any type of treatment*. The MHA, however, does not distinguish between "standard" and more intrusive treatments, including psychotropic medications and electroconvulsive therapy.

Other jurisdictions have granted different procedural protections in relation to the more invasive forms of treatment, including the recognition in the United States of a qualified right to refuse the more intrusive of these treatment techniques;[88] or the application in Australia to a quasi-judicial body for approval to have electroconvulsive therapy on the basis of the incapable patient's best interest.[89]

[76] Consideration of the 'best interest' of a person found incapable were explicitly rejected by the Supreme Court of Canada in *Starson* v. Swayze, [2003] S.C.J. No. 33.

[77] The presumption of competency has been argued from a therapeutic jurisprudence model for civil commitment. See for example Bruce J. Winick (1995), 6–42 and (1996) 57–95.

[78] Sections 10(1)(b) and 20.

[79] Treatment may arguably also be "forced" on a person under a community treatment order.

[80] HCCA, section 25.

[81] HCCA, section 25(1).

[82] HCCA, section 25(3).

[83] HCCA, s. 25(6).

[84] Section 6 of the HCCA provides that the legislation does not affect any law relating research. Proxy consent for medical research involving incapable individuals has been allowed in certain circumstances. Council for International Organizations of Medical Sciences (CIOMS) (2002), Guidelines 4 and 15.

[85] Article 7 of the ICCPR is non-derogable and cannot be limited even under conditions of emergency.

[86] Principle 11(14).

[87] MHA, s. 49 MHA.

[88] See generally B. J. Winick (1997).

[89] See *Mental Health Act, 2000* dealing with application to the Mental Health Review Tribunal, Queensland, Australia, http://www.mhrt.qld.gov.au. There are similar provisions under the *Mental Health and Related Services Act, 1998* governing the Mental Health Review Tribunal, Northern Territory Government, Australia, http://www.nt.gov.au/justice/graphpages/courts/mentalhealth/index.shtml; and under the Mental Health Act 1990 governing the Mental Health Review Tribunal, New South Wales, Australia, http://www.mhrt.nsw.gov.au/.

Lastly, the MI Principles contain a number of procedural safeguards against abuse, such as the requirement that each use of restraints or seclusion be recorded in the patient's record, along with an explanation of the "reasons for them and their nature and extent." The "personal representative" of the patient should be informed promptly of any use of physical restraint or seclusion.[90] Ontario legislation provides similar protections and expands it to the use of a 'chemical restraint' as well. However, it does not require the substitute decision maker to be advised of the use of restraints or seclusion.[91]

4.6. Notice of rights

International standards require that patients in mental health facilities be notified of their rights and of how to exercise them.[92] The grounds for involuntary admission "shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient's personal representative, if any, and, unless the patient objects, to the patient's family".[93] Additionally, Article 5(2) of the European Convention specifies that "everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest". The ECHR has indicated that this section applies to involuntary patients[94] and that the essential legal and factual grounds for the involuntary admission must be notified to the patients "in simple, non-technical language."[95]

There are numerous provisions under Ontario mental health legislation dealing with notice requirements. Ontario legislation requires that a patient be given *written* notice both when an application for psychiatric assessment[96] and a certificate of involuntary status[97] are made. The notice for a certificate of involuntary status must include the reasons for detention, that the patient is entitled to a hearing and that the patient is entitled to counsel.[98] There are similar notice requirement for individuals who were issued community treatment orders,[99] and certificates of incapacity for property.[100]

The Courts and the Board have been reluctant to add additional procedural protections to the ones afforded by the legislation, given what have been found to be the very particular purposes of mental health legislation. The more extensive Charter obligations that, for example, require police to inform a detainee for criminal purposes orally of the right to counsel and the opportunity to access free legal advice have been found not to apply in the mental health context.[101]

Regulations under the MHA require that a written notice be given and a rights adviser be notified when a patient (involuntary or not) in a psychiatric facility is found incapable with respect to treatment.[102] However, the MI Principles do not accommodate the multi-faceted jurisdiction of the Board. The legislation does not include notice requirements for people found incapable regarding treatment in a non-psychiatric facility setting. Not surprisingly, the Board receives a relatively large number of calls from evaluators (e.g. physicians, nurses, social workers) in the community who do not know which procedures should be followed once a finding is made. Ontario's College of Physicians and Surgeons[103] and Ontario's College of Nurses[104] have partially addressed this situation through the issuance of

[90] Principle 11(11).
[91] MHA, s. 53.
[92] Principle 12(1).
[93] Principle 16(2).
[94] *Van der Leer v. The Netherlands* (1990) 12 EHRR 567.
[95] *Fox, Campbell and Hartley v. The United Kingdom* (1990) 12 EHHR.
[96] MHA, s. 38.1.
[97] MHA, ss. 20(7) and 38(1).
[98] MHA, s. 38(2).
[99] MHA, s. 33.1(10).
[100] MHA, s. 57(2) and 59(1).
[101] *C.B. v. Sawadsky*, *op. cit.* 50, dealing with procedural requirements re psychiatric assessments. See also *Heuberger v. Stenn*, [2002] O.J. No. 1285, holding that principles of natural justice do not require advice of right to counsel for purposes of assessing capacity to consent to admission to a care facility.
[102] RRO 1990 Reg. 741, s. 15(1).
[103] College of Physicians and Surgeons of Ontario, Policy No. 1-01 (May/June 2001).
[104] College of Nurses of Ontario, Practice Guidelines: Consent (2004).

professional guidelines.[105] Health practitioners must provide information about the consequences of the findings to persons found incapable as is specified in the guidelines. These guidelines, however, only apply to findings of incapacity with respect to treatment. Other Colleges have yet to follow suit.

4.7. Right to legal representation

A person whose mental capacity is at issue is entitled to be represented by counsel.[106] The MI Principles refer to procedural safeguards such as the patient's right to choose and appoint counsel to represent the patient.[107]

Ontario legislation gives parties before the Board the right to be represented by legal counsel or an agent[108]. The Board often arranges for individuals appearing before it to secure legal representation.[109] However, the legislation only allows the Board to make such arrangements if the person:

a) *"is or may be incapable with respect to a treatment, admission to a care facility or a personal assistance service"; and*
b) *is a party to a proceeding before the Board and does not have legal representation*.[110]

The grounds above may not cover applications from involuntary patients in which incapacity is not an issue or individuals found incapable regarding the management of their property. Nevertheless, in practice the Board often extends its authority to secure counsel for those applicants as well.

International standards also specify that "[i]f the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it."[111] Most of the subjects of applications before the Board are of limited means. The majority receives legal aid to obtain legal representation before the Board. Those individuals who do not qualify for Legal Aid are responsible for their legal fees.[112] However, Legal Aid Ontario has established internal policies which facilitate the payment of legal fees for certain parties before the Board who would not otherwise qualify to get free legal representation. Legal Aid Ontario's policies, however, are not well-known among the parties and counsel appearing before the Board.

The MI Principles also address the need to appoint a personal representative, other than a family member, to represent the mentally ill.[113] Ontario legislation does not prohibit a family member from representing the mentally ill person, but in practice the Board will not allow it if it finds a conflict of interests. Similarly, the *Rules of Professional Conduct*[114] governing lawyers in Ontario prevent the conflict of interest which may arise from lawyers representing both the mentally ill and the health practitioner or a member of the family of the person whose capacity is at issue.[115]

When the Board arranges for legal representation for an individual, she or he is "deemed to have capacity to retain and instruct counsel."[116] From a civil rights perspective, this is quite a broad protection and is certainly in the spirit of MI Principle 18 which establishes the patient's right to choose and appoint a counsel to represent the patient. This provision may, however, be problematic when put into practice. Patients may sometimes wish to appear un-represented or give instructions which may run against their interests. When the patient appears un-represented, the Board sometimes appoints counsel as *amicus curiae* (friend of the court) to help it hold a fair hearing.

---

[105] HCCA, s. 17.
[106] Principle 1(6).
[107] Principle 18.
[108] SPPA, s. 10.
[109] HCCA, s. 81(1)(a).
[110] HCCA, s. 81(1).
[111] Principle 1(6).
[112] HCCA, s. 81(2).
[113] Principle 2.
[114] Law Society of Upper Canada, 2000, Rule 2.04.
[115] Principle 1(6).
[116] HCCA, s. 81(1)(b).

Principle 18 of the MI Principles also refers to the patient's right to the services of an interpreter. The Board's *Rules of Practice* address this matter by establishing a procedure to notify the Board in advance of the hearing of the need to have an interpreter.

4.8. Access to information[117]

The MI Principles provide that "copies of the patient's records and any reports and documents to be submitted to the review body be given to the patient and to the patient's counsel."[118] Access to information is essential for a person to know why his or her fundamental rights are being abrogated. It is also necessary for preparation for a hearing before the CCB. An applicant cannot fully participate in a hearing without full disclosure of the relevant health records.

The HCCA provides that parties be "given an opportunity to examine and copy any documentary evidence that will be produced and any report whose contents will be given in evidence" before the hearing.[119] It also gives a party and his or her counsel or agent the right to examine and to copy, at their own expense, any medical or other health record prepared in respect of the party..."[120] As with the powers of the Board to arrange legal representation, the legislation does not necessarily cover involuntary patients who are capable. In practice, hospitals and health practitioners would not question the grounds upon which access is requested, so long as there is an application pending before the Board. Common law principles of fairness and natural justice would, in any case, require that access be given to the applicant (or his representative) in advance of any type of hearing held by the Board.

However, physical access to the records may not always be available in a timely fashion. Given the tight time requirements under which the Board functions (hearings must begin within seven days of the application being received), the Board may have to adjourn a hearing to allow counsel enough time to prepare for a hearing on the basis that access to their clients' medical record was not given in a timely fashion.

An additional problem with the legislation is the lack of clarity as to how much a facility may charge a party for photocopying medical records. This is an important issue because most of the applicants before the Board lack financial means. Under the legislation, the Province has the power to regulate the amounts that a person who is entitled to copy medical or other health records may be charged for copies of the records.[121] No regulations have been issued to this date. As a result, health facilities may unilaterally impose prohibitive photocopying costs.[122]

International standards provide that the right to access is not absolute and "may be subject to restrictions in order to prevent serious harm to the patient's health and avoid putting at risk the safety of others." Any document not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel.[123] When access is denied, the patient must receive notice of the withholding and the reasons for it. This decision should be "subject to judicial review."[124]

In Ontario, lawyers are required to produce medical reports to their clients if instructed by them to do so.[125] Patients have the right to request access to a record of personal health information. That record may be refused if disclosure could "result in a risk of serious harm to the treatment or recovery of the individual or a risk of serious bodily harm to the individual or another person."[126] In case of refusal, patients are entitled to receive a written notice which states the reasons for the refusal and stating that the individual is entitled to make a complaint about the refusal to Ontario's Information and Privacy Commissioner.[127]

---

[117] Principle 19.
[118] Principle 18(4).
[119] HCCA, s. 76 HCCA.
[120] HCCA s. 76(2).
[121] HCCA, s. 85(1)(j) A.
[122] The Board has received complaints from lawyers appearing before the Board about this issue.
[123] Principle 19.
[124] Principle 19.
[125] Law Society of Upper Canada, *op. cit.* 112, Rules 2.02(7), (8) and (9).
[126] PHIPA, s. 52(1)(e).
[127] PHIPA, 54(1)(c) and (d).

5. The review body

5.1. Nature of tribunal

Article 9(4) of the ICCPR reads as follows: "Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that the court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful." This provision is applicable to cases of administrative deprivation of liberty, such as the one provided by the MHA.[128] Similarly, Article 6(1) of the European Convention requires an independent and impartial review and a public hearing.

In addition, international standards also require an "independent and impartial tribunal established by domestic law" which, in formulating its decisions shall "have the assistance of one or more qualified and independent mental health practitioners and take their advice into account."[129]

The CCB is an independent body created by the provincial government of Ontario. Reviews of involuntary status[130] are chaired by a lawyer member, with a psychiatrist member, and a public member also on the panel. On occasion, a panel of five members, which must include at least one psychiatrist, may hear reviews of civil committals by the Board.

Equally, the MI Principles establish that a patient has a right to appeal to a judicial or other independent authority concerning any treatment given to him or her".[131] They require that findings of incapacity be reviewed by an "independent and impartial tribunal."[132] Under the HCCA, the Board reviews findings of incapacity concerning treatment.[133]

5.2. Procedures used by the tribunal

According to the ECHR, a body reviewing involuntary admissions should be a "competent national authority" whose procedure "should have a judicial character."[134] International standards prescribe that reviews should be conducted "in accordance with simple and expeditious procedures as specified by domestic law."[135]

The procedures of the Board are governed by the *Statutory Powers Procedure Act*[136] and the Board's *Rules of Practice*. Both give the Board ample authority to control its own procedures and maintain flexibility and simplicity in its procedures. Hearings generally take place where the subject of the application is (generally in a health care facility).

The patient and the patient's personal representative and counsel should be entitled to attend, participate and be heard personally in any hearing under international standards.[137] Further, the person who wants to challenge a medical finding should have a stand alone right to challenge the opinion of the health practitioner. The availability of the review should not depend on the good will of the detaining authority.[138] A person challenging a certificate of involuntary status,[139] CTO[140] or finding of incapacity[141] before the CCB is a party to the hearing. As such, that individual and his or her counsel or agent have the right to be present, present evidence and cross examine other parties.

The MI Principles provide that a decision to have an open hearing and whether it may be publicly reported should "give full consideration to the patient's own wishes, to the need to respect the privacy of the patient and of other persons and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others."[142] Unlike other mental health tribunals, the Board's hearings are open to the public. Transcripts of the hearings are taken by court reporters.

---

[128] Human Rights Committee, United Nations Compilation of General Comments, p. 117, para. 1.
[129] Principle 17(1).
[130] MHA, sections 39(5.1) and 39(6).
[131] Principle 11 (16).
[132] Principle 1(6).
[133] See for example HCCA, 32(1).
[134] Johan Legemaate, *op. cit.* 14 § 78.
[135] Principle 17(2).
[136] RSO 1990, c. S.22.
[137] Principle 19(5). The EHRC has found that Article 5 of the Convention includes a similar requirement. Johan Legemaate, *op. cit.* 14 § 78.
[138] *Rakevich v. Russia*, *op. cit.* 29 para. 44.
[139] MHA, s. 42.
[140] MHA, s. 39.1(9).
[141] See for example section 32(3) HCCA and section 60(2) MHA.
[142] Principle 18(7).

The Board, however, has the power to close its hearings when "the desirability of avoiding disclosure thereof in the interests of any person affected or in the public interest outweighs the desirability of adhering to the principle that hearings be open to the public."[143] In practice, the Board rarely receives requests to close a hearing. Requests to exclude witnesses are sometimes made to prevent specific information from being heard by a witness or close family member.

5.3. Onus and standard of proof

The various Acts which establish the Board's jurisdiction do not specifically set out which party is responsible to prove to the Board that a finding of incapacity or certificate of involuntary status should be upheld. Nevertheless, the legislation establishes a presumption of capacity.[144] Both the courts[145] and the Board have consistently held that the burden of proof is on the party who made the finding of incapacity or issued the certificate of involuntary admission.[146] This is in accordance with international standards that establish that everyone is entitled to liberty unless it is proved by the state that they need to be detained.[147]

The standard of proof used by mental health tribunals appears to be an issue which carries some controversy in different jurisdictions. Courts have generally indicated that the more serious the consequences for the rights of an individual the higher the standard that will be required to meet the onus of proof. In the mental health context, this has created some confusion concerning the standard of proof to be used by the Board. Courts have referred to the Board's standard of proof as either proof on an "*enhanced* balance of probabilities"[148] or on a "balance of probabilities."[149] The latter is customarily used in civil litigation and has been interpreted by Canadian courts to mean anything more than a 50% likelihood. The former was interpreted by a number of Board decisions to be higher than the balance of probabilities but less than the proof beyond reasonable doubt, the standard used for criminal cases.

This interpretation appeared to arise from a confusion between a stricter evidentiary standard and a different standard of proof. In fact, what the nature of the applications before the Board requires is a higher *quality* of evidence that must be used to satisfy the onus, namely, what courts have identified as "persuasive, cogent and compelling" evidence.[150] This view is in line with the Supreme Court of Canada decision of *Starson* which held that the standard of proof for a physician to establish incapacity with respect to treatment is proof on a balance of probabilities.[151] This decision triggered a debate among Board members which was reflected in Board decisions using both standards, sometimes depending on the type of issue to be decided by the Board.

This matter was finally put to rest by the Ontario Court of Appeal in *Stetler v. Ontario Flue-Cured Tobacco Growers' Marketing Board*.[152] The Court held that in civil and administrative matters, absent an express statutory provision to the contrary (Ontario mental health legislation does not have such provision), the standard of proof is on a balance of probabilities, where the consequences to an individual are very serious, the evidence must be clear, cogent and convincing, *within the civil standard of proof*.[153]

---

[143] SPPA, Section 9(1).
[144] HCCA, s. 4(2).
[145] *Azhar v. Anderson* (June 28, 1985) (Ont. Dist. Ct.) (Unreported), at p.7.
[146] Mental health legislation in other jurisdiction put the onus of proof on the applicant (i.e. the patient). See for example section 72 of the *Mental Helath Act* 1983 (UK).
[147] See for example European Convention, art. 5 and the UK decision of *R(H) v Mental Health Review Tribunal* [2002] QB 1, [2001] Mental Health Law Reports 48.
[148] In *L.C. v. Pinhas*, [2002] O.J. No. 5309, the court held that the Board had to apply an enhanced civil standard when reviewing a finding of incapacity. The court also indicated it could only make a finding of incapacity if there was clear and cogent evidence to support it.
[149] In *J.P. v. Harrison*,[1999] O.J. No. 4059, the court expressly set out the standard of proof as the civil standard of proof. The case concerned the review of the appellant's involuntary status. The Court found that the Board had persuasive, cogent and compelling evidence to make the finding that it made, on the basis of the civil standard. *Kirpiev v. Peat*, [2002] O.J. No. 2210 dealt with a review of incapacity regarding treatment. The court followed *J.P. v. Harrison*.
[150] *Ibid.*
[151] *Starson v. Swayze*, [2003] S.C.J. No. 33.
[152] *Stetler v. Ontario Flue-Cured Tobacco Growers' Marketing Board*, 2005 CanLII 24217 (ON C.A.).
[153] As stated before, the UK legislation places the burden of proof on the patient–applicant. The use of a criminal law standard is double-edged. It has been argued that UK Mental Health Review Tribunal de facto requires proof beyond reasonable doubt, although the issue to be decided is not one under criminal law. J. Peay (1989).

5.4. Reviews: how soon?

International standards do not preclude the initial decision to involuntarily admit a person being taken by a person without a legal background. However, the MI principles provide that an initial review of involuntary admission is to take place "as soon as possible."[154] Equally, under the European Convention, patients deprived of their liberty are entitled to speedy review of the decision to make them involuntary. [155]The Board must hold a hearing within seven days after the day the Board receives an application, whether it is a first certificate or a renewal, unless the parties agree to a postponement. [156]However, the seven days' requirement may result in an adjournment, as parties to the hearing or their representatives may not be available on such short notice.[157]

6. Following the review by the CCB

6.1. Subsequent periodic reviews

Under international standards, reviews of involuntary status are to be held at "reasonable"[158] or "regular"[159] intervals. In Ontario, the first certificate of involuntary admission extends for two weeks, the second certificate for one month, a second renewal for two months and the next and subsequent certificates for three months.[160] A patient has a right to apply to the Board every time a certificate of involuntary status comes into force.[161] The review is patient-generated but the MHA also requires an automatic review of involuntary status on the completion of every fourth certificate of renewal.[162]

MI Principle 1(6) also provides a right to the review of any decision regarding capacity "at reasonable intervals prescribed by domestic law."[163] The Board can only review a finding of incapacity to make a treatment decision six months after a previous final disposition (unless the applicant obtains leave from the Board to have it reviewed earlier).[164] There are similar provisions for other findings of incapacity the Board has the jurisdiction to review.[165] However, Ontario legislation does not include any legal requirement that a physician reassess capacity regularly. In fact, a physician may rely on a relatively old finding of incapacity to treat a patient.[166]

6.2. Publication of outcome

Principle 18(8) requires that "[t]he decision arising out of the hearing and the reasons for it shall be expressed in writing. Copies shall be given to the patient and his or her personal representative and counsel." The Board issues a written decision within one day after the day the hearing ends and reasons for decision (if requested by a party) within two business days.[167] All parties to an application, including the patient and his or her personal representative, are entitled to receive copies of decisions and reasons for decisions.[168]

---

[154] Principle 17(2).
[155] Art. 5(4).
[156] HCCA, s. 75(2) HCCA.
[157] British Courts have addressed claims for breach of art. 5(4) of the European Convention on the basis of a shortage of members of the Mental Health Review Tribunal in *R (KB and others) v Mental Health Review Tribunal* [2003] Mental Health Law Reports 1 and *R (B) v Mental Health Review Tribunal* [2003] Mental Health Law Reports 19.
[158] Principle 17(3) and European Convention, art. 5(4). The decision of *R (D) v. Home Secretary* [2003] Mental Health Law Reports 193, deals with the application of art. 5(4) in the UK re involuntary patients.
[159] *A. v. New Zealand,* Human Rights Committee in Communication No. 754/1997, p. 254, para. 7.2., interpreting Article 9(4) of the ICCPR. As well, the EHRC has also held that Article 5 of the European Convention requires "a review of lawfulness at regular intervals". Johan Legemaate § 78 (2003).
[160] MHA, s. 20(4).
[161] MHA, s. 39(2).
[162] MHA, s. 39(4).
[163] Principle 1(6), see also Principle 17.
[164] HCCA, s. 32(5).
[165] See for example MHA, section 60(2) and SDA, section 20.2(2).
[166] TO-03-1123 in which the Board allowed a physician to rely on a finding made during a prior admission to the hospital.
[167] HCCA, s. 75(3)and 75(4).
[168] HCCA, s. 75(3)and 75(4).

A more problematic issue is whether the outcome of the hearing should be published in whole or in part. International standards dealing with the determination of whether to publicly report decisions state that such determination should "consider the patient's own wishes, the need to respect the privacy of the patient and of other persons and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.[169]

The law concerning the disclosure of tribunal documents containing health information to the general public is an unsettled area in the law in Canada. On one hand, the Board must take into account the privacy rights of parties to its applications. The Board is subject to privacy legislation that prohibits the release of 'personal information' which "constitutes an unjustified invasion of personal privacy."[170] Personal information is presumed to constitute an unjustified invasion of personal privacy where the personal information "relates to a medical, psychiatric or psychological history, diagnosis, condition, treatment or evaluation."[171] On the other hand, Board hearings are open to the public and there is a public interest in openness and public accountability.[172]

To balance these conflicting interests and pursuant to its statutory power to determine its own procedures and practices,[173] the Board releases information to non-parties about the location and date of the hearing (i.e. the docket number). The Board is currently reviewing its practice with respect to the release of documents which form part of a case file.

The Board attempts to address the need for an open administration of justice and to enhance its public accountability by publishing its reasons for decision in electronic format. Free access to all reasons for decision of the tribunal also facilitates research for the legal profession, the media, and the public. Nevertheless, reasons for decision often contain sensitive personal information. To address this concern, the Board uses acronyms instead of the full name of the subject of the application and family members. It also de-identifies any other information that may disclose the identity parties to the application. This procedure attempts to balance the different competing interests enumerated in Principle 18(8) and Ontario privacy legislation.

6.3. Right to appeal a tribunal's decision

The MI Principles establish that "[t]he person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision."[174] With regard to involuntary status, international standards also refer to a right to appeal to a "higher court" against a decision. This right is given to a "patient or his personal representative or *any interested person*."[175] As mentioned above, Article 6(1) of the European Convention gives an individual who is deprived of his liberty the right to challenge the lawfulness of his detention. Such review must be carried out "speedily." The ECHR has held that the scope of the review must be wider than the judicial review of administrative decisions provided in common law jurisdictions.[176]

Any decision made by the CCB can be appealed as of right to the Ontario Superior Court of Justice, on a question of law or fact or both.[177] However, only *a party* to the hearing has the right to appeal.[178] Section 80 of the HCCA contains special procedures to ensure that appeals are heard promptly. This is critical given the nature of the cases heard by the Board. On average, it takes approximately 8 months from the moment an appeal is launched until the Court renders a decision.[179]

7. Summary and conclusion

The Ontario experience shows a relatively high level of compliance with international human rights norms that protect and promote the interests of persons with mental disabilities. A review of the legislation and practice also reveals that such international standards can and should be incorporated into a domestic legislative structure. Further

[169] Principle 18(8).
[170] *Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c.f.31, s. 21.1(2) (hereinafter FIPPA).
[171] FIPPA, s. 21.1(3).
[172] *Attorney General of Nova Scotia v. MacIntyre*, [1982] 1 S.C.R. 175.
[173] Board's *Rules of Practice*, Rule 20; SPPA, s. 25.0.1.
[174] Principle 1(6).
[175] Principle 17(7).
[176] *H.L. v. The United Kingdom*(2004) Application No. 45508/99.
[177] HCCA, s. 80(1).
[178] HCCA, s. 80(1).
[179] Board's statistics for 2003–2004 as of September 16, 2005.

research is needed to comprehensively assess how Ontario rates in comparison to other domestic jurisdictions and practices. Such a comparative perspective is also necessary to assess whether and how those jurisdictions comply with international human rights standards.

Recommendations to modify domestic law and/or incorporate international human rights standards in national mental health schemes should follow from measuring compliance with human rights obligations.[180] The current major emphasis on human rights in general, as a democratic right, and specifically on the rights of the mentally ill at a global level, makes the description and evaluation of the mental health legislation in jurisdictions with advanced legislation, such as the province of Ontario, all the more important.

Postscript

On 13 December 2006, the United Nations General Assembly adopted the International Convention on the Rights of Persons with Disabilities (G.A. res. A/61/611, 2006). The Convention and its Optional Protocol will come into force after 20 ratifications (as of September 2007, only 5 countries ratified the Convention and only 3 the Optional Protocol). Canada has so far signed the Convention but not the Optional Protocol. The Convention applies to persons "who have long-term physical, mental, intellectual or sensory impairment" (art. 1). The Convention includes provisions dealing with liberty and security (art. 14), right to manage property (art. 12.5) and consent to medical or scientific experimentation (art. 16). However, the Convention only provides general principles that are difficult to use to measure compliance of state parties.

Acknowledgements

The author would like to thank Dr. Federico Allodi, Susan Opler and Bernard Starkman for their comments and suggestions.

References

American Psychiatric Association (1994). *Diagnostic and Statistical Manual Disorders, DSM-IV.*

College of Nurses of Ontario (2004). Practice Guidelines: Consent. http://www.cno.org

College of Physicians and Surgeons of Ontario (2001, May/June). Policy No. 1-01. http://www.cpso.on.ca/

Committee on Economic, Social and Cultural Rights (2000). *General Comment*, *Vol. 14* (E/C.12/2000/4).

Council for International Organizations of Medical Sciences (CIOMS) (2002). *International Ethical Guidelines for Biomedical Research Involving Human Subjects.* Prepared in collaboration with the World Health Organization (Geneva: WHO).

Herr, S. S. (2003). From wrongs to rights: International human rights and legal protection. In S. S. Herr, L. Gostin, & H. H. Koh (Eds.), *The Human Rights of Persons with Intellectual Disabilities* (pp. 115−150). Oxford: Oxford University Press.

Human Rights Committee, *United Nations Compilation of General Comments*.

International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities. G.A. Res. A/61/611 (2006).

International League of Societies for the Mentally Handicapped (2006). Declaration of general and special rights of the mentally retarded Brussels: ILSMH.

Kasper, S., et al. (1997). Prospective study of patient's refusal of antipsychotic medication under a physician discretion review procedure. *American Journal of Psychiatry*, *154*, 483−488.

Law Society of Upper Canada (2000). Rules of Professional Conduct. http://www.lsuc.on.ca

Legemaate, J. (2003). The rights of involuntary admitted psychiatric patients. In K. Diesfeld & I. Freckelton (Eds.), *Involuntary Detention and Therapeutic Jurisprudence* (pp. 75−91). Aldershot: Ashgate.

Peay, J. (1989). *Tribunals on trial: a study for decision making under the Mental Health Act 1983.* Oxford: Hart Publishing.

Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. GA Res 119, UN GAOR, 46th Sess, Supp No 49, Annex at 188, UN Doc A/46/49 (1992).

Rosenthal, E., & Sundram, C. J. (2002). International human rights in mental health legislation. *NYLSJICL*, *Vol. 21*. (pp. 469−536).

Rosenthal, E., & Sundram, C. J. (2004). The role of international human rights in national mental health legislation. Geneva: World Health Organization.

Standard Rules on the Equalization of Opportunities for Persons with Disabilities. UN Doc A/48/96 [GA Res 48/96 (1993)].

UN Declaration of the Rights of Mentally Retarded Persons. GA Res 2856, 26 UN GAOR, Supp (No 29) 99, UN Doc A/8429 (1971).

[180] The United Kingdom has many of the human rights standards addressed in this article through the *Mental Health Act 1983*, c. 20 (Eng.) and the draft *Mental Health Bill*, Dept. of Health (UK), from http://www.dh.gov.uk. In addition, it has passed legislation incorporating the case law of the European Court into its domestic law. See Human Rights Act, 1998, c. 42 (Eng.).

Winick, B. J. (1995). The side effects of incompetence labelling and the implications for mental health law. *Psychology, Public Policy, and Law*, *1*, 6−42.
Winick, B. J. (1996). Advance directive instruments for those with mental illness. *University of Miami Law Review*, *51*, 57−95.
Winick, B. J. (1997). *The right to refuse mental health treatment.* Washington, DC: American Psychological Association.
World Health Organization (1993). *ICD-10 Classification of Mental and Disorders: Clinical Descriptions and Diagnostic Guidelines.*
World Health Organization (2005). *WHO Resource Book on Mental Health, Human Rights and Legislation.* Geneva: World Health Organization.

Legislation

Brian's Law (2000). *Mental health legislative reform.*
Canadian Charter of Rights and Freedoms. Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11.
Consent and Capacity Board (2003). Rules of practice. http://www.ccb.on.ca
Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c.f.31.
Health Care Consent Act, S.O. 1996, c. 2, Sch A.
http://www.nt.gov.au/justice/graphpages/courts/mentalhealth/index.shtml
Human Rights Act, 1998, c. 42 (Eng.).
Mental Health Act 1983, c. 20 (Eng.).
Mental Health Act, R.S.O. 1990, c. M.7 (Ontario).
Mental Health Act 1990. New South Wales, AU. http://www.mhrt.nsw.gov.au/
Mental Health Act, 2000 (Queensland, AU). http://www.mhrt.qld.gov.au
Mental Health and Related Services Act, *1998* (Northern Territories, AU). http://www.nt.gov.au/justice/graphpages/courts/mentalhealth/index.shtml
Mental Health Bill, Dept. of Health (UK). http://www.dh.gov.uk.
Personal Health Information Protection Act, S.O. 2004, c. 3, Sch. A.
Substitute Decisions Act, S.O. 1992, c. 30.

Case Law

Attorney General of Nova Scotia v. MacIntyre, [1982] 1 S.C.R. 175.
A. v. New Zealand. Human Rights Committee. Communication No. 754/1997. Views adopted on 15 July 1999. In UN doc. *GAOR*, A/54/40 (vol. II).
Azhar v. Anderson (June 28, 1985) (Ont. Dist. Ct.) (Unreported).
Baker v. Canada (Minister of Citizenship and Immigration), [2003] 1 S.C.C. 722.
C.B. v. Sawadsky, [2005] O.J. No. 3682.
Ciarlariello v. Schacter [1993] 2 S.C.R. 119.
Clark v. Clark (1982), 40 O.R. (2d) 383 (Co. Ct.).
Fleming v. Reid (1991) 4 O.R. (3d) 74 (C.A).
Fox, Campbell and Hartley v. The United Kingdom (1990) 12 EHHR.
HA-04-1939. CCB.
HA 05-6183. CCB.
Herczegfalvy v. Austria (1992) 14 EHRR *J.P. v. Harrison,* [1999] O.J. No. 4059.
Heuberger v. Stenn, [2002] O.J. No. 1285.
H.L. v. The United Kingdom (2004), ECHR, Application No. 45508/99.
Kirpiev v. Peat, [2002] O.J. No. 2210.
L.C. v. Pinhas, [2002] O.J. No. 5309.
Levinkas v. Hutson, April 6, 1989. District Court of Ontario. Unreported.
McCorkell v. Director of Riverview Hospital Review Panel (1993), 104 D.L.R. (4th) 391.
PE-04-3270, 3310. CCB.
Penetanguishene Mental Health Centre v. Stock, [1994] O.J. No. 1545 (Gen. Div.).
Rakevich v. Russia, [2003] ECHR 558.
R (B) v Mental Health Review Tribunal [2003] Mental Health Law Reports 19.
R (D) v. Home Secretary [2003] Mental Health Law Reports 193.
R (H) v Mental Health Review Tribunal [2002] QB 1, [2001] Mental Health Law Reports 48.
R (KB and others) v Mental Health Review Tribunal [2003] Mental Health Law Reports 1.
Re Koch (1997) 33 O.R. (3d) 485.
Reibl v. Hughes [1980] 2 S.C.R. 880.
Schuurs v. the Netherlands, App. No 10518/83, 41 Dec., & Rep.186, 188–189, 1985, European Commission of Human Rights, Council of Europe.
Starson v. Swayze, [2003] S.C.J. No. 33.
Stetler v. Ontario Flue-Cured Tobacco Growers' Marketing Board, 2005 CanLII 24217 (ON C.A.), from http://www.canlii.org/on/cas/onca/2005/2005onca10505.html
TB-03-0089, 0090. CCB.
TO-01-894, 895. CCB.
TO-02-1167. CCB.

TO-03-0804. CCB.
TO 03-1454. CCB.
TO-05-7474, 7475, 7476.
Van der Leer v. The Netherlands (1990) 12 EHRR 567.
Victor Rosario Congo v. Ecuador, Case 11.427, Inter-Am. C.H.R. 63/99, (1999), from www.cidh.oas.org/annualrep/98eng/Merits/Ecuador%2011427.htm
Winterwerp v. The Netherlands (1979) 2 EHHR 387.
X. v. the United Kingdom, judgment of 5 November 1981, Series A, No. 46.