THE CHALLENGE OF THE CANADA ACT, 1982
TO EXISTING MENTAL HEALTH LEGISLATION:
IMPLICATIONS FOR PLANNING, MENTAL HEALTH LEGISLATION
AND RIGHTS IN CANADA

BY

BEATRICE ANN GEDDES

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Department of Health Care and Epidemiology

The University of British Columbia
1956 Main Mall
Vancouver, Canada
V6T 1Y3

Date April 26, 1984.
ABSTRACT

With the proclamation of the Canada Act, 1982 there has begun in Canada a questioning of legislation that is restrictive of human rights. Mental health legislation is an example of a restrictive act in that it defines procedures for enforced or compulsory treatment procedures that remove certain human rights.

This study examines mental health legislation in the light of the challenge posed by the Charter of Rights and Freedoms entrenched in the Canada Act by using a descriptive analysis of legislation. Legislation in Canada, and mental health legislation in England and Canada are examined according to their administration and subject development. The mental health acts for five Canadian provinces are used for the sample.

The framework of the study is that of a planner commencing with problem definition, analysis and resultant solutions or recommendations. The planner in this context advises on legislation, and on the implementation of legislation.

From the analysis of the study it was found that legislation is interactive with the economic, technological and social value issues within society. For mental health it was noted that the legislation does not address health or treatment but rather compulsory treatment of individuals deemed to be "mentally disordered" and in need of treatment.
for their own or society's protection. As well, it was found that the label "mental disorder", defined differently in each province, results in the application of restrictions on an individual so defined, in the contents of other provincial acts.

As Canadians are not asking for the removal of compulsory treatment procedures but for a recognition of rights and freedoms, this study makes recommendation to address the limiting items in mental health acts so that injustices in provincial statutes do not continue.
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Chapter I
INTRODUCTION

In 1982, with the proclamation by the federal government of the Constitution Act, the contents of existing statutes in Canada assumed a new significance. The Constitution Act, 1982, with the Charter of Rights and Freedoms entrenched within it, was developed by all the provincial governments jointly with the federal government. The former constitutional document, the British North America Act, 1867, (BNA Act) reflected the British tradition of constitutional legislation in that it did not address rights and freedoms explicitly. Now values that individuals have recognized as integral and essential to a nation, like the right to life, liberty and security of person, are protected, not in provincial statutes but in an act for Canada. These values are no longer restricted by place of residence or judicial interpretation of relevant statutes.

The Charter of Rights and Freedoms lists the rights and freedoms that are guaranteed in twenty-four of the thirty sections making up the Charter. These values are proclaimed subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society. The section headings in which the freedom or rights are proclaimed are:

(i) Fundamental Freedoms
(ii) Democratic Rights
All of the Charter has relevance for study of mental health legislation but particularly important are the sections regarding fundamental freedoms; democratic, mobility, legal and equality rights, and enforcement. Those sections guarantee that the freedom of conscience, religion, thought or opinion, and expression thereof, including freedom of the press or other media of communication will not be based upon provincial residency or membership of a majority group but are to be enjoyed by all Canadians. The right to life, liberty and security of person and the right not to be deprived thereof except according to the principles of fundamental justice; together with the right not to be subject to any cruel and unusual treatment or punishment; and the right not to be arbitrarily detained or imprisoned are examples of matters that pose a challenge to existing mental health legislation.

The Constitution Act, 1982 (Constitution Act) is a
A federal statute developed over a period of ten years of bargaining at formal federal-provincial conferences and at discussions of bureaucrats and politicians holding this assignment. The response of the provincial governments to this overriding federal act has been guarded and is only now beginning to be worked through. With the provincial governments indicating their commitment to the proclamation of the Constitution Act at the Constitutional Conference of November, 1981, there is reason for these governments to make their own statutes conform to this recent statute.

The provincial governments, in their efforts to attain congruence between federal and provincial acts, raise the issue of responsibilities assigned to the two levels of government by the earlier "constitutional" document, the BNA Act. Health, civil and property rights are examples of matters given to provincial governments to administer. However, since the proclamation of the BNA Act, there has been a change in the responsibility assumed by the federal government regarding rights and freedoms and regarding health, in particular, the financing of health services. Over the years the government has recognized that values and beliefs such as freedom, human rights, health and availability of treatment are not bounded by the geographic structure of provinces.

Health legislation is the general designation for statutes that provide for the administration of services
like hospitals and for compulsory treatment of diseases; examples are hospital acts, venereal disease acts, tuberculosis control acts and mental health acts. In this study it is proposed to examine one component of health legislation, the provincial mental health acts, to determine whether there is concordance with the Constitution Act and, in particular, with the entrenched Charter.

Mental health legislation has been chosen because of the concerns raised by the restrictive nature of the contents in the acts. In providing for the treatment of the mentally disordered, these statutes include sections to apprehend and contain certain of the disordered in order to provide compulsory treatment. This process may be compared with a criminal procedure in that apprehension and containment are similar, but for the criminal, unlike the disordered, there is a process to establish the guilt and the punishment to be given. Mental health acts, written to promote mental health as an outcome of the compulsory treatment, lack similar procedures to establish illness and appropriate care and therefore may be restrictive in the current Canadian scene. It is timely for the examination of existing provincial statutes given the recent enactment of a "new" Constitution.

The question under study for this paper is to determine whether the contents of the provincial mental health acts are restrictive of the rights and freedoms that are now protected in the Canadian Constitution and the implications
of the findings for a planner of provincial mental health services. This study will examine and analyze the contents of five provincial mental health acts selected to represent:

(i) all the regions of Canada;
(ii) the French and English legislative roots;
(iii) recent and early proclamation; and
(iv) large and small provincial populations.

The selection of five provincial mental health acts from the ten provinces was made with these variables in mind.

The method used to analyze and discuss the question follows generally a qualitative approach described by Glaser and Strauss. This method of analysis is particularly suited for subjects that are in a continuous state of change like social issues. In Chapter II, the method of analysis for this study is described.

In Chapter IV the division of authority between the federal and provincial governments is reviewed. However, the emphasis is on governmental responsibilities for health and mental health and the problems that have arisen from this structuring.

Next follows the analysis of the contents of the mental health legislation to reveal the sections that are impacted by the Charter of Rights and Freedoms. The legislated authority ascribed to a federal or provincial instrument is considered along with the rights and freedoms written in the Charter. The concepts of mental illness written into laws
are reviewed vis à vis the restrictions embodied in the acts.

In Chapter VI, the differences in the contents between the five provincial mental health acts will be described, noting especially those sections that impinge upon the issues of rights and freedoms. Included in this chapter are the limitations the mentally disordered suffer because of the contents of other provincial acts.

This study first considers the challenge created by the Constitution Act on the existing provincial mental health acts and subsequently proposes a plan for change. A planning framework defines a problem, examines and analyzes the variables of the problem, then develops a set of solutions or recommendations. In this context, the restrictions contained in mental health legislation create a problem for those who are mentally disordered and for those who administer the act. The outcome of the analysis of this problem is stated in the final chapter.
Footnotes

Chapter II
WHY EXAMINE MENTAL HEALTH LEGISLATION AND THE RIGHTS ISSUE?

For much of Canadian history there has been no piece of legislation specifically written to protect rights and freedoms. These values were regarded by the early political leaders to be social matters and sufficiently protected by the traditions of the judiciary and government. However, a general interest in rights and freedoms has been emerging since World War II. This interest was given shape and recognition in 1960 when the federal government passed a Bill of Rights. As well, in the years that followed, many provincial legislatures enacted human rights legislation.

The enacting of the federal and provincial instruments to assure the protection of rights and freedoms was not the end result of the issue. These governmental activities were part of the process that culminated in 1982 with the proclamation of the Constitution Act. This federal act was a recognition at the national level of the necessity to write into legislation and make explicit the rights and freedoms of Canadians along with other constitutional matters. These social values are not limited by legislative or geographic boundaries but are part of the social fabric of people, wherever they may reside. Considered in the development of this particular enactment were the demands of minority ethnic groups, special interest groups and the handicapped. Each presented their concerns about restricted
rights to the public generally and governing bodies especially. These issues were not discussed in Canada only but were recognized internationally. The International Year of Disabled Persons, 1981, or the United Nations Decade for Women, 1975 to 1985, for example, gave focus to the promotion of action taken on behalf of the particular group.

A major thrust in the twenty years following the passage of the Bill of Rights was the federal-provincial constitutional discussions. These meetings provided a forum to address the issues of rights, freedoms and legislative responsibility. The event of invoking the War Measures Act by the Prime Minister in the province of Quebec in 1970 gave prominence to the values of freedom of speech, of the right to associate in groups and not to be detained without just cause. As well, this action indicated the authority of the federal government in relation to a provincial government matter.

The assignment of various subjects either to federal or provincial bodies was established in sections 91 and 92 of the BNA Act, and will be discussed more fully in Chapter IV of this study. At this point, suffice it to mention that property and civil rights were matters that appeared to be assigned to the provinces. Consequently, the passing of legislation by the federal and provincial governments on the same subject can create jurisdictional problems. Thus, in regard to rights and freedoms, the federal government became involved in what had earlier been a provincial matter. So,
from 1970 to 1982 there was confusion regarding governmental responsibility for rights and freedoms and, as well, new implications were created regarding the restriction of these values in many pieces of legislation, mental health statutes being one example.

**Implications for Mental Health Legislation**

With the proclamation of the Constitution Act, the contents of various federal and provincial statutes require study to ensure that potentially conflicting items are clarified. In the BNA Act, health matters generally and mental health specifically were assigned to the provincial legislatures. At the time of writing that instrument (1867), mental ill health was defined as insanity and treated or contained in an asylum. Since the Act was written long before governments became involved in taking much responsibility for social welfare, including health, the wording is not specific and subject to interpretation. It states in section 92(7) that the province is to provide and maintain asylums.

As many health treatment modalities have changed in the years since 1867, so too have the services for the mentally ill. "Asylum" is no longer a word used generally by the public or health professionals. Now an asylum is replaced by a psychiatric facility or hospital that offers a treatment program, not just custody. Since each province has the authority to legislate for and administer services
for mental illness, there have been many changes in the acts regulating the facilities and services necessary to treat the disturbed. However, the changes in treatment procedures have not caused major changes in the contents of mental health legislation. The matter of compulsory treatment still remains an essential issue or core matter written in all the provincial acts. It is this part of all the statutes that is restrictive of individual rights and freedoms proclaimed in the entrenched Charter of Rights and Freedoms and that may be perceived to conflict with the Charter. (The Charter was described in Chapter I and is presented in further detail in Appendix A.)

Reasons for Choosing to Study Mental Health Legislation

The legislation governing an aspect of health care or the regulation of professional practice is not always evident to all the professionals working in health services. Nurses, psychologists and other health professionals may care for individuals in hospitals or community clinics for a long time before the contents of a hospital act or other relevant acts are brought to their notice. However, mental health professionals usually have reasonably good knowledge of the section of the mental health act that describes compulsory treatment. This knowledge is a necessary aspect of any psychiatric program.

With a background of many years in community psychiatry, the writer already had an interest in mental health
legislation, especially the effects of the compulsory aspects of it upon the mentally ill.

This interest was given focus and shape during a student clerkship in 1980. One of the tasks in the clerkship was to review all the provincial mental health acts and to document or catalogue their contents. At this time the task was regarded as important because there had been discussions by the provincial directors of mental health services regarding the difficulties of administering a provincially bounded service with the jurisdictional problems created by the mobility of the disordered. The other concern was the recognition that rights and freedoms legislation might affect existing mental health acts. The mobility of Canadians created the special concern of these directors, that of applying the mental health act of one province in the province where the "involuntary patient" had relocated. To take an example, if a physician had completed a certificate in British Columbia stating that a person required compulsory treatment for mental disorder and within 15 days of the signing of that certificate that person took a bus to Ontario, would the Ontario health authorities be obliged to apprehend and treat the person or apprehend and then return him to British Columbia for treatment? The resolution of problems of this kind requires time and expenditure of mental health program funds. The directors were questioning whether a standard act applying to all Canadians might be
necessary; consequently, they wanted to know whether each of the provincial acts governing their decisions needed to be brought into line with the other ten acts.

In looking at the contents of the ten provincial acts more closely, it became evident that the problem was complex and that more study of mental health legislation needed to be done. The following questions had become apparent:

1. Were all mental health acts restrictive in that they have sections regarding enforced treatment and custody without voluntary consent?

2. Have these issues always been in acts for the mentally ill and is there a likelihood that they may remain?

3. Many restrictive acts have review and appeal procedures. Were similar procedures laid down in all the mental health acts?

4. Was the wording loose and subject to interpretation and, if so, what changes needed to be made?

Some of the questions had no immediate answer but served as a stimulus for this project.

Selection of Provincial Acts

During the initial review of all the ten provincial mental health acts, it was noted that in the contents of all were sections that now conflict with the federal Charter of Rights and Freedoms. But for the purpose of this study, only five of the provincial statutes were selected. The selection was made considering the variables of geographic
representation, large and small provincial population variation, French and English legislative traditions, and recent and earlier dates of enactment. The provincial acts selected are from the provinces of British Columbia, Saskatchewan, Ontario, Quebec, and Nova Scotia. These acts do reflect mental health legislation in Canada.
Chapter III
METHOD OF ANALYSIS

In this chapter, the writer will describe the method of analysis used to develop the recommendations for change regarding provincial mental health legislation.

This study is not one of questioning the necessity of mental health legislation nor of the implications of implementing the statute nor if it should have a medical or social focus, but rather it examines the content of the mental health acts to learn if the rights of the mentally ill are not restricted. The subject is mental health legislation and the sections of the legislation that are considered restrictive. Since statutes are not static but subject to the pressures of the society and the government for whom and by whom they are written, qualitative analysis underlies the approach. As David Weisstub, a leading Canadian authority on the law, states: "Law is a product of the society in which it is formulated and enforced as well as being a derivative of antecedent societies. It remains subject to continuous pressure for alteration by society."1

With the dynamic nature of statutory instruments, an analysis that incorporates the changes occurring presently and over time is needed. As well, legislation fits in the context of the social environment of a nation or province and requires examination that is sensitive to this. Some of the elements of qualitative analysis described by Glaser

1"
and Strauss in *The Discovery of Grounded Theory*\(^2\) were especially suited to this study.

The analysis can be ordered into four areas, as follows:

(i) a comparative/descriptive approach to provincial mental health legislation;

(ii) an historical evolutionary/comparative approach to English and Canadian mental health legislation;

(iii) a comparative/descriptive approach to federal and provincial legislation; and

(iv) an analytical approach to the issue of rights in the mental health legislation of five provinces.

Following the analysis, recommendations will be made for change in acts of these five provinces in the light of the powers and responsibilities of the provincial mental health administrators.

The question of the study is: "Do the contents of the mental health acts, now in effect in Canada, conflict with the contents of the Charter of Rights and Freedoms?"

The answer to the question will be developed from the perspective of a planner. A planner in mental health has, for this study, two functions: to advise on legislation and to advise on the implementation of it. The legislation is the tool that sets out the authority and boundaries of a subject. In the field of health, for example, there are acts for mental health, venereal disease control, and public health. The written document becomes a tool of social order
when its contents are implemented. The planner, in analyzing a question, will take into account all the factors that are relevant to the problem and its implementation of a solution. The framework used in this study follows the process of problem definition, analysis of the variables, consideration of the implications and conclusions with recommendations. To do this, information and material had to be gathered, reviewed, and used according to the requirements of this study.

Materials and Information Collection

The first step in the preparation of this paper was to obtain a copy of the mental health act or acts for each of the ten provinces. As well, a literature search for journal articles using the key words "health legislation", "mental health legislation" and "restrictions found in mental health legislation" was done. The next step was to conduct a library search in the general field of legislation, law-making and law-writing. This was done in the general library as well as the legal libraries of the University of Victoria and University of British Columbia.

The administrators of the provincial mental health services were written to determine if there were any changes planned for the mental health acts. If changes were planned, the section or sections to be amended was requested. At the time of contact, there were no changes being planned for the acts in this study.
Following the initial collection of material and information on mental health legislation, additional material was gathered on the process of law-making in Canada, the Constitution Act, and other provincial acts that place restrictions on the mentally disordered.

The Scope of the Study

For a subject to be written into law there are basic requirements to be met. The topic must be within the jurisdiction of the government making the law and if that criterion is satisfied the contents are set out according to the established format. The format in this context means or includes the descriptive title, administrative authority of proclaiming government, definition of terms, general and special provisions, and the date of enforcement. Considering these factors and the purpose of this study, mental health legislation had sections that were restrictive, rather than the entire act being restrictive. The study is limited to the following sections in the provincial mental health acts: the title, the definitions, the compulsory treatment and appeal procedures and the sections that recognize patient rights.

Each of these sections of the act are a necessary part of the analysis using a planning framework. This model includes the forces that affect the implementation and development of an act, such as the allocation of human and financial resources required for administration and the
various groups with a special interest seeking to influence the enforcement of the law.

**Limitation of the Study**

The study does not include data on the application of the mental health acts. There are no figures on the number of people treated compulsorily in each of the provinces in the study. This information, although most useful for comparing the use of compulsory treatment procedures between provinces or within a province, is not easily obtained. The information that is available may not be gathered in the same way and from the same sources, thus affecting the validity of the comparisons. The scope of the study is limited to the sections of the five provincial mental health acts described above, and is done in the framework of a planner to provide advice on mental health legislation and its administration.
Footnotes


Chapter IV

THE DIVISION OF LEGISLATIVE AUTHORITY BETWEEN FEDERAL AND PROVINCIAL GOVERNMENTS AND THE PROBLEMS RAISED

The legislative structure was formally set out for Canada in 1867 when four independent Canadian provinces together requested the British government to grant them a "constitution" when they joined in a Confederation. The BNA Act established the two levels of government and set out their powers and responsibilities, particularly in sections 91 and 92 (see Appendix A). The writing and the contents of that document reflect the values and beliefs held by the people of that day. The Fathers of Confederation adopted the traditions of the English parliamentary government and judiciary system for Canada. One implication of transplanting these traditions was not writing into the BNA Act a section on rights and freedoms. Other countries, the United States for example, had written documents or bills on rights and freedoms as part of their constitutions long before 1867. But, England and its loyal colonies guarded the values much less explicitly in the parliamentary process and judicial procedures.

Prior to the signing of the BNA Act, the residents of the various separate colonial jurisdictions of Upper and Lower Canada, Prince Edward Island and Nova Scotia had been administered or managed by appointees of the reigning monarch and parliament of England. These colonies or
provinces developed their systems of government from the colonial experiences of the predominant group of settlers, so that Lower or French Canada followed the traditions of France while Upper Canada and the maritime provinces adhered to those of England and Scotland. The concerns about immigration and quarantine, land clearing and development of the economy and the maintenance of order and justic were organized separately for each area. The BNA Act established the government for all the areas joining in confederation in 1867 and for additional provinces thereafter; e.g., British Columbia joined in 1871 followed by Manitoba, then Saskatchewan and Alberta in 1905 and Newfoundland in 1949. In joining with the confederating provinces, the more recent participants were committed to govern according to the national authority proclaimed in 1867. Matters such as financing services, developing the economy, and managing elections that formerly had been the sole responsibility of a province were now, following confederation, administered according to the assignment of functions declared primarily in sections 91 and 92.

Federal Government Responsibility

The matters within the responsibility of the federal government other than the specifics of electing and organizing government are noted in section 91 of the BNA Act and noted in Appendix A. Generally, the federal government was to be responsible for protection from foreign invasion,
international trade and tariffs, national transportation, communication, banking and the monetary system. The only health matters that fell into the federal jurisdiction were quarantine, the establishment and maintenance of marine hospitals and health services to the native population as part of the overall responsibility to native peoples.

The management or administration of health by the federal and provincial governments is interesting. Health services in 1867 mainly consisted of providing uncontaminated food, water and milk supplies and isolating those people who had recognized diseases. As well, the social norms of the day were for families, the churches and charitable groups to care for their sick and poor, limiting the government involvement to a minimum, especially the national government. So from 1867 to 1919, federal health responsibilities for quarantine and public health were administered by the Department of Agriculture.

It is of interest to note where health was placed in the federal organizational structure from 1867 to now. As stated, for forty years it was in the Department of Agriculture. Then, following the swine flu epidemic of 1919, health was transferred from Agriculture to a separate Department of Health until 1928. In 1928, the Department of Health was joined with the Soldiers Civil Re-establishment Section to form the Department of Pensions and National Health. This structure remained until 1944, when two
departments were created: the Department of Veterans' Affairs and the Department of National Health and Welfare. The latter department still exists and has within it the following divisions:

- health services to Indians, northern residents, the federal public service, immigrants and civil aviation personnel
- quarantine services
- food and drug inspection, Narcotics Control
- environmental health (radiation protection)
- hospital and medical care insurance with the provinces
- poison control
- aid to the blind
- medical research
- health promotion, fitness and amateur sport (reporting to a separate minister of state).

The organizational changes outlined above, in part mirror the events occurring throughout all parts of the nation such as technological advances, economic cycles, population increases, wars and the rise of pressure groups for the handicapped or disadvantaged.

Nationally, mental health was a subject recognized in the organizational structure of the Department of Health from 1922. Although the Department had no authority to deliver services for the mentally ill, the Division of Mental Health was central in the assembling, co-ordinating
and disseminating Canadian ideas about the organization of services and treatment for the mentally ill. The Advisory Committee on Mental Health was an active part of the Division for twenty years from 1946 to 1966. The journal Canada's Mental Health, in its thirtieth year of publication, is one example of the output from the Division of Mental Health.

Before turning to the responsibilities of the provincial governments for health, a brief comment on the fiscal activities of the federal government is necessary in a review of legislative development. The BNA Act specified the authority of the national and provincial governments to tax so as to raise the funds necessary to implement the various programs. The provinces could apply direct taxation on individuals and businesses for provincial purposes, whereas the federal government applied tariffs and any mode of taxation according to the BNA Act. This system was satisfactory for the early years after Confederation but with World War I and the depression years these original fiscal arrangements became strained. In order to reduce the financing pressures the government was experiencing, the federal government instituted a personal taxation, primarily to assist with the war expenses. With the passing of the Income Tax Act, this preliminary arrangement became a permanent tax and federal government involvement in the provincial fiscal arena gradually increased.
The government programs like public health and veterans services required increased funding because of demands arising from a growing population and new technology. With the social, technological and economic changes in Canada from 1867 to 1935, the federal government recognized that a thorough investigation of federal-provincial responsibilities was needed and to that end appointed a commission. The Royal Commission on Dominion-Provincial Relations (referred to as the Rowell-Sirois Commission) was appointed in 1937 and reported to Parliament in 1940. This was the first objective assessment since 1867 of the economic and financial basis of Canada and the distribution of federal and provincial powers. This was an important document for the future direction of financial arrangements of the federal government. The recommendations from this report were not all implemented immediately but many of them, especially regarding taxing and federal grants to the provinces, were eventually acted upon. Thus, the Dominion accepted responsibility for old age pensions, unemployment assistance (now insurance), health insurance and aid in natural resource development. These new undertakings in resource allocation were assumed by agreement with the provinces following negotiations rather than by constitutional entrenchment.

The federal government then passed a number of acts that indicated its new role in the health care system. With the Health Grants Act, 1948; the Hospital Insurance and
Diagnostic Services Act, 1957; and the Medical Care Act, 1966 each of the statutes gave more visibility to the federal government on a social policy matter via financing health programs. The changing role of the federal government in health followed along with the change within the population; that is, health no longer was a private concern but a service available to all. To fully describe the changes in federal financing, especially that of health, would require much more space than is possible in this study. For this study it is necessary to note that funding services is an essential part of the policy enacted by government.

Provincial Government Responsibility

Health has been one of the matters assigned to the provincial governments in section 92(7) of the BNA Act that states: "the Establishment, maintenance, and managements of Hospitals, Asylums, Charities and Eleemosynary Institutions in and for the Province, other than Marine Hospitals." At the time of confederation, individuals and their families were used to caring for those members who were ill. Immunization against communicable diseases had not been greatly developed and certainly medical knowledge limited treatment to a few surgical procedures, a minor pharmacopeia and to rest in bed. The mentally ill were placed in asylums that did little more than provide custodial care.

The organizational structure of the provinces under study will be described now for mental health rather than
for health generally. British Columbia placed public health, mental hospitals, homes for the aged and vital statistics within the Department of the Provincial Secretary until 1947. With health care for the most part considered to be the regulation of professions and control of communicable diseases by the government, it is reasonable to have health so placed in the administrative structure. The Institute for the Insane of British Columbia was located in Victoria from 1872 to 1877 when it was relocated to New Westminster. This one psychiatric service was expanded in 1947 with the Child Guidance Clinic in Vancouver, followed by continued development of community mental health services. With the establishment of a Department of Health and Welfare, 1946, public health and all community health matters were removed from the administration of the Provincial Secretary, who retained mental health and hospital inspection. Mental health was finally placed within the administration of the Department of Health in 1959.

Saskatchewan, entering into confederation in 1905, had a fairly well developed administrative structure for health services. In 1905 psychiatric services consisted of two provincial mental hospitals, one at North Battleford and one at Weyburn, and a psychopathic ward in the Regina Hospital. The Department of Public Health administered the latter services in Regina as well as medical and general hospital services. The Department of Public Works administered the
two provincial hospitals until 1950 when the administration was transferred to the Department of Public Health, Psychiatric Services Branch. It was interesting to note in the early description of the functions of the Department of Public Health that there was to be an evaluation of the treatments available. Research and development was an acknowledged responsibility of the Department.

The development of the administration of health programs in Ontario is interesting. From 1864 to 1930 hospitals and provincial asylums were under the jurisdiction of the Inspector of Prisons and Public Charities who reported to the Provincial Secretary. In 1930 the Department of Health established a division to supervise and license private hospitals, to inspect and administer grants to public hospitals and to maintain the mental hospitals known as the Ontario Hospital and mental health clinics. This was a new division added to the division already administering public health matters. In 1950, the Department placed mental health in a division for that purpose alone. Public Health administered by the Provincial Board of Health from 1882 submitted its reports to the Provincial Secretary, then the Minister of Labour, then in 1924 to the Minister for the newly created Department of Health.

In Quebec, the Provincial Secretary had health matters as part of the portfolio until 1936. Health was a separate department until 1972 when health was linked with social
services. Mental health came under the division of health responsible for inspection of prisons and asylums. Psychiatric hospitals managed or administered by religious orders like the Grey Nuns appeared to report directly to senior managers in the Department of the Provincial Secretary prior to 1936. In Quebec the religious orders of the Roman Catholic Church provided hospital and charitable services. With this resource in the province, administering health services took a different form from that of the rest of the provinces. The church provided an important service by encouraging its members to give donations to institutions and in some cases to enter religious orders to provide care to the sick. For this study, the administration of mental health services by government is of prime interest and the social context of this province is reflected in its administration of these services. The services managed by religious orders were not a major part of government administration and mental health was primarily a governmental service.

In Nova Scotia, the last province included in the review of the assignment of health within the government structure, the Board of Commissioners of Public Charities established in 1878 was responsible for the Nova Scotia Hospital for the Insane and the Victoria General Hospital in Halifax. The Board of Commissioners was then put under the Commission of Public Works and Mines from 1884 to 1910. Then,
for nineteen years these facilities were administered by the Department of Public Charities. Following a two-year period in the Ministry of Public Works and Mines, Humane Institutions, Nova Scotia Sanatorium, Victoria General Hospital and the Nova Scotia Hospital were assigned to the Department of Public Health in 1931. Community health matters like the control of tuberculosis and venereal diseases had been the responsibility of the Provincial Board of Health under the Provincial Secretary from 1893 to 1931. Thus, in 1931, the Public Health Department had in one department both community health and hospital care, including mental health.

Changes Impacting Upon Mental Health Legislation

It has been said that "an act of law is the product of the society in which it is formulated and enforced as well as being a derivative of antecedent societies and it remains subject to continuous change."¹ Canadian life style has changed dramatically since 1867 with the advancement of transportation and communication systems and expanded medical knowledge regarding treatment. These social, economic and technological changes have separately and collectively had an impact upon legislation but with the recognition that the legislative changes occur after a lapse of time. Legislative changes and social structural changes are interactive.

Effect of Social Change on Legislation

The social structure of Canadian society has moved from
being based upon an extended family unit carving out a livelihood on a homestead or farm to a "blended" mobile family working in urban centres. More children now grow and develop in a family with only one natural parent or a step-parent and step-siblings than was the case thirty years ago. The move to the cities began in the 1930's following the first World War and during the Depression which dramatically affected the prairie farmers. This trend continued so that now the agrarian population has diminished and the urban-suburban population predominates. Now care for the sick and health care generally is provided by professionals funded by government in a context of absent extended family members and of highly technical and complex treatment procedures. Responding to these social changes were changes in the mental health legislation in the thirties and again in the late 1960's and thereafter.

Another perspective on laws stated by Blondel is that "the statutes are always to a greater or lesser degree behind the reality, the statutes changing in periodic jumps in a vain effort to keep up." The law is part of the structure of society so that all the interactions of social groups impinge upon the making and maintenance of statutes. Thus, the change in family structure and place of residence has had an impact upon health legislation in that less care can be provided by family members and governments are urged to provide more services.
Effect of Economic Change on Legislation

The first World War followed by the Depression in the 1930's were significant events in the recent history of Canada and moved the governments, provincial and federal, to consider offering more or different social services, including medical care. Insured health or medical care was discussed and described in 1935 in British Columbia governmental reports but not proclaimed in legislation. Health funding was put aside for the years of the war until 1948 when the Health Grants Act passed by the federal government injected funds into the provinces for health care. Mental health services benefited from the statute by being recognized as a component of the medical care system, not as a separate organization outside the mainstream of health care. Two additional pieces of legislation that had a direct effect on the health care system were the Hospital Insurance and Diagnostic Services Act, 1957, and the Medical Care Act, 1966. All these acts, primarily financial in purpose, affected health legislation and medical practice in all of the provinces. The federal government, through its fiscal responsibility, began to play a major part in the health care system. Its part was not to remain small but gradually assumed significantly large proportions. Provincially, mental health services were all administered by Departments of Health by 1959 through legislated measures.
Effect of Technological Change on Legislation

Knowledge about disease and its treatment has expanded dramatically since 1867. New technical devices and chemical discoveries have aided both the diagnosis and treatment of disease. New therapies have been added to the physician's armamentarium for the treatment of infections, cancer and mental disorders. Mental illness treatment procedures with the advent of chemotherapies have changed from custody in an asylum to community based treatment provided by psychiatrists and other professional clinicians, thus allowing the disordered to remain at home and, when feasible, continue employment. Most of these changes in psychiatric treatment took place after 1960 with the discovery of psychotropic medication. With more people being treated while at home, there has been a change in the perception of mental illness by the general population. The mystique surrounding the mentally ill has lessened and unusual behavior associated with it is more tolerated. Treated individuals have participated in group actions on behalf of the mentally ill confined in units primarily used for custody. Legislation for mental illness written since 1960 does indicate that treatment is provided in community facilities as well as in-patient facilities.

Another technical development that has had an effect on our way of life as well as our attitudes towards mental illness is improved distant communication. With radio, television and computer technology, new ideas are shared and
validated amongst a wider audience with ease. It is more
difficult now to ignore situations or proven hypotheses when
the information is made available so broadly. For the mentally ill the asylum is no longer remote. Mental hospitals are now readily accessible to the public with the use of television cameras, radio documentaries, telephones, or simply with automobiles. More people can visit psychiatric institutions. With more open communication the public can be exposed to media presentations of treatment given in mental hospitals. Special interest groups concerned about the mentally ill made use of these opportunities to publicize the injustices in the treatment of the mentally ill.

In summary, health legislation has changed in Canada with the federal government assuming a more active part in the financial arrangements for health services. This change in funding arrangements has not removed the responsibility for providing health services delegated to provinces in 1867. The role of government, in particular, the provincial government, has increased in the last 100 years with individuals and their families being responsible for purchase of care rather than giving care. Mental health legislation has retained the compulsory treatment item present in all the earlier statutes. With new technology, changed economy, and an increasingly mobile society, the statutes have not removed the enforced treatment aspects of psychiatric care. The legislation has merely added to the
core element of custody, opportunities for administering treatment services outside the hospital.
Footnotes


Chapter V

DESCRIPTIVE ANALYSIS OF MENTAL HEALTH LEGISLATION

In the preceding chapter, discussion of the assignment matters to federal and provincial governments indicated that health and mental health regulation was the responsibility of the provinces. As well, the interaction between social, economic, and technical developments and this regulatory legislation was described briefly. In this chapter, mental health legislation will be analyzed beginning with the basic content of an act, the evolution of the statutes for mental health in Great Britain and Canada, and the process of development of legislation in the federal and provincial governments. In the next chapter a comparison of the contents of the current provincial mental health acts will be undertaken.

Content of Mental Health Legislation

In Canada acts of Parliament have a format that is consistent no matter what the subject. The act is titled and numbered by chapter according to the provincial or federal governments revised statutes. For example, in the Revised Statutes of British Columbia 1979 (R.S.B.C. 1979), the current Mental Health Act is Chapter M. 13, 1978 and in Nova Scotia mental health is found in the Revised Statutes of Nova Scotia, 1967 (R.S.N.S. 1967) Chapter 249, 1978, the Hospitals Act.

Following the title, the contents of the act are set
out, first with an introductory statement; followed by the
definition of terms and of the authority given to administer.
The body of the act includes general provisions and special
or exceptional provisions. This is followed by a list of
the regulations and, finally, the date that the act comes
into effect. In 1915, Canadian Bar Association established
a committee with representatives from across the country to
promote uniformity of the legislation in Canada. From then
on, this group has reviewed the legislation on many subjects;
however, mental health legislation was only recently
reviewed, in 1980. But their rules of drafting legislation
have established a basic outline that insures certainty and
clarity of meaning and conciseness of expression in all acts.
Thus, both federal and provincial statutes are written in
the same manner but it is the treatment of the subject that
reflects a provincial perspective. For example, the extent
or comprehensiveness of definitions in the statute can
result in variation between provinces, or if in a mental
health statute, mental retardation, alcohol and drug
addiction are included in the definitions, provincial
differences can be noted.

The definitions of terms, following the statement of
introduction or short title, are of prime importance in the
application or interpretation of the legislation. The
definitions state who is to implement the act and to whom
the contents apply. In mental health instruments "physician",
"director", "administrator", "mental health worker", and "patient" are defined according to the purposes of each particular act. "Director", for example, may mean the individual in charge of all the provincial mental health services in one act or of one in-patient or out-patient facility in another. The government department or ministry responsible for the administration of the act is noted in the definition of "Minister." As noted in the previous chapter, health and mental health acts would have named the Minister of Mines and Public Works in Nova Scotia in the definitions for the period of time 1890 to 1919 and the Provincial Secretary in British Columbia in the 1930's and 1940's.

Following the definition is a short section stating the principle or intention of the act. And this section enunciates in a concise form who has the authority to administer the act. It is this statement that, in effect, commits the government to regulate the procedures, services or actions proclaimed in the statute. Although the authority is stated in a short, simple sentence, the implications resulting from exercising the authority can be complex and far-reaching. Some of the implications of these mental health laws are restriction of rights, loss of freedom to communicate and others to be noted later in this chapter. The general and special provisions which follow next make up most of the content of an act. For mental health,
the main consideration is the provision for and prescribed procedures regarding compulsory treatment. The method by which compulsory treatment is to be put into effect is set down; i.e., the process to be followed by one or two physicians is established with its limitations and the necessary documentation; alternatively, the nonmedical commitment process via magistrate or judge is described. As well, in the general provisions are matters such as appeal against compulsory treatment, absence from treatment facilities without authorized leave, confidentiality of records and release of information. In all provincial mental health acts is a section providing for individuals who face charges under the Criminal Code of Canada and are deemed to be mentally ill. The final section of the act is the statement giving the date that the statute comes into effect.

A list of the regulations may be attached after the statement of the effective date or just prior to it. This list of regulations outlines or, rather, specifies items that may be delegated through the authority of the Lieutenant-Governor in Council. By this mechanism, the government can administer within the authority of the act while addressing the changing requirements of the principal purpose of the statute. Legislation is written in terms that are somewhat general. Regulations are more specific but can be amended as needed to meet the current situation, while legislation
is revised infrequently and through parliamentary procedure in the legislature. Some citizen groups have questioned governments that administer mainly by the use of delegated legislation, viewing this as governing outside the parliamentary system, relying instead upon executive activity of the governing party.

An analysis of the contents and order of the statutory instruments relating to mental health in Canada indicate that there is considerable uniformity in the written laws. The Canadian Bar Association rules of drafting legislation have clearly served as a guide to the provincial writers of these laws. For this particular study, the sections of the mental health acts that are under scrutiny are the definitions, compulsory treatment procedures, appeal and review processes, and statements of rights. All but the definitions are part of the general provisions of the mental health legislation and relate to the issue of rights and the impact of the new Constitution Act. The remainder of this chapter will focus on the concepts of mental illness and how they were addressed in laws. This information is useful prior to the analysis of sections of study in the provincial acts.

**Historical Evolution of Concepts Relating to Mental Health in England**

In England, prior to the mid-1800's, mental illness had been viewed as demon or spirit possession, not an illness.
The religious groups were charged with casting out the evil within persons. This was a time when witches were ostracized and sometimes burned by the community. Aside from that group of "nuisances", others who were a problem for the community, in particular, the vagrants, were subject to the benevolence of the government, lord or king. The mentally ill, who were often vagrant poor, have had a long history of being the outcasts of the community and subjects of restrictive laws.

At this point, it is important to add a comment about the link between mental illness and poverty. At the period when the legislation was first written, the English social structure was organized on a feudal system. The lord and overseers cared for or managed the property and business associated with their holdings. The people who did not work or provide a useful service because of weakness for any reason were a nuisance to their families, guardians or masters. In some areas, charitable organizations provided shelter as did religious groups but elsewhere the community had to care for its residents who were poor and without identifiable support. The other "nuisance" group needing care were the disordered without families. So the facility, a poorhouse/asylum, was built away from the town to house the unwanted members of the community. Some of the behaviors of the poor were similar to the disturbed so it seemed reasonable to deal with all these people in one place. As
paupers did not contribute to the wealth of the community, their social rights were of no consequence and so were disregarded. Legislation for the poor and the mentally ill incorporated these social values of worthlessness at the time when the two were treated under one law. These concepts no longer co-exist as they did in the 18th and 19th centuries but vestiges of those social values remain. In the application of today's mental health legislation, more people in the lower socio-economic category are compulsorily treated in large provincial mental hospitals and fewer by psychiatrists in their offices. This is cited as an example to clarify the relationship of legislation to social values, not of the use of application of legislation.

Mental health legislation has had a long history. Not always have the statutes been written in the present form nor was the content the same as it is now. Statutes have reflected the contemporary view of mental disorder for a society. The focus of the law at any particular time was limited to the needs that the government of the day was prepared to address and the evolution of legislation has been dependent on the evolution of ideas about custody, treatment and society's tolerance of deviants.

Development of English Legislation

The essence of early restrictive laws was the protection or containment of the disordered person and care of his property. In the 18th century England there was considerable
concern about the exploitation of heirs and heiresses by their legal guardians who could have them confined as lunatics although, in fact, they may have not been mentally ill.

In the mid-19th century, England began to enact new kinds of legislation from instruments regulating institutions to ones controlling people. Among the sources of pressure for change were concerns about the treatment of King George III who was known to have suffered greatly from the restraints put upon him because of a mental disorder. Parliament had inquired into the necessity for this form of "care." At that time, as in the present, the social, technological and political issues affected the content of legislation. New treatment methods developed in France by Pinel, who removed the chains from his asylum patients, led to the development of the moral treatment ideas of English Quakers and the subsequent reform of private mental hospitals. Poor law institutions and, later, asylums lagged behind in the use of newer forms of treatment. Gradually, however, the mentally ill were separated out from the paupers and were sent to special insane asylums built for their custodial care. These were intended to provide moral treatment and limited rehabilitative care.

With these changes in concepts of treatment, legislative changes were made between 1845 and 1891. The thrust of the new acts was the recognition that the disordered needed
treatment and might benefit from it and that custody alone
was of little value. In this period, the legislation had
physicians named as the treaters of the ill. Custodial
aspects of treatment were not removed from these statutes,
but custody now meant containment-with-treatment, not solely
containment. The recognition that poverty and insanity were
not synonymous (although initially provided for under one
act) took time to be acknowledged separately in the laws.

Society's view of mental illness problems is shown by
the changes in the titles of the Acts from Lunatic to Idiot
to Mental Treatment and finally to Mental Health Act. A
list of the acts passed between the years 1845 and 1959 by
the Parliament of England in part indicates the change in
focus from merely restrictive custody to such treatment as
could be made available at the time:

1845 Lunatic Act
1853 Lunacy Regulation Act
1853 Lunatics Care and Treatment Amendment Act
1853 Lunatic Asylum Amendment Act
1862 Lunatic's Law Amendment Act
1886 Idiots Act
1889 Lunatic Law Amendment Act
1890 Lunacy (Consolidated) Act
1891 Lunacy Act
1921 Local Government Act
1930 Mental Treatment Act
Many items in the acts continued to be set out as before like the admission criteria, the place of confinement, who gave the label of "mad" or "insane" and what that meant at that time. There was also included a procedure to remove individuals from the community to the asylum and a definition of the worker designated or authorized to implement the procedure. However, the labels describing the afflicted did change from lunatic and idiot to mentally ill and mentally defective. Physicians assumed responsibility for labelling and prescribing treatment. Involved with some removals from open society into hospital (and later return to the community) were those known as Poor or Relieving Officers whose titles became Duly Qualified Officer, then Duly Authorized or Mental Welfare Officer. Also, the police still continued to have a function in removing some of the disturbed from their communities to mental hospitals, though many were brought in by families and friends.

As mentioned above, there were changes in the organization and financing of treatment institutions, though not at first in the financing of patient payment systems. Gradually, however, as the separation of the indigent, the mentally ill and those with illness and poverty was done, treatment for the disturbed was defined within a medical context. With the introduction of the National Health Service in 1946, the
next step was to review the legislation within this organizational context. A Royal Commission on Mental Illness and Mental Defect 1955-1958 resulted in the Mental Health Act, 1959, which provided a model for other countries to follow. One comment made regarding the commission was that varied research investigations were not initiated nor were the major policy changes accompanied by plans for research designed to assess their effects. The Commission was used, rather, to test the "general will" for change. It seems that, despite considerable moves forward at that time, mental health legislation consistently continues to retain procedures for compulsory custodial treatment even when other treatment alternatives exist.

**Development of Canadian Mental Health Legislation**

In Canada, mental illness did not come within the jurisdiction of the federal government, but from the outset, in 1867, it was a provincial matter. As described before, the early statutes were passed to permit the provincial governments to provide and manage asylums. But the underlying purpose of these legislative instruments was much more complex than simply providing a facility to segregate the insane. They addressed the problems of housing the poor, and protecting the community from bizarre, unacceptable behavior in legal phrases that were written in general terms. For mental illness, this format was well suited as diagnosis is not specific and precise.
After the 1930's, each of the provinces began to write about treatment of the mentally ill rather than about institutions in their statutory instruments. The title changes are similar to those found in England, for the Insane Asylum Acts or Insane Hospitals Acts were now retitled Mental Health Acts and Mental Hospital Acts.

In the 1930's or thereafter, the administration of the mental health statutes became part of health department responsibility after years of being in a department like Public Works and Mines in Nova Scotia and in the Inspector of Prisons and Public Charities division of the Provincial Secretary in Ontario.

The protection of the disordered person's property remains part of some of the provincial mental health acts, namely those of Nova Scotia, Ontario and Saskatchewan and in three other provincial statutes not included in this study. Elsewhere, the matter of estates and property is addressed in separate legislation to ensure that the property of patients and others, considered or deemed incompetent, are managed as long as their mental competency is in question.

But even with organizational, administrative and wording changes in mental health legislation, compulsory treatment to protect the individuals and those around them has remained unchanged; so have the assessment procedures and decision making by physicians, police, and magistrates to enforce protective custodial treatment. But now the acts
focus particularly on the mentally ill who require treatment in a medical setting and particularly on those who are compulsorily treated.

Pressures for Change

Changes in legislation are brought about by the actions of politicians, administrators, physicians, lawyers, staff of mental facilities, disordered individuals and their families. Another strong force in the society is the media: reporters for television, newspapers or radio. It is necessary to recognize that interest groups do have to be considered when changes are planned in existing statutes, for it was and is to the politicians that pressure groups direct their views regarding legislation and, in this case, mental health legislation. While the traditional groups within the province supporting or confronting the revised legislation are physicians, lawyers and administrators, new groups which bring pressure to bear are the consumers and human rights advocates.

However, the general interest of the public seems to be protection from dangerous, unpredictable or bizarre acts with the least expenditure of tax dollars, rather than promoting the use of nonrestrictive treatments. The interest of the medical and legal professions is to care for and treat only those rightfully requiring it. In the legislative process these have been the central issues. The legislation has served as a focus particularly for the
interests of political, class, and professional groups regarding mental illness and its treatment.

In British Columbia, the medical group with a major concern are the psychiatrists. For the Medical Association, the Section of Psychiatry provides the forum in which issues of current psychiatric treatment practices are discussed. As well, this group may be requested to review proposals or to offer recommendations on draft legislation or an amendment to legislation affecting mental health services. Other professions active in mental illness treatment such as psychology, psychiatry, social work and psychiatric nursing provide input into mental illness policy development through their professional associations. The point of view expressed by other groups, even those working in the field of mental illness, may not support the view expressed by physicians or psychiatrists, and therefore is necessary in order to have more complete information on the subject.

Since the late sixties, we have seen the development of an active consumer group in British Columbia, the Mental Patients Association. The membership of this group includes treated individuals as well as those still in treatment. It has focused upon the issue of compulsory treatment and the restrictions imposed by this treatment. Other types of intrusive treatment such as electro-shock treatment and psychosurgery have been denounced by this group. The Mental Patients Association supports the concept that appeal
processes against compulsory treatment as well as frequent review periods should be written into legislation. As all the members have experienced psychiatrists' services as recipients, this cohesive group has developed a method of pressuring for change of treatments they consider undesirable. An example of the group's action was at the World Congress of Mental Health held in Vancouver in 1978 when spokespersons made their demands for change more broadly known.

Across Canada there are similar groups established. In Saskatchewan, there is the Schizophrenics Anonymous, in Ontario the Friends of Schizophrenics Society--each of these with groups in other parts of Canada. The longer-established Canadian Mental Health Association founded in Ontario has branches in all the provinces.

Traditionally, the lawyers have had their part in developing mental health legislation and increasingly some may become advocates for rights. At the British Columbia provincial mental hospital one lawyer especially has had considerable influence in the establishment of a mental patients' advocacy office. At the present time, the legal profession may have requests to represent patients in court on cases regarding an unfair procedure of compulsory treatment.

All of these groups, professional and consumer, apply pressure on government in their own geographic areas as well as nationally, for changes to the legislation. Now with a
Charter of Rights and Freedoms proclaimed by the federal government and with the assent of the provincial governments the "interests of the patients' rights" groups will have a new focus, that of ensuring that mental health legislation is not in conflict with the new Act.
Footnotes

1 Magistrates in Canada are the individuals appointed to hear cases for a defined area of the law. The courts in which these officials preside are entirely under provincial control. In the early days, the incumbent may not have had education in law but was considered to merit the position because of demonstrated ability in the community. In some cases, the appointment was made to reward political or other social favors. Included in the duties of magistrates were those of Justice of the Peace. Now magistrates, almost universally, are lawyers.

Stipendary magistrate is a term no longer used in Canada. The Northwest Territory was the last place to use the term, discontinuing it in 1955.

2 Donald Miller, Community Mental Health, D. C. Heath and Company, Canada, 1974, p. 41.

Chapter VI
DESCRIPTIVE ANALYSIS OF FIVE PROVINCIAL MENTAL HEALTH ACTS
AND THE IMPINGEMENT UPON THE CHARTER OF RIGHTS AND FREEDOMS

In this chapter, the Mental Health Acts of British Columbia, Saskatchewan, Ontario, Quebec and Nova Scotia are to be compared regarding the definition, the compulsory treatment procedure, the appeal or review procedure and rights and freedoms.

The Definitions of Mental Disorder

As stated earlier in this study, the terms used for the mentally ill have changed over the years. The definitions of these terms are important in order to clarify the intent and application of the legislation. The relevant terms defined in the acts are "director", "mental disorder", "patient", "physician", "private mental hospital", "provincial health facility", and "involuntary patient." The definitions of these terms as they appear in the five provincial statutes are noted in Appendix C.

The definition of mental disorder varies from no definition in the Quebec Act to the broad one of "any disease or disability of the mind, including alcohol or drug addiction" in the Nova Scotia Act.

All of the Acts require physicians to determine the presence of mental disorder. However, in Quebec the determining physician must be a psychiatrist and in that regard the act for Quebec is an exception to the others. In
Nova Scotia, any physician can determine the presence of mental disorder but a psychiatrist must decide if compulsory treatment is needed. In Nova Scotia, the certified patient is called a "formal patient" or "formal admission."

The determination of the label "mental disorder" is a subjective one since an objective, well developed procedure that has proven infallible is not available at this time. The definition of mental disorder in all the acts has inherent in it compulsory treatment. Mental illness and compulsory treatment are not generally considered together by physicians, psychiatrists and psychologists in the daily practice of their profession. This issue of enforced treatment occurs infrequently but when it does it is incumbent upon the physician or psychiatrist to exercise a judgment and label the patient "mentally disordered." When this subjective process occurs, the individual is subject to the restrictions attendant with enforced treatment.

In the analysis of the five acts, it is evident that there is extreme variation in the provincial definitions. In British Columbia the definition of mental disorder is so broad or imprecise that it could include individuals who are mentally retarded or impaired from excessive alcohol consumption. The application of the definition depends upon the assessing physician and his judgment of the intent of the act relative to the condition of the individual. A Canadian living in Nova Scotia can be defined "mentally
disordered" due to an alcoholism problem and then placed in a facility for enforced treatment. This same individual could move to any other province and not be so defined, or conversely, one who moves to Nova Scotia would be subject to the labelling of the legislation there.

The definition of "mental disorder" in all the provincial mental health acts lacks specificity. Or rather, the precise interpretation depends upon the judgment of the individual applying the definition. For example, in Nova Scotia, at what point is alcohol or drug addiction determined to be "mental disorder"? Or, in British Columbia, is an individual driving a vehicle in a dangerous manner then "mentally disordered" requiring protection for himself or others? The different definitions for "mental disorder" in the provincial acts as well as the discretion given physicians provides the opportunity for unequal application of the legislation within a province and across the nation.

**Place of Treatment**

Generally, all the acts provide for treatment within a facility and those for the province of British Columbia, Saskatchewan and Quebec include community facilities such as mental health clinics designated as centres for psychiatric treatment. The facility is the place where most often voluntary treatment of psychiatric disorders is offered but where compulsory or involuntary treatment may be given. There are other acts that have a section regarding compulsory
treatment for disease (e.g., venereal disease and tuberculosis) but the difference between those acts and the mental health acts is that the compulsory treatment for these diseases does not include custodial care. The treatment for these diseases do not normally require confinement in a facility.

Compulsory Treatment and Rights

All of the provincial mental health acts including that of Quebec have a procedure to place an individual in hospital for compulsory treatment. This practice of removing an individual from the community has a long history dating back to the Roman code of 450 B.C. The procedure has not been removed from the laws 2400 years later. The labels of the disorder or behaviour requiring removal have changed but custody has remained entrenched.

Compulsory treatment procedures have two routes to be completed; one is the medical route and the other is the judicial or legal route. Each method requires that the disordered person be seen either by a physician or a law officer. The physician or a judge then writes or signs orders, often called certificates, to have the individual taken to a facility or hospital that provides compulsory treatment. The judge does not necessarily have to see the disordered person but the physician does. One table has been used to present the medical route graphically. The procedure followed by one or two physicians includes the
time allowed for various steps taken to confirm compulsory treatment, the people needed to complete the process and the times of review and renewal of compulsory treatment (see Table 1).

Table 1 schematically presents the variation in the provincial procedures of compulsory treatment. The time between the individual being seen and the validity of the physician's report, and the time the person may be held in the facility until assessed by the facility's or other specialist staff are two areas of difference between the provinces. In British Columbia, the certificates signed by two physicians are valid to hold a person in a facility for compulsory treatment for one year. The procedures in Quebec allow less time to pass while the various steps are being taken compared to the other provinces. Another difference between the provinces is the period of time lapsed before a review and renewal of compulsory treatment is made. Again, the British Columbia act is the most restrictive, with a year as the time for the first and subsequent renewals. Most other provinces have at least three reviews for renewal in one year. The provincial mental health acts do have wide variations in the way in which they address a common matter, compulsory treatment.

The five provincial acts have a section that defines the review process. The one from the British Columbia instrument is the least developed. There, action depends
upon the patient requesting a review, and to make a request implies that the patient comprehends what is meant by compulsory treatment and also understands that an appeal or review can be requested. The other provinces' statutes describe the procedure, who participates and with what frequency so that the patient does not initiate the action.

In the mental health acts of the provinces included in this study, the issue of rights is not uniformly addressed. Those rights that are included relate to consent to treatment, to confidentiality of records, to appeals or reviews of involuntary treatment, to sending or receiving communication and to having visitors.

Again, each of the provincial acts is different in what is included regarding the matter of rights. For each province, the rights that are mentioned will now be noted.

**British Columbia**

The Mental Health Act for Biritsh Columbia contains little specific information on rights. There is no section on confidentiality of records or consent for treatment. What is stated is that:

the Director of the facility shall send in writing to the next of kin of the patient a notice stating forth the rights of the patient under Section 27. In the event that there is no next of kin known to the Director, notice may be sent to the Public Trustee to comply with the Act.¹

The rights stated in Section 27 are the right to apply to the court for a discharge. As well, in Section 27 it states: "Nothing in this section affects the right of a
person to apply for a writ of habeas corpus or other prerogative writ."

In regard to treatment, the Act states:

that a person over the age of 16 applying on his own behalf to be admitted is deemed to have the capacity to make application and an agreement for payment for maintenance and treatment in the facility and to authorize his treatment in the facility.²

**Saskatchewan**

In the Saskatchewan Act for Mental Health there is no section on consent to treatment or confidentiality of records. Sections 29, 30 and 31 of the Act deal with appeal against involuntary admission procedures. The Act, however, does state:

Communications may be written by or sent to a patient in an in-patient facility without being opened, examined or withheld, and the delivery of the communication not obstructed in any way or delayed except when there are reasonable and probable grounds to believe that the contents of the communication written by the patient would be offensive or prejudice his best interest; or that the contents received by a patient would interfere with his treatment and cause unnecessary distress.³

In this manner the Saskatchewan Act recognizes the right of an individual to express or communicate ideas or wishes.

**Ontario**

The Mental Health Act for Ontario has explicit content regarding rights. The right of consent to treatment is included in this Act by the following statement:

The psychiatric treatment shall not be given to an involuntary patient without the consent of the patient, or, where the patient has not reached the age of majority or is not mentally competent, the consent of the nearest relative of the patient, except under the
authority of an order of a Regional Review Board made on an application of the officer in charge. 4

There is the additional proviso related to psychosurgery and in the Act it states:

The consent of the involuntary patient or the nearest relative of an involuntary patient to treatment while an involuntary patient does not include and shall not be deemed to include psychosurgery. 5

In the Ontario Act, confidentiality of the patient's record is covered in Section 26a. Generally, no person shall disclose, transmit or examine a clinical record. Those who can, as well as situations that warrant it, are described.

Regarding freedom to communicate, the act states:

No communication written by a patient or sent to a patient shall be opened, examined or withheld, and its delivery shall not in any way be obstructed or delayed. 6

However, there is a section of the act that puts limits to the above statement by withholding or obstructing those pieces of communication that may interfere with the treatment or cause unnecessary distress. To this end:

The officer in charge of the facility has the authority to open and examine the contents of written communication, with the exception of that from a Barrister and Solicitor or a member of the Review Board. 7

Appeal against involuntary treatment is written in section 27 and 28 primarily.

Quebec

For the province of Quebec, there is no item regarding consent to treatment and confidentiality of records in the Mental Patients' Protection Act. However, the individuals receiving compulsory or close treatment 8 are provided with
more information about the rights at the outset than other provincial acts would indicate. Patients' rights are included in this legislation with a section stating that:

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      every hospital centre or reception centre to which a person is admitted in close treatment must inform such person in writing, in accordance with the regulations of the rights and recourses granted to him by this Act; it must also inform him in writing that his close treatment is terminated as soon as it is ended.9
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Some of the rights included in the regulations are the rights to have the family notified of the measures being taken to hasten the individual's recovery. The patient must also be informed of such measures unless it is not in his best interest at that time to be informed. There is a comment on the requirements of the exchange of correspondence with an advocate, a physician, a notary, the public curator, the Board of Review or one of its members. The appeal procedure is included in the written information on rights given to a patient. The mechanisms for ending informal or close treatment are also briefly stated in the notice of rights given to a patient admitted under close treatment.

**Nova Scotia**

Nova Scotia has the most recent proclamation of an act for mental disorder, the Hospitals Act, 1978. The Nova Scotia legislation has a rather lengthy section, Section 62, dealing with patient rights. Within this section are the rights to communicate by letter and how the mail shall be dealt with, in particular, communication that may have a detrimental effect on the addressee. In regard to letters
or written communication there is inclusion of access to writing materials, including stamps. The section on communication also deals with the use of the telephone. Visiting of a patient shall be permitted at all reasonable times and circumstances. The facility is responsible for posting copies of the rights of people under observation or of patients in a place within the hospital where they are visible to these groups of people.

All patients or persons admitted for observation are to receive written information on their right to send and receive letters, their right to make and receive telephone calls, visiting rights, the right to counsel, the right to have a file reviewed by a Review Board or a Court, and the right to have a declaration of competency or capacity reviewed by a Review Board or a Court. A verbal explanation, and assistance is to be provided to a patient or a person admitted for observation to contact a Barrister and to apply for a review by the Review Board.10

Section 63 addresses confidentiality of records stating terms and conditions of release of information with consent. If consent by the patient is not possible because of inability or incapacity, then the guardian, spouse, next of kin or Public Trustee is designated to act. Consent to treatment is stated specifically in the legislation in these words: "No person admitted to a hospital shall receive treatment unless he consents to such treatment."11 And the person may be admitted to a facility for observation with his consent and upon the request of a qualified medical practitioner. If the individual is found to be incapable of consenting to treatment, then the designates of that person may give consent.
The citations from the provincial statutes reveal that, on the matter of rights for the mental patient, there is no consistency or agreement between provinces. These rights as set down apply to the person defined as a patient. Again, in the definitions, a patient is, for the most part, one receiving compulsory treatment although occasionally it may mean one voluntarily admitted to hospital. Little is spelt out about rights in the British Columbia Act compared to the more extensive content on rights in the Nova Scotia Act.

Restrictions on Mentally Disordered in Other Provincial Statutes

In the first part of this section, compulsory treatment was noted to be restrictive of rights and freedoms. The restrictions were inherent in the act of taking a patient into custodial care in a mental hospital. As well, there are restrictions placed on the mentally ill in other provincial statutes. For example, in the British Columbia Land (Wife Protection) Act section 9(1) states:

where she is a mentally disordered person or person of unsound mind. . . the Supreme Court may, on application by petition dispense with the consent of the wife.\textsuperscript{12}

The Married Woman's Property Act in this province states in section 23(c)

whose husband is a mentally disordered person with or without lucid intervals shall have as her separate property. . . \textsuperscript{13}

The Superintendent of Motor Vehicles in British Columbia is given wide discretionary powers. In carrying out his
responsibilities he could consider mental disorder as a cause to restrict an individual from driving. The act provides the authority in the following clause:

... for any other reason that the Superintendent in his discretion deems reasonable from the inspection of the person's driving record or any other information the Superintendent has respecting the person's ability to drive, and without formal public or other hearing may cancel or suspend. ...14

The mentally disordered have restrictions placed upon them by other British Columbia statutes; consequently, labelling as a compulsorily treated mental patient carries heavy penalties.

Similar examples of restrictions on the mentally disordered person written into other provincial acts can be found in the statutes of Ontario, Nova Scotia and Saskatchewan. In the province of Ontario, the Election Act Part II section 13 states:

persons who are prisoners ... or who are patients in mental hospitals ... are disqualified from voting.15

The Marriage Act of Ontario section 7 states:

... no person shall issue a license to or solemnize the marriage of any person whom he knows or has reasonable grounds to believe ... by reason of being mentally ill.16

The Law Society Act section 35 states:

... if a member has been found pursuant to any Act to be mentally incompetent or mentally ill or ... Convocation may by order limit or suspend his rights and privileges as a member for such time. ...17

The Nova Scotia Motor Vehicle Act, chapter 251 section 1(c) states:
revoke drivers license when registrar has such reason to believe that such a person is incompetent to drive a motor vehicle or afflicted with mental or physical informatics or disability rendering it unsafe for such a person to drive a motor vehicle upon the highways.18

The Married Woman's Property Act in chapter 176 Protection Orders section 26(c) states:

... any married woman (1) whose husband is a lunatic, with or without lucid intervals may apply to a judge for an order for protection entitling her to have and enjoy all the earnings of her infant children and any acquisition therefrom free from the debts or obligations of her husband and from his control or disposition.

In summary, the present mental health statutes and other legislation for five provinces have shown variation in their clauses and wording for those deemed to need compulsory care. For Canadians who are "mentally disordered", the restrictions they face depend upon the province in which they live. The restrictions or limitations are not confined to the mental health acts but are found in other provincial acts. Most important is the variation found in the determination of mental disorder arising from the definition procedure based upon the subjective opinion of the physician. This confinement prescribed by a physician is without adequate safeguards and may constitute cruel and unusual treatment. The Charter protects for all Canadians their rights and freedoms. It is this document that poses a challenge to the restrictive contents of present mental health acts. The limitation of rights and freedoms are present in each of the provincial acts although not in exactly the same form. Thus
mental health legislation is in need of revision to redress the restriction placed on the disordered and the administrative complexities arising with a mobile population.
Footnotes


2 Ibid., section 22.


5 Ibid., section 31a(3).

6 Ibid., section 19(1).

7 Ibid., section 19(3a).

8 Close treatment is the term used in Quebec legislation to mean compulsory or certified treatment.


11 Ibid., section 46(1).


13 British Columbia: R.S.B.C. 1979, c. 252, Married Woman's Property Act, section 23(3).


Chapter VII
CONCLUSIONS AND IMPLICATION AND PLAN FOR CHANGE

This study has examined the mental health legislation of five Canadian provinces and the development of these statutes from earlier acts passed in England and Canada. The study has shown that these acts are tools to apprehend some of the mentally disordered in the community, to transport them to a treatment facility and to define the authority to implement the compulsory treatment. These acts were studied in the Canadian context with reference to rights and freedoms as proclaimed in the Canadian Charter of Rights and Freedoms.

It was stated earlier in this study that there are inter-provincial variations in the sections of the mental health acts under review; and it was noted that each provincial mental health act has restrictions of rights and freedoms in its contents. The definition of "mental disorder" varies and may be interpreted differently within each province because of the imprecision of the definition. Compulsory treatment, the process of implementation, and appeal against this treatment is also restrictive. Communication with those not in a facility by the person having enforced treatment is not open but restricted and scrutinized. Finally, it is concluded that these acts do not address the issues of treatment for the "mentally disordered" or the promotion of mental health. They are
legislative documents that define a procedure to place restrictions on certain mentally disordered individuals, and that provide for the administration of mental health services within a province. These statutes do not address these issues uniformly in all provinces; rather they have definitions and procedures that meet local requirements. The essence of each of the provincial acts is to place a person who is posing a danger to himself or those around him in a place where treatment may be enforced.

Further, it was found that the restrictions of enforced treatment written into the act were of wider impact in that other provincial statutes placed limitations on the "mentally disordered." The restrictions on rights to vote, manage property and drive were examples of the limiting effects of other laws. The sources of the restrictions in the mental health acts were the subjective nature of defining "mental disorder" and the appeal process to challenge the enforced treatment and confinement. Even though it was shown that the contents and administration of acts for mental health changed over the last fifty or more years, the "mentally disordered" are still subject to injustices of the law. With a generally more mobile population, including the "disordered", the escape from one set of provincial restrictions are met with new or different ones in another province. An added problem, that of administering the act to a mobile population at a time when there is a national
Charter of Rights and Freedoms was also noted.

To answer the questions raised by this study, it was shown that mental health acts, as with all legislation, are interactive with social, economic and technological conditions of the nation or province. Thus, societal beliefs about mental illness and the stigma attached to the disorder, economic affluence or depression, and new advances in technology, especially in disease processes and treatment, all must be considered when developing legislation. With this understanding and the possibility of discovering new treatments for mental illness in the future, there is reason to amend the existing statutes and truly change the content from confinement to treatment. The continuation of values or perceptions of the "disordered" from the indiscriminate law that was written to control the poor and the insane needs to be altered in new acts.

From this study it has been shown that provincial mental health acts in Canada do impose restrictions upon the "mentally disordered" and that the restrictions are different for each province as well as how they are applied by each physician in the province. It is possible to make changes in the statutes in an orderly manner even though the pressures for change come from widely diverse sources. The plan for change will address the contributions made by the various interested groups, the administrative and economic issues, together with technological change.
Plan for Change

The plan for changing mental health legislation will involve professional groups, patient and special interest groups, and the government administrators of mental health. The plan, based on recommendations developed from this study will describe the role of the participants and a method of processing.

Recommendations

From this study it is recommended:

1. that a national standard be developed for defining mental disorder and a confinement procedure.

2. that current provincial mental health statutes be modified to conform with a national standard regarding the definition of mental disorder and a confinement procedure.

3. that the title of these provincial acts more accurately reflect the contents; e.g., Mental Disorder Confinement Act.

4. that the definition of mental disorder not include addictive or habituated states as with ingestion of alcohol or drugs.

5. that the application of the definition of mental disorder for the purpose of confinement be made by two individuals from two professional groups such as physician and psychologist, or police and nurse.

6. that the confinement procedure be defined separately on admission from the community and for that from
within a facility.

7. that review and appeal procedures regarding confinement be developed nationally for inclusion in provincial statutes and that these not be dependent or based upon the victim initiating the process.

8. that sections regarding communication, confidentiality, consent and non-intrusive treatment procedures be written into the act.

9. that other current statutes with sections that set restrictions on the compulsorily treated mentally disordered be reviewed in the light of the recommendations and the Charter of Rights and Freedoms.

To implement this or any plan to re-write or amend legislation will take time. However, there are already some existing mechanisms to consider these recommendations and others and then to take needed actions. The time required for the task will be subject to delay or urgency according to the political pressures, social pressures and other service delivery issues. But as a planner with a responsibility to advise on legislation and its implementation, it is possible to plan for necessary changes despite other pressures. So, this plan will first describe the role of the participants to be followed by a method of proceeding.

Role of Participants

The government administrators of mental health services
will take the lead role. This group's response is central in reviewing all the implications of present legislation, and social, economic and interest group actions for change. This group can integrate the pressures for legislative change that are outside the view of each of the parts of the system such as the medical or governmental organizations. Administrators of provincial mental health services are able to advise on provincial services as well as represent provincial services to counterparts in other provinces. These officials can seek out and respond to comments submitted by concerned groups from all parts of society.

The specialist physicians together with physicians generally will need to examine their current practice regarding the definition and treatment of the disordered, especially as it relates to the use of compulsory treatment. These people need to consider the necessity of enforced treatment procedures for the mentally ill, particularly if there are already tools available to provide treatment to non-consenting individuals; e.g., the unconscious traffic victim. Further, this group needs to review their education, both formally and informally, as it related to mental disorder, its definition, treatment and especially enforced treatment. This perspective has relevance to the physician knowing that inter- and intra-provincial differences may occur.

The other professional groups will be asked for their
opinions regarding the treatment of the mentally disordered. But it is not only the treatment that is significant but also the definition or determination of a mental disorder that is equally important. The education these professionals have regarding their responsibility towards the existing legislation needs to be responded to as it may need to be considered with a new statute being written. The professions sought out to provide evidence are lawyers, legislative writers, police, psychologists, social workers, nurses and academics.

One interested group not mentioned above are the consumers. Their evidence is necessary regarding issues with current legislation and the possible effects of proposed acts.

Method of Proceeding

The method of proceeding has four parts: first, review of current acts together with relevant data; second, revision and writing of the amendments or new act; third, implementation of the statute; and last, an evaluation of the administration of the act. Some of these activities are ongoing within each of the provincial mental health departments but may require changes so that the issue of rights and mental disorder is addressed.

The lead group can begin reviews of the mental health legislative items with legislative writers within the province and nationally. For a beginning, those items that
can be changed quickly should be considered at the outset, followed by those items that require refinement and development over a longer period of time. To take an example, although compulsory treatment is restrictive, presently society views it as a needed control mechanism, but appeal and review procedures are not adequately addressed or protected in the statutes and people generally want redress. Thus, work can commence in the appeal and review sections of the provincial acts to ensure that any changes are compatible with the Canada Act. Other less complex items can be worked on; the "title" mentioned in Recommendation 3; and communication, confidentiality, consent and non-intrusive treatment procedures mentioned in Recommendation 9 above.

The next and more complex task of refining the definition of mental disorder needs to be addressed by each provincial administrative group and interprovincially as well. The criteria for determining disorder need to be spelled out so they are made less dependent upon subjective judgements. The factor of danger may require consideration to be appropriate as part of the definition of mental disorder.

With a clear definition for mental disorder then the procedure for compulsory treatment, if necessary, needs to be worked out. Or two procedures—one to apprehend and convey, and one to forcibly give treatment—may be required.
These tasks do not have simple solutions and will require considerable time to complete. Time is needed so that the statutory changes are made based upon adequate, well developed information.

In summary, for mental health legislation, first it is necessary to re-define mental disorder and confinement procedures by examining the evidence solicited from the various groups mentioned above and then followed with the process of re-writing the legislation so that the contents are treatment not custody oriented. Once the new or amended act is proclaimed, a review of the application or implementation of the statute will complete the process ensuring the needs of society are reflected in the law.

Legislation can provide an organization for managing an issue but the actual control of human behavior will not occur as a result of legislating for there are many factors that are involved in putting principles into practice. But legislation can state the principles which recognize the current social values and beliefs as well as the state of knowledge on the issue. For these reasons and all the other observed deficiencies in the current mental health legislation, it is time now for a new focus.
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APPENDIX A

British North America Act, 1867

Section 91-92

Part VI. Distribution of Legislative Powers

Powers of the Parliament

Section 91. It shall be... of such House.
1a The Public Debt and Property.
2 The Regulation of Trade and Commerce.
2a Unemployment insurance.
3 The raising of Money by any Mode or System of Taxation.
4 The borrowing of Money on the Public Credit.
5 Postal Service.
6 The Census and Statistics.
7 Militia, Military and Naval Service, and Defence.
8 The fixing of and providing for the Salaries and Allowances of Civil and other Offices of the Government of Canada.
9 Beacons, Buoys, Lighthouses, and Sable Island.
10 Navigation and Shipping.
11 Quarantine and the Establishment and Maintenance of Marine Hospitals.
12 Sea Coast and Inland Fisheries.
13 Ferries between a Province and any British or Foreign Country or between Two Provinces.
14 Currency and Coinage.
16 Savings Banks.
17 Weights and Measures.
18 Bills of Exchange and Promissory Notes.
19 Interest.
20 Legal Tender.
21 Bankruptcy and Insolvency.
22 Patents of Invention and Discovery.
23 Copyrights.
24 Indians, and Lands reserved for the Indians.
25 Naturalization and Aliens.
26 Marriage and Divorce.
27 The Criminal Law, except the Constitution of Courts of Criminal Jurisdiction, but including the Procedure in Criminal Matters.
28 The Establishment, Maintenance, and Management of Penitentiaries.
29 Such Classes of Subjects as are expressly excepted in the Enumeration of the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces.

And any Matter coming within any of the Classes of Subjects enumerated in this Section shall not be deemed to come within
the Class of Matters of a local or private Nature comprised in the Enumeration of the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces.

Exclusive Powers of Provincial Legislatures

Section 92. In each Province the Legislature may exclusively make Laws in relation to Matters coming within the Classes of Subject next herein-after enumerated; that is to say,——

1. The Amendment from Time to Time, notwithstanding anything in this Act, of the Constitution of the Province, except as regards the Office of Lieutenant Governor.
2. Direct Taxation within the Province in order to the raising of a Revenue for Provincial Purposes.
3. The borrowing of Money on the sole Credit of the Province.
4. The Establishment and Tenure of Provincial Offices and the Appointment and Payment of Provincial Officers.
5. The Management and Sale of the Public Lands belonging to the Province and of the Timber and Wood thereon.
6. The Establishment, Maintenance, and Management of Public and Reformatory Prisons in and for the Province.
7. The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals.
8. Municipal Institutions in the Province.
9. Shop, Saloon, Tavern, Auctioneer, and other Licences in order to the raising of a Revenue for Provincial, Local, or Municipal Purposes.
10. Local Works and Undertakings other than such as are of the following Classes: (a) Lines of Steam or other Ships, Railways, Canals, Telegraphs, and other Works and Undertakings connecting the Province with any other or others of the Provinces, or extending beyond the Limits of the Province; (b) Lines of Steam Ships between the Province and any British or Foreign Country; (c) Such Works as, although wholly situate within the Province, are before or after their Execution declared by the Parliament of Canada to be for the general Advantage of Canada or for the Advantage of Two or more of the Provinces.
11. The Incorporation of Companies with Provincial Objects.
12. The Solemnization of Marriage in the Province.
13. Property and Civil Rights in the Province.
14. The Administration of Justice in the Province, including the Constitution, Maintenance, and Organization of Provincial Courts, both of Civil and of Criminal Jurisdiction, and including Procedure in Civil Matters in those Courts.
15. The Imposition of Punishment by Fine, Penalty, or Imprisonment for enforcing any Law of the Province made in relation to any Matter coming within any of the Classes of Subjects enumerated in this Section.
16. Generally all Matters of a merely local or private Nature in the Province.
Related to mental illness, the following sections from Part One of the Canadian Charter of Rights and Freedoms, Constitution Act, 1982 are relevant to this study.

6. (2) Every citizen of Canada and every person who has the status of a permanent resident of Canada has the right:
   (a) To move to and take up residence in any province; and
   (b) To pursue the gaining of a livelihood in any province.
   (3) The rights specified in subsection (2) are subject to:
   (a) Any laws or practices of general application in force in a province other than those that discriminate among persons primarily on the basis of province of present or previous residence; and
   (b) any laws providing for reasonable residency requirements as a qualification for the receipt of publicly provided social services.

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

8. Everyone has the right to be secure against unreasonable search or seizure.

9. Everyone has the right not to be arbitrarily detained or imprisoned.

12. Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, color, religion, sex, age or mental or physical disability.
   (2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, color, religion, sex, age or mental or physical disability.

24. (1) Anyone whose rights or freedoms, as guaranteed by this charter, have been infringed or denied may apply to a
court of competent jurisdiction to obtain such remedy as the
court considers appropriate and just in the circumstances.

32. (1) This charter applies:
(a) To the Parliament and government of Canada in respect
of all matters within the authority of Parliament including
all matters relating to the Yukon Territory and Northwest
Territories; and
(b) To the legislature and government of each province in
respect of all matters within the authority of the legislature
of each province.
APPENDIX C

Definitions Found in Five Provincial Mental Health Acts for "Mental Disorder", "Director", "Patient", "Facility", "Physician."

The definitions that appear in the five provincial mental health acts are as follows.

**BRITISH COLUMBIA**
(R.S.B.C. 1979, c. 256, Mental Health Act, 1964)

**Director** - means a person who is appointed in charge of a provincial mental health facility and includes a person authorized by a Director to exercise power or carry out a duty conferred or imposed on the director under this Act.

**Mentally Disordered Person** - means a person who is suffering from a disorder of the mind that seriously impairs his ability to react appropriately to his environment or to associate with others; and that requires medical treatment or makes care, supervision and control of the person necessary for his protection or welfare or for the protection of others.

**Patient** - means a person who under this Act:
   (i) is receiving psychiatric care and treatment; or
   (ii) is received, detained or taken charge of as a mentally disordered person or as an allegedly mentally disordered person.

**Physician** - means a medical practitioner.

**Private Mental Hospital** - means an establishment licensed under Section 5.

**Provincial Health Facility** - means a provincial mental health facility designated under this Act.

**SASKATCHEWAN**
(R.S.S. 1978, c. M. 13, Mental Health Act, 1978)

**Physician or Practitioner** - means a duly qualified medical practitioner on the register of the College of Physicians and Surgeons of Saskatchewan.

**Facility** - means an institution, psychiatric centre, psychiatric ward, mental health clinic or any other building or portion thereof set aside for the care, treatment or training of mentally disordered persons.

**Mental Illness** - means a disorder of mind other than psychopathic disorder or mental retardation, that results in
a disturbance in a person's behaviour or feelings or thoughts and conversation and that results in mental distress or impaired ability to associate with others or results in a person's inability to react appropriately or efficiently to his environment and in respect of which medical treatment is advisable; and mentally ill person has corresponding meanings.

Patient - means a person receiving psychiatric care or treatment or diagnostic services for the purpose of determining the existence of mental disorder.

ONTARIO
(R.S.O. 1980, c. 262, Mental Health Act, 1978)

Physician - means a legally qualified medical practitioner.
Mental Disorder - means any disease or disability of the mind.
Psychiatrist - means a physician who holds a specialist's certificate in psychiatry issued by the Royal College of Physicians and Surgeons of Canada or equivalent qualifications acceptable to the Minister.
Patient - means a person who is under observation, care and treatment in a facility.
Involuntary Patient - means a person who is detained in a psychiatric facility under certificate of involuntary admission or a certificate of renewal.
Psychiatric Facility - means a facility for the observation, care and treatment of persons suffering from mental disorder and designated as such by the regulations.

QUEBEC
(R.S.Q. 1977, c. P. 41, Mental Patients' Protection Act, 1974)

Hospital Centre - a hospital centre within the meaning of the said Act respecting health services and social services, equipped to admit and treat persons suffering from mental disorders.
Local Community Service Centre - a local community service centre within the meaning of the said Act respecting health services and social services, equipped to admit and treat persons suffering from mental disorders.
Psychiatric Establishment for Detained Persons - any establishment contemplated in Section 58.
Psychiatric Clinical Examination - an examination held to determine if the state of mental health of a person requires that he be placed under close treatment.
Psychiatrist - a physician holding a specialist's certificate in psychiatry in force issued by the College of Physicians and Surgeons of the Province of Quebec.

There is no definition of mental disorder in the Mental Patients' Protection Act. There is a minor reference to mental disorders in the Act Respecting Health Services and Social Services. Hospital centre is defined in that act as a facility to which persons are admitted for preventive purposes, medical diagnosis, medical treatment, physical or mental rehabilitation excluding, however, a professional's private consulting office and an infirmary where a religious or educational institution receives its staff and students.

NOVA SCOTIA
(R.S.N.S. 1967, c. 249, Hospitals Act)

Patient - means a person who receives diagnosis, lodging or treatment at or in a hospital.

Person Under Observation - means a person who is in a hospital pursuant to Section 27.

Psychiatrist - means a physician who is recognized as a specialist in psychiatry by the Provincial Medical Board, or who, on or before the 31st day of December, 1977, is eligible to write for a Canadian Fellowship in Psychiatry of the Royal Collège of Physicians and Surgeons (Canada).

Facility - means a hospital or that part of a hospital so designated by the Minister for the observation, care and treatment of persons suffering from psychiatric disorder.

Mental Disorder - means any disease or disability of the mind and includes alcoholism and drug addiction.
<table>
<thead>
<tr>
<th>Stage of procedure</th>
<th>British Columbia</th>
<th>Saskatchewan</th>
<th>Ontario</th>
<th>Quebec</th>
<th>Nova Scotia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient seen</td>
<td>2 physicians</td>
<td>2 physicians</td>
<td>1 physician</td>
<td>1 psychiatrist</td>
<td>2 psychiatrists</td>
</tr>
<tr>
<td>Order written</td>
<td>Within 14 days</td>
<td></td>
<td>Within 7 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conveyed to facility</td>
<td>Within 7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td>Not more than 120 hours</td>
<td>Within 24 hours</td>
<td></td>
<td>Within 48 hours</td>
<td></td>
</tr>
<tr>
<td>Certificate(s)</td>
<td>good to completed anniversary</td>
<td>good for 14 days (1 physician)</td>
<td>1 certificate</td>
<td>With 96 hours by physician</td>
<td>Within 24 hours by psychiatrist</td>
</tr>
<tr>
<td></td>
<td>from when 1st seen</td>
<td>good for 2 weeks</td>
<td>(1 psychiatrist)</td>
<td>good for 21 days</td>
<td></td>
</tr>
<tr>
<td>Renewals</td>
<td>1st year 1st 3 Mon.</td>
<td>1st 1 Mon.</td>
<td>1st 2 Mon.</td>
<td>1st 3 Mon.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2nd 2 years 2nd 6 Mon.</td>
<td>2nd 2 Mon.</td>
<td>2nd 3 Mon.</td>
<td>2nd 3 Mon.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>all rest 3rd 3 Mon.</td>
<td>3rd 6 Mon.</td>
<td>3rd 6 Mon.</td>
<td>3rd 6 Mon.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12 Mon. 4th 12 Mon.</td>
<td>4th 12 Mon.</td>
<td>4th 12 Mon.</td>
<td></td>
<td>Rest 12 Mon.</td>
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</tbody>
</table>