Canadian Mental Health Legislation, the violation of Individual Rights and the Promotion of Discrimination

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Abstract: The World Health Organization in its Mental Health Action Plan 2013-2020 has reported that mental illness is one of the largest causes of disability worldwide. Shockingly high rates of inadequate treatment of mental disability exist: 76-85% of mentally disabled individuals in low and moderate income countries and 35-50% of those in high income countries receive no treatment. Yet, in Canada and some other nations that can best afford to provide medical services, legislation designed to facilitate the treatment of mental disabilities also intends to soothe the public's stereotype-based fears by providing mechanisms for state control of mentally disabled individuals. In doing so, some statutes strip the disabled of fundamental human rights by authorizing arbitrary detention and involuntary treatment. The Canadian province of New Brunswick is currently revisiting its mental health statute, which fails to meet the requirement of the United Nations *Convention on the Rights of Persons with Disabilities*. If the human rights of mentally disabled individuals are to be advanced, governments must reconsider the discriminatory stereotypes that some mental health statutes are perpetuating.

Keywords: Mental Health Act, Rights, Disabled, Detention and Decision Making Capability.

Introduction

The July 24, 2016 violent arrest and subsequent death of Abdirahman Abdi in Ottawa, Canada has served as a bleak signal of the urgent need to reevaluate society's enforcement of behavioural expectations concerning mentally differently - abled citizens. Abdi, who was described as having been affected by mental illness, died after being pepper sprayed and struck with batons by police officers who responded to a report of a disturbance at a donut shop on a July 2016 morning.[1] In Canada, there is evidence of increased confrontations between police and

[1] Harford, Evelyn, *Ottawa man Abdirahman Abdi dies after confrontation with police,* Ottawa Citizen, July 26th, 2016. http://ottawacitizen.com/news/local-news/ottawa-man-abdirahman-abdi-dies-after-confrontation-with-police, Last visited December 30, 2016.

the mentally disabled[2] and research also suggests that in the United States of America, citizens challenged by mental illness are 16 times more likely to be shot by the police than other individuals.[3] Although, not all police altercations with mentally disabled individuals occur in the context of enforcing mental health legislation, nevertheless these statutes serves as a bellwether of society's attitude regarding the appropriate treatment of citizens thought to be challenged by mental disorders. Currently, the Canadian province of New Brunswick is reviewing its mental health legislation and, in doing so, it will make a guiding statement to its population regarding the treatment of its mentally disabled members. Early indications suggest that like some other North American jurisdictions, New Brunswick will not take a leadership role in the establishment of mental health legislation that fully recognizes the rights of mentally disabled individuals under the *Charter of Rights and Freedoms*[4] (the "*Charter*") and the United Nations *Convention on the Rights of Persons with Disabilities* [5](the "Convention").

An opportunity for progress against discrimination

It is beyond dispute that individuals challenged by mental disabilities are vulnerable to potential human rights abuses[6]. Internationally, it has been acknowledged that governments should be particularly alert in the protection of the human rights of mentally disabled[7]. In that regard, a legislation that permits state detention and forced treatment of individuals has been adopted by governments in many jurisdictions, including all of the Canadian provinces,[8] to address society's discomforts with and concerns regarding the conduct and personal needs of mentally disabled individuals. Compulsory treatment is frequently imposed through services frameworks such as Supervised Community Care ('SCC') and Community Treatment Orders ('CTO').

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[2] Moore, Dene, *Interactions between police, people with mental illness on the* rise, The Globe & Mail, August 27th, 2014, http://www.theglobeandmail.com/news/national/interactions-between-police-people-with-mental-illness-on-the-rise/article20221770/, Last visited December 30, 2016.

[3] Fuller, Doris A., H. Richard Lamb, M.D., Michael Biasotti and John Snook, *Overlooked in the undercounted: The role of mental illness in fatal law enforcement encounters*,Treatment Advocacy Center, December 2015. http://tacreports.org/storage/documents/overlooked-in-the-undercounted.pdf, Last visited December 30, 2016

[4] *The Constitution Act*, 1982, being Schedule B to the *Canada Act 1982*, U.K., 1982, c 11.

[5] United Nations General Assembly, *Convention on the Rights of Persons with Disabilities*, January 24, 2007, pages 2-29,http://www.un.org/disabilities/convention/conventionfull.shtml, Last visited December 30, 2016.

[6] Drew, N., Funk, M. Tang, S. et al, *Human Rights Violations of People with Mental and Psychosocial Disabilities: An Unresolved Global Crisis*, Lancet, 2011, 378: 1664-75.

[7] United Nations General Assembly,*Convention on the Rights of Persons with Disabilities*, January 24, 2007, Note 4.. http://www.un.org/disabilities/convention/conventionfull.shtml, Last visited December 30, 2016.

[8] Fistein, E.C., Holland, A.J., Clare, I.C.H. and Gunn, M.J, *A comparison of mental health legislation from diverse Commonwealth jurisdictions.* International Journal of Law and Psychiatry,2009 May; 32(3): 147–155.

Currently, the government of the Province of New Brunswick is considering SCC legislation that would provide mentally disabled New Brunswickers with increased mental health services, but, additionally, would permit detention of particular individuals. The proposed legislation would replace the Province's current *Mental Health Act*[9](the "*Act*"), which already empowers the state to restrain the liberty of individuals challenged by mental disorders in particular circumstances. Both the current *Act* and the proposed legislation provide disabled individuals with lesser protections against detention and invasions of their personal security than are available to the non-disabled, in spite of the fact that at least some disabled individuals have decision making capacity. Further, both statutes fall short of meeting the directives of the *Convention* and, together, they invite a broader consideration of the legality of SCC and CTO schemes that, while forcing potentially beneficial treatments on patients, also result in a deprivation of liberty.

Firstly, the paper reviews the existing and proposed New Brunswick mental health legislation and their attendant impacts on individual autonomy and security of the person. Secondly, the paper examines the legal rights of Canadians under constitutional and international legal principles that safeguard them against arbitrary detention, their rights to retain and instruct counsel without delay, to be tried and to not self-incriminate, and their international human right to be protected from these governmental actions. Thirdly, the paper examines alternate models of mental health legislation and proposes that the New Brunswick *Act* should be amended in a manner that affords greater decision-making autonomy to mentally disabled citizens.

The existing New Brunswick mental health legislation

The existing *Mental Health Act*[10] (the "*Act*") has been in effect in New Brunswick for more than three decades, although some legislative amendments have been made during this period. The statute identifies its purposes, in section 1.1, "*to provide protection from dangerous behavior caused by a mental disorder and to treat suffering from a mental disorder that is likely to result in dangerous behavior, which treatment may include involuntary custody, detention, restraint, observation, examination, assessment and care"*[11].

[9] *Mental Health Act*, R.S.N.B. 1973, c. M-10.
[10] *Ibid.*
[11] *Ibid.*, section 1.1.

In furtherance of its objectives, the *Act* permits the detention and involuntary treatment of individuals in some instances. The manner and extent to which the *Act* respects the rights of individuals whose freedom is infringed under it is an essential consideration under this *Act* and its proposed successor legislation.

Fundamental freedoms and human rights

Every mental health statute that empowers the state to detain and involuntarily treat individuals must be considered in the context of fundamental freedoms and human rights. In Canada, individual rights and freedoms emanate from several sources. All citizens are entitled to particular rights under the *Charter of Rights and Freedoms*[12] (the "*Charter*"), Federal and Provincial Human Rights statutes ("HR Legislation"), as well. Further, Canada is a state party to the U.N. *Convention*, which is of particular interest in this paper.

The *Charter* confirms Canadian foundational rights and freedoms that are particularly relevant in the context of detention and forced treatment under the *Act.* These include: the right not to be denied of liberty and security of the person except in accordance with the principles of fundamental justice; the right not to be arbitrarily detained; the right, on detention, to be informed of the reasons thereof and to retain legal counsel without delay; and to have the validity of any detention determined by way of *habeas corpus*. Under ss. 15(1) of the *Charter*, individuals are assured equal protection and benefit under the law without discrimination, including discrimination based on mental disability.[13]

HR Legislation in New Brunswick and other Canadian provinces prohibit discriminatory treatment of individuals in services available to the public, including medical services, based on mental disability[14]. Under the *Act*, differential treatment is permitted in the sense that individuals who are or are perceived to be mentally disabled can have their rights fettered, such that they (unlike non-mentally disabled individuals) may be subjected to detention and involuntary treatment.[15] Even beyond the *Charter* and HR Legislation, the *Convention* acts as an overarching international reiteration of the obligation of Canada and other states parties to ensure the existence of legal protection for individuals

[12] *The Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.
[13] Ibid., ss. 7, 9, 10, 11 and 15.
[14] *Human Rights Act*, R.S.N.B. 2011, c 171, s. 6.
[15] *The Mental Health Act*.

with disabilities, including "…the right to liberty and security of person and … that the existence of a disability shall in no case justify the deprivation of liberty."[16].

As it considers an amendment of the *Act*, New Brunswick has an opportunity to align its mental health legislation with other jurisdictions and international disability rights principles.[17] That process of alignment will be assisted by a review of the existing *Act*, potential amendments that would increase independence, equality, and other alternatives for the disabled. In essence, the new legislation could be designed to increase respect for mentally disabled individuals by opting for the least restrictive available means of treating their conditions.

The use of detention, involuntary treatment and restraint under the *Act*

The *Act* empowers the State to facilitate the detention and involuntarily treatment of individuals who are perceived to be mentally disordered, and the potential invasiveness of that empowerment should be underscored. Initially, a person will be detained under the *Act* if they are the subject of a physician's (and not a psychiatrist's) opinion that the individual "*may* be suffering from a mental disorder of a nature or degree so as to require hospitalization in the interests of the persons own safety or the safety of others, and [that they are not] suitable for admission as a voluntary patient"[18] (an "Examination Certificate"). Since an Examination Certificate authorizes the detention of an individual who may not require hospitalization and who may not be dangerous to themselves or to others but, who may not have the ability or resources to effectively respond to detention, it can be argued that the document ought to be issued only with extreme caution and thorough assessment, such as may be conducted by a specialist in the field of psychiatry. However, on the certification of a family physician to the effect that the person in question *may* require hospitalization, the State is entitled to detain and to authorize involuntarily treatment and restraint of the individual for a period of seventy-two hours.[19] Given that family physicians may have more regular interaction with mentally disabled patients who require but, have not been referred for psychiatric treatment, it may be practically useful to vest in them the extensive power to order detention. However, it is questionable as to whether or not a family physician has the requisite psychiatric skills to accurately identify a mental condition that justifies a

[16] *Convention on the Rights of Persons with Disabilities*, Article 14.
[17] *Ibid.* The Convention intends to promote freedom, equality and independent, accessible living for the disabled.
[18] *Mental Health Act*, section 7.
[19] *Ibid.*, section 7.1(4).

deprivation of personal freedom. While it is conceivable that an initial detention under an Examination Certificate could arise without the use of information obtained directly from the individual (effectively, information comparable to self-incriminatory information), it is more likely that the physician issuing the Certificate will rely on communications received from the individual in a confidential context as the basis for seeking detention and involuntary treatment. Here, detention under the *Act* is a higher risk than detentions in non-disabled contexts, since the *Charter* offers protection to individuals accused of crimes against detention caused by self-incrimination[20]. In addition to an increased risk of detention, mentally disabled individuals have less protection under the *Act* than non-disabled subjects have under the *Charter*.

Although, an individual may be detained under the *Act* based on the equivalent of self-incriminating information provided to their physician, that person is entitled, under s. 7.1(5) of the *Act*, to be informed of the reasons for their detention, where they are being detained, and their right to retain and instruct counsel without delay[21]. While ss. 7.6(2) mandates the New Brunswick Psychiatric Patient Advocate Service ("PPAS") to offer advice and assistance to individuals detained under ss. 7.1, 8 and 12 of the *Act*[22], unlike in non-disabled detention contexts, free legal advice is not offered under the *Act*. Under the *Charter*, conversely, it has been recognized that an individual charged with a criminal offence is entitled to state-funded legal representation when the lack of counsel would compromise their right to a fair trial.[23] In *New Brunswick (Minister of Health and Community Services) v G. (J.)*., the Supreme Court of Canada ruled that a parent whose custody of her children was the subject of a challenge under provincial legislation, was entitled to legal aid-funded counsel because her rights under s. 7 of the *Charter* (security of the person) were in jeopardy.[24] In that regard, the sufficiency of counsel, being the training and quality of advocates and advisors made available to detainees, amongst other fundamental rights and freedoms safeguards furnished in mental health legislation should be questioned and will be discussed later in this paper.

During the initial seventy-two hour detention authorized under an Examination Certificate, the detention and treatment of a mentally disabled person is transferred from the individual's family

[20] Dufraimont, Lisa,*The Patchwork Principle against Self-Incrimination under the Charte*r, Supreme Court Law Review, 57 *S.C.L.R*. (2d), 2012, 57, pp.242-262.
[21] *Mental Health Act*, subsection 7.1(5).
[22] Ibid., subsection 7.6(2).
[23] *R. v Rowbothan,* Supreme Court of Canada, 1988, 41. C.C.C. (3d) 1.
[24] *New Brunswick (Minister of Health and Community Services) v G. (J.).* Supreme Court of Canada, 1999, 3 S.C.R 46.

physician to an attending psychiatrist. The psychiatrist may apply for further detention of the individual if it is deemed that:

a) The person suffers from a mental disorder;
b) The person's recent behaviour presents a substantial risk of imminent physical or psychological harm to the person or others;
c) The person is not suitable for admission as a voluntary patient; and
d) Less restrictive alternatives would be inappropriate.[25]

An application for continued detention is not heard by a court but, instead, by the chairperson of a mental health tribunal (the "Tribunal").[26] The required composition of the three-member Tribunal under the *Act* is two non-lawyers and only one lawyer[27], so that decisions made concerning the legal rights of a detainee are substantially influenced by individuals who are unlikely to be educated and trained in such matters. The *Act* goes so far as to permit the Tribunal to authorize involuntary treatment with restraint and without consent, as is deemed appropriate in a psychiatrist's opinion[28]. Under the existing legislation, then, a patient may be involuntarily detained and involuntarily treated based on a legal order made by an administrative tribunal rather than a court. This is yet another difference in the procedural protections available to a person being detained or involuntarily treated under the *Act* as compared with protections provided to non-disabled individuals subjected to State detention. Although, the tribunal model offers potential benefits to the detainee, such as faster accessibility and a less complicated process, it must also be recognized that the detainee loses the benefit of the procedural certainty of the court, including its public openness and transparency.

It is notable that the Tribunal's order of detention and involuntary treatment may be made without ever considering whether or not the individual has decision making capacity and, if so, how that individual wishes to exercise his/her liberty.[29] While the *Act* later takes into account the mental competence of an individual to give or refuse consent in relation to routine clinical medical treatment, it does not require consideration of that individual's decision making capacity[30] in the context of detention. Even in the case of an individual who is deemed mentally competent to give or refuse

[25] *Mental Health Act*, subsection 8(1)(c).
[26] *Ibid.*
[27] General Regulation - *Mental Health Act,* Reg. 94-33.
[28] *Mental Health Act*, subsection 8(5), 8.01(1), 8.01(3) and 8.11(1).
[29] *Ibid.*
[30] *Mental Health Act*, subsection 8.11(2).

consent, the Tribunal has jurisdiction under the *Act* to authorize treatment without consent if, for example, it is of the opinion that the refusal does not constitute of reliable and informed instructions based on the person's knowledge of the effect of the treatment on the person or that the treatment is in the best interest of the person, and that, without the treatment, the person would continue to be detained as an involuntary patient with no reasonable prospect of discharge.[31]

The *Act* applies different criteria to decisions concerning detention and treatment, which is an observed characteristic of mental health legislation in a number of North American jurisdictions.[32] The approach has been criticized on the basis that it can facilitate a circumstance where a patient lawfully detained in a psychiatric facility due to a mental disorder may then refuse to be treated and, thus, avoid or be deprived of the opportunity to satisfy a mental competence assessment[33].

Concerns arising from the existing legislation

Non-mentally disabled individuals do not share the additional risk of a denial of fundamental rights and freedoms that the mentally disabled face under the *Act.* Further, the deprivation under the *Act* is not only an additional risk for the mentally disabled, it is also a higher risk as a consequence of the reduced safeguards it offers to its mentally disabled subjects. Table 1 below demonstrates several circumstances in the *Act*'s processes wherein the rights and freedoms of a mentally disabled detainee are inadequately protected.

[31] *Mental Health Act*, subsection 8.11(b).
[32] Dawson, John and Kamph, Annagrett, *Incapacity Principals and Mental Health Laws in Europe*, Psychology, Public Policy, and Law, 2006 12(3) 310-331.
[33] Szmukler, G., Dow, R. and Dawson, J, *A Model of Law using Incapacity and Mental Health Legislation*, A Journal of Mental Health Law, 2010 No. 11, 11-24.

TABLE 1: Protection of mentally disabled individuals from detention and involuntary treatment

Rights and freedoms protection	**The Charter of Rights and Freedoms**	**The UN Conventions**	**The Mental Health Act, RSNB 1973, c. M-10**
The right to be protected against self-incrimination	*Yes*: ss. 7, 11 and 13	*Yes: Model Code of Criminal Procedure*, Article 57	*No.* Information may be obtained from the individual in question to support detention without advising of the purpose (s. 7.1)
The right to legal counsel	*Yes:* s. 10(b); in fact, even if counsel is instructed, there is a requirement of counsel effectiveness for additional protection to the accused.	*Yes: The Convention on the Rights of Persons with Disabilities*, Articles 12, 13. In Art. 13, State parties are required to provide procedural accommodations when necessary.	*Yes:* s. 7.6 requires detained individuals to be advised of their right to counsel. However, this requirement must be taken in the context of the detention (a perceived mental disorder). The *Act* does not require additional analysis of the individual's comprehension of the right, nor is the notice requirement repeated in respect of continued detention under s. 8 or involuntary

			treatments.
The right to a trial in court	*Yes:* s. 11(b)	*No:* Article 12 requires review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.	*No:* Individuals detained under the *Act* do not appear in a court for a trial; instead, they participate in an administrative hearing process that is less formal than a court trial and is not presided over by a judge.
The right to be protected against arbitrary detention	*Yes:* s. 9	*Yes:* Art. 14, the *Convention*.	*No:* detention can be initiated by a suspicion of mental disorder and may be continued based on a *risk* of harm to that person or others.

Rights violations under the *Act* are motivated by an assumption of incapacity

Sections 7.1 and 8 of the *Act* are difficult to reconcile with Article III of the Guidelines on Article 14 of the *Convention.*[34] Article III observes that "….*states parties should refrain from the practice of denying legal capacity of persons with disabilities and detaining them in institutions against*

[34] United Nations Human Rights Commission, *Guidelines on Article 14 of the Convention of the Rights of Persons with Disabilities*, Committee on the Rights of Persons with Disabilities, September 2015,www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc, Last visited January 5, 2017.

their will, either without the free and informed consent of the persons concerned or with the consent of a substitute decision-maker, as this practice constitutes arbitrary deprivation of liberty and violates Articles 12 and 14 of the Convention."[35] On this point, the *Act*'s requirement that a detainee be simply advised of their right to retain and instruct counsel without providing additional safeguards to ensure the understanding and exercise of that right seems incongruent with the individual's circumstances as a person whose mental condition has been judged to be of a nature or degree that requires hospitalization. If the detained person is actually mentally incompetent, it is unreasonable to then extend to that person legal rights that require competence in their proper exercise and, in that scenario, the *Act* extends inadequate protection. If the individual has decision-making capacity, it is foreseeable that accessing legal advice in order to give proper effect to the right to retain counsel may be difficult, particularly since the *Act* does not extend to the detainee the same opportunities that are available to detainees in the criminal context to access state-funded legal counsel. The practical effect of informing the detained individual of their right to retain and instruct counsel must be questioned, then, in the context of the detention itself. The mere provision of information concerning the exercise of rights to a person who has been judged to be affected by a significant mental disorder may be insufficient in some cases, as the ability of the individual to comprehend their rights and the application of the same to their circumstances, particularly on the event of a detention that may have been unexpected, is likely to be compromised. The *Act* does not consider a need for and, indeed, does not authorize, an assessment of the detainee's mental capacity, or decision-making capability ("DMC") [36]at the initial detention stage.

An initial detention under s. 7.1 of the *Act* is only permitted for seventy-two hours. If the detention is to continue, a new application under s. 8 must be made. As noted above, the s. 8 application is made by the attending psychiatrist and, although, the psychiatrist is required to provide an opinion regarding the detainee's mental disorder and the related existence of a substantial risk of imminent harm to the detainee or others, no opinion regarding the detainee's DMC is required except with regard to the individual's mental competence to give or refuse consent in respect of routine medical treatment ("Competence Regarding Routine Medical Treatment Decisions", or "CRRMTD").[37] Here, it is important to recognize that the Tribunal considering a s.8 application must be presented with an attending psychiatrist's opinion concerning CRRMTD only if the order being sought includes authority

[35] *Ibid.*
[36] See Szmuckler, G., Daw, R. and Callard, F, *Mental health law and the UN Convention on the Rights of Persons with Disabilities,* International Journal of Law and Psychiatry, 2014, 37(3) 245-252.
[37] *Mental Health Act*, subsection.8.01(1).

for giving routine medical treatment without consent.[38] If no order is being sought to provide routine medical treatment without consent (perhaps, for example, because no routine medical treatment will be required or because the attending psychiatrist is of the opinion that the detainee has the capacity to, and will, consent to routine medical treatment), then no further assessment of the individual's DMC is considered. The *Act* underscores its distinction of routine medical treatment, "medical treatment other than routine medical treatment", "other psychiatric treatment" and detention (or admission to a psychiatric facility as an involuntary patient) in ss. 8.2-8.4[39]. As a consequence, the *Act*'s consideration of CRRMTD and not DMC should be examined, as it leaves open the potential for detention and some types of involuntary treatment with limited rights safeguards.

The *Act* is incongruent with the requirement of the *Convention* that State parties obtain an individual's free and informed consent prior to the administration of care.[40] In commanding a new and higher level of respect for the legal and mental capacity of disabled individuals, the *Convention* asserts that a presumption of both capacities should be attributed to all.[41] The General Comment adopted by the United Nations Committee on the Rights of Persons with Disabilities concerning Article 12 of the *Convention* obligates State parties to abolish substituted decision-making schemes, to provide support for disabled individuals in the exercise of their legal capacity and to safeguard the exercise of legal capacity in respect of the rights and preferences of individuals.[42] Conversely, the *Act* allows for disabled and presumed disabled New Brunswick citizens to be stripped of their DMC, in some cases without even considering its existence[43] and also of their legal rights, with only minimal regard for their legal capacity. The shortcomings of the *Act* are amplified by the findings of Fistein *et al*. in their research comparing mental health legislation enacted in a variety of Commonwealth jurisdictions.[44] The study applied to selected Commonwealth mental health legislation a multi-axial framework based on the World Health Organization ("WHO") Mental Health Policy and Report of the Expert Committee 10 of

[38] *Ibid*., subsection.8.01(3).
[39] *Ibid*., sections.8.2-8.4.
[40] Freeman, M.C., Caldas de Almedia, J.M., Kleinman, A., Makhasvili, N., Phakathi, S., Saraceno, B. and Thornicroft, G, *Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities*, The Lancet Psychiatry, 2015, 2:9, 844-850.
[41] Ibid.
[42] Arstein-Kerslake, A. and Flynn, E, *The General Comment of on Article 12 of the Convention on the rights of persons with disabilities: a roadmap for equality before the law*, The International Journal of Human Rights, Volume 20, 2016 – Issue 4.
[43] *Mental Health Act*, section. 7.1.
[44] Fistein, E.C., Holland, A.J., Clare, I.C.H. and Gunn, M.J., *A comparison of mental health legislation from diverse Commonwealth jurisdictions*, International Journal of Law and Psychiatry, 2009, 32, 147-155.

the Council of Europe ("CE").[45] The WHO guidelines support United Nations Resolution 46/119 and the *Universal Declaration of Human Rights*,[46] and generate an autonomy rating of 16 in multi-axial framework.[47]A purpose of the analysis conducted by Fistein *et al*. was to assess the compliance of various legislations to the guidance provided by the WHO and the CE, particularly regarding respect for individuals' autonomy and fair assessment of their capacity.[48]

The study's framework establishes measures of autonomy on five axes: diagnosis, therapeutic aim, risk, capacity (for hospitalization and for other treatment) and review process.[49] On the diagnosis axis, for example, five levels of autonomy are identified, from "Level 1: No definition of mental disorder in the legislation, and no standard set for determining its presence" to "Level 5: Narrow 'disorder' approaches – based on internationally recognized system of classification, e.g., ICD-10 or DSM-IV." Regarding capacity, the framework contemplates three levels of autonomy, being "Level 1: No capacity threshold – treatment permitted without a capacity assessment…"; "Level 2: Outcome approaches – the patient makes an irrational choice …" and "Level 3: Ability approaches: the patient is found to lack the ability to make the treatment decision." In essence, the framework measures the extent to which legislation considers DMC. Statutes that contain no DMC assessment produce low autonomy measures on the framework's axes permits and encourages paternalistic treatment of individuals who are challenged by, or who are perceived to be challenged by, mental disability.[50] In turn, paternalism can offend an individual's prima facie right to self-determination.[51]

Fistein *et al*. applied their autonomy scale to the mental health legislation in Canada's 10 provinces and in the 2 territories that existed at that time, amongst other Commonwealth jurisdictions. The New Brunswick *Act* scored an autonomy rating of 14, which was lower than the ratings of all other Canadian jurisdictions except for the provinces of Newfoundland and Quebec.[52] The *Act* scored at the lowest level in respect of autonomy concerning patient admission/detention and treatment. In those regards, once an individual is deemed to be mentally disabled, the *Act* does not consider their capacity

[45] *Ibid*., 149.
[46] *Ibid*., 148.
[47] *Ibid*., 151.
[48] *Ibid*., 147-149.
[49] *Ibid*., 149.
[50] McMillan, J.R., *Mental illness and compulsory treatment,* in R.E. Ashcroft, A. Dawson, H. Draper and J.R. McMillan (Eds.), Principles of Health Care Ethics, (2nd ed.), 2007: John Wiley and Sons.
[51] Fistein et al., *supra* 44.
[52] *Ibid*., 151.

to self-determine admission/detention or treatment.[53] By contrast, the Province of Prince Edward Island has legislation similar to the *Act* but, that scores at the highest level of autonomy in respect of the treatment axis by requiring consideration of a subject individual's decision-making capacity before compelling treatment.[54] The provinces of Nova Scotia and Ontario and the territories of the Northwest Territories and the Yukon all scored equal to New Brunswick (and at the lowest level) regarding autonomy in respect of admission but, at the highest level of autonomy in respect of treatment, while Saskatchewan scored higher on both axes.[55] Amongst the most respectful Commonwealth jurisdictions of individual autonomy in their mental health legislation are 7 of 8 Australian territories, which are rated between 16 and 25.[56]

The Commonwealth jurisdiction with the highest score in the autonomy framework, the Northern Territory of Australia, requires an assessment of an individual's decision-making capacity and a confirmation that informed consent cannot be obtained before compelling either admission/detention or treatment.[57] In Scotland, the *Mental Health (Care and Treatment) (Scotland) Act, 2003*,[58] which generated a score of 22, also requires a determination that an individual's "ability to make decisions about the provision of medical treatment is significantly impaired" before admission/detention and treatment are imposed. It is of interest that Fistein *et al*. graded the legislation of England & Wales at 12 in total on the framework and Level 1 in respect of both admission/detention and treatment. Although, the *Mental Capacity Act 2005*[59] provides for an assessment of an individual's DMC, it also allows for compulsory admission and treatment when it is deemed to be in the patient's best interests to do so even if DMC exists.[60]

The New Brunswick *Act* advances a contrasting approach to more autonomy-respectful legislation in key areas. First, the *Act* does not assume an individual's DMC. Further, the *Act* does not insists that all practicable steps be taken to help an individual make a decision, it also does not contemplate that an individual with DMC should be permitted to make an unwise decision and it does

[53] See Note 24.
[54] *Ibid*. See also *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1.
[55] *Ibid.*
[56] *Ibid.*
[57] *Mental Health and Related Services Act*, 2016, Northern Territory of Australia.
[58] *Mental Health (Care and Treatment) (Scotland) Act,* 2003, A.S.P 13.
[59] *Mental Capacity Act* 2005, c 9 (UK).
[60] Fennell, Phil. *Best interests and treatment for mental disorder*. Health Care Analysis, 2008, 16(3), 255-267.

not inquire into the least restrictive means of imposing a decision on an individual when doing so is deemed necessary.

Recognizing that the current *Act* is discordant with foundational principles of the *Convention*, it is unsurprising that the Province of New Brunswick is in the process of considering replacement legislation (the "New Act") that may facilitate supervised community care (SCC) orders.[61] While the nature of proposed SCC orders in the New Act is not yet known, it is possible that they will resemble the Ontario community treatment order provision, since, in the author's view, New Brunswick has often followed Ontario in legislative drafting and since New Brunswick has expressed interest in aspects of the Ontario model. The Ontario legislation sets particular criteria for restricting a mentally disabled person's liberty which are dependent on medical rather than judicial assessments. For example, prior treatment in a psychiatric facility is a consideration that can favour the implementation of a CTO.[62]

CTOs often require individuals to comply with treatments that in some cases generate significant intended and unintended effects. But, in Ontario, CTOs have contained additional invasive directives such as required pregnancy testing, personal hygiene schedules, continuation in social support programs and even continuation in particular personal relationships.[63] Based on the use of similar orders in other jurisdictions, SCC orders under the New Act are expected to cover a range of forced treatments and other invasions of individual freedoms.

The concept of SCC orders has been introduced in other jurisdictions, including the United Kingdom[64] and most Canadian provinces,[65] with questionable results.[66] In their study of involuntary patients who were released from hospital on under either an SCC order or a leave without restrictions pursuant to s. 17 of the United Kingdom's *Mental Health Act*,[67] Burns *et al*. found that the number of

[61] Pillay, Sukanya and Aviv, Noa Mendelsohn, Letter to Premier Brian Gallant and Minister Boudreau regarding Mental Health Bill. Canadian Civil Liberties Association, June 23, 2016, https://ccla.org/cclanewsite/wp-content/uploads/2016/06/Letter-to-Premier-Gallant-Minister-Boudreau-re-mental-health-bill.pdf. Last visited January 3, 2017.
[62] *Mental Health Act*, R.S.O. 1990, c. M.7, s. 33.1.
[63] Fabris, Erick, *Tranquil Prisons: Chemical incarceration under Community Treatment Orders*, Toronto Press, Toronto: University of, page 65.
[64] *Mental Health Act 2007,* 2007 c 12, U.K..
[65] Rynor, B, *Value of community treatment orders remains at issue*. Canadian Medical Association Journal. 182(8):337-338.
[66] Tom Burns, Jorun Rugkåsa, Andrew Molodynski, John Dawson, Ksenija Yeeles, Maria Vazquez-Montes, Merryn Voysey, Julia Sinclair, and Stefan Priebe, *Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial,*The Lancet, 381, 9878, 11–17 May 2013, 1627-1633.
[67] *Mental Health Act, 1983*, 1983 c 20 U.K., see also Note 64.

patients from each group requiring readmission to hospital did not differ.[68] Further, the effectiveness of community treatment orders made in North America and other continents has also been called into question.[69] In Canada, the Schizophrenia Society of Ontario[70] and the Canadian Civil Liberties Association[71] have both observed the lack of conclusive evidence of the effectiveness of SCCs, and it has been noted that SCCs appear to generate negative outcomes including higher relapse rates, future treatment avoidance, mistrust of the system, perceptions of coercion and longer hospital stays.

Conclusion

In New Brunswick, the *Act* has fostered and is continuing to foster discrimination against disabled individuals by unreasonably restricting their legal freedoms and rights. As a jurisdiction that permits detention and even involuntary medical treatment of mentally disabled individuals (or those perceived to be mentally disabled) with only Level 1 autonomy protections rather that providing the same legal safeguards afforded to the non-disabled, it is conceivable that societal fears arising from mental disability stereotyping may have caused, and may continue to cause law enforcement officials, medical practitioners and public administrators to subordinate the rights of the disabled to protection of the public. This paper observes that, as compared to New Brunswick, some other jurisdictions have adopted mental health legislation that extends greater respect for the decision-making abilities of mentally disabled individuals and of their right to exercise those abilities. Especially in light of encouragements by the United Nations and the World Health Organization to maximize the autonomy of the mentally disabled, it is argued that New Brunswick should utilize its current review of the *Act* to consider and to ultimately implement legislative amendments that will identify and respect subjects' DMC. By introducing legislation that narrowly defines mental disability and that requires DMC assessment, New Brunswick and other jurisdictions will increase the opportunity for disabled individuals to achieve a more equitable position in society.

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[68] *Ibid.*

[69] See Note 61 referencing Dreezer & Dreezer Inc., *Report on the Legislated Review of Community Treatment Orders Required under Section 33.9 of the Mental Health Act* (prepared for the Ontario Ministry of Health and Long-Term Care, December 2005) at 124 and R.A. Malatest & Associates Ltd., *The Legislated Review of Community Treatment Orders: Final Report* (prepared for the Ministry of Health and Long-Term Care, May 2012) at 17; Kisely S., Campbell L. A.(2007). Does compulsory or supervised community treatment reduce "revolving door" care? Legislation is inconsistent with recent evidence, *British Journal of Psychiatry*, 191, 373-374.

[70] Scizophrenia Society of Ontario, *It Doesn't Work: Unpacking Mental Health Policy and Legislation*, April, 2013, page 32.

[71] See Note 48.