Mental Health Law Reform for a New Government in New Brunswick

Timothy T. Culbert*

1. Introduction

In February 2009, after almost a year of consultations with experts on mental health care, service providers, and people suffering from a range of mental illnesses, Judge Michael McKee released his report entitled *Together into the Future: A Transformed Mental Health System for New Brunswick.* This report contained over 80 recommendations to the provincial government for reforming the mental health care system including: strengthening community networks, reducing the stigma associated with mental illness and investing in early intervention through the education system.[1] This follows a trend in Canadian provinces of reforming mental health policies.[2] While this report was a positive step for the reform of New Brunswick's mental health care system, it was never acted upon.[3]

The then-Minister of Health for New Brunswick, Mary Schryer, did respond to the report in writing in September 2009, but expert reactions to this response

---

* B.A. (Saint Mary's University) 2003, M.A. (Wilfrid Laurier University) 2004, LL.B. (University of New Brunswick) 2011. Dedicated to the memory of my friend and classmate, Kevin Gervais. His untimely and tragic passing gave me the courage to continue researching and writing about mental health laws without fear of stigma.

1 See New Brunswick Department of Health, *Together Into the Future: A Transformed Mental Health System for New Brunswick* by the Hon. Judge Michael McKee (Fredericton: Minister of Health New Brunswick, 2009) [*McKee Report*].

2 See for example, Canada, Standing Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Ottawa: Senate of Canada, 2006), online: Senate of Canada <http://www. parl.gc. ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02may06part1-e.htm#_Toc133223057>.

3 The author wrote on this topic in a newsletter article for a National Mental Health and the Law Society started by students at law schools across the country. See Tim Culbert, "UNB Mental Health and the Law Society: A Time for Advocacy in New Brunswick" in *Compos Mentis (Having Mastery of the Mind), First Annual Newsletter by the Mental Health and the Law Society* (Fall 2009), online: Mental Health Law Society <http://mentalhealthlawsociety.com/wp-content/uploads/2010/01/ Fall_ Newsletter_2009_ Email_Version.pdf.>.

were mostly critical.[4] Following Schryer's response, the provincial government left the McKee Report on the shelf. In October 2010, a new government was elected in New Brunswick under the Progressive Conservative leadership of Premier David Alward. The Minister of Justice for this new government, Marie-Claude Blais, stated that she intends to review the McKee Report and move forward with some of its recommendations.[5]

Why is the reform of mental health laws in New Brunswick so important? One only needs to mention the name "Ashley Smith" and the answer to this question comes into sharp focus. Our mental health laws have let us down: they stigmatize the mentally ill, they criminalize the mentally ill, and they tend to paint all people suffering from mental illness with the same brush. While it is beyond the scope of this paper to delve further into Ashley Smith's story, one cannot properly analyze mental health laws in New Brunswick without mentioning this terrible tragedy.[6]

The purpose of this paper is to analyze the current status of New Brunswick's mental health care system against this backdrop and to provide ideas for reform. These suggestions for reform focus primarily on mental health legislation. They underscore the fact that legislation plays a key role in mental health care. This point has been forgotten in the various government reports to date. Thus, in this paper I argue that the fact that the new Minister of *Justice* (as opposed to the new Minister of Health) is considering this report is significant. This paper uses the theory of therapeutic jurisprudence as a lens through which to analyze the current status of mental health laws in New Brunswick.

Section II defines the concepts of "mental health law" and "therapeutic jurisprudence" and then briefly describes some of the key issues discussed by mental health law academics. Because mental health law is a vast domain, many topics such as criminal responsibility, discrimination in the workplace, and adult guardianship legislation, for example, will remain untouched.

---

[4] For example, Dr. Jane Walsh was highly critical of the government's response: "My initial impression, and one I share with my colleagues, is that we are disappointed...Although we feel the intention is good on the government's behalf in acknowledging some of the key area that need to be addressed, we really felt the minister's response lacked substance." See Adam Huras, "Psychologists Pan Response to Mental Health Report" *The Telegraph Journal* (1 October 2009) A3, online: Telegraph-Journal <http://telegraphjournal.canadaeast.com/rss/article/809685>.

[5] See "Mental Health Review will be Revisited: Blais, Judge Michael McKee's report contained 80 reforms but was never acted on" *CBC News (13 October 2010),* online: *CBC News* < http://www.cbc.ca/canada/new-brunswick/story/2010/10/13/nb-blais-mckee-report-mental-health-1243.html > [Mental Health Review will be Revisited].

[6] For a full account of Ashley Smith's story and accompanying recommendations, see New Brunswick, Ombudsman and Child and Youth Advocate, *The Ashley Smith Report,* (Fredericton: Office of the Ombudsman & Child and Youth Advocate, 2008).

Section III provides a cursory overview of mental health legislation in Canada. It emphasizes the coercive nature of mental health laws in Canada. The New Brunswick *Mental Health Act* is used as an example in this section, even though I recognize there are differences among provincial mental health laws. While my understanding of Canadian mental health laws aligns somewhat with Kaiser, I have significant criticisms of his approach to mental health law reform. Indeed, Kaiser's dislike of the "medical model" is overstated. Therefore, while his research and analysis of Canadian mental health laws is exceptional, I argue that there are times when the medical treatment of people with mental illness is the only alternative. Thus, I am more aptly a proponent of Gray et al.'s "human needs perspective."[7]

Section IV evaluates the McKee Report and submits that one of the key shortcomings of this report is its failure to include legislative reform within its list of recommendations. This section concludes by providing suggestions for legislative reforms that will enhance mental health laws in the province of New Brunswick and lead to stronger protection of the rights of the mentally ill.

I conclude that if we are to properly reform the mental health care system in New Brunswick, the government should review and revise the *Mental Health Act* and move it away from its current "coercive nature" by incorporating positive rights in order to empower individuals suffering from mental illness. However, I do not suggest that in order to reform the mental health system we must completely move mental health legislation away from the medical model. Instead, I argue that there is a place for the medical model in treating individuals with serious mental illnesses, but this model must be balanced with legislative change, more efficient community-based treatment and programs that utilize the government's administrative tools to promote mental health awareness.

2. Understanding Mental Health Law

(A) Definition of "Mental Health Law"

One of the greatest challenges faced in analyzing mental health law is defining the terms. Indeed, attempting to find a standard definition of "mental health law" is challenging. Bartland and Sandland state that "mental health law and policy is, by its very definition, an interdisciplinary study. It is not an area where law should be considered independently, divorced from the realities of clinical practice or life for the client in the community."[8] The legal and medical communities in New Brunswick

---

[7] *See* H. Archibald Kaiser, "Mental Disability Law" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 2d ed (Markham: Butterworths Canada, 2002), 251 at 263-265 [Kaiser, "Mental Disability Law"]. Kaiser draws a distinct line between proponents of the "human needs" perspective, such as Gray et al., and proponents of the "disability model," such as himself.

[8] Peter Bartlett & Ralph Sandland, *Mental Health Law: Policy and Practice*, 3d ed (Oxford: Oxford

are thus left to try to create a tenable definition of "mental health law" by piecing together various definitions concerning "mental illness," "disability" and examining how these areas interact with the law. Black's Law Dictionary defines "mental illness" as follows:

> 1. A disorder in thought or mood so substantial that it impairs judgment, behavior, perceptions of reality, or the ability to cope with the ordinary demands of life. 2. Mental disease that is severe enough to necessitate care and treatment for the afflicted person's own welfare or the welfare of others in the community.[9]

Barron's Canadian Law Dictionary defines "mental disorder" as:

> A disease of the mind or mental illness; used as a defence to criminal charges... disease of the mind is broadly interpreted. It embraces any illness, disorder or abnormal condition which impairs the human mind and its functioning, excluding, however, self induced states caused by alcohol or drugs, as well as transitory mental states such as hysteria or concussion.[10]

These definitions reflect a common theme in mental health law literature: that "mental health law" is often defined with reference to an individual's functioning vis-à-vis the community. This theme assumes that a mentally ill individual is or will become a threat to him or herself or others in the community. Thus, laws that deal with mental illness in Canada refer to "worst-case" scenarios or emergency situations, leaving a large demographic of individuals with mental illness without the protection of or protection from legislation.

Kaiser provides an instructive definition of "mental disability law":

> "Mental disability law" is not used here with the same precision as "contracts" or "torts." Instead, it is an umbrella term which embraces any impairment that affects a person's emotional or cognitive functions, with a focus upon the legal dimensions of disability. One then looks for the ways in which the disability attracts the attention of the law and, in particular, one strives to see the precise legal effects of disability on an individual's existence as a citizen and member of society.[11]

University Press, 2007), at 31.

[9] *Black's Law Dictionary*, 9th ed, *sub verbo* "mental illness".

[10] John A. Yogis & Catherine Cotter, *Barron's Canadian Law Dictionary* (Hauppauge, NY: Barron's Educational Series, 2009) at 175, *sub verbo* "mental disorder".

[11] Kaiser, "Mental Disability Law", *supra* note 7 at 253.

It is important to recognize that three unique definitions of mental diseases are presented above: it is first defined as "mental illness;" it is next defined as "mental disorder;" and finally, it is referred to as a "mental disability." The varying definitions of mental diseases reflects different authors' views on exactly what is a mental disease. On the one hand, proponents of the "medical model" of mental health law view mental disease as an "illness" comparable to physical illness, which requires medical treatment (by therapy or medications) to mitigate the consequences of the illness. On the other hand, critics of the medical model argue that defining mental disability as an "illness" allows medical professionals to label individuals. One clinical psychologist makes the following observations:

> Labels are depersonalising and strip people of their individuality by making assumptions without getting to know the person. The use of labels by mental health professionals could be viewed as defensive, as a means of distancing oneself from the service user by treating them as different by virtue of the label.[12]

The section below on mental health laws in Canada further examines the academic debates surrounding mental health law and terminology. One should note that this area is highly politicized and wording must be approached with care.

Gray et al. state, "the term 'mental health law' covers three types of legislation: the 13 *Mental Health Acts*, the *Criminal Code of Canada* mental disorder sections and provincial/territorial consent to treatment, adult guardianship and adult protection legislation."[13] This paper primarily uses the first of these definitions, reviews legislative reforms to mental health acts proposed by various academics across Canada, and applies these suggestions for reform to the New Brunswick context.

(B) Definition of "Therapeutic Jurisprudence"

In the early 1990s Wexler and Winick became aware that "mental health law" as an area of academic study had "lost its driving force and much of its lustre."[14] Mental health law, according to these authors, was born out of the civil rights movement in the US and was buttressed by a concern for the constitutional rights of patients suffering from mental illnesses. Wexler and Winick responded to a lull in mental health law research by proposing new approaches to analyzing mental health policies

---

[12] Hellen Scott, "The medical model: the right approach to service provision?" (2010) 13:5 Mental Health Practice 27 at 27.

[13] John E Gray, Margaret A. Shone & Peter F. Liddle, *Canadian Mental Health Law and Policy*, 2d ed (Markham, Ont: LexisNexis Canada, 2008) at 1 [Gray, Shone & Liddle].

[14] David B. Wexler & Bruce J. Winick, "Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research" (1991) 45 U Miami L Rev 979 at 979-80.

and legislative reforms. Thus, the authors proposed a new lens through which to view mental health law research, called "therapeutic jurisprudence." This theory is:

> interdisciplinary, empirical, and international in its orientation. It seeks to sensitize legal policymakers to a frequently ignored aspect of mental health law policy analysis—the therapeutic impact of legal rules and procedures—and to serve as a tool to frame a new and useful research agenda.[15]

Diesfeld and Freckelton provide the following definition of therapeutic jurisprudence: "... [it is] a lens through which the effects of the law can be viewed and analyzed. It inquires whether the law is, or could be, employed for pro-therapeutic ends."[16]

(C) Mental Health Laws in Canada

i. Coercive Nature of Legislation

Mental health legislation in Canada has a "long and frightening history."[17] Indeed, it is a misnomer to name the provincial statutes "mental health acts" because they deal primarily with treatment, admission and discharge from a hospital.[18] The mental health acts in provinces across Canada are similar insofar as they regulate under what circumstances individuals with mental illness can be involuntarily committed and treated within care facilities.

In the early days provincial mental health acts referred to the mentally ill as "lunatics" or "insane." These references came from the reception of the *British Lunatic Asylums Act* in various forms in provinces across the country. In British Columbia, for

---

[15] *Ibid* at 981.

[16] Kate Diesfeld & Ian Freckelton, "Mental health law and therapeutic jurisprudence" in Ian Freckelton & Kerry Petersen, eds, *Disputes and Dilemmas in Health Law* (Sydney, Australia: The Federation Press, 2009) 91 at 91. Therapeutic jurisprudence has been applied in many legal and policy settings both within and outside mental health law. For instance, Schneider, Bloom and Hereema discuss this theory's usefulness in developing "problem solving" courts throughout North America such as drug courts, prostitution courts, juvenile mental health courts, domestic violence courts, child abuse courts, aboriginal courts, teen courts, handgun courts, and homeless courts. According to these authors, therapeutic jurisprudence arose in response to court dockets that were over-crowded with the mentally ill. Hence, proponents of therapeutic jurisprudence suggest that legal institutions (i.e. the court) can be used for pro-therapeutic means; See Richard D. Schneider, Hy Bloom & Mark Heerema, *Mental Health Courts: Decriminalizing the Mentally Ill* (Toronto: Irwin Law, 2007) at 40.

[17] Lorne E. Rozovsky, *The Canadian Law of Consent to Treatment* 3d ed (Markham: LexisNexis Canada, 2003) at 61.

[18] See Nigel Eastman & Jill Peay, *Law Without Enforcement: Integrating Mental Health and Justice* (Oxford: Hart Publishing, 1999) at 1-2.; while these authors focus on the UK, their comments are nonetheless relevant to the Canadian context.

example, the UK *Act* became the *British Columbia Insane Asylums Act* of 1873.[19] From the beginning, provincial mental health acts contained built-in stigmas and prejudices because they referred primarily to protecting society from the mentally ill and to institutionalization for the welfare of those with mental illness. Little mention was given to the rights of individuals under early mental health legislation; individuals with mental illness could be institutionalized and treated in psychiatric facilities based on broadly worded criteria without an opportunity to appeal this decision. All that was required was that an attending physician believed treatment was "necessary."

After the *Charter*, many provincial governments were forced to change their mental health statutes. For example, in *Lussa v The Health Science and Director of Psychiatric Services*, Kroft JA for the Manitoba Court of Queen's Bench held that the detention of an individual who shows moderate signs of mental illness without providing him or her with a meaningful opportunity to question the decision of the attending physician was a violation of that person's *Charter* rights under ss. 7, 9 and 10.[20]

The key criterion for the involuntary committal of mentally ill persons today is based on the wording, "danger to oneself or others." While this is a narrower criterion than before, the acts still deal with worst-case scenarios under which the mentally ill are seen as a threat to themselves or others. As a consequence, these acts are "incompatible with the needs of the majority of mentally disordered people, who are, and are most sensibly treated, within the community."[21] Also, they continue to carry with them underlying stereotypes that *all* persons with mental illness are "violent" or "dangerous" or "unable to make their own decisions."[22]

ii. Debates in Mental Health Law Academia

Much debate about mental health law reform in Canada has revolved around the coercive nature of provincial mental health laws. On the one hand, authors such as

---

[19] Gray, Shone & Liddle, *supra* note 13 at 34.

[20] See *Lussa v. The Health Science And Director of Psychiatric Services* (1983), 9 CRR 350 (MBQB). In this case, the accused was involuntarily committed in a Winnipeg care-facility after causing a disturbance in a restaurant. Upon delivering Ms. Lussa to the hospital, the attending physician committed her for twenty-one days under Section 9 of the Manitoba *Mental Health Act*, RSM 1970, c. M110, s. 9(1) as amended by RSM 1980, x. 62, ss. 15, 38. Under this section, police could detain someone who "is believed to be mentally disordered or in need of treatment such as is provided in a hospital."

[21] Eastman & Peay, *supra* note 18 at 2.

[22] Sensationalized media stories about people with mental illness have played into these stereotypes. One need not look any further than the story of Vincent Li, who was found not criminally responsible for decapitating Tim McLean while the two were passengers on a Greyhound bus en-route to Winnipeg, MB. Manitoba Court of Queen's Bench Justice, John Scurfield, held that Li was obviously suffering from a major mental illness and therefore could not be held responsible for his actions; *See* Mike McIntyre, " 'I saw the entire attack, heard the screams...' Vincent Li not criminally responsible for bus killing, beheading, cannibalization", *Winnipeg Free Press* (6 March 2009).

Gray, Shone and Liddle present a "human needs perspective," which focuses on balancing the rights of individuals with mental illness against their need for treatment. Proponents of this approach argue that people with severe mental illnesses should be admitted and/or involuntarily treated by health care workers if voluntary treatment is not a viable option. However, treatment must be administered in the least restrictive manner possible in order to adhere to the patient's *Charter* rights.[23] This approach recognizes a biological basis for mental illness. Gray, Shone and Liddle argue that a plethora of evidence suggests that mental illness is a biological phenomenon: "strong hereditary loading, brain structural abnormalities, brain functioning abnormalities, brain chemical abnormalities and therapeutic response to biologically active chemicals (medications)."[24]

On the other hand, mental health authors who support a "civil libertarian" approach to mental health law are more critical of state intervention in the lives of people with mental illnesses. One such author, Professor Kaiser, argues that "the early twenty-first century substantive legislative regime emerges as more paternalistic and interventionist than its predecessors of the previous three decades."[25] He maintains that the "medical model" wrongly treats a person with mental illness as though he or she is abnormal and in need of medical treatment in order to eradicate the behaviours associated with the illness. The psychiatrist in this model

> becomes the authority figure and decision maker, wielding the wide discretionary powers provided by legislation, to ensure that ill individuals, once several preconditions are present, can be forcible assessed, hospitalized and treated.[26]

Based on this assessment, Kaiser supports a "disability model" for assessing mental health laws. Building on Supreme Court of Canada cases such as *Eldridge* and *Swain*, he argues that society's stigmatizing views of people with mental illness is one of the greatest threats to equality. This, he claims, leads to a paternalistic state that makes decisions for the best interest of people with mental disabilities instead of recognizing that discrimination and improper characterization of people with mental illness further denigrates their ability to receive proper treatment.

iii. A Balanced Approach for Mental Health Law Research

Throughout this paper I use the term "mental illness" to signal support for the "human needs perspective" of mental health law research. In his search for an equality-based

---

[23] Gray, Shone & Liddle, *supra* note 13 at 10-12.

[24] *Ibid* at 10.

[25] H. Archibald Kaiser, "Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State" (2009) 17 Health L.J. 139 at 139 [Kaiser, "Redirecting the Ship"].

[26] *Ibid* at 7.

approach to mental health research, Kaiser too quickly dismisses the medical model in its entirety. He is correct in judging mental health legislation as coercive and discriminatory, but he fails to recognize that mental illness has been shown to have biological roots and is not merely a social construct. By this statement, I am not denying that, through the medical model, people have been wrongfully detained and treated within care facilities because they were thought to be a threat to themselves or others. However, the legal community must acknowledge that psychiatrists and psychologists are trained experts in their field and that they are likely the best suited to be making decisions *if* an individual is not able to make decisions for him or herself. Indeed, if medical professionals are not best suited to be dealing with issues concerning mental illness, or mental "disability" as it may be called, then where would we turn to ensure that individuals with severe mental illness are best able to receive the treatments they need?[27]

On the other hand, we must not allow the medical model to become too hegemonic. It is true that stigma and discrimination associated with this model have historically hampered the rights of individuals with mental illnesses. Nevertheless, a proposal that seeks to seriously restrict the reach of the medical model is bound to fail. It is likely that medical professionals will not take kindly to a complete discharge of their ability to make medically informed decisions on behalf of and for their patients.[28]

How, then, can we find a middle ground between proponents of the medical and disability models of mental health law research? In this paper, I argue that there is a need to build bridges between the legal, policy and medical professions in order to establish best practices and progressive legislative changes, which will allow for stronger protection of the rights of people with mental disabilities. This approach represents a middle ground between the medical and disability models. It respects the knowledge and expertise of the medical profession but recognizes that the law has an important role to play in upholding the rights of the mentally disabled.[29]

---

[27] For example, the Canadian Schizophrenia Society supports early intervention as a key way to reduce suffering and future reoccurrence of symptoms. *See* Canadian Schizophrenia Society, *Early Intervention in Schizophrenia,* online: Canadian Schizophrenia Society <http://www.schizophrenia .ca /Early InterventionInSchizophrenia.pdf>.

[28] One-time Psychiatrist-in-Chief and Clinical Director at the Queen Street Mental Health Centre, Toronto, describes this dilemma in the following manner: "While there are differences of opinion, my impression is that psychiatrists generally feel attacked from both sides of the patients' rights debate. They do not want to function as agents of social control and wish to distance themselves from historically negative reputations. Yet they feel their responsibilities and commitment to the care and treatment of their patients." See Dr. Samual A. Malcolmson, "Are Mental Health Laws a Barrier to Treatment?" (1988/89) 9 Health L. Can. 14.

[29] Luther and Mela state that one of the top ten issues in law and psychiatry is the strained relationship between doctors and lawyers. According to these authors, "[d]octors...are interested in treating patients and have very little interest in looking backward in time to dissect past events that often have little relation to their interest in treating present medical conditions." See Glen Luther & Mansfield Mela, "The Top Ten Issues in Law and Psychiatry" (2006) 69 Sask L Rev 401 at 437-38.

Instead of viewing the medical model as a foreign and undesirable system that strips the rights of individuals with mental illness, the medical model should be respectfully criticized for carrying with it the stigmas inherent in the legislation. However, these criticisms must regard medical professionals as important stakeholders in the process of reforming the mental health care system through legislation. This paper discusses below the recommendations in the McKee Report for reforming New Brunswick's mental health care system. Coordination and collaboration of government departments is a consistent theme of this report. This coordination should include legislative policymakers and members of the mental health care profession in order to properly reflect all interests affected by reform.

3. Informed Consent, the NB Mental Health Act and Key Canadian Cases

(A) Common Law Doctrine of Informed Consent

The common law of informed consent to medical treatment applies when an individual with a mental illness is able to make decisions for him or herself. The current law of informed consent to medical treatment was primarily established in two cases.

In *Hopp v Lepp,* the Court defined "material risks": "Materially connotes an objective test, according to what would reasonably be regarded as influencing a patient's consent."[30] Under this test, a physician must "disclose the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation."[31] If a physician does not properly disclose all material facts of a medical procedure, the second stage of the informed consent test in Canada looks at "what the patient would have chosen to do had there been proper disclosure."[32] Exceptions to the common law doctrine of informed consent arise when an emergency situation necessitates treatment in order to save an individual's life, or when a patient waives her right to refuse treatment.[33]

In *Reibl v Hughes*[34] the Supreme Court of Canada held that a doctor was negligent because he failed to provide adequate information to a patient who underwent surgery for a blocked artery. The Court established that a physician has a duty to disclose the material risks associated with a medical procedure. The Court held that Dr. Hughes did not properly dispose of his duty to inform after Mr. Reibl suffered a crippling stroke, which paralyzed his right arm. This left Mr. Reibl unable to continue to work, thus excluding him from receiving his pension. Had he known that this risk

---

[30] [1980] 2 SCR 192 at para 32, 112 DLR (3d) 67, Laskin CJ.

[31] *Ibid* at para 34.

[32] C. Adèle Kent, *Medical Ethics: The State of the Law* (Markham, Ont: LexisNexis Canada, 2003) at 133.

[33] For a more in depth discussion of these exceptions, See Sarah MacKenzie, "Informed Consent: The Right of Psychiatric Patients to Refuse Treatment," (1993) 2 Dal J Leg Stud 59.

[34] [1980] 2 SCR 880, 114 DLR (3d) 1.

was possible, he stated that he would not have chosen to undergo the surgery at that time.

(B) New Brunswick Mental Health Act and Psychiatric Treatment

i. Voluntary vs. Involuntary Committal and Key Canadian Cases

In New Brunswick a patient can consent to voluntary committal within a care facility under s. 7 of the *Mental Health Act*.[35] In order to legally consent to further treatment once an individual is admitted in a care facility, the following common law steps from *Reibl* must be satisfied:

1. The consent must be a consent to the treatment actually performed;

2. The consent must be voluntary;

3. The consent must be informed; and

4. The person must be mentally competent to consent.[36]

The common law of informed consent is codified in section 1(2) of the New Brunswick *Mental Health Act*:

> 1(2) For the purposes of consent under this Act, a person is mentally competent to give or refuse to give consent if the person is able to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or refusing to give consent, and, if the consent relates to a proposed treatment for the person, the subject-matter is the nature of the person's illness and the nature of the proposed treatment.[37]

Voluntary consent to treatment poses fewer problems for mental health law academics than does involuntary commitment and treatment under the *Mental Health Act*.[38] Involuntary commitment is based on two different powers of the state: the police

---

[35] *Mental Health Act*, RSNB 1973, c. M-10, s 7 [Mental Health Act].

[36] Harvey Savage & Carla McKague, *Mental Health Law in Canada* (Toronto: Butterworths, 1987) at 99.

[37] *Mental Health Act*, *supra* note 35, s 1(2).

[38] For a comparative review of voluntary and involuntary committal, See Gerald B. Robertson, *Mental Disability and the Law in Canada*, 2d ed (Scarborough: Thomson Canada, 1994) ch. 15 at 367.

power and *Parens partria* power.[39] Under section 7.1(1) of the New Brunswick *Mental Health Act*, a person can be involuntarily committed in a care facility

> if a physician examines [that] person and is of the opinion that the person (a) may be suffering from a mental disorder of a nature or degree so as to require hospitalization in the interests of the person's own safety or the safety of others, and (b) is not suitable for admission as a voluntary patient.[40]

Involuntary committal provisions in mental health acts have been the subject of much litigation throughout Canada. For example, in *Fleming v Reid,*[41] Robins JA for the Ontario Court of Appeal held that the treatment of individuals with neuropathic drugs, who refused this treatment when they were competent to do so, is a violation of their section 7 *Charter* right to security of person and is not demonstrably justifiable in a free and democratic society under section 1. In this case, two individuals with schizophrenia were involuntarily committed and treated within a care facility. Their legal guardian refused consent to this treatment on their behalf, explaining that the two men had earlier refused the treatment at a time when they had the requisite capacity to do so.

Following this refusal of treatment, Dr. Fleming applied under section 35a(1) of the Ontario *Mental Health Act*[42] to the mental health review board to authorize the involuntary treatment of Reid and Gallagher. The board granted his request. On appeal, the District Court held that the Review Board's decision was not a violation of the appellant's *Charter* rights. The Ontario Court of Appeal allowed an appeal, overturned this decision, and declared sections 35a and 35(2)(b)(ii) of the *Mental Health Act* inoperative. Robins J.A. for the Court stated in his decision that "[f]ew medical procedures are more intrusive than the forcible injection of powerful mind-altering drugs which are often accompanied by severe and sometimes irreversible adverse side-effects."[43]

Many cases have either followed or approved of the decision in *Fleming v. Reid.*[44] In *Starson v Swayze*[45], for example, the majority for the Supreme Court

---

[39] For a more in depth discussion of these two powers of the state as they are applied under the *Mental Health Acts*, See Carla McKague, "Involuntary Hospitalization: Are New Mental Health Laws Necessary? A Patients' Rights Perspective," (1988) 9 Health L. Can. 15 at 15.

[40] *Mental Health Act, supra* note 35, s. 7.1(1)

[41] (1991) 4 OR (3d) 74, 82 DLR (4th) 298 (Ont CA) Robins JA [*Fleming*].

[42] RSO 1980, s 262, ss 35a and 35(2)(b).

[43] *Fleming, supra* note 41 at para 42.

[44] For example, see *Canadian Aids Society v. Ontario*, (1995) 25 OR (3d) 388 (ONCJ).

[45] [2003] 1 SCR 722, 225 DLR (4th) 385.

of Canada agreed with the Ontario Court of Appeal, which upheld the ruling of the Ontario Superior Court of Justice. The Superior Court of Justice had overturned the decision by the Consent and Capacity Board to involuntarily commit and treat Professor Starson for bipolar disorder. Citing *Fleming*, Major J asserted that "the right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy. This right is equally important in the context of treatment for mental illness."[46]

Major J for the majority in *Starson* held that the Consent and Capacity Board was unreasonable in its decision that Professor Starson lacked the requisite capacity to refuse treatment. In coming to this decision, he noted that the board wrongfully applied the two branches of the capacity test for involuntary treatment. Further, he stated that there is a presumption that an individual with a mental illness has the requisite capacity necessary to make decisions for his/herself. The onus of rebutting this presumption rests with the party attempting to treat an individual against her will.

McLachlin CJ in dissent provided an excellent outline of the test that must be applied in determining capacity:

> I would summarize the important points as follows:
>
> 1. The person is presumed to be competent and the standard of proof for a finding of incapacity is a balance of probabilities.
>
> 2. The test relates to the capacity or ability to understand and appreciate, not actual understanding and appreciation.
>
> 3. The first component of the test for capacity is that the person be "able to understand the information that is relevant to making a decision about the treatment" at issue.
>
> 4. The second component of the test is that the person be "able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."[47]

According to the majority in this case, the mere fact that an individual has a mental illness is not sufficient evidence to conclude that the individual is incapable of refusing treatment.

---

[46] *Ibid* at para 75.

[47] *Ibid* at para 13.

ii. Lack of New Brunswick Case law

Few cases have been brought to New Brunswick's courts that have questioned holdings of Mental Health Tribunals under the *Mental Health Act*. *Chiasson v Bathurst Regional Hospital*[48] is one of the few cases dealing with s. 7.1(1) of the *Mental Health Act* that was brought before the New Brunswick Court of Appeal. In this case, the judge of the Provincial Court ordered that Mr. Chiasson be detained by police and brought to a psychiatric care facility for examination pursuant to s. 9 of the *Mental Health Act*.

Mr. Chiasson was later diagnosed with paranoid delusions and was kept in the hospital for examination pursuant to s. 7.1(1) of the *Mental Health Act*. In the opinion of the attending psychiatrist, he "suffered from a mental disorder...he represented a threat of physical harm to himself or others, and...he was not capable of giving or refusing his consent to undergo medical treatment due to his mental condition."[49]

In December, 2000, a tribunal heard an application from another psychiatrist, recommending that Mr. Chiasson be involuntary committed in the psychiatric ward of the hospital pursuant to section 7.1(1) of the *Act*. The tribunal held that further detention was unwarranted. Mr. Chiasson applied to the Court of Queen's Bench under Rule 16.04(j) of the New Brunswick Rules of Court for compensation, arguing that he was arbitrarily detained by the hospital and its staff, was subject to cruel and inhuman treatment and punishment, and for an alleged attempted murder. Both the Trial Court and the Court of Appeal dismissed Mr. Chiasson's applications. Applying *Steeves v Moncton (City)*[50]., the Court of Appeal held that an individual cannot use rule 16.04(j) of the NB *Rules of Court* to bring a case before the court if there are significant facts in dispute. In this situation the Court decided that there were too many facts in dispute to bring the case forward in this way. [51]

iii. Therapeutic Jurisprudence and the New Brunswick Mental Health Act

As we can see from the preceding analysis, most cases dealing with the *Mental Health Act* refer to detention and treatment within a care facility. The characteristics of the *Act* described herein have been rightly criticized by mental health law academics. Indeed, Kaiser is not alone in his disdain for current day mental health acts and the medical

---

[48] 2006 NBCA 30, 297 NBR (2d) 311.

[49] *Ibid* at para 3.

[50] (2003), 42 NBR 465, 17 DLR 560 (QB).

[51] Rule 16.04(j) of the NB *Rules of Court* refers to a "Notice of Application...Where an Act or rule authorizes an application or motion to the court without requiring the institution of an action, a Notice of Application (Form 16D) may be used and, in addition thereto, a proceeding may be so commenced where the relief claim is (j) in respect of any other matter where it is unlikely that there will be a substantial dispute of fact." Thus, the Court of Appeal in this matter dismissed Mr. Chiasson's applications based on purely procedural grounds. Curiously, no further filings were made by Mr. Chiasson after this dismissal.

model upon which they were founded.[52] The problem, Savage and McCague explain, relates to the history of mental health laws and their relationship with the *parens patria* and police powers of the state:

> *Parens partria* is a concept derived from both Roman and English law that in some circumstances the state should relate to the citizen as a parent to a child. In Roman law it originated in the fifth century B.C. in the Twelve Tables, which provided for non-judicial personal guardianship in the following manner:
>
> > If a person is a ***fool***, let his person and his goods be under the protection of his family or his paternal relatives, if he is not under the care of anyone.[53]

Seen through the lens of therapeutic jurisprudence, mental health laws can have a profoundly negative impact on the rights of people suffering from mental illnesses.[54] They are subject to age old labels that define people with mental illnesses as "lunatics" and other pejorative terms.[55] However, there are some safeguards of rights both inside and outside of the *Mental Health Act*. For example, section 7.6(1) of the *Act* allows the Lieutenant-Governor in Council to "designate persons, services or organizations as psychiatric patient advocate services."[56] Section 7.5 creates tribunals to hear applications by physicians for the involuntary commitment of psychiatric patients. Section 30 creates a review board staffed by one practicing lawyer, one physician and one person who is neither a lawyer nor a physician.

---

[52] For a physician's view of the "medical model", see George L. Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," (1977) 196:4286 Science at 129.

[53] Savage & McCague, *supra* note 36 at 74 [emphasis added].

[54] See David B. Wexler, "Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence" (1992) 16 Law & Hum.Behav. 1. What is particularly interesting about this article are Wexler's views on the "anti-psychiatry movement" in the United States. This movement seems to parallel arguments made by Kaiser, who shows distrust of the medical profession. Wexler's commentary is particularly instructive: "Accordingly, mental health law has in large measure been part of the antipsychiatry movement, mistrust of the mental health disciplines and of their practitioners...The lesson—learning to be sceptical of supposed scientific expertise—is an important one, and I doubt the law will ever again simply defer to psychiatry and the related disciplines, as it once did in the area of civil commitment of the mentally ill. But to the extent that the legal system—and even legal academics—now ignore developments in the mental health disciplines, the lesson of healthy scepticism has been overlearned.".

[55] For an interesting look into the history of the term "lunatic" in mental health law, see Richard D. Schneider, *The Lunatic and the Lords* (Toronto: Irwin Law, 2009). In this book, Schneider, a former psychologist and current Judge of the Toronto Mental Health Court, takes us through the story of the famous "*M'Naughten* case." This case still stands today as the foundation for determining criminal responsibility as it applies to mental disorder. In the forward, Professor Kent Roach states that "readers familiar with modern law and psychiatry will also find much in this marvellous book that is familiar. Public suspicion and even fear of those who suffer from mental disorder remain a regrettable constant."

[56] *Mental Health Act*, *supra* note 35, s 7.6(1).

Many of these rights safeguards were implemented in provincial mental health laws in the post-*Charter* era. These rights include:

> (a) the right] to be informed promptly of the reasons therefor; [for the detention]
>
> (b) [the right] to retain and instruct counsel without delay and to be informed of that right and
>
> (c) [the right] to have the validity of the detention determined by way of habeas corpus and to be released if the detention is not lawful.[57]

As stated earlier, these rights relate primarily to individuals with severe mental illnesses, leaving out a large demographic of society. All individuals with mental disabilities are protected under section 15 of the *Charter* and under various sections of the *Human Rights Act*.[58]

However, these are negative rights, meaning that individuals are protected against the infringements of others, but no correlative *positive* duty is placed on government to provide sufficient services for the mentally ill. As the SCC stated in *Chaoulli v Quebec (Attorney General)*, the "*Charter* does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*."[59] While I do not agree with Kaiser's anti-medical model approach to mental health law, discussed below, I argue below that his criticisms of mental health legislation and his arguments for legislative reform are correct.

4. Current Status of Mental Health System in NB and McKee Report

(A) Mental Health Care in New Brunswick

Like other provincial mental health systems, the New Brunswick mental health care system currently faces many serious setbacks. While available empirical data is minimal, some statistics are available concerning people with mental illnesses in New Brunswick. According to the 2008/09 annual report from the New Brunswick Department of Health, 15,872 individuals received treatment under the category of

---

[57] Gray, Shone & Liddle, *supra* note 13 at 27.

[58] For example, the *Human Rights Act*, RSNB 1973, c H-11 protects against discrimination "because of race, colour, religion, national origin, ancestry, place of origin, age, physical disability, *mental disability*, marital status, sexual orientation, sex, social condition, political belief or activity" [emphasis added].

[59] [2005] 1 SCR 791, 254 DLR (4th) 577.

"Acute and Short Term Adult Mental Health Services." between 2008/09.[60] This program is delivered

> [t]hrough community-based, multidisciplinary teams...[it] provides a variety of services, depending on clients'needs. Services include screening, assessment, crisis intervention, short-term therapy, prevention, consultation and service delivery coordination. This program aims at preventing deterioration in clients' mental health state through early and short term intervention that target the problems at hand.[61]

Further, the report notes that there were 1,753 cases referred to the Psychiatric Patient Advocate under the *Mental Health Act* during this time.

In 2002, Statistics Canada asked a number of questions to Canadian citizens about mental illnesses. Table 28 of the *Canadian Community Health Survey (CCHS) Mental Health and Well-being profile, by age group and sex, Canada and provinces, 2002* **looks at** "[c]ontact with services and support for problems concerning emotions, mental health or use of alcohol and drugs, by sex, household population aged 15 and over, Canada and provinces, 2002." According to this survey, of the 608,013 total respondents in New Brunswick, 57,470 (9.4%) stated that they had contacted a mental health professional over the past year.[62]

While mental illnesses are on the rise, there is a shortage of psychologists and psychiatrists in the province who are capable of dealing with these illnesses.[63] Yet of the total Department of Health budget (approx. 2.4 billion dollars), only about 72 million dollars (about 3%) of the overall budget goes to mental health services provided through community mental health centres, psychiatric hospitals and regional hospital psychiatric units. According to a 2008 study, in 2003/2004 New Brunswick spent 6.0% of its total health care budget on mental health care (public and private spending). Similarly, this study noted that New Brunswick spent 7.3% of its public spending in 2003/2004. This study revealed that when compared to other provinces, New Brunswick ranked second in mental health care spending as a proportion of its total health care budget. However, it also noted that spending less than 5% of a total

---

[60] New Brunswick Department of Health, *2008-2009 Annual Report* (Fredericton: Department of Health NB, 2009) at 9, online: Government of New Brunswick <http://www.gnb.ca/0051/pub/ pdf/6698ef.pdf>.

[61] *Ibid.*

[62] Statistics Canada, *Canadian Community Health Survey (CCHS) Mental Health and Well-being profile, by age group and sex, Canada and provinces,* **online: Statistics Canada** <http://www. statcan.gc.ca/pub /82-617-x/4067678-eng.htm>.

[63] See Ann Graham-Walker, "Psychiatrist shortages a problem in Atlantic region: recruitment efforts fall flat in wake of poor remuneration" 36:28 *Medical Post* 8. Also See Celia Milne et al., "Mental health care in Canada: as chronic shortages of psychiatrists plague the provinces, specialists have turned to other sources—especially general practitioners—to help deliver much needed care [Province by province survey]" 38:30 *Medical Post* 26.

health care budget represents an unfair allocation of resources to mental health.[64] All provinces, including New Brunswick hover within 2-3 per cent of this number.

The McKee Report states that "[a]pproximately 20% of us will experience a mental illness at some point in our lives, and the remaining 80% will be affected by the illness of a relative, friend or colleague."[65] This report quotes a study done by T. Stephens and N. Joubert, which states that "... in 2001... the cost of mental illness to the Canadian economy [was] more than $14 Billion."[66] The McKee Report sought to overcome many of the issues discussed above. However, no mention is given to legislative reform in this report. The next section evaluates the McKee Report, noting this oversight.

(B) McKee Report and Government Policy

There are many positive aspects of the McKee Report. For example, Goal 1.1 proposes that the province create a wide network of holistically integrated services. Similarly, Goal 4 fosters coordination and collaboration amongst government departments. In the opinion of this author, coordination should include the Department of Justice and should require changes to the *Mental Health Act* as a foundation on which to build a reformed mental health system. Goal 6.1 looks at linking the Mental Health Commission with schools and other professionals to promote anti-discrimination campaigns. Also, Goal 7 discusses linking mental health professionals with the community. While many of these recommendations are positives steps, they must be buttressed by a strong *Mental Health Act*.

The McKee Report also sets a number of timelines (many of which have already passed), but does not give any indication about how the responsible departments should measure success. Kaiser notes that both Australia and Scotland have developed national mental health strategies including revised *Mental Health Acts*. One of the innovations of these mental health strategies is a Rights Analysis Instrument (RAI) through which these jurisdictions are able to measure and evaluate the progress of their mental health law reforms.

---

[64] See Philip Jacobs et al, "Expenditures on Mental Health and Addictions for Canadian Provinces in 2003/04" (2008) 53:5 *The Canadian Journal of Psychiatry* 306 at 311.

[65] See McKee Report, *supra* note 1 at 3.

[66] T. Stephens & N. Joubert, "The economic burden of mental health problems in Canada" (2001) 22:1 Chronic Diseases in Canada at 1-10 cited in McKee Report, *supra* note 1 at 4.

5. Legislative & Policy Reform

(A) Applying Kaiser's Equality-Based Approach to the New Brunswick Mental Health Act

In his article "Health Law in the 21st Century,"[67] Kaiser argues that mental health legislation in Canada should include positive rights and reflect the broad purposive goals of government. These goals help to mitigate many negative stigmas and stereotypes towards people with mental disabilities. His paper "advocates a leadership role for legislation."[68] In a similar sense, this paper argues that strengthened mental health legislation is a foundation upon which New Brunswick's mental health care system should be built. To this end, Kaiser quotes a 2001 WHO report on mental health:

> Mental health legislation should codify and consolidate the fundamental principles, values, goals, and objectives of mental health policy. Such legislation is essential to guarantee that the dignity of patients is preserved and that their fundamental human rights are protected.[69]

Canadian mental health laws, according to Kaiser, fail to provide adequate protection of the rights individuals with mental disabilities. The WHO report further describes the importance of reforming the mental health acts in many countries:

> Of 160 countries providing information on legislation (WHO 2001), nearly a quarter have no legislation on mental health (Figure 4.1). About half of the existing legislation was formulated in the past decade, but nearly one-fifth dates back over 40 years to a period before most of the current treatment methods became available.
>
> Governments need to develop up-to-date national legislation for mental health which is consistent with international human rights obligations and which applies the important principles mentioned above, including those in United Nations General Assembly Resolution 46/119.[70]

---

[67] H. Archibald Kaiser, "Health Law in the 21st Century: Imagining An Equality Promoting Alternative to the Status Quo of Canadian Mental Health Law" (2003) Health L.J. 185 [Kaiser, "Health Law in the 21st Century"].

[68] *Ibid* at 187.

[69] See World Health Organization, World Health Report 2001: Mental Health: New Understanding, New Hope (Geneva: World Health Organization, 2001), online: World Health Organization <http://www.who.int/whr/2001/en/whr01_en.pdf> at 84 cited in Kaiser, "Health Law in the 21st Century," *supra* note 67 at 186.

[70] World Health Organization, *ibid* at 84

New Brunswick's current *Mental Health Act* has been amended a number of times since it came into force in 1973. One of the key additions to the *Act* was the creation of mental health tribunals and a psychiatric patient advocate's office in the 1980s. The Lieutenant-Governor in council is given the power to appoint one or more mental health tribunals under section 7.5(1) of the Act; section 7.6(1) grants to the Lieutenant-Governor similar powers to appoint "services or organizations as psychiatric patient advocate services." Section 7.6(2) states that "[it] is the duty of a psychiatric patient advocate service to offer advice and assistance to persons who are detained in a psychiatric facility."

These additions to the *Act* are a step in the right direction for protecting the rights of mentally ill persons. But one must remember that these services are available only to people who are either voluntarily or involuntarily admitted in treatment facilities. Many of these people are suffering from severe mental illness such as schizophrenia, various types of psychoses, drug and alcohol-related disorders, and other acute stress-related disorders.[71]

Kaiser advocates the creation of a new *Mental Health Act*, which would be entitled "*An Act to Promote a Mental Health and Community Participation*." There are a number of things that are novel about Kaiser's approach. His proposed preamble discusses the particular problems faced by individuals with mental illness. According to Kaiser, "providing a preamble for any statute is essential as a way of declaring the purposes of the legislation. It has both educative and interpretive functions."[72] The preamble in his proposed legislation includes statements such as the following:

> WHEREAS mental health problems directly affect one in five people during their lifetime;
>
> AND WHEREAS people with mental health problems have suffered abuse, neglect, stigma, exclusion, poverty, and overall discriminization;[73]

Another idea Kaiser proposes that is even more innovative is the guarantee of positive rights to services and support for the mentally ill:

> A person with a mental health problem(s) shall have enforceable rights to;

---

[71] New Brunswick, *Statistics and information provided by New Brunswick Patient Advocate's Office* (New Brunswick Patient Advocate's Office, 2010) [unpublished].

[72] Kaiser, "Health Law in the 21st Century," *supra* note 67 at 193.

[73] *Ibid* at 192.

(1) Information on available services and supports;

(2) Establish his or her own recovery and community participation goals in partnership with health care and social support providers, family and friends;

(3) Receive sufficient services to support full community participation;

(4) Receive and terminate the provision of services on a purely voluntary basis, except in extreme circumstances, as noted in section (6) herein; and

(5) Advocacy services, to assist the consumer in asserting his or her entitlement to services and supports.[74]

What is perhaps most significant about Kaiser's approach is that it would apply to all individuals with mental illness and not just severe cases. The change in name represents a clear signal for the goals to come in the *Act*. However, Kaiser knows full well that change of this magnitude would require proportional changes in funding for mental health care. In Nova Scotia, instead of changing or guaranteeing positive rights and describing the mentally ill in equality terms, the province's mental health legislation is called the *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42. With this at least we see a true representation of what the act is about: involuntary committal and treatment.

Kaiser's approach "keeps recovery and community participation in the foreground, as an integral notion of equality."[75] This follows a general trend in international declarations, which focus on the rights of individuals with mental illnesses.[76] While beyond the scope of this paper, Kaiser points to a number of different international declarations that provide inspiration for mental health law reform. However, he states that "[u]nfortunately, none of these instruments have been credited with producing meaningful mental health law reforms."[77]

---

[74] *Ibid* at 195.

[75] *Ibid* at 190.

[76] For example, see Bernadette McSherry, ed, "International Trends in Mental Health Laws" (2008) 26:2 LIC.

[77] Kaiser, "Redirecting the Ship" *supra* note 25 at 159.

(B) Mental Health Law and Connection to the Community

A report by the Bazelon Center for Mental Health Law is similar to the equality-based approach put forward by Kaiser. The Bazelon Center advocates mental health legislation that promotes "independence, gainful employment and fulfilling relationships."[78] In its *Model Mental Health Act* entitled "*An Act Providing Mental Health Services and Supports*," the Bazelon Center suggests a number of legislative reforms that resemble the broad suggestions presented by the McKee Report in New Brunswick. For example, their *Act* emphasises community-based services and the involvement of people with mental illness in the planning of their own recovery.

Goal 7 of the McKee Report recommends that the New Brunswick Government work to "[c]reate or strengthen partnerships with community resources in business, education and other sectors to foster inclusion of people with mental illness."[79] Article 1, section 7 of the model *Act* states that

> [t]he overriding goal of mental health reform is for people who need care to have access to high-quality, tailored mental health services and supports in their communities, in least restrictive settings, designed to foster recovery, community integration and economic self-sufficiency.[80]

Further, Goal 8 of the McKee Report recognizes the importance of input from people with mental illness in their own service plans. One recommendation is that the provincial Department of Health should "create formal mechanisms to promote active participation of people with mental illness in service provision, evaluation, and training of service providers."[81]

We can see many similarities between the McKee Report's recommendations and the Bazelon Center model *Mental Health Act*. The key difference is that the McKee Report does not embrace legislative changes. Instead, it focuses on policy changes and a reorganizing of government priorities. A number of provincial mental health acts include community treatment provisions.

For example, section 33 of the Ontario *Mental Health Act* allows a psychiatrist to order a mentally ill person to be treated within the community and to follow a community treatment plan instead of hospitalization. The objective of community

---

[78] Bazelon Center, "An Act Providing a Right to Mental Health Services and Supports: A Model Law" at 1, online: Bazelon Center <http:// www.bazelon.org /LinkClick.aspx?fileticket=-DdBd 7lS2l8 %3d&tabid=104> ; Indeed, Kaiser often refers to reports written by the Bazelon Center.

[79] *McKee Report*, *supra* note 1 at 18.

[80] Bazelon Center, *supra* note 78 at 9.

[81] *McKee Report*, *supra* note 1 at 19.

treatment is "to provide a person who suffers from a serious mental disorder with a comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility."[82]

Community treatment orders (CTOs) are "the latest trend of legislation following the de-institutionalization movement of the 1970s and are premised on the transfer of treatment of persons with mental illness from the institution to the community."[83] Wandzura notes that five Canadian provinces currently have community treatment provisions included within their mental health laws: Saskatchewan in 1995, Ontario in 2000, Nova Scotia in 2005, Newfoundland and Labrador in 2006, and Alberta in 2008.[84]

Even though the goals of community treatment provisions are similar to the sections in the Bazelon Center model *Act* and the McKee Report's community participation recommendations, these provisions have been widely criticized by mental health law academics. Kaiser criticizes CTOs as a means by which the state can further stretch its "...tentacles well into the community."[85] Wandzura, on the other hand, criticizes CTOs in Saskatchewan for how they have been implemented. According to her, there are a number of reasons why CTOs have not worked in that province: paradoxes [in] the eligibility criteria for the issuance of a CTO, the administrative burdens imposed on physicians, the scope of enforcement powers conferred on physicians, the liability concerns of physicians, and the lack of ministry review.[86]

While there are problems with CTOs, these problems are attributable to their implementation rather than their conceptual underpinnings. Indeed, CTOs look theoretically similar to the ideas submitted by Kaiser, the McKee Report and the Bazelon Center: people with mental illnesses are best cared for within the community with respect for human dignity. The main difference between their assessments is the emphasis they place on legislative reform. Whereas Kaiser and the Bazelon Report both advocate legislative reform, the McKee Report is disappointingly silent on this matter.

The next section looks at Victoria, Australia as an example of where mental health legislation is currently being reformed to include positive rights and statements

---

[82] *Mental Health Act*, RSO 1990, c M.7, s 33.1(3).

[83] Shelley Trueman, "Community Treatment Orders and Nova Scotia: The Least Restrictive Alternative?," (2003) 11 Health L.J. 1 at 1.

[84] Anita G. Wandzura, "Community Treatment Orders in Saskatchewan: What Went Wrong?" in (2008) 71 Sask. L. Rev. 269.

[85] Kaiser, "Redirecting the Ship" *supra* note 25 at 143.

[86] Wandzura, *supra* note 84 at 274-75.

recognizing the dignity of people with mental illnesses. This follows a general trend of mental health law reform in Australia, which is mentioned by Kaiser.

(C) An Australian Example

Over the last few decades, Australia "developed its first National Mental Health Plan."[87] This plan falls under the Department of Mental Health and Well-Being. The "Fourth National Mental Health Law Policy" recognizes that the treatment of people with mental illness is best-accomplished in the community:

> The community has a better understanding of the importance and role of mental health and wellbeing, and recognises the impact of mental illness. People with mental health problems and mental illness have improved outcomes in relation to housing, employment, income and overall health and are valued and supported by their communities.[88]

Also, this policy promotes legislative reform and among its fundamental principles is the "[r]espect for the rights and needs of consumers, carers and families"[89] The Australian Government's mental health law policy includes a *Mental Health Statement of Rights and Responsibilities*.[90] This statement outlines the responsibilities of all members of Australian society to respect the rights of people suffering from mental illness. While it is not within the scope of this paper to review all of the rights and responsibilities included in this document, a few of these rights are as follows:

- the right to respect for individual human worth, dignity and privacy;

- the right equal to other citizens to health care, income maintenance, education, employment, housing, transport, legal services, equitable health and other insurance and leisure appropriate to one's age;

---

[87] Kaiser, "Redirecting the Ship" *supra* note 25 at 141.

[88] Australia, Department of Mental Health and Well-Being, *Fourth National Mental Health Law Policy: An agenda for collaborative government action in mental health 2009–2014* (Commonwealth of Australia, 2009) at iv, online: Commonwealth of Australia <http://www .health.gov.au /internet /mentalhealth/ publishing.nsf/Content/doha-pol-national-mental-hlth-strat-1/$File/4th%20Plan%20-%20final%20 -%20web%20version%20-%20251109.pdf>.

[89] *Ibid* at 13.

[90] Australia, *Report of the* Mental Health Consumer Outcomes Task Force, *Adopted by* The Australian Health Ministers, *Mental Health: Statement of Rights and Responsibilities* (Canberra: Commonwealth of Australia,2000); online:Commonwealth of Australia <http://www.health.gov.au /internet/main/ publishing.nsf/Content/mental-pubs-m-rights>.

- the right to appropriate and comprehensive information, education and training about their mental health problem or mental disorder, its treatment and services available to meet their needs;
- the right to timely and high quality treatment;
- the right to interact with health care providers, particularly in decision making regarding treatment, care and rehabilitation;
- the right to mechanisms of complaint and redress; and
- the right to refuse treatment (unless subject to mental health legislation);[91]

The federal mental health policies extend to the provinces in Australia, where recent reform of mental health laws has included broadly described rights and responsibilities within the scope of Mental Health Acts. One such example is Victoria, where the government is currently undergoing reform of its Mental Health Act, 1986. In order to facilitate the reform process, the government created an Exposure Draft Mental Health Bill 2010 for public comment. The deadline for public responses is December 3, 2010 and the government intends on passing a revised version of this bill in the new year of 2011.[92]

Many sections of this bill are typical of mental health laws: criteria for voluntary and involuntary committal, the creation of mental health tribunals, review boards, and so on. However, what is atypical about the bill is its focus on patient rights vis-a-vis care providers. For example, section 7 outlines a number of general principles:

> (1) Persons with a mental illness have the *same rights and responsibilities as other members of the community and should be empowered to exercise those rights and responsibilities.*

---

[91] *Ibid* at 1-2.

[92] See Victoria, Australia, Department of Health, *Exposure Draft Mental Health Bill 2010* (Melbourne: Department of Health, 2010); online: Commonwealth of Australia <http://www.health.vic.gov.au/mentalhealth/mhactreview/mental_health_bill2010.pdf>.

> (4) A person with a mental illness must as far as is reasonably possible in the circumstances—(a) be consulted in accordance with this Act in the making of decisions about their mental illness;
>
> (b) be supported to enable the person to make his or her own decisions, including in developing a treatment plan;
>
> (c) be provided with the support and information necessary to enable the person to exercise their rights under this Act;
>
> (d) have their preferences and wishes considered in the making of decisions affecting the person.[93]

A search of the New Brunswick *Mental Health Act* reveals no mention of the word "dignity." Also, the New Brunswick *Act* makes little reference to patient's rights to due process and security of person.[94] However, as shown in the *Starson, Fleming* and *Lussa* cases discussed above in Section III, these rights are protected under the Canadian *Charter*.

Then again, when applying Driedger's Modern Principle of statutory interpretation or even a purposive approach to the legislation, one is left with the feeling that something is missing from the New Brunswick *Act*. According to the Driedger's Modern Principle,

> ...the words of an Act are to be read in their entire context, in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the ***intention of Parliament***."[95]

Applying this principle to the New Brunswick *Act*, I submit that the legislature has focused more on the treatment of individuals with severe mental illness rather than providing rights safeguards to *all* individuals with mental illnesses, regardless of whether they are in need of treatment within a care facility. One must be careful, however, not to use the Victorian example described above as though it could easily be transplanted in the New Brunswick context. John Dawson raises the point that parliaments in Australian regimes such as New Zealand, Victoria and New South Wales are not constrained by a constitutionally entrenched Bill of Rights like the *Charter*

---

[93] *Ibid* at 14-15.

[94] *Mental Health Act*, RSNB, *supra* note 35.

[95] Ruth Sullivan, *Sullivan on the Construction of Statutes*, 5th ed (Markham, Ont: Lexis Nexis Canada, 2008) at 1 [emphasis added].

in Canada. Therefore, Dawson argues that these jurisdictions "have considerable freedom in the design of CTO...legislation, and they have used that freedom to enact reasonably enforceable outpatient treatment schemes."[96]

This may explain why Canadian jurisdictions have not increased rights recognitions within the provincial *Mental Health Acts*. They may believe that the *Charter* provides enough protection. On the other hand, recognition of the rights of people with mental illness within the provincial *Acts* is about more than protecting individuals who may be hospitalized and treated against their will. It is about leadership and symbolically emphasizing government priorities. As Kaiser puts it, "the law has not been fulfilling a leadership role"[97] The proposed mental health bill in Victoria, and the Bazelon Center *Model Act* discussed above, provide inspiration for legislative reforms in New Brunswick. Whether such examples can be practically implemented in New Brunswick is another matter altogether. One thing is for certain: the types of changes made to mental health laws proposed by these jurisdictions should inform mental health care reform in New Brunswick.

6. Conclusion

The new Minister of Justice and Attorney General, Marie-Claude Blais, recently stated that she would be reviewing the McKee Report and recommending changes to mental health care in New Brunswick:

> I have worked with youth in the past. I have worked on the criminal side with different clients who have had mental health issues. We need to address that question but we really need to bring that forward and it's something that I have very close to my heart and that I want to work on.[98]

Given the current state of the economy, it may be difficult to convince the government and the public that these changes are a priority. In spite of this, the government has many administrative tools at its disposal, which if used correctly, can make a considerable impact on public opinion and the treatment of individuals with mental illness. One such example is the use of state regulatory tools in the battle against smoking. As stated by Flood and Sossin:

> Legal intervention to suppress smoking is a story of such intervention interacting with shifting public attitudes and social norms regarding cigarettes. In four decades or so smoking has gone from a glamorous,

---

[96] John Dawson, "Community Treatment Orders and Human Rights," in McSherry, *supra* note 76 at 149.

[97] Kaiser, "Redirecting the Ship" *supra* note 25 at 194.

[98] "Mental Health Review will be Revisited," *supra* note 5.

> sophisticated pastime to a filthy, dangerous addiction in the minds of most of the public.[99]

In this paper I have argued that legislative reform is a necessary foundation for reforming mental health care in New Brunswick. While legislative reforms such as those mentioned above are not sufficient for "re-directing the ship of state,"[100] as Kaiser puts it, these changes are necessary first steps towards a reformed mental health care system in New Brunswick. Through the lens of therapeutic jurisprudence, one can see how current mental health laws have negatively impacted people with mental illness.

Legislative reform should be embraced by our government officials as they move forward with mental health care reform. The Mckee Report presents some excellent suggestions for reform of the mental health care system in New Brunswick. However, the government's response to this report should be coloured by legislative reform. As long as our laws still carry with them the stigmas of a checkered past, it will be difficult to change public perceptions and treatment of the mentally ill. Many commentators and other jurisdictions mentioned herein have acknowledged these shortcomings and presented ideas for change. Until we refocus our mental health laws away from simply dealing with the hospitalization and treatment of people suffering from mental illness, the negative history discussed by Lamer C.J. (as he then was) in *R v Swain* will continue to be true:

> The mentally ill have historically been the subjects of abuse, neglect and discrimination in our society. The stigma of mental illness can be very damaging.
>
> - Chief Justice Lamer in *R. v. Swain*[101]

---

[99] W.A. Bogard, "The Tools of the Administrative State and the Regulatory Mix" in Colleen Flood & Lorne Sossin, *Administrative Law in Context* (Toronto: Edmond Montgomery Publications, 2008) at 26.

[100] Kaiser, "Redirecting the Ship" *supra* note 25.

[101] [1991] 1 SCR 933, 63 CCC (3d) 481 at para 39.