Legal Services for the Mentally Ill: A Polemic and a Plea

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This article maintains that the mentally ill have been neglected by the Canadian legal profession, despite the many needs of this sorely disadvantaged group. The problems faced by the mentally ill are introduced and suggestions are made concerning the appropriate legal response. Issues which both individual lawyers and legal services delivery organizations must confront in dealing with the mentally ill are discussed. Limitations on the overall effectiveness of lawyers in the mental health setting are presented.

L'auteur de l'article soutient que les avocats canadiens ont délaissé les malades mentaux, malgré les besoins immenses de ce groupe cruellement désavantagé. Il expose les difficultés auxquelles ce groupe fait face et fait des propositions quant au rôle que les avocats devraient jouer. Il aborde également les questions que les avocats et les organismes d'aide juridique doivent résoudre relativement aux malades mentaux et indique les contraintes qui limitent l'efficacité de l'intervention des avocats dans le secteur de la santé mentale.

In this article it is argued that the mentally ill have a broad array of unmet legal needs which the Canadian legal community has shown little enthusiasm to recognize, let alone comprehensively treat. These exigencies are felt across the entire range of medical responses to the symptoms of the mentally ill, whether or not the sufferer is treated in an institutionalized setting. They involve many related problems, mainly legal in character, arising out of the social, economic and legal marginality of the mental patient. Although no single issue can be exhaustively explored in a piece of this length, an effort will be made to explain the requirements of the mentally ill, emphasizing the special plight of those confined in psychiatric hospitals. Attention will be directed to the traits which should be shown by legal services set up to fulfill these needs. Further, suggestions will be made for the application of legal resources beyond the provision of services, as services are conventionally conceived. Finally, aspirations the legal community might evince will be counterposed against the limitations which lawyers working in this field must face.

Before addressing the substance of this comment, it must be noted that the phrase "mentally ill" is used herein guardedly but intentionally. The

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author is aware of the widespread and virulent controversy between those of the anti-psychiatric school and those supporting psychiatry's usual assumptions, although there are within each group wide variations of opinion.[1] One side basically maintains that mental illness does not exist in the way that other sicknesses do. Rather it is said to be a mere social construction brought into being by labelling processes for purposes of the social control of the "sick" and the consolidation of the power of the interest groups (including doctors and others) which benefit by being able to stigmatize and isolate them. The other side, perhaps equally varied in its expression, would hold that mental illness, in its many forms, is a disease like any other. It can and ought to be subject to diagnosis and treatment, and has causes which emerge from genetic and other physiological factors, some of which may be exacerbated by interaction with environmental variables. A choice between either of these schools often turns as much on articles of faith as scientific reasoning and conclusions; such are the complexities of the phenomena and the passion of the values which underlie this discussion.

The author emerges from the first ideological and intellectual niche as much as from anywhere else. Although the basic beliefs on the subject which one holds will be relevant to the way in which one prefers the law to respond, the writer has not for present purposes sought to become entangled in this debate. Rather, this article is founded on the premise that the mentally ill suffer either because of the way society is inclined to treat them or because of their "illness", or both. In any case, the availability and use of legal services are seen as likely contributing to the alleviation of some of this misery in most instances, regardless of one's theoretical orientation to mental illness. Further, the extent of the interests of the mentally ill which are affected or threatened by many aspects of their treatment will often demand legal attention in spite of one's predisposition as to the etiology of mental illness.

Most Canadians would realize, either by means of media coverage or personal experience, that mental illness is a phenomenon affecting a large segment of the citizenry. The actual numbers of people so suffering probably cannot be more than a matter of speculation, as undoubtedly many actual instances do not result in the person either complaining or being reported to a clinician, or being treated in an institution. None the less, some idea of the breadth of the problem may be gathered from data on hospital admissions and separations. A recent study has shown that for the period 1976-78, there were 231,759 admissions to mental and psychiatric hospitals and psychiatric units of general hospitals in Canada (excluding Quebec), of which 25 *per cent* (57,031) were in-

[1]Dr. T.S. Szasz has provided stimulus to the debate surrounding the existence of mental illness. Two articles are representative of his work and will assist in orienting the reader to the anti-psychiatric school: "The Sane Slave: Social Control and Legal Psychiatry" (1976), 45 *Univ. of Cinn. L. Rev.* 437 and "On the Legitimacy of Psychiatric Power" (1983), 14 *Rutgers L.J.*479. As a counterbalance, C.G. Schoenfeld, "An Analysis of the Views of Thomas S. Szasz" (1976), 4 *J. Psych. and Law* 245, H. Shwed, "Social Policy and Rights of the Mentally Ill: Time for Re-examination" (1980), 5 *J. of Health Politics, Policy and Law* 193 or B. McConville, "Obstacles to the Treatment of Psychiatric Patients" (1984), 29(6) *Can. J. of Psychiatry* 449, would be instructive.

voluntary.[2] Other sources indicate, based on hospital separations, that the average length of patient stay for the same two years is about 31 days.[3] Generally, there would appear to have been a decline in involuntary admission rates for the population as a whole during the 1970s.[4] Reductions in the length of stay[5] and decline in the number of patients in institutions[6] are consistent with the deinstitutionalization trend in psychiatric treatment, but indicate that many people are still being dealt with in an institutional setting. Given that in-patient status in a psychiatric facility is the most serious and conspicuous form of treatment, the actual number of people being treated for mental illness, let alone those suffering without any form of diagnosis or assistance, must be exponentially larger.

The economic cost to Canadian society of mental illness must be vast when one considers direct expenditures such as the money spent to operate psychiatric facilities[7] and other sums beyond hospital care: indirect expenditures on social welfare programs and the lost opportunities represented by having a major portion of the total population unable to participate fully in economic society. The overall social costs of mental illness are not quantifiable but must be pervasive and severe.

In the face of such a major social problem as evidenced by the number of patients, the amount of pub[illegible] monies expended and the unaccounted-for suffering [illegible] thousands not [illegible] to the available treatment systems, one should reasonably expec[illegible]ould have something to say on mental illness and that lawyer[illegible]cantly involved with the attendant legal issues. On one level [illegible] may claim some responsibility, these expectations are bo[illegible] statutes dealing with many aspects of the treatment of t[illegible] received active attention during approximately the las[illegible]nately, most of the other major indicators of interest and co[illegible]w that the Canadian lawyers have maintained a somnolent, perhaps [illegible]ose, posture toward the mentally ill. This verdict should be a source of [illegible]barrassment and shame for a legal community which would probably like to have the public view it as being sensitive, compassionate and responsive to urgent social needs.

[2]R. Riley and A. Richman, "Involuntary Hospitalization in Canadian Psychiatric Inpatient Facilities, 1970-1978" (1983), 28 *Can. J. Psych.* 536 at 538. The authors of this paper note that the actual number of admissions is somewhat larger than the number of persons actually treated and that mental retardation, alcoholism and alcoholic psychosis are eliminated from analysis. The last year Statistics Canada collected data on voluntary and involuntary admissions was 1978.

[3]Statistics Canada, *Mental Health Statistics*, 1979-80, Volume 1, Institutional Admissions and Separations, Catalogue Number 83-204, at 15.

[4]*Supra*, footnote 2 at 536.

[5]*Supra*, footnote 3.

[6]*Ibid.*, at 14.

[7]About $412 million was spent in 1980-81 to operate 231 mental institutions. Statistics Canada, *Mental Health Statistics*, 1980-81, Volume III, Institutional Facilities, Services and Finances, at 36.

Thus, the provinces and territories have all introduced major amendments to legislation dealing with the mentally ill since 1970.[8] This comparative beehive of activity (without assessing the merits of the results for present purposes) may have been in part due to the pressure emanating from lawyers. However, one suspects, especially in light of the legal vacuum in the post-amendment era, that the lawmakers were more likely responding to patient dissatisfaction in an era when "consumers" in general were more vocal, to media discussion of patient abuse or neglect, and to changing attitudes or treatment modalities within the medical and social work sectors.

Discerning the level of legal application to the problems of the mentally ill is no easy task. One inevitably must feel somewhat apologetic for the impressionistic nature of the data one calls up to support one's observations or conclusions, as there is no authoritative measurement system for such subtle cross-references. However, an examination of some representative vital signs which might show the dedication of the legal community to the problems of the mentally ill in the civil context produces very little positive evidence. Manual and computerized searches of several reports for the period 1970-85 (including *Dominion Law Reports*) reveal less than 25 cases dealing with issues surrounding the civil commitment of the mentally ill; indeed, less than six reached the court of appeal level and only one the Supreme Court of Canada.[9] Four important and likely typical law journals showed only a few major articles relating to the civilly insane.[10] Less than half of 15 Canadian common law school calendars examined recently, offered a course on the professional, policy or substantive issues arising out of the plight of the mentally ill.[11] Of the seven bar societies contacted, not one presented specific instruction on these topics.[12] Only one specialist legal resource centre catered to the legal needs of

[8]Noting only the citations of the new acts or major amendments dealing directly with mental illness, the provincial statutes and territorial ordinances are indicative of a relatively lively interest: *The Mental Health Act, 1971*, S.N. 1971, No. 80; *Hospitals Act*, R.S.N.S. 1967, c. 249, as am. by S.N.S. 1977, c. 45; *Mental Health Act*, R.S.P.E.I. 1974, c. M-9, as am. by S.P.E.I. 1974, c. 65, s. 5 and S.P.E.I. 1981, c. 23; *Mental Health Act*, R.S.N.B. 1973, c. M-10; *Mental Patients Protection Act*, R.S.Q. 1977, c. P-41; *Mental Health Act*, R.S.O. 1980, c. 262, as am. by S.O. 1981, c. 66; *The Mental Health Act*, R.S.M. 1970, c. M-110, as am. by S.M. 1980, c. 62; *The Mental Health Act*, R.S.S. 1978, c. M-13, as am. by S.S. 1979, c. 39; *Mental Health Act*, R.S.A. 1980, c. M-13, as am. by S.A. 1981, c. 72; *Mental Health Act*, R.S.B.C. 1979, c. 256; *Mental Health Ordinance*, C.O.N.W.T. 1976, c. M-7; *Mental Health Ordinance*, R.O.N.W.T. 1974, c. M-11.

[9]*Re Jenkins; Reference Re Mental Health Act* (1984), 5 D.L.R. (4th) 577, 132 A.P.R. 131 (P.E.I.C.A.); *Lindsay* v. *M.* (1981), 121 D.L.R. (3d) 261 (Alta. C.A.); *Re Craig* (1983), 23 Man. R. (2d) 13 (C.A.); *Re Reinking* (1984), 3 O.A.C. 137 (Ont. C.A.); *Moose* v. *Prince County Hospital et al.* (1977), 22 Nfld. and P.E.I.R. 369 (P.E.I.C.A.); and *Williams* v. *Ballam* (1964), 48 W.W.R. (N.S.) 182 (B.C.C.A.) are the only appellate court decisions of which the author is aware in this area. *Beatty and Mackie* v. *Kozak*, [1958] S.C.R. 177 was the only Supreme Court decision touching the mentally ill located in the author's research.

[10]For the period 1970-1984, the *University of Toronto Law Review*, the *Canadian Bar Review*, the *Osgoode Law Review*, and the *Dalhousie Law Journal* (1974+) were chosen as sample periodicals. Less than five relevant articles appeared.

[11]Usually the courses took the form of Law and Psychiatry or Law and Behavioural Science. Of the institutions surveyed (some of the calendars of which may not be entirely up to date), courses were offerred at Alberta, British Columbia, Ottawa, Saskatchewan, Osgoode, McGill and Dalhousie. It is possible that portions of other courses may have peripherally treated mental health issues, *e.g.* Poverty Law or Administrative Law.

[12]A telephone survey of seven provincial bar societies was conducted in June 1985, by a research assistant, Ms. Elaine Seifert, working for the author (British Columbia, Manitoba, New Brunswick, Nova Scotia, Ontario, Alberta and Saskatchewan). None of the respondents indicated that courses were offered in the bar admission program which dealt directly with the major issues surrounding the civil commitment of the mentally ill. Some

the institutionalized mentally ill, the Mental Patient's Advocate Project, at the Riverview Hospital in Burnaby, B.C.[13] No major Canadian texts or treatises, or edited collections published since 1970 appear in the catalogue of a major law library which might be expected to have such holdings.[14] The Uniform Law Conference of Canada has not produced any agreement upon a uniform act which might be adopted by legislatures.[15] Of course, a more diligent and comprehensive dissection of all of the above types of legal weather-vanes might reveal more than noted herein. However, it would be quite astonishing if such an exercise would alter the basic observation of this article: lawyers in Canada have chosen to concentrate on other areas of significance in the law and have neglected issues touching upon the mentally ill in the civil process.

Having made this allegation, it behooves the author to attempt, however tersely, to provide reasons which might have brought about this lamentable state of affairs. Several interrelated factors are offered which together supply a plausible explanation. They may either satisfy the legal reader or provoke him to submit an alternative analysis.

Canada is an advanced capitalist country with an extensive social welfare program which ameliorates some aspects of the harshest inequalities that would otherwise condemn its lowest classes.[16] It is in many ways a society which defers to authority and the ideologies which ruling elites symbolize and perpetuate.[17] Its social services are regularly portrayed as privileges which a paternalistic polity extends to the unfortunate, not as rights inherent in societal

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programs touched on related areas such as obtaining instructions from the mentally handicapped (often in connection with wills and estates). Occasionally, the estates of the civilly committed might be mentioned in portions of bar courses covering the operations of the public trustee office. Overall, the bar societies would therefore appear to give the psychiatric patient very little or no attention. It must be conceded that the survey was not methodologically rigorous; therefore, some data may have been missed (particularly from provinces where no response was elicited).

[13]The Burnaby project was favourably described by the Department of Justice in A. Himelfarb and A. Lazar, *Legal Aid for Mental Patients - An Evaluation Report* (Ottawa: Department of Justice, 1981). Other general legal aid services do deal with mental patients, but not as sensitively and extensively as will be argued, *infra*. See R. Gordon, "Legal Services for Mental Health Patients: Some Commonwealth Developments" (1981), 4 *Int. J. of Law and Psychiatry* 171.

[14]The Dunn Library of Dalhousie Law School, with a collection of about 150,000 volumes, showed in its main catalogue in June 1985 only two recent publications relating to civil mental patients, both of the self-counsel genre. These [L. Alper, *Mental Patients and the Law*, 4 ed. (Vancouver: People's Law School, 1982) and S. Page, *Mental Patients and the Law* (Toronto: Self-Counsel Press, 1973)] are undoubtedly useful works; but this is obviously a very small body of writing compared to most areas where there is a significant body of statute law and administrative practice. Although books may be in progress, one can hardly expect an avalanche of legal materials.

[15]As of June 1985, no recommended statute has been published by the Uniform Law Conference.

[16]There is obviously much skepticism concerning both the success of Canada's social welfare system, in terms of whether the worst off are actually helped by any relief programs, and societal motivations for these measures in the first place. These observations are by no means unique to the 1980s: "The system often appears to provoke the very results it should be designed to avoid ... The entire system urgently needs to be examined ..." [Economic Council of Canada, *Sixth Annual Review* (Ottawa: Queen's Printer, 1969) 118; see also A. Finkel, "Origins of the Welfare State in Canada", in L. Panitch (ed.), *The Canadian State: Political Economy and Political Power* (Toronto: University of Toronto Press, 1977).]

[17]See, for example, E.Z. Friedenberg, *Deference to Authority: The Case of Canada* (White Plains, N.Y.: M.E. Sharpe, 1980).

membership or through legal entitlement.[18] Canada's legal profession, not surprisingly, reflects this broad-brush portrayal of Canadian society.

Canadian lawyers are middle class or upper-middle class, usually by origin and almost always by ascription once they enter the profession. They serve their middle class brethren reasonably well. Those in higher social classes, either in person or through services rendered to corporations, are attended to enthusiastically. The lower classes are not forgotten and are usually eligible for free or subsidized services through the various provincially administered and federally cost-shared legal aid programs, although the concentration of resources is in the family and criminal spheres.[19] Law schools and bar training programs tend to emphasize the bread and butter of the profession, offering instruction across corporate, commercial property and estate fields. Emphasis in the litigation area is on civil, family and criminal law. The mentally ill simply are not accommodated in this nexus of legal characteristics, since they are likely to have emerged from the most socio-economically disadvantaged segments of society, particularly when one is considering those in the psychiatric hospitals, whether voluntary patients or not.[20] These people are demographically not from classes with which lawyers have an affinity; as it has been frequently observed in the general legal aid literature, a great distance is created between lawyer and potential client.[21] To the potential recipient of legal aid services, lawyers and their offices are seen as (and likely are) unreachable and detached from the client's milieu — even hostile to it in some instances.

This abyss between lawyers and the mentally ill is not merely a function of the educational, professional and general predilection of a profession which is more accustomed to treating the legal problems of its peers. Just as important is the whole process of how a dispute or query comes to be classified as a "legal problem". There is no difficulty in saying for example, that the accused in *R.* v. *Doe* has a legal problem, or that the defendant in a motor vehicle suit or respondent in a custody application have legal problems, which can be ad-

[18]This observation is certainly consistent with the perspectives of critics from a very wide ideological spectrum; *cf. Poverty in Canada: Highlights from the Special Senate Committee Report* (Ottawa: Information Canada, 1971) *ix:* "The [welfare] system has become an instrument of paternalism whereby recipients have been compelled to do what others thought was good for them, and to conform to middle class norms that the poor themselves may often have neither comprehended nor appreciated."

[19]In 1978-79, about $89 million was expended on legal aid plans in Canada (*Legal Aid, 1981*, Statistics Canada, Cat. No. 85-507); 1979-80 saw this rise to approximately $100 million [*Legal Aid Services in Canada, 1979/80* (Ottawa: National Legal Aid Research Centre, 1981)]. Neither source provides aggregate figures by type of case for Canada, although for most of the provinces and territories it would appear that only five to ten *per cent* of the total case load would be represented by matters outside the criminal and family areas.

[20]For example, in the Burnaby project, *supra*, footnote 13 at 44, it was noted that "Eighty-three *per cent* of the clients easily met the financial eligibility criteria for legal aid in British Columbia". This data will readily be confirmed by observation should one visit any mental hospital. In the author's experience, the ambience of the patient segment of the institutional population is overwhelmingly that of the most destitute of *strata* in society.

[21]The clientele of the legal, as opposed to the medical, profession is more likely to be drawn from the middle and upper classes: "First, the incidence of problems defined as legal tends to be higher in the middle and upper classes; second, the elasticity of demand for legal services is greater than for medical services; third, tax and charity funds tend to be more generously supplied for medical than legal problems. This situation structurally shields the legal profession against the full impact of the dissensus about relevant values while associating it more closely with the middle and upper classes." [D. Rueschemeyer, "Lawyers and Doctors: A Comparison of Two Professions", in V. Aubert (ed.), *Sociology of Law: Selected Readings*, (Middlesex, England: Penguin, 1969) 273.]

dressed by lawyers. Far more elusive in terms of classification and treatment are those matters which are generally susceptible to the "social problem" label, but which may be possessed of many hidden legal dimensions[22], features which are obscure both for the normally passive client and the attitudinally disinclined lawyer. Still more ethereal is the notion of the lawyer simply as an advocate and counsel for one who cannot speak for herself. Although the affairs at hand may not have legal dimensions either from a typical or broadened perspective, nevertheless vigorous representation may be called for, which the lawyer may be well equipped to deliver. The search for a legal problem may have been properly embarked upon, but may not always serve the interests of the client whose problems may be partially or not at all legal, yet who still urgently requires the lawyer's skills — in advocacy especially, but also in interviewing and counselling.[23]

The factors which apply in the instance of the conventional legal aid client are amplified by the inferior and distorted status of the mentally ill as a group. The legal profession is not comfortable dealing with what are seen as medical matters; the mentally ill are often seen as emerging exclusively from this diagnostic slot. Indeed, lawyers seem to want to delegate responsibility for these issues to psychiatrists or other specialists, because of the former's eager and ironic disclaimer of familiarity with issues such as competence, responsibility or sanity, and the hungry appropriation of these fields by the latter professions.[24] The nature and cause of mental illness are without doubt complex issues in which it is easier to accept that there is some organic injury, disease or mysterious (but psychiatrically explicable) mental dysfunction, rather than a societal failure, inadequacy, abandonment of or hostility toward the person. However, these issues are ones which lawyers should confront in order to comprehend their clients and the *real* etiology of their apparent illnesses. The oft-observed circularity of the economic, family, criminal and mental health problems of the poor mean that the lawyer is dealing with only one aspect of a troubled life. A legally successful resolution will not necessarily affect the other oppressive features of the client's existence. The mentally ill are

[22]Many factors are relevant in determining whether a person is likely to seek out and obtain legal representation. The influential work "Legal Representation and Class Justice" (1965), 12 *U.C.L.A. Law Review* 381, by J. Carlin and J. Howard, cited lack of economic resources, as well as (1) awareness or recognition of a problem as a legal problem; (2) willingness to take legal action for solution of the problem; (3) getting to a lawyer; and (4) actually hiring a lawyer, as being important variables. Subsequent research has tended to emphasize the salience of the problem being subjectively defined as legal before any active steps will normally be taken by persons who objectively have problems capable of legal solution. See B. Abel-Smith *et al.*, *Legal Problems and the Citizen* (London: Heineman, 1973) or P. Morris *et al.*, "Public Attitudes to Problem Definition and Problem Solving: A Pilot Study" (1973), 3 *British Journal of Social Work* 301.

[23]"Legal professionals naturally define need by what they can do as professionals. Not only does this definition have a harmful tendency to be static, but more importantly from my point of view, it also raises the issue of whether professionalism has gone to far ... there is the danger that professionals will shut off alternative, possibly nonprofessional channels for change..." [B. Garth, *Neighborhood Law Firms For the Poor* (The Netherlands: Sijthoff, 1980) 11.]

[24]S. Morse, in "Crazy Behaviour, Morals and Science: An Analysis of Mental Health Law" (1977), 51 *S.Cal.L.R.* 527, has eloquently presented this professional see-saw at 530, 535 and 538: "Society and the legal system have always been confused and often frightened by mental disorders..... Most lawyers regard mental disorders as arcane and disturbing phenomena that are beyond their comprehension and are understood by only a *few* highly trained experts. ... Lawyers therefore tend to defer to mental health experts.... The essential moral and legal nature of questions of freedom, competence, and responsibility then come to be seen as proper questions for largely expert determination."

therefore daunting representatives of what is already the most professionally challenging stratum of society, the poor.[25]

As individuals, it must always be recalled that the poor are not likely to resemble the mythical ideal client: relating facts in a coherent manner, cognizant in a general sense of their rights, responsibilities and aims, and appropriately responsive to the lawyer's counselling. The social class variable intrudes to render the poor client likely less efficiently communicative, more unsure of the desired outcome, and either oblivious to attempts at direction or perhaps unduly eager to follow the lawyer's advice.[26] The disabilities of the mentally ill client include these problems, but are complicated by her emotional suffering, instability and the objective existential difficulties of being delegitimized by being labelled mentally ill and severed from regular contact with the outside world by institutionalization or treatment.

As shall be discussed more fully later, the mere provision of legal resources will not provide a cure for mental illness. Neither will the availability of conventionally conceived individual or more broadly aimed legal services guarantee that all legal, let alone related non-legal problems, will be swept away. What is certain is that continuing neglect by the legal profession of the mentally ill will assist in perpetuating their marginality, powerlessness and wretchedness. What, then, are some of the most urgent unmet needs of the mentally ill to which lawyers might usefully respond?

When one confronts the diverse unfulfilled needs of the mentally ill in Canadian society, one sees a vast social landscape with few guidelines for the lawyer. What follows is an outline of the spectrum of problems which the mentally ill face, offering some primitive classifications, but for the most part without any real effort at providing a hierarchy of urgency. Given the deep-rooted interdependence of most of the major issues and the dearth of legal attention, this comprehensive but unranked listing seems appropriate.

Civil Commitment and Discharge

Every Canadian province and the two territories provide regimes whereunder individuals may be examined, involuntarily confined in institu-

[25]The alleviation of poverty has obviously been a matter of urgent concern for many lawyers and laypersons. The political and economic climates may have changed in the past decade; as a result, many lawyers may have drifted away from serious professional commitments to this cause. Nonetheless, the challenges proclaimed below remain, in the author's view: " 'Civil rights' cannot help the poor unless and until a decent living is seen as a 'civil right'.... Law teachers and law students like to work hard if they think that they are thereby indirectly advancing justice.... And law people are filled with anxiety. They are anxious because they do not know in what direction their efforts may usefully flow.... The lawyer can see that the culture ... is light-years from being ready to put forth the kind of effort and sacrifice it would take to give relief against the injustice of poverty ... [I]t is well perceivable ... that ... the early years of the process will have little work for the lawyers as such." [C. Black Jr., "Some Notes on Law Schools in the Present Day" (1969), 9 *Ventures* 69, reprinted in (1970), 79 *Yale L.J.* 505 at 509.]

[26]The Canadian Bar Association has produced a *Code of Professional Conduct* which sets forth the lawyers' duties to their clients. In the face of the difficulties alluded to herein, the professional obligations would not seem to alter, but do become more demanding as the client departs from the paradigm of middle class rationality. The *Code* states at 8: "Whenever it becomes apparent that the client has misunderstood or misconceived his position of what is really involved, the lawyer should explain as well as advise, so that the client is apprised of his true position and fairly advised with respect to the real issues or questions involved."

tions and ultimately forcibly treated.[27] There are normally two bases for this vigorous exercise of state authority, *parens patriae* and police power. "The state, as *parens patriae*, becomes a benevolent benefactor with a moral responsibility to protect and care for mentally ill persons and their property".[28] Under the police power umbrella, "the state seeks to protect societal interests rather than the interests of the mentally ill individual".[29] The most recent wave of Canadian legislation normally relies on a blending of these two broad justifications in order to commit the mentally ill citizen. Thus, the statute might say that a person suffering from a psychiatric illness which may be treated in an institution may be brought to and confined in a psychiatric facility if the person constitutes a danger to herself or others, or is unable to care for herself. Initial processes which could result in the person being conveyed to an institution for assessment typically include the execution of one or two certificates by physicians that the previous allegations are verified following examination; an order made by a magistrate upon an information; and the observation by a police officer of a person apparently disordered and dangerous and, in some jurisdictions, who is about to commit an indictable offense, where other methods of dealing with the situation would be impracticable.[30]

Obviously, any of these invocations of the legal system can deprive a person of her liberty. Such intrusions may be more drastic and unchecked than one witnesses in the criminal process, with its panoply of protections for the accused.[31] Since the passage of the *Canadian Charter of Rights and Freedoms*[31a], it is clear that the mentally ill must begin to benefit from the broad range of safeguards previously only available to the criminal. "The rights of those subjected to involuntary confinement as either being mentally ill, [or] suffering from a mental disorder ... are ... now protected by the *Charter*."[32] Without in any way derogating from the basic and real

[27]For fairly representative examples of the statutory expression of these powers, one might examine ss. 28-36 of the *Hospitals Act*, R.S.N.S. 1967, c. 249, as am. by S.N.S. 1977, c. 45, or ss. 9-14 and ss. 35-36 of the *Mental Health Act*, R.S.O. 1980, c. 262, as am. by S.O. 1981, c. 66.

[28]Comment, "The 'Crime' of Mental Illness: Extension of 'Criminal' Procedural Safeguards to Involuntary Civil Commitment" (1975), 66 *J. Crim. Law and Criminology* 255 at 255.

[29]*Ibid.*, at 256.

[30]There is a broad similarity in the principles and effects of the legislation across Canada although the nets of some statutes have somewhat tighter mesh, such as in Newfoundland, where the safety of property is also an interest said to be protected from the actions of the mentally ill (*The Mental Health Act, 1971*, S.N. 1971, No. 80, s. 6).

[31]In the United States, arguments have been made for introducing equivalent rights into the civil commitment process. See, for example, *supra*, footnote 28; R. Slovenko, "Criminal Justice Procedures in Civil Commitment" (1977), 24 *Wayne L.R.* 1; or K. Matheson, "Involuntary Civil Commitment: The Inadequacy of Existing Procedural and Substantive Protections" (1981), 28 *UCLA L.R.* 906.

[31a]Part 1, *Constitution Act, 1982*, which is Schedule B, *Canada Act 1982*, 1982 (U.K.) c.11.

[32]M. Manning, *Rights, Freedoms and the Courts: A Practical Analysis of the Constitution Act, 1982* (Toronto: Emond-Montgomery, 1983) 550. Beyond the other sections of the *Charter* herein discussed, it is obvious that the equality rights provisions of the recently promulgated section 15, which specifically mention "mental or physical disability", should provide further force to any argument on the salience of the *Charter* for the mentally ill.

significance of this observation,[33] it is now hackneyed to reiterate that *Charter* rights can only be reliably guaranteed in practice if counsel, as in section 10, is retained and instructed without delay. In the civil commitment process, this guarantee must mean that the allegedly mentally ill person should have access to counsel contemporaneously with the commencement of any of the above processes intended to lead to observation and confinement. The spectre of the mentally ill being spirited away under the auspices of physicians, magistrates or police officers, without the opportunity to consult with a lawyer as required by the *Charter* could be eradicated with a major expansion of legal services for the mentally ill and concommitant statutory amendments or authoritative common law pronouncements providing for a right to counsel explicitly applicable to the mental health setting.[34]

Although the permitted duration of involuntary hospitalization varies, there are some features generally common among the provinces and territories. Usually a person will be mandatorily released after an initial commitment for observation,[35] unless she chooses to remain as a voluntary patient or is held as a formal or involuntary patient following certification by physicians under criteria similar to those which justify the person being brought to the facility in the first place[36]. If the patient remains in the hospital as an unwilling inmate, the typical confinement will be 30 days, followed by successive stays of

[33]Such notions are not mere novelties introduced in the context of post-*Charter* fervour. The same assertions were made in the *Bill of Rights* era. For example, see B. Donnelly, "Right to Counsel" (1968/69), 11 *Crim. L. Q.* 18. Early post-*Charter* case law would appear to support the applicability of section 10 in the mental health setting. See, for example, *Lussa* v. *Health Sciences Center* (1983), 5 C.H.R.R. D/2203 (Man. Q.B.) and *Re Jenkins, supra,* footnote 9.

[34]The right to counsel provisions of the *Young Offenders Act,* S.C. 1980-81, c. 110, s. 111 provides a good demonstration of a statutory statement of the right to counsel. Similar sections could be used in the mental health area with appropriate variations. Revisions to the *Mental Health Act* of Ontario, proclaimed March 1, 1984, may provide a model for other provinces in this regard. Section 66 reads as follows:

> Section 30a(1) — An attending physician who completes a certificate of involuntary admission or a certificate of renewal shall give or transmit a notice in writing of completion and filing of the certificate to the patient who is the subject of the certificate and to the Area Director for the area, in accordance with the Legal Aid Act, in which the psychiatric facility is located.
>
> (2) — A notice under Subsection (1) shall inform the patient and the Area Director that the patient or any person on his behalf is entitled to a hearing by the regional board if the patient or the person gives or transmits to the officer in charge or to the regional review board notice in writing requiring a hearing and the patient or the person may so require such a hearing.

However, it would appear that even this section could be altered to provide a more meaningful provision of legal counsel in the mental health setting: "The Area Director is not under any obligation to do anything upon the receipt of the certificate or notice. The forwarding of the notice to the Area Director is simply to forewarn the Area Director that the patient might make an application pursuant to the provisions of the The Legal Aid Act for representation in the review process which is established under The Mental Health Act." (Law Society of Upper Canada, *1984 Annual Report: Ontario Legal Aid Plan* at 16.) Subsequent news stories indicate that there has been some real controvery on the impact of these sections. See "Legal Aid ignoring psychiatric patients, health minister says", *The Globe and Mail,* November 23, 1984, and "Psychiatric patients held involuntarily deprived of right", *The Globe and Mail,* May 7, 1985.

[35]In the various provincial and territorial statutes, the initial period of observation and assessment will vary between three days and one month, with the average being about 15 days.

[36]The first period of confinement following a decision to detain the patient after assessment varies from 21 days to one year, at maximum, with most juridictions falling within 21 days to two months.

varying lengths as long as requisite stipulations are made on an ongoing basis[37] to the effect that the person is mentally ill and dangerous to themselves or others. To assess the progress of the patient and to decide whether there will be further treatment, the case will be reviewed regularly, usually by the attending physician. The types of regular review envisaged may diverge widely. However, a decision by a physician or director of the institution to recommend release of a patient will, for all practical purposes, cause the subject to be set free, and may result in her leaving the hospital or attending as a voluntary patient only.[38] Most jurisdictions provide for an independent review process to be initiated at any time by the patient or her representative, subject to some restrictions on multiplicity of reviews within certain periods.[39] Many provinces also provide for the hearing of a review application before a court as an alternative remedy.[40] Finally, under the *Charter, habeas corpus* may be used to determine the validity of the detention.[41]

Although one expects a hearing held before a review board to be less formal than one conducted in a court, the matters at issue are obviously serious and weighty for the patient and society in both instances. Furthermore, the substantive, evidentiary and procedural issues probably would be too complicated for most patients.[42] Counsel is therefore necessary on the basis of these considerations alone for any type of review. The need for legal assistance is compounded in light of the disability imposed by the appellation "mentally ill" and the confusion and isolation which may be caused by hospitalization and emotional distress. All of these factors argue strongly for the presence of counsel during any review-related procedure, in addition to legal services being made available from the commencement of the patient's exposure to the mental health system.

[37]Most acts provide for successive confinements, once an order to detain is renewed, to become longer, increasing to maxima of from three months (Ontario) to two years (British Columbia). Only Manitoba provides no restriction on the period of involuntary hospitalization before a renewal is required. The majority of provinces have provided that six months or one year shall be the longest stay authorized by any single certificate, although it is conceivable in every instance that one could become a lifetime inmate. Indeed, some recent statistics indicated that about 35 *per cent* of patients had been institutionalized for 10 years or more. (Statistics Canada, *Mental Health Statistics*, 1976, Volume II, Patients on Books of Institutions, Catalogue No. 83-208, at 37.) Some decline in this proportion of patients staying in hospital more than 10 years ought to have been seen since 1976.

[38]Most provinces stipulate that a patient shall be discharged when she is no longer in need of observation, care or treatment, and empower the physician or director to release the person upon issuance of a certificate to this effect. Of course, absence without leave prior to release according to the statute may result in the patient being returned to the institution without a warrant being issued during the early weeks of her being at liberty and later upon a warrant being obtained.

[39]Almost all provinces and territories have set up mental health review boards (or panels and commissions) to determine whether continued detention is justified and sometimes to assess other issues which may pertain to the treatment being received. Some jurisdictions (Newfoundland, New Brunswick and Saskatchewan, for example) provide for appeals to a county or supreme court of decisions made by a review board.

[40]Nova Scotia, Newfoundland and British Columbia offer this alternative route. In Nova Scotia no cases are reported of applications for review having been brought before the courts since the establishment of the Mental Health Review Board.

[41]Section 10(c) provides that everyone has the right on detention to have the "validity of the detention determined by way of *habeas corpus* and to be released if the detention is not lawful".

[42]Section 10(b) of the *Charter* which accords a detained person the right to "retain and instruct counsel without delay and to be informed of that right" may be seen as buttressing any other argument for entitlement to counsel. Some provinces, such as Nova Scotia and Newfoundland, make provisions for consulting and retaining counsel for general or review hearing purposes.

Institutional Life

The need for legal assistance at the commitment and discharge stages is likely to be readily accepted by most Canadian lawyers. The citizen's liberty is obviously at risk by the use of state power derived from the various provincial statutes dealing with the mentally ill. Despite the *parens patriae* aura, lawyers should, perhaps instinctively, see themselves as being appropriately involved with processes that so closely resemble those used in the criminal law.[43] Such confident generalizations cannot be made with respect to many issues which arise within psychiatric institutions, both for voluntary and involuntary patients (if more acutely for the latter), and for former in-patients who are gradually absorbed in the deinstitutionalization wave. This paper will continue to concentrate on those being kept involuntarily in psychiatric facilities, with some peripheral attention being devoted to other categories of patients who have other legitimate and unfulfilled needs for legal representation, but who should be the subject of further discussion.[44]

A host of well-intentioned and legally authorized intrusions by the state on the individual's rights to autonomy and self-determination may be launched upon the invocation of the appropriate portions of mental illness statutes. To begin in the material realm, most jurisdictions provide for the individual losing control over her estate upon the person being certified as incompetent to manage her affairs.[45] The fact that most psychiatric patients have little property in the first place[46] ought not to minimize the significance of this unusual removal of such an otherwise important feature of the market economy — the right to administer one's own finances. Assessment of competency is a delicate and complex process[47] where an unfavourable decision has very wide personal and social implications. Legal services can help to ensure that there will neither be any arbitrary deprivation or unnecessarily prolonged state of legal incompetency.

[43] "Involuntary confinement is the most severe punishment, short of the problematic death penalty, that a state can impose upon an individual.... Few safeguards, however, accompany proceedings for civil commitment of the mentally ill, although civil commitment, like imprisonment, subjects an individual to serious deprivations of liberty." (C.W. Combs, "Burden of Proof and Vagueness in Civil Commitment Proceedings" (1973), 2 *Am. J. Crim. Law* 47.) "The mentally ill are perhaps the most dependent of all citizens upon the law to safeguard their constitutional rights. Yet, the constitutional adequacy of the legal procedure for involuntary commitment has largely been ignored by the courts, legislatures and society." (S. Coleman, "The Standard of Proof Necessary in Involuntary Civil Commitment of the Mentally Ill — *Addington* v. *Texas*" (1980), 25 *South Dakota L.R.* 379.)

[44] Voluntary patients might wish to consult a lawyer concerning problems such as the degree of consent to specific treatment, tortious acts by physicians or staff members, discrimination in the workplace, or related social welfare problems.

[45] Generally, the statutes will provide for either the public trustee or other appointed officials to manage the patient's estate until the person's incapacity is certified to be terminated.

[46] *Supra*, footnote 20.

[47] Determination of issues such as "dangerousness" for purposes of commitment or competance are normally left to experts. However, the authority of that expertise may disappear under scrutiny: "The best evidence of the reliability of present diagnostic categories indicates that if two professionals independently diagnose a person on the basis of the same or similar data, it is rare for them to agree on the diagnosis in more than half the cases." (Morse, *supra*, footnote 24 at 607.) See also J. Robitscher, "Legal Standards and Their Implications Regarding Civil Commitment Procedures", in *Dangerous Behaviour: A Problem in Law and Mental Health* (Washington: U.S. Dept. of Health, 1978) 61 or H. Steadman, "Some Evidence on the Inadequacy of the Concept and Determination of Dangerousness in Law and Psychiatry" (1973), 1 *J. of Psychiatry and Law* 409.

The power of the state to act without the person's consent extends beyond the material sphere. A patient may be given treatment which she does not comprehend or emphatically refuses. Under the guise of it being of benefit, a wide array of therapeutic activities may be forced upon the unwilling patient[48], even where the methods and effects are debated inside and outside the medical profession[49]. One should recall the diversity of methods capable of being used by psychiatrists, such as individual or group psychotherapy, psychopharmacology, biofeedback and behaviour therapy, electroconvulsive therapy and psychosurgery.[50] The modicum of protection offered by modern Canadian statutes is not commensurate with the level of violation of individual integrity which many treatments impose. The threshold before involuntary treatment commences does not usually presuppose such low-level hurdles as right to counsel or a quasi-judicial hearing[51], although with the most violent mode, psychosurgery, a more stringent regulatory structure may intervene[52]. For most conventional medical procedures, a person who is said to be suffering from a mental illness which impedes her comprehension of the proferred diagnosis and recommended treatment simply has her usual right to consent supplanted by the authorization of a relative or public trustee. Section 12 of the *Charter*, guaranteeing the right not to be subjected to any cruel and unusual treatment or punishment, is thereby arguably infringed by every act of forcible treatment, given the manifest uncertainties of psychiatric diagnosis and treatment and the degree of intervention involved in many therapeutic techniques.[53] So too is the protection offered by section 7, guaranteeing "security of the person". Unless principles of fundamental justice accord with

[48]One finds in many instances a presumption in the statute that no treatment will be given without consent. However, where a patient is deemed to lack the capacity to consent, provision is made for approval of the proposed treatment by the spouse, next-of-kin or public trustee, thus substituting the consent of a third party.

[49]Electro-convulsive therapy is an example of a type of treatment which is currently being heatedly discussed in many countries. See J.P. Morrissey *et al.* "Developing an Empirical Base for Psycho-Legal Policy Analysis of ECT: A New York State Survey" (1979), 2 *Int. J. of Law and Psychiatry* 99 or A. Clare, "Therapeutic and Ethical Aspects of Electro-Convulsive Therapy: A British Perspective" (1978), 1 *Int. J. of Law & Psychiatry* 237. The Canadian Psychiatric Association was recently told that "half of 820 Canadian psychiatrists surveyed recently expressed some opposition to the process, with three *per cent* totally opposed to its use." (Canadian Press news release, appearing in the [Halifax] *Chronicle-Herald*, October 12, 1984.

[50]Lawyers working in this field must acquaint themselves with the full range of therapeutic techniques available to the psychiatrist. One would be well advised to start with a textbook and then to conduct more detailed research as the occasion arises. This sample list of treatment modes was obtained from L. Rees, *A Short Textbook of Psychiatry*, 3d ed. (England: Hodder and Stoughton, 1982), but any comparable text will serve as an introductory source.

[51]See, *supra*, footnotes 42 and 48. Counsel, judges or mental health review boards would generally only appear to have the right to intervene when requested to do so by the patient or her representative. No statute directly demands this kind of supervision over involuntary treatment as a matter of routine for most procedures.

[52]For example, under section 52(1) of the *Hospitals Act*, *supra*, footnote 8, the Mental Health Review Board must ensure that all the requirements of the *Act* have been met before psychosurgery may proceed.

[53]It may be that the so-called non-intrusive modes of treatment would not be seen as offending the *Charter* when administered without consent. Such decisions on the borderlines of constitutional offensiveness ought to be put squarely before the Canadian courts. See M.D. Wade, "The Right to Refuse Treatment: Mental Patients and the Law (1976), 1 *Detroit College of Law Review* 53; A.E. Doudera and J.P. Swazey (eds.), *Refusing Treatment in Mental Health Institutions — Values in Conflict* (Ann Arbor: A.U.P.H.A. Press, 1982); G.H. Morris, "Dr. Szasz or Dr. Seuss: Whose Right to Refuse Mental Health Treatment?" (1981), 9 *J. Psych. L.* 283 or J. Litman, "A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill" (1982), 82 *Columbia L.R.* 1720 for an exposition of the relatively mature American case law on the constitutional protection of the patient with respect to involuntary treatment. See also R. Gordon and S. Verdun-Jones, "The Right to Refuse Treatment: Commonwealth Developments and Issues" (1983), 6 *Int. J. of Law and Psychiatry* 57. In general,

its deprivation, this security is in jeopardy by the present system of forcible treatment.[54] One's entitlement to the safety of the constitutional umbrella is easily forgotten or overridden in the absence of the monitoring and assertion of rights by counsel.

The right to refuse treatment is one of many areas in the United States of genuine development touching upon the rights of the mentally ill.[55] Legal attention ought first to be centred on obtaining an enunciation and clarification of this principle in Canadian jurisprudence. Of almost equivalent stature has been the recent American pronouncement to the effect that the mental patient has the right to the least restrictive alternative treatment available when the basic decision has been made to let the interest of the state in treating the unconsenting patient outweigh the individual's right to self-determination.[56] Further progress has been made in the clarification of the right to treatment by the United States Supreme Court, which promises appropriate, individualized and planned attention to the problems of the institutionalized mentally ill and to former mental patients who are, it is assumed, receiving help in a community based treatment setting.[57]

The various treatment-related issues need the devotion of legal energies on an urgent basis. Other difficulties experienced by the institutionalized mentally ill may be less viscerally menacing, but still worthy of examination by courts and legislatures at the instigation of patients and their lawyers. Rights to communicate by telephone or in writing, to have visitors and to make outside excursions are taken for granted by most Canadians and indeed are constitutionally enshrined in the case of the former two freedoms and likely in the latter.[58] Unsurprisingly, mental patients may not fully enjoy the same rights.[59]

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these authors are quite pessimistic about the effects of the *Charter*. They state at 72: "Rather than relying on the toothless tiger of the *Charter* to improve, expand and protect the rights and interests of mental health patients, it is clear that fundamental reform to mental health legislation must be attempted."

[54]Some cases have begun to raise this kind of argument. For example, in *Lussa* v. *Health Services Center, supra,* footnote 33, it was found that continued detention of the plaintiff under the *Mental Health Act* of Manitoba without court interference would not be in accordance with the principles of fundamental justice.

[55]American case law would appear to accord involuntarily confined patients a qualified constitutional right to refuse treatment, with some limitations on this right in emergencies and for judicially declared incompetent persons. *Rennie* v. *Klein,* 653 F. 2d 836 (3rd Cir. 1981) and *Mills* v. *Rogers,* 102 S. Ct. 2442 (1982) are good examples of common law guideposts for clinicians and legislatures on the rights of involuntary patients to say, "No".

[56]The basic principle seems to be that where a constitutionally protected right of an individual may be fettered, the degree of intrusion should be minimal, while still accomplishing a valid state purpose. The cases of *Brewster* v. *Dukakis,* No. 76-4423-F (D. Mass., Dec. 6, 1978) or *Lessard* v. *Schmidt,* 349 F. Supp. 1078 (E.D. Wis. 1972) illustrate the impact of the fundamental doctrine when the liberty of psychiatric patients has been placed in jeopardy by overly vigorous state action.

[57]The right to quality treatment, assuming that there is legal authority to intervene and that this intervention is constitutionally circumscribed, might assist the individual patient in her recovery. It prescribes that treatment shall suit the individual, be revised if appropriate, be planned with some consultation with the patient, be as unobtrusive as possible, and protect the patient from harm in a humane environment where there is regular contact with qualified persons. *Wyatt* v. *Stickney,* 325 F. Supp. 781 (M.D. Ala. 1971) gave some early impetus to the line of cases said to have developed the principle.

[58]Sections 2, 6, 7 and 9 of the *Charter* might be invoked by psychiatric patients to support such assertions, but of course, section 1 might be held to impose limits on otherwise justifiable statements of constitutionally protected rights.

[59]Institutionalization, assuming it is justified legally, will inevitably carry some constraints on the individual's freedom. "Nevertheless, institutionalization itself is no reason for the curtailment or forfeiture of any civil rights

General institutional rules are potentially an additional objectionable feature of hospital life, as may be questions surrounding loss or reduction of privileges or problems arising with medical and non-medical staff. In some settings, the lawyer may find issues and firm legal arguments emerging after consultation with the patient and following further research. Other problems may call for the skills of advocacy without depending on a legal framework, and may draw upon the lawyer's counselling and mediation talents.[60]

Regular Civil Legal Concerns

Few people spend all of their lives in mental institutions.[61] Most patients will have had some experience with the outside world, either prior to the first admission[62] or in the periods between successive stays in the hospital. Many conventional problems will therefore likely have been encountered, some of which may be defined by reference to a legal framework and may be susceptible to resolution through the legal sysem and its actors. The sub-title, "regular" civil legal concerns, may be somewhat misleading given the poverty, prejudice and genuine travails inherent in being, or being said to be, mentally ill. It has nevertheless been employed to indicate the existence of legal adversities at least nominally similar to those experienced by persons at liberty in the outside world. This broad identification of problems between those who are institutionalized and those who are not should not be seen as an argument for simply directing the patient to a regular legal aid office. The physical, social and legal context in which the patient finds herself, the interrelatedness of her mental health and other legal problems, and the special need for theoretical understanding and empathy by the lawyer for the patient all echo the need for specialist legal services, even in the face of ostensibly familiar substantive areas.[63]

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that are not a necessary concomitant of loss of liberty." [A. Mewett, "The Rights of the Institutionalized", in R.St.J. MacDonald and J.P. Humphrey (eds.), *The Practice of Freedom: Canadian Essays on Human Rights and Fundamental Freedoms* (Toronto: Butterworths, 1979).] The extent to which rights and freedoms may be altered by reason of hospitalization will surely have changed since this pre-*Charter* article, but a careful assessment of each encroachment must still be made.

[60]Although the environment of a mental hospital may put special pressures on the lawyer, the well-trained and sensitive among the profession ought to be able to adapt their talents and experience to meet the demands at hand: "The need to make an adequate 'translation' from legal service demand to legal service, the need to counsel wisely, is particularly compelling [in the mental hospital setting]. The dissonance between the client's first perception or expression of legal need and how the lawyer ultimately disposes of the case is likely to be especially great in this context, and the consequences of all-out pursuit of the client's first request, without interposition of the latter's considered counsel on what can be achieved and how best to do it, are particularly serious." (S.J. Brakel, "Legal Aid in Mental Hospitals", [1981] *A.B.F. Research Journal* 21 at 84.) For a comment on Brakel's research, see R.H. Woody, "Public Policy and Legal Aid in Mental Hospitals: The Dimensions of the Problem and Their Implications for Legal Education and Practice", [1982] *A.B.F. Research Journal* 237.

[61]Although it has been earlier observed that there is a trend towards deinstitutionalization (or perhaps transinstitutionalization) for the mentally ill in Canada, the latest statistical records for duration of stay indicate that 34.1 *per cent* of patients had been in hospital for 10 years and more in 1976, a life sentence by *Criminal Code* standards (s. 669 (b)), Mental Health Statistics, 1976, *supra*, footnote 37 at 31.

[62]*Supra*, footnote 3 at 12: The median age for admission for all diagnoses was 33 for men and 39 for women in 1979-80.

[63]Brakel, *supra*, footnote 60 at 86, presented similar questions and responses following his exhaustive study into the operations of six projects delivering legal services to the mentally ill: "Would one argue for the duplication of these project experiences? Was this money well spent? The answer is, yes, there ought to be lawyers for patients

Family law impediments will subsist, even following institutionalization. Indeed, these problems may have led to the patient's distress or may have been expressive of the patient's latent turmoil. A recent Canadian study of an experimental specialist legal service in an institutional context demonstrated that general family law matters will be a significant concern, representing 16 *per cent* of the caseload.[64] Other surveys have shown similar levels of family law involvement.[65] Although variables such as the legal service's definition and measurement of problems and the general civil commitment regime may cause some fluctuation in these figures, one can be confident that family law will always be a major legal priority. Another ubiquitous problem area is the broad range of government benefit entitlement issues such as social assistance, unemployment insurance, public housing and provision for special needs.[66] Landlord and tenant and debtor-creditor matters are examples of mainly private civil legal burdens which may loom over the patient.

All these types of problems may have commenced before hospitalization, may fester throughout treatment and return to haunt the patient upon release. If the patient and her lawyer make significant progress during the hospital stay in identifying and resolving these difficulties, the likelihood of further emotional difficulty and possible need for treatment may be reduced. Finally, the lawyer should remain involved with those matters outstanding upon the release of the patient from the hospital. The patient is likely to feel reassured by this continuity of representation which may assist in minimizing the stresses of readjustment to life outside the institution.[67]

Directions for Legal Services

It would be artificial to prescribe a paradigm for the provision of legal services to the mentally ill which purported to be suitable for importation to any jurisdiction or treatment setting. On the other hand, many of the needs of the mentally ill are likely to be replicated across boundaries so that one may at least suggest some characteristics which a delivery system ought to emulate. Neither is it inappropriate to suggest responses to the rights of the mentally ill which might be expressed in programs other than legal service delivery in the usual sense.

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in mental institutions, but *only on certain conditions*: on condition that they be certain types of lawyers, doing certain kinds of work, in certain kinds of ways. The general proposition that it is good simply to have any lawyers or legal aid projects available for patients in mental hospitals is not supportable."

[64] *Supra*, footnote 13 at 46. Of the family law segment of the caseload, 89 *per cent* involved divorce or child custody.

[65] Brakel, *supra*, footnote 61 at 36-40.

[66] *Supra*, footnote 64.

[67] These references to the lawyer's role in confronting and ameliorating difficulties faced by the patient both within and beyond the hospital environment are not to be taken as artificially inflating the role of the law and lawyers in assisting the mentally ill. See, *infra*, text accompanying footnotes 76 to 78. The societal backdrop against which the scenes of mental illness are acted out remains depressingly static: "No one takes care of the socially marginal in the true sense of the term 'caring', indeed, it could be argued that caring itself is a casualty of alienated society." [C. Warren, *The Court of Last Resort: Mental Illness and the Law* (Chicago: University of Chicago Press, 1982) 207.]

Legal services for the mentally ill should be offered by specialists. It has already been noted that the members of this group of clients carry heavier burdens than the average citizen and therefore are more demanding upon both the lawyer's presumed repository of talents and her reserves of sensitivity, flexibility and special interests. The client's delicate emotional state, one's own reaction to such suffering and the necessity to adopt unusual or eclectic approaches to problems conspire to demand of the lawyer more than one would expect of a competent advocate with a more commonplace problem and client. The further necessities of having some coherent notions about the multifaceted causation of mental illness and of possessing some familiarity with standard (as well as alternative) ideological and treatment perspectives should close the door to novices — except those making a commitment to the field. Finally, the body of law out of which many mental health issues will arise is probably foreign legal territory. For most Canadian lawyers, this factor should prove to be less of an ultimate obstacle than the others discussed above.

Accessibility should be another keynote in the lawyer's service to the mentally ill. The institutionalized mentally ill are restricted in their freedom of movement within and without the hospital. The usual difficulty of the poor in seeing a problem in legal terms and taking the extra step of seeking a professional opinion is compounded by this institutional barrier. The likelihood of assertive action being taken by the patient to resolve her legal dilemmas is considerably reduced or eliminated. Legal services must be made available within the institution, making consultation easier, faster and more with the frame of reference of the patient population. Just as those appearing before criminal courts will normally be able to see duty counsel before any further contact with the legal system, so should newly admitted or prospective patients be given simple written summaries of their legal position, supplemented contemporaneously by a first meeting with a lawyer.[68] Every effort should be made to reduce the social and physical distance between lawyer and client throughout and beyond the treatment process, to the point where patients routinely look for advice, just as any non-institutionalized citizen would in facing particular legal problems or generally worrisome circumstances. The present high threshold obstructing the patient's perception of the legal dimensions of her situation and of her need for employment of legal counsel would then be broken down, so far as this is ever possible.[69]

Independence must be another hallmark of legal services for the mentally ill. The patient/client must have full confidence that her advocate's assumption of her case is unfettered by other loyalties, as any client justifiably ex-

[68]The recently enacted Ontario provisions, *supra*, footnote 34, begin the movement in this direction. Both relevant changes in the provincial statutes and thoroughgoing and sensitive shifts in the administrative practices of hospitals and legal aid service delivery units are required before one can begin to be confident that the law has done all it can for the newly admitted psychiatric patient.

[69]D.J. Black in "The Mobilization of Law" (1973), 2 *J. Legal Studies* 125 at 141, maintains that: "In fact, the availability of law is in every legal system greater for the citizenry of higher social status, while the imposition of law tends to be reserved for those at the bottom". He notes at 140 that strong informal antimobilization norms "in total institutions such as prisons, concentration camps, mental hospitals, and basic training camps in the military" operate to prohibit citizens from invoking the legal system.

pects.[70] One must acknowledge that in-house lawyers in this type of setting could succumb to a variant form of the same institutionalizing pressures which may so radically and (arguably) detrimentally alter the patient's persona.[71] Independence may be guarded if the apparent dangers are examined and confronted continuously by the lawyers involved; indeed, an ongoing spirit of professional introspection should be fostered. On the organizational level, funding from sources extraneous to the hospital and ministry of health should provide salaries at least comparable to civil service legal positions. Each delivery unit should be separate from other similar facilities and should have general policy and staffing matters dealt with by a board composed of staff and other lawyers, laypersons and former patients/clients. A loose federation on the provincial and national levels could co-ordinate action in areas of common interest, such as lobbying or continuing education.

Lawyers must themselves control the conduct of individual cases subject to conventional professional restraints. This spirit of independence must be tempered, of course, in the sense that the lawyer should attempt to adopt a mature and non-abrasive stance even in the face of the resistance which may arise in the face of strident advocacy. The problems of professional responsibility which will undoubtedly appear in a practice centred in such an unusual setting will only partially be ameliorated by the usual sources of professional guidance.[72] The lawyers must also be equipped with a sympathetic attitude toward the mentally ill, a sophisticated appreciation of the genesis and manifestation of mental illness and a real familiarity with the mental health industry and its various actors. From these bases, the lawyer should be able to serve effectively the needs of her client and may contribute to the solution of the legal problems of the mentally ill at a broader level.

However laudable and necessary it may be to respond to individual problems once they have occurred, mere reaction will not suffice. To the extent that legal and other difficulties recur and that there are thereby common interests among patients, legal services should assume a pro-active stance.[73] Debate has raged within the general legal aid movement since its inception on the most appropriate and effective way to put this aspiration into concrete terms. It is probably more helpful in this context to adopt an eclectic approach to legal and social reform, choosing methods which may vary according to the

[70] *Supra*, footnote 26 at 16: "The reason for the rule [against conflict of interest] is self-evident; the client or his affairs may be seriously prejudiced unless the lawyer's judgment and freedom of action on his client's behalf are as free as possible from compromising influences."

[71] Of course, lawyers should strive to avoid merely being part of a system which already has the effect of increasing the dependency needs of its subjects, without offering meaningful change in patients' lives outside the institution. See, *supra*, footnote 67 at 211: "Institutionalism creates a new or additional pattern of dependence in addition to preexisting dependence." Legal counsel should encourage notions of responsibility and autonomy in clients, in so far as this is realistic. E. Goffman's classic work, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, N.Y.:Doubleday/Anchor, 1961), is an obvious source for furthering one's understanding of the socio-psychological effects of being a patient in an institution such as a psychiatric hospital.

[72] *The Code of Professional Conduct* of the Canadian Bar Association contains no specific references to the representation of the mentally ill; it can only be used as a guide with appropriate adaptations for the client and setting.

[73] The benefits, perhaps even the necessity, of a proactive approach to the delivery of legal services for the indigent was a dominant theme in Garth's comparative study, *supra*, footnote 23.

nature of the dispute and the client, and the political, legal and institutional environment.[74]

Test cases, whether brought as class actions on behalf of other persons similarly situated where there is no or inadequate precedent, or which relate to a single but typical type of legal dispute where a right of recovery or redress is being sought which will settle other oustanding claims, may bring about favourable legal developments for the mentally ill. Legislative lobbying may be more promising for some issues and might be conducted through associations of legal services offices, patients' rights organizations or other groups with interests in common with the mentally ill. Public legal education — defined so as to include minimally patients, ex-patients, health care and legal workers in its audience — may pay real dividends for the mentally ill by both upgrading the knowledge and skills of those involved directly with mental health issues and bringing relevant issues to the attention of the wider populace for whom these matters have previously been *sub rosa*.

These efforts to change the law relating to the mentally ill and to make their lives better will be most relevant to actual experience if the areas chosen for action emerge from actual problems, as observed by legal service units and as informed by patients' associations. Lawyers must therefore not stop at monitoring legal problems seen from their vantage point. They should also encourage the formation of patient groups. Even if this role seems to be an unfamiliar one for lawyers, it is consistent with the lawyers' ethical responsibilities.[75]

Aspirations and Limitations

The cautious observer will likely conclude that in spite of the merit of the author's solution for the array of legal problems faced by the institutionalized mentally ill, there are counterposed significant issues which should make one skeptical, particularly when considering the legal and psychiatric professions and their relationships.

[74]The political context of 1985 must be squarely faced as one not generally favourable to the extension of state funded social welfare programs, under which rubric the provision of legal services to the mentally ill will generally fall. Paradoxically, in an era when economic conditions seem to be worsening for the lowest societal stratum, where exponents of individual responsibility for the causation and elimination of personal problems are becoming more numerous, and where one can predict an increasing incidence of individual suffering, the mentally ill will not likely receive the commitment of resources they require for legal or other services. With these considerations in mind, it is obvious that merely attempting to satisfy individual legal needs will not be sufficient to create meaningful change for the mentally ill and the poor in general. See Garth, *supra*, footnote 23 at 171: "Lawyers can help poor individuals by making them aware of their rights and bringing legal actions to enforce them, but the cumulative effect will not do much to help the poor as a class: it will neither make welfare state rights effective for most poor individuals nor help unleash energies that will result in increased political power or economic strength to the poor."

[75]Rule 12 in the *Code of Professional Conduct* at 51-52 appears to lend support to this aspect of the practice of the mental health lawyer: "Lawyers should make legal services available to the public in an efficient and convenient manner which will command respect and confidence and by means which are compatible with the integrity, independence and effectiveness of the profession .... The individual lawyer may also assist in making legal services available by participating in legal aid plans and referral services, by engaging in programs of public information, education or advice concerning legal matters, and by being considerate of those who seek his advice but who are inexperienced in legal matters or cannot readily explain their problems." It must be acknowledged, however, that some aspects of the organization of mental patients or ex-patient groups might be better and more appropriately handled by community legal workers — legal para-professionals with special interests and training in mobilizing the disadvantaged.

The legal profession should be enriched by increased representation of the mentally ill. It could become more sensitive and responsive to its overall responsibilities by having to face the challenge of serving a new and more demanding group of clients.[76] The psychiatric profession should be better able to help the emotionally disabled if its police functions were stripped away or at least strongly counterbalanced by vigorous advocacy in a legal context, thereby guaranteeing real openness and respect of patients' rights. Indeed, many physicians might themselves be inclined to represent patient interests in several areas with greater vigour and commitment if they worked in an environment where rights issues became part of daily life and parlance.[77] Relations between the professions would gradually improve as each body perceived its role more clearly and saw the hope accorded by pursuit of the common goal of ensuring that the mentally ill receive their maximum social, personal and legal entitlements. Within the context of more co-ordinated efforts between lawyers and psychiatrists, the law should be reformed sooner and more sensitively, with consequent positive effects for both professions and, of course, the patients.

These legal developments would by no means provide redress for all the grievances which the mentally ill may have, whether presently articulated or not. The author does not want to be said to be labouring under a "quintessential rescue fantasy", a condition which allegedly afflicts legal activists in the mental health field.[78] The extent of real change for the mentally ill generated by these ameliorative legal measures must not be exaggerated, nor must the barriers to co-operative work between lawyers and physicians be overlooked.

Psychiatry is portrayed by some defensive observers as being over-regulated already.[79] Therefore, it might be said that the presence of more lawyers in the psychiatric hospital setting and the attendant increase in legal challenges to independent clinical judgments would hinder and stifle the practice of medicine. In response, one must frankly confront the issue of the extent

[76]The thesis that the legal profession changes, likely in a manner which benefits it and the public, with greater commitment to legal rights activities, has been generally supported by some recent research, albeit in the American context. See, *e.g.* J.F. Handles *et al., Lawyers and the Pursuit of Legal Rights* (New York: Academic Press, 1978), where the author states at 187, 194: "The new types of [legal rights] organizations, by providing a structured cutting edge, have extended the recognition of legal rights of the poor and helped provide the professional talent that defined and enforced those rights.... [L]egal rights activities are a growing area of law. If all else remained equal, we would expect legal rights lawyers to have a steadily increasing influence on the profession as society at large .... Professions and professional organizations tend to generate their own momentum. Once engaged, the organized bar is unlikely to back away from poverty and public interest law as long as the political and financial costs are not too high."

[77]"The fight for patients' rights is not a transitory phenomenon .... Fortunately, the profession has achieved some accommodation with patients' movements and other diligent advocates and the lawyers who represent them .... [M]ental-health professionals will reclaim their historic mission as healers, not jailers. That result will certainly benefit the broad profession.... As social-welfare concerns sink lower on political priority lists, mental-health professionals, consumers, and advocates must join together in fighting to protect human rights and to satisfy human needs." [S.S. Herr *et al., Legal Rights and Mental Health Care* (Lexington, MA: Lexington Books, 1983) at 168.]

[78]Schwed, *supra*, footnote 1 at 197 provides some helpful restraining comments which ought to be confronted by reformist lawyers: "[T]hose who seek to redress ills in our mental health delivery systems, would do well to re-examine the new laws which may add to the burdens of the mentally ill, handcuff mental health professionals in effecting treatment, or prove too rigid to have any practical value."

[79]Of course, this type of complaint is shared by groups as apparently disparate as small business, the professions and multi-national corporations, and reflects a nostalgia for an era of unfettered discretion.

to which decisions with respect to institutionalized people are made without specific knowledge of, or with only grudging reference to, patients' rights. Surely a different consciousness might be required of many health service personnel from the psychiatric level and throughout the mental health hierarchy; but this change does not mean that medical concerns must be disavowed. Instead, doctors and related professionals must learn to understand that patient welfare and treatment must be pursued with both a broader conception of what constitutes the overall best interests of patients and a stricter eye toward the patient as citizen and autonomous decision maker.

Closer examination of psychiatric reaction to law reform has shown that the profession may be more open to change than lawyers expect and, at times, may be more enthusiastic about the progressive evolution of the law than lawyers themselves.[80] Lawyers may help to clarify issues, identify levels of responsibility for decision-making more clearly and in some cases take the weight of a particularly difficult question of appropriate treatment or release from the physician's shoulders by exposing the matter to judicial or quasi-judicial scrutiny. It is surely an optimistic sign that some doctors argue for both stronger and more visible advocacy by lawyers and an acknowledgement that the two professions share the duty for patient representation in relation to many issues.[81] On the other hand, it has been observed earlier that lawyers have, if anything, been willing to defer to medical and psychiatric expertise, enabling the legal profession to escape confrontation with some of the more troubling questions of social life.

These two sides of the same coin, psychiatric disinterest in the law and reverence by lawyers of psychiatric wisdom, have conspired to accord psychiatry a level of independence which it probably ought not to want and certainly does not deserve. More lawyers in the mental health area may reduce the level of psychiatric power to everyone's satisfaction and may also force the legal profession to deal with its pervasive neglect of the psychiatric field.

Although legal services may already be theoretically available to patients through the private bar and legal aid schemes, the actual level of involvement by lawyers has been low compared to the obvious needs of the mentally ill. Amplification of the legal role should lead to a more satisfactory situation for mental patients, with legal services demonstrating expanded availability and enhanced capability and sensitivity. The *status quo* is an unjustifiable resting place.

Limitations are apparent in this justification for expanded legal services for the mentally ill. For example, the sole concern of the mental health advocate can seldom be the patient's liberty at all costs, although she must seek this strenuously if so instructed in the individual case. Sometimes, consistent with her responsibilities as advocate, more conciliatory and longer term views must be taken which are cognizant of both the interrelationships among legal,

[80] L.H. Kahle *et al.*, "On Unicorns Blocking Commitment of Law Reform" (1978), 6 *J. of Psychiatry and Law* 89. This readiness to support law reform by psychiatrists was clearly demonstrated, both with respect to due process of law protections and rights for patients, during and after civil commitment proceedings.

[81] *Supra*, footnote 77, especially Chapter 11.

psychiatric and social problems and the desirability of action being taken on broader or many fronts. Frequently there may be nothing the lawyer can do to assist the individual, but one may see new guideposts or goals which may help others in similar situations in the future.

Effective liberty — in the sense of either freedom from control by fate or release from the captivity imposed by economic and social deprivation — has never existed for many mental patients; release may be a hollow victory, merely returning the individual to a milieu of poverty and desperation. This conundrum throws into relief the terrible problems which mental illness presents to society. In an aggressive, materialistic culture such as ours, material and spiritual rewards go mainly to the already endowed and the mythically hard working and fortunate entrepreneur. The mentally ill are seen merely as extras or outcasts. These distraught and confused people will tragically continue to be isolated, labelled and punished. Lawyers cannot make a great contribution to changing all of these conditions, but can help to maximize a patient's liberty and dignity. Psychiatrists can assist the most disadvantaged in coping with an unwelcoming social fabric, especially by providing assistance which takes into account the influence of social and economic factors. That both disciplines may be seen as mere devices for social control[82] does not mean that more liberating perceptions of the lawyer's and physician's role cannot form part of their self-perceptions and eventual professional practices. Mental illness will not be eradicated by the increased availability of lawyers to the institutionalized patient, nor will doctors change their world view overnight in response. Nonetheless, Canadian lawyers must still face the challenge presented by the mentally ill client and begin to deal with this neglected legal frontier.

[82]This point is eloquently argued in L. Langman's "Law, Psychiatry and the Reproduction of Capitalist Ideology: A Critical View" (1980), 3 *Int. J. of Law and Psychiatry* 245.