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One Step Forward, Two Steps Back: a Charter Analysis of s.39 of Nova Scotia's *Involuntary Psychiatric* Treatment Act

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Abstract

Nova Scotia's recently updated *Involuntary Psychiatric Treatment Act* significantly updated mental health law in the province in many respects. However, s.39 of the Act deviates from this record in that it contains a clause that permits overriding the competent prior wishes of involuntarily committed psychiatric patients. This is problematic because it displaces established Canadian common law and legislation on advance directives for psychiatric patients but not other patients, suggesting possible discrimination The paper explores whether s.39 might survive challenge under s.15 of the *Canadian Charter of Rights and Freedoms*, as either an affirmative action program under s.15(2) of the Charter or as an overriding societal concern under s.1 of the Charter.

Key words: non-consensual treatment; treatment refusal; advance directive; discrimination.

In 2005, Nova Scotia updated its mental health legislation with the *Involuntary Psychiatric Treatment Act*[1] ('IPTA'), a long-awaited improvement over earlier legislation that termed psychiatric patients 'lunatics' or 'the insane.'[2] While IPTA no longer uses disrespectful language, it remains problematic in another way, however.

IPTA's s.39 empowers a substitute decision-maker to make treatment decisions for an involuntarily committed psychiatric patient[3] using patients' prior capable informed expressed wishes, unless doing so endangers the patient's (or others') "physical or mental health or safety", whereupon "best interests" are substituted.[4] These words harbour radical negative effects: imposing treatment despite capable prior wishes displaces Canada's common law[5] and legislation governing advance directives.[6] Requiring only mentally but not physically ill persons[7] to have medical decisions imposed upon them seems intuitively unacceptable and suggests blatant discrimination.[8] Mentally ill persons have endured a long history of discrimination, inconsistent with modern *Charter* values. It is disappointing to see this same dynamic within IPTA,[9] one of Canada's most recent provincial mental health statutes.

This paper argues that IPTA s.39 violates the *Canadian Charter of Rights and Freedoms*'[10] s.15(1) equality guarantee. First, applying the vision of substantive equality elucidated in *R. v. Kapp*,[11] I explore whether s.39 creates a distinction under s.15(1). Next, in light of disadvantages affecting psychiatric patients, I ask if s.39 constitutes affirmative action, under s.15(2) of the *Charter*, immunizing it from challenge. If not, does s.39 violate the equality guarantee of s.15(1), in its treatment of patients? Finally, I examine whether any infringement may be upheld as a policy decision under s.1 of the *Charter*.

Does s.39 draw a distinction based on an enumerated or analogous ground?

A long history of exclusion, shame, fear, segregation, and mistreatment has been associated with mental illness. Under, s.39 patients detained involuntarily due to mental illness may be treated with mind-altering pharmaceuticals against their express wishes, made earlier, while competent. While some may claim such treatment to be beneficent and aimed at furthering the patient's best interests, in reality, such forced treatment seems to have more in common with historical mistreatment, because it suggests that these patients' wishes are not worthy of respect and that their legal rights are trivial. This does not seem in keeping with the concepts of equality and human dignity central to the *Charter*.

Section 15(1) of the *Charter* states: "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on ...mental or physical disability."[12] In *Law v. Canada*, the purpose of s.15(1) of the Charter was found to be:

> ...to prevent the violation of essential human dignity and freedom through the imposition of disadvantage, stereotyping, political or social prejudice, and to promote a society in which all persons enjoy equal recognition at law as human beings or as members of Canadian society, equally capable and equally deserving of concern, respect and consideration.[13]

In turn, s.15(1)'s purpose is to identify discrimination (against individuals or groups), defined as:

> …a distinction, whether intentional or not, but based on grounds relating to personal characteristics of an individual or group, which has the effect of imposing burdens, obligations or disadvantages on such individuals or groups, not imposed on others, or which withholds or limits access to opportunities, benefits and advantages available to other members of society.[14]

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IPTA s.39 satisfies the threshold criteria for a s.15 *Charter* challenge. Section 39 constitutes sufficient State involvement and reveals evidence suggesting (a) a distinction or differential treatment of one group compared with another, (b) in which one group receives greater benefits, legal protection or other advantage, without justification. Section 39 permits overriding prior wishes in involuntary psychiatric patients but not patients without mental illness, but suffering from physical illness.[15] In both groups, patients have competent prior wishes, but in only one group are those wishes respected. Thus a distinction exists based on the enumerated ground of mental disability, which creates lesser legal protection for these individuals, attracting s.15's attention.

Is s.39 an ameliorative program under s.15(2) of the Charter?

Charter ss. 15(1) and 15 (2) must work together, to promote an overall "vision of substantive equality."[16] Upon finding a distinction, attention shifts to s.15(2), asking if the differential treatment "has as its object the amelioration of conditions of disadvantaged individuals or groups", allowing it to escape being ruled discriminatory. "Any law, program or activity" may constitute an ameliorative program so IPTA s.39 may qualify.

Is s.39 an ameliorative program under s.15(2) for redressing psychiatric patients' disadvantage? The test is: "A program does not violate the s.15 equality guarantee if the government can demonstrate that: (1) the program has an ameliorative or remedial purpose; and (2) the program targets a disadvantaged group identified by the enumerated or analogous grounds."[17] This requires determining s.39's objectives, whether they are ameliorative, and whether any amelioration favours disadvantaged groups.

Some may argue that s.39 has an ameliorative purpose. The 'Thank-You Theory' of psychiatric treatment[18] claims many patients lack insight and may later be grateful for treatment. Psychiatrist John E. Gray (2000) argues that non-consensual treatment is necessary to prevent greater patient suffering, increased patient restraint or seclusion, longer detention (i.e., 'warehousing')[19], poorer prognoses for youth, negative impacts on staff, fellow patients and the therapeutic environment, greater costs[20] and lost treatment opportunities due to 'blocked beds.'[21] Yet treatment refusals may be an infrequent concern hardly warranting s.39's existence: in one study only 7.2% of patients refused treatment, averaging just 13 days, while only 2% refused beyond 14 days. [22]

Some, including the 'anti-psychiatry movement'[23] which has legally empowered some competent psychiatric patients to refuse unwanted treatment, counter that forced treatment is not ameliorative. Patients may have valid reasons to reject treatment, including undesirable side-effects, a preference for their own untreated thoughts and a right to make seemingly unwise choices. In addition, forced treatment may impair outcomes. Yet refusing treatment may sometimes mean an untreated patient cannot be released into the community, needing long-term hospitalization,[24] which some term "rotting with their rights on."[25]

Untreated mentally ill face grave disadvantages --possible direct suffering from the illness, and negative societal attitudes-—deserving amelioration. Yet IPTA s.39 may not qualify as affirmative action, as it does not fit the typical format. Usually in affirmative action, a legal disadvantage, lack of benefit or exclusion is conferred on a relatively privileged group (e.g., white people), to confer needed advantages on a less privileged group (e.g., Aboriginals).[26] Section 39 confers a disadvantage on a less privileged group and re-labels this as an 'advantage' to it. A similar argument failed in *R. v. Music Explosion, Ltd*.,[27] where a restrictive bylaw[28] was claimed as a s.15(2) program "for the benefit of the special needs of young persons."[29] The Appeal Court, however, held that such a *restriction* was not a *conferral of special benefits* but simply a colourable attempt to discriminate.[30] Thus, restricting the rights of psychiatric patients to make their own treatment decisions may not qualify as a 'special ameliorative program'. *Kapp* also stressed the importance that an ameliorative *purpose* be more than a "shield to protect a program or activity which is...discriminatory."[31] There must be a genuine nexus between the claimed goal and the law's form and implementation:

> It is insufficient to declare that the object of a program is to help a disadvantaged group if in fact the ameliorative remedy is not *directed to the cause of the disadvantage*. There must be unity ...among the elements of the program, [suggesting] that the *remedy...is rationally related to the cause of the disadvantage.*[23] (Emphasis added).

Many psychiatric patients are competent to choose their own treatment, contradicting societal myths of their global incompetence and the seeming foolishness[33] of their choices. These unchallenged societal myths reflect stereotypes and stigmatization[34] of difference, affecting psychiatric patients' in and beyond the hospital. They generate disadvantages[35] in employment, housing, financial credit, and social participation, causing increased poverty, homelessness,[36] addictions[37] and criminalization,[38] which in turn impede recovery.[39] The Kirby Report (2006) into Canada's mental healthcare left little doubt that people with mental illnesses experience disadvantage. Yet the real 'cause' of much of this disadvantage is often *not* illness itself, but false, over-generalized stereotypes that exclude patients from the community. Thus, while IPTA s.39 may reduce surface differences between mentally ill patients and others through enforced treatment, it leaves intact and even perpetuates underlying societal myths about people with mental illnesses. Since IPTA s.39 does nothing to ameliorate these myths--the major cause of patients' disadvantage-- a court may not find that s.39 constitutes affirmative action.

Does s.39 of IPTA infringe the s.15(1) *Charter* equality right?

Different treatment may not always constitute discrimination. Substantive inequality does not always require identical treatment between groups because, where relevant differences in group characteristics exist, "like treatment can generate serious inequality."[42] For s.39 to constitute discrimination requires satisfying a two-part test: "(1) Does the law create a distinction based on an enumerated or analogous ground?[43] and, (2) does the distinction create a disadvantage by perpetuating prejudice or stereotyping?" The second question requires examining four contextual factors identified in *Law*[44] and *Kapp*: any pre-existing disadvantage affecting the group; any correspondence between the different treatment and the group's 'reality;' whether the impugned law has an ameliorative purpose (or effect); and the nature of the

interest affected. Consider two of these factors in the context of s.39.

The mentally ill have endured a long history of discrimination, marginalization, and stigmatization. As noted, the lesser legal protection accorded patients' prior wishes under s.39 perpetuates societal myths about psychiatric patients' competence,[45] infantilizing them and oversimplifying the more complex reality.[46] It continues patterns wherein the opinions of the mentally ill are deemed of lesser significance and worth, suggesting a discriminatory aspect to s.39.

The nature of the interest at stake in s.39 – the right to bodily integrity and autonomy – is profoundly intimate, fundamental, and central to an individual's sense of self. So important is it that, as noted in *Fleming v. Reid*, it is not only protected by the common law but also warrants constitutional protection under s.7 of the *Charter* as a right to security of the person, only to be denied according to the principles of fundamental justice. While the court in *Fleming* observed that the right is not absolute,[48] but is subject to overriding societal interests, it stated that bodily integrity and autonomy deserve the "highest order" of protection.[49] In this, "… few medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs...often accompanied by severe and sometimes irreversible side-effects..."[50]

Overall, the *Law* and *Kapp* factors suggest that s.39's differential treatment perpetuates prejudice and denies psychiatric patients' s.15(1) 'equality under the law', suggesting that s.39 discriminates, based on mental disability.

Can s.39 of IPTA be saved by s.1 of the *Charter*?

Legislation may be saved as a "reasonable limit, prescribed by law in a free and democratic society"[51]: a public policy choice, reflecting overriding societal interests, under s.1 of the *Charter*. Analysis follows the four-step Oakes test below.

Is there a pressing and substantial objective? Section 39's purpose seems directed at ensuring that patients receive medical treatment and are released rather than warehoused.[53] Some feel this goal has been frustrated by lawyers more concerned with clients' civil liberties than with patient well-being and potential. Herschel Hardin (1993),[54] former director of the British Columbia Civil Liberties Association and father to a schizophrenia patient explains:[55]

> Far from respecting civil liberties, legal obstacles to treatment limit or destroy the liberty of the person...Such victims... cannot think for themselves or exercise any meaningful liberty...The opposition to involuntary committal and treatment betrays a profound misunderstanding of the principle of civil liberties. Medication can... restore [patients'] dignity, free will and the meaningful exercise of their liberties.

Thus in view of the human values at stake[56] the objective of ensuring involuntary treatment *does* seem 'pressing and substantial.'[57]

Are the means taken rationally connected to the objective sought? If s.39's objective involves ensuring treatment to optimize chances of release, the rational connection branch may also be met. A legislative attempt to redress marginalization of patients –ensuring treatment to remove stigmatizing symptoms—seems *somewhat* rationally connected to the goal, even if it cannot hope to eliminate stigma.

Anti-psychiatry's supporters may disagree. Arguably, psychiatry has a long history of State suppression of eccentric, provocative (but non-dangerous) people whose non-conformity, threatens public order, or those in power.[58] Labelling and treating mental illness may be powerful tools for silencing, suppressing minority views and enforcing conformity. Kate Millett (1990), a lawyer with bi-polar disorder, also notes that psychiatry -- "the system that keeps millions in line"[59] — may have somewhat tenuous foundations:

> The entire construct of the "medical model" of "mental illness"—what is it but an analogy?...whereas in physical medicine there are verifiable psychological proofs...in mental illness alleged socially unacceptable behaviour is taken as a symptom, even as proof...Diagnosis is based on impressionistic evidence: conduct, deportment, and social manner. Such evidence is frequently imputed. Furthermore, it may not even be experienced by the afflicted party but instead may be observed [only] by others...[60]

Psychiatry is a field in some chaos: the scientific connection between mind and brain remains unclear[61] and even explaining the biological basis of the *healthy* human mind poses challenges. Does *any* competent patient possess autonomy in a medical decision, or is such freedom illusory?[62] Uncertainties abound:[63] psychiatric diagnoses may vary and feigned illness may go undetected.[64]

Medications[65] also raise doubts regarding efficacy and side-effects.[66] Physical side effects among older anti-psychotic drugs include stigmatizing neurological symptoms. The older drug Haldol may risk lethal cardiac arrhythmias.[67] Such side-effects give patients valid reasons to consider refusing these older, but still used, drugs.[68] While newer ('atypical') anti-psychotics exhibit improved efficacy and lack these side-effects, they possess other effects. Although cardiac rhythms are not affected, significant weight gain,[69] metabolic changes and possible diabetes may pose cardiovascular risks to be weighed against benefits. Yet despite such doubts, s.39 may still demonstrate a sufficient rational connection to satisfy the test.

Does the impugned legislation `minimally impair` the right infringed? The legislature must tailor any rights intrusion, or provide exceptions to it. IPTA's requirement of the "least restrictive" treatment[70] suggests efforts to tailor s.39's intrusion.[71] A "least restrictive" choice implies sometimes using physical restraints, seclusion, persuasion and incentives[72] to gain cooperation, prevent harm and preserve the therapeutic environment. Yet if *any* psychiatric treatment refusal progressively damages brain and mind, or risks 'mental harm to others'[73] s.39 may subject almost *any* competent patient to unwanted medication. This seems inconsistent with tailoring. Moreover, the specific right infringed by s.39 seems inconsistent with minimal impairment. While neither rights to liberty nor bodily integrity are absolute, both are important s.7 *Charter* rights, only to be infringed in

accordance with the principles of fundamental justice. Yet they may warrant different treatment.

Liberty and security of the person differ in their sensitivity to interference. It is easier to tailor intrusions on liberty. This may be done spatially, limiting a person's movements, activities or interactions, or at the extreme, by restricting almost all activity, using seclusion, chemical or physical restraints.[74] Liberty intrusions may also be modified temporally, by duration. Security of the person,[75] however, is much more sensitive to interference, and more difficult to infringe in a tailored way. Bodily integrity either is, or is not, entirely breached by intrusions. Temporal tailoring of intrusions seems meaningless when even brief intrusions on bodily integrity, as in unwanted sexual contact, may have profound negative effects.

Bodily integrity and autonomy rights –the right to dictate what is done to one`s body, brain and mind --also seem of more central value than liberty, given the importance of a person's physical 'being' to identity, self-determination and survival. Individuals express their unique personal identities through their bodies,[76] via temporary adornment,[77] or permanent body modifications,[78] communicating beliefs, affiliations and social status. A person's self-identity, memories and personality also exist in a specific body part: the brain. The body is therefore central to a person's identity and most intimate self-concept.[79]

Thus, while both liberty and security of the person are important, security of the person seems both more fragile and more central to the person, warranting greater protection. The 'least intrusive' (i.e., most minimally impairing)[80] option requires infringing liberty over bodily integrity.[81] Yet s. 39 adopts the opposite approach of infringing bodily integrity[82] to promote patients' liberty, so it fails to minimally impair psychiatric patients' equality rights, clearly failing this third *Oakes*' branch.

Is there proportionality between benefits and costs of the means chosen or objective sought? For certainty, the final *Oakes* test branch will also be explored. Here, the means (s.39) allows interference with the personal autonomy of involuntary psychiatric patients, against their express, competent wishes. These patients are a dependent and isolated group, vulnerable to coercion, possibly confused by illness and sedation, who cannot easily air their views. Thus further restricting these patients` choices require caution, to preserve patient autonomy wherever possible.

Bodily integrity warrants "the highest order of protection"[83] in law, so proportionality requires s.39's goal to be of comparable or higher priority. Section 39 offers some benefits: it reduces violence, verbal abuse and stress to staff or other patients, and may reduce the application of more severe liberty restraints, shorten hospital stays[84] and lower costs.[85] Yet s.39's forced treatment is an overly simplistic approach to psychiatric illness that may cause harmful side-effects and impair real treatment progress.[86]

Tragic as such lost potential may be, it may be a necessary sacrifice to respect patient autonomy. The power difference and information asymmetry between medical staff and patient imply a trust situation, requiring respect for patient choices. Also in a diverse, pluralistic society should the views of only one group --healthcare staff—determine the 'best interests' of all patients?[87] Patients have many dimensions to their lives, only one of which involves their biomedical status. Biomedical assessments cannot canvas all of the values a person may treasure, which define him personally. Some patients prefer their own unique mental processes, as 'Starson' (2003) preferred his rapid thoughts, supporting his research.[88] Others enjoy the emotional highs,[89] or find meaning and livelihoods using artistic states inaccessible in treatment.

Emerging concepts such as 'Mad Pride' seek to reclaim and celebrate, rather than pathologize,[90] mental difference. The 'neuro-diversity[91] movement' holds that healthy human neurological function forms a continuum of (equally acceptable) ways of thinking, including conditions labelled as illness or disability.[92] Mental differences may be a 'way of life,'[93] as is 'deaf culture' to some. Some argue the true location of mental 'disability' may lie within mainstream society's unconscious reactions to difference, not in the person claimed to be different.

Accordingly, is s.39's cost-benefit ratio proportional to the goal's importance? The answer will depend on the values of highest priority—those less reasonable to sacrifice. Here, freedom from interference with a patient's bodily integrity and autonomy are of higher priority than staff morale, and patients' potential and conformity with mainstream values. Thus the goal of recovering psychiatric patients' full potential, rather than warehousing them, while important, cannot support serious impositions on the sacrosanct Canadian value of security of the person. The proportionality step of the *Oakes*' test must fail, therefore. Accordingly, at trial, it seems highly likely that s.39 would fail on at least two *Oakes* test branches and could not be saved under s.1. However, what remedies a judge might impose, such as striking down s.39 or reading in certain requirements, must await an actual challenge in a court of law.

Conclusion

Non-consensual treatment of competent psychiatric patients ranks among the most controversial healthcare issues. Some regard it as a travesty for a patient not to be treated, if there is any chance of restoring healthy function. The issue seems all the more glaring with younger patients, who face a longer period of potential illness (or health), and who may forfeit opportunities to establish career paths and important social relationships due to illness. There is thus a temptation to view constitutional rights (including legal equality) as of lesser *practical* importance than a patient's mental health status.

Some may see s.39 as a compassionate response to mental illness. Yet its disregard for involuntary patients' legal rights perpetuates damaging stereotypes about patients, such as that their competent wishes are unworthy of respect. Such healthcare double standards in the treatment of physically and mentally ill patients *add to* rather than alleviate any burdens from mental illness.

This paper has asked whether IPTA s.39 could survive a s.15 *Charter* challenge. Overall, it seems it may not. While s.39 may superficially ameliorate the most *visible* disadvantages of mental illness through required treatment, it thereby reinforces our society`s *invisible* barrier to inclusion: stigma. Overall, s.39 starkly denies the *Charter* legal equality guarantee, infringing a right --bodily integrity and

autonomy—considered sacrosanct in Canadian health law, which warrants stronger legal protection than liberty. Thus s.39 seems unlikely to be saved by s.1of the *Charter*, due to failures in minimal impairment and proportionality.

Although IPTA updated many aspects of Nova Scotia's mental health legislation, s.39 is less than progressive. In contrast to the 'emergence from the shadows' heralded for mental illness this century, s.39 suggests a return to a more paternalistic era. Unchallenged, s.39 represents several steps backwards for psychiatric patients, compared with those in Canada`s physical healthcare system.

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Endnotes

1 *Involuntary Psychiatric Treatment Act*, S.N.S., 2005, c.42 [' IPTA']

2 *Incompetent Persons Act*, R.S.N.S., 1989, c.218, s.2 (b).

3 *Involuntary Psychiatric Treatment Act*, s.3(m): an 'involuntary patient' means "a patient who is admitted to a psychiatric facility pursuant to a declaration of involuntary admission." A psychiatrist can make a declaration of involuntary admission where he or she is of the opinion that:

(a) the person has a mental disorder;
(b) the person is in need of the psychiatric treatment provided in a psychiatric facility;
(c) the person, as a result of the mental disorder,
  (i) is threatening or attempting to cause serious harm to himself or herself or has recently done so, has recently caused serious harm to himself or herself, is seriously harming or is threatening serious harm towards another person or has recently done so, or
  (ii) is likely to suffer serious physical impairment or serious mental deterioration, or both;
(d) the person requires psychiatric treatment in a psychiatric facility and is not suitable for inpatient admission as a voluntary patient; and
(e) as a result of the mental disorder, the person does not have the capacity to make admission and treatment decisions."

4 *Involuntary Psychiatric Treatment Act*, s. 39: The substitute decision-maker shall make the decision in relation to specified psychiatric treatment and other related medical treatment

(a) In accordance with the patient's prior capable informed expressed wishes; or
(b) in the absence of awareness of a prior capable informed expressed wish or if following the patient's prior capable informed expressed with would endanger the physical or mental health or safety of the patient or another person, in accordance with what the substitute decision-maker believes to be in the patient's best interests.

5 *Malette v. Shulman* (1990), 72 O.R. (2d) 417, 67 D.L.R. (4th) 321 at para. 18 and 24: "Under the doctrine [of informed consent], no medical procedure may be undertaken without the patient`s consent..." and: "A doctor is not free to disregard a patient`s advance instructions any more than he would be free to disregard instructions given at the time of the emergency..." *Fleming v. Reid*,[1991] 4 O.R. (3d) 74 at para. 31: "The right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent."

6 Hospitals Act, R.S.N.S. 1989, c.208. s. 54A states (for example): The substitute decision-maker shall make the decision in relation to specified medical treatment

(a) in accordance with the patient's *prior* capable informed *expressed wishes*; or
(b) In the absence of awareness of a *prior* capable informed *expressed wish*, in accordance with what the substitute decision-maker believes to be in the patient's best interest.

A second example, Prince Edward Island's *Consent to Treatment and HealthCare Directives Act*, R.S.P.E.I. 1988, c.C-17.2, ss.20 and 24 state:

20. (1) Every person over the age of sixteen years who is capable may execute a directive.

(2) A directive may

(a) stipulate treatment, procedures, or medication that the maker authorizes or refuses to consent to, or directs to be discontinued, in the circumstances set out in the directive;
(b) stipulate circumstances in which the maker shall be permitted to die a natural death, receiving only palliative care intended to reduce pain and suffering;
(c) appoint a proxy;
(d) specify an event or condition upon which the directive becomes effective;
(e) make any other direction concerning the health care or treatment of the maker.

24. (1) A decision contained in a directive shall be as effective as if made by the maker when the maker had capacity to make the decision.

7 *Fleming v. Reid*,[1991] 4 O.R. (3d) 74 at para.60.noted that the right to bodily integrity and autonomy is not absolute. Thus there may be limited circumstances where competent psychiatric patients' autonomy may validly be curtailed, for example, in emergency mental health situations, where a patient must be temporarily chemically restrained using sedative drugs. This seems reasonable since individual rights are never absolute but must be weighed against other rights, or those of other parties or the community. For instance, in physical healthcare, autonomy rights of competent patients may also be curtailed in limited circumstances, such as where a patient has been diagnosed with a serious communicable disease (e.g., multiple-drug resistant tuberculosis) that presents a serious public health risk. It should be noted that the patients affected by s.39 of IPTA are not at large in the community or able to leave the hospital at will. All are involuntarily hospitalized and thus pose no danger to public safety in the wider community.

8 IPTA s.39 is not entirely unique in Canada in its attempts to override the competent advance wishes of psychiatric patients. For example, Manitoba's *Mental Health Act*, C.C.S.M., c.M110 s.28(4)(b)(ii) accomplishes much the same end. Section 28(4) states:

A person who makes treatment decisions on a[n incompetent] patient's behalf under subsection (1) shall do so

(a) in accordance with the patient's wishes, if the person knows that the patient expressed such wishes when apparently mentally competent; or
(b) in accordance with what the person believes to be the patient's best interests if
  (i) the person has no knowledge of the patient's expressed wishes, or
  (ii) following the patient's expressed wishes would endanger the physical or mental health or the safety of the patient or another person.

While this paper focus specifically on IPTA s.39, many of the arguments may be applicable to other provincial legislation that attempts to override psychiatric patients' competent wishes in this manner.

[9] While IPTA is in the minority in its overriding of psychiatric patients' competent wishes, it is not entirely alone in so doing in Canada. For example, the Manitoba's *Mental Health Act* s. 28(4)(b)(ii) permits an almost identical situation, overriding the patient's expressed wishes (made while competent) with best interests where following such wishes would "endanger the physical or mental health or safety of the patient or another person." In addition, British Columbia's *Mental Health Act* s.31(1) may override competent patient wishes by *deeming* patient consent to treatment have been given, on the basis of detention; and New Brunswick's *Mental Health Act* s.8.11(2) may override competent advance directives if they are not reliable, not current, or not applicable.

[10] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11. ['the *Charter*'].

[11] *R. v. Kapp* [2008] S.C.J. No. 42

[12] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11, s.15(1).

[13] *Law v. Canada (Minister of Employment and Immigration)* [1999] 1 S.C.R. 497 at para. 51.

[14] *Law Society of British Columbia v. Andrews* [1989] 1 S.C.R. 143 at para. 37

[15] While no comparator group may be perfect, and others could perhaps have been selected, patients suffering physical illness seemed the most useful comparator group for the purposes of this paper. Ideally, in a s.15 *Charter* analysis, the comparators should be very similar in all respects except for their legal treatment, which is the focus of the comparison. Choosing the physically ill seemed to appropriately emphasize the role of illness in creating the undeservedly unequal legal situation on which this paper focuses. Alternatively, it might have been possible to compare, for instance, the mentally ill detained under s.39 with the group composed of non-mentally ill persons detained criminally. While some might think it appropriate to thereby place the emphasis on detention and loss of liberty, this appeared less useful due to the very different purposes detention may express in these two groups: in the former, protection (of patient and potentially public), and in the latter, public protection but also punishment and the expression of societal disapprobation. The additional aspect of justly deserved punishment and moral disapprobation in the latter group renders it sufficiently different from the mentally ill detained involuntarily as to make it an inappropriate comparator, because in that case there genuinely appears to be a non-discriminatory reason for any different treatment.

[16] *R. v. Kapp* [2008] S.C.J. No. 42 at para. 16.

[17] *R. v. Kapp* [2008] S.C.J. No. 42 at para. 41.

[18] The 'Thank-you theory' has been attributed to psychiatrist Alan Stone by T.Kirk and D.N. Bersoff, 'How many procedural safeguards does it take to get a psychiatrist to leave the light-bulb unchanged? A due process analysis of the MacArthur Treatment Competence Study,' (1996) *2 Psychology, Public Policy, and Law* 45 at 46. Some related concepts are of note. The 'human needs perspective' on mental illness is promoted by some as an antidote to civil libertarian efforts to legally empower psychiatric patients to contest involuntary committal and resist unwanted medical treatment. J.E. Gray, M.A. Shone and P.F. Liddle, C*anadian Mental Health Law and Policy* (Toronto: Butterworths, 2000) at 10-12. P.S. Appelbaum also discusses the 'common-sense model' in which he argues psychiatrists and judiciary in practice often ignore the law, preferring involuntary committal and treatment of patients. This, he claims, priorizes (presumed) patient suffering over legal rights. P.S. Appelbaum, *Almost a Revolution: Mental Health Law and the Limits of Change* (New York: Oxford University Press, 1994) at 42.

[19] There may is a belief by some that the entire *purpose* of hospitalization is to treat and discharge psychiatric patients, rather than simply detaining them long-term to protect them or the public, termed 'warehousing.' J.E. Gray, M.A. Shone and P.F. Liddle, *Canadian Mental Health Law and Policy* (Toronto: Butterworths, 2000) at 208; C. Slobogin, *Minding Justice: Laws that Deprive People with Mental Disability of Life and Liberty* (Cambridge, MA: Harvard University Press, 2006) at 222. Psychiatrist C.H. Cahn described the situation as a trade-off or *quid pro quo*, in which he claimed restriction of a patient`s liberty could only be justified by giving a patient (effective, non-harmful) treatment in return. C.H. Cahn, 'The ethics of involuntary treatment: the [1982] position of the Canadian Psychiatric Association', (1982) 27 *Can. J. Psychiatry* 67 at 70. Countering this is the view that psychiatric hospitalization is *itself* a form of treatment, or a vital part of the healing process for psychiatric patients. The hospital environment offers supportive human relationships, monitoring and interaction, improved hygiene, shelter, nutritional and educational benefits, freedom from illicit street drugs, physical abuse, hypothermia, criminal justice system involvement and other dangers, compared to the potentially isolated and impoverished circumstances of homelessness, to which a patient may have been subject prior to involuntary hospitalization.

[20] From longer hospitalizations, added nursing and administrative workloads.

[21] J.E. Gray, M.A. Shone and P.F. Liddle, C*anadian Mental Health Law and Policy* (Toronto: Butterworths, 2000) at 202-7; B.A.Weiner and R.M. Wettstein, *Legal Issues in Mental Health Care* (New York: Plenum Press, 1993) at 120, 124.

[22] T. Kirk and D.N. Bersoff, How many procedural safeguards does it take to get a psychiatrist to leave the light-bulb unchanged: a due process analysis of the MacArthur Treatment Competence Study, (1996) *2 Psychology, Public Policy, and Law* 45 at 46.

[23] The anti-psychiatry movement formed the basis for the novel *One Flew Over the Cuckoo's Nest*, a novel which harshly critiqued psychiatry's treatment of involuntarily committed psychiatric patients; K. Kesey, *One Flew Over the Cuckoo's Nest* (New York: Viking, 1962).

[24] There are, of course, similarities between involuntary psychiatric committal and criminal incarceration: both share "loss of liberty, separation from family and friends, stigma of being institutionalized and reliance on the state to satisfy basic needs." D.H.J. Hermann, *Mental Health and Disability Law* (Eagan, MN: West Publishing, 1994) at 193. However, there are also important differences, such as that the purpose underlying psychiatric detention is not punitive or deterrent.

[25] i.e., in full possession and awareness of their legal rights, yet *because* of these legal rights supporting treatment refusal, unable to access their seeming 'right' to their full potential in life and a place in society. D. Treffert, quoted in C. Slobogin, *Minding Justice: Laws that Deprive People with Mental Disability of Life*

and Liberty (Cambridge, MA: Harvard University Press, 2006) at 244.

[26] As noted by the Court in Law, "Legislation which seeks to ameliorate disadvantage may not offend s.15(1) of the Charter even if it excludes certain other individuals or groups...However, this is *only* the case *where the group excluded ...is more advantaged* in a relative sense *than those the legislation seeks to assist*." (Emphasis added). *Law v. Canada (Minister of Employment and Immigration)* [1999] 1 S.C.R. 497 at para. 72

[27] *R. v. Music Explosion, Ltd*., (1990), 68 Man. R. (2d) 203 at para. 18. Yet the Court noted that in two different cases, sections of the *Criminal Code* and *Young Offenders Act* were upheld as affirmative action programs under s.15(2): *Re Rebic and The Queen* (1985), 20 C.C.C. (3d) 196 (B.C.S.C.), aff'd (1986), 28 C.C.C. (3d) 154 (B.C.C.A.) and *Re M and The Queen* (1985), 21 C.C.C. (3d) 116 (Man. Q.B.). Both cases upheld differences in incarceration periodsas ameliorative of the special needs of certain classes of offenders: mentally ill offenders found not guilty by reason of insanity (then detained under a Lieutenant-Governor's Warrant), and youth serving time while awaiting trial, respectively. In both cases, the impugned law seemed rationally related to identified unique needs of the parties affected: the need for long-term separation of dangerous mentally ill patients from society for their own and others' safety, and the need for greater leniency with youthful offenders. In contrast, in *Music Explosio*n, the impugned bylaw's attention to younger teenagers did not seem to reflect a rational ameliorative purpose related to the youths' abilities or special needs, appearing almost arbitrary. The circumstances of s.39's involuntarily hospitalized but competent mentally ill treatment-refusers more closely resembles the fact pattern in *Music Explosion*, with its seemingly arbitrary restriction of these patients' rights to have their competent advance directives obeyed.

[28] Limiting younger teenagers' use of a musical 'amusement device' without parental consent.

[29] *R. v. Kapp* [2008] S.C.J. No. 42 at para. 53.

[30] *R. v. Kapp* [2008] S.C.J. No. 42 at para. 54

[31] *R. v. Kapp* [2008] S.C.J. No. 42 at para. 46.

[32] *R. v. Kapp* [2008] S.C.J. No. 42 at para. 48, quoting *Manitoba Rice Farmers v Human Rights Commission (Man.)*, [1985] M.J. No. 446

[33] As the court in *Fleming v. Reid* said: "This right [to refuse treatment] must be honoured... regardless of how ill-advised the patient's decision may appear to others." *Fleming v. Reid*,[1991] 4 O.R. (3d) 74 at para. 32-33.Also in *Starson v Swayze*. [2003] S.C.J. No. 33 at para 76, the Supreme Court stated: "The right knowingly to be foolish is not unimportant; the right voluntarily to assume risks is to be respected. The State has no business meddling with either."

[34] Stigma involves "negative attitudes or beliefs that are held about people who are perceived as different"; since they are often semi-conscious, they are difficult to address directly. The World Health Organization (WHO) stated in 2001 that stigma was "the single most important barrier" faced by people with mental illnesses. Reported by the Canadian Mental Health Association, 'Stigma and Mental illness' accessed online at www.cmha.ca As one contributor noted: "We attach no blame to someone who develops a physical illness, but when it comes to mental illness, people experience discrimination on a daily basis."

[35] While not *all* individuals with mental illness may experience disadvantage, it is not necessary that all mentally ill individuals be found to be disadvantaged to advance an argument of affirmative action. As the Court noted in *Corbiere v. Canada (Minister of Indian and Northern Affairs)*, [1999] 2 S.C.R. 203 at para.70-72: to qualify as ameliorative of disadvantage, it is not necessary for *all* individuals members of a generally `disadvantaged` group to suffer disadvantage, or to the same degree; confirmed in *R. v. Kapp* [2008] S.C.J. No. 42 at para. 59.

[36] Individuals with psychiatric diagnoses are overrepresented among the homeless, totalling 20-25% of the homeless population. G. Sullivan, A. Burnam and P. Koegel, 'Pathways to homelessness among the mentally ill,' (2000) 35 *Soc. Psychiatry Psychiatr. Epidemio*l. 444 at 444. In contrast, individuals with schizophrenia, bipolar disorder and major depression account for only 1%, 2% and 5% of the population respectively; M.F. Bear, B.W. Connors and M.A. Paradiso, *Neuroscience: Exploring the Brain*, 3rd ed. (Lippincott, Williams & Wilkins: New York, 2001) at 673, 674, 679.

[37] More than 50% of people with psychiatric disorders also have substance abuse problems; Canadian Mental Health Association (British Columbia), 'Criminalization of Mental Illness' online at: www.cmha.bc.ca/files/2-criminalization.pdf

[38] One estimate is that 15-40% of inmates in Canada's criminal justice system have a mental illness; Canadian Mental Health Association (British Columbia), 'Criminalization of Mental Illness' online at: www.cmha.bc.ca/files/2-criminalization.pdf

[39] The Kirby Report into Canadian mental healthcare found widespread stigma and discrimination against mentally ill people in employment, housing, social opportunities and even healthcare, with debilitating effects on lives and recovery. One contributor stated: "Some patients struggle with poverty so grinding and housing so appalling, it would challenge the sanity of even the strongest among us." Another added: "Individual recovery from mental health [problems] is impossible when struggling with the consequences of poverty alongside stigma and discrimination." The Hon. Michael J.L. Kirby and the Hon. Wilbert J. Keon, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, Final Report of the Standing Committee on Social Affairs, Science and Technology, May 2006 at7, 8 ['the Kirby Report']

[40] Numerous scholars have discussed the social construction of disability (or difference) and the question of where precisely such disability (or difference) is located: in the individual claimed to be different or in a society unwilling to accept or accommodate that difference? D. Pothier, 'Miles to go: some personal reflections on the social construction of disability', *Dalhousie Law Journa*l 526 at 530-1; R. Chadwick and M. Levitt, 'Genetic technology: a threat to deafness' (1998) 1 *Medicine, Healthcare and Philosophy* 209 at 210; and K.T. Bartlett 'Feminist legal methods' (1990) 103 *Harvard Law Review* 829 at 843. Mental illness has similarly been claimed to be a social construction located not so much in the affected individual, but in the society in which that person lives, which is unwilling to accept and accommodate their mental illness and the differences it represents.

[41] An absurd analogy might be an attempt to eliminate racism by superficially 'whitewashing' people of different ethnicities without addressing and rooting out the underlying myths, fears and stereotypes fueling (often semi-conscious) racist attitudes.

[42] In *Andrews* , McIntyre J. quoted that "...there is no greater inequality than the equal treatment of un-equals;" *Law Society of British Columbia v. Andrews* [1989] 1 S.C.R. 143 at para 26. The view that like treatment does not accord with true, substantive

equality was also re-iterated by the Court in *R. v. Kapp* [2008] S.C.J. No. 42 at para. 15.

43 Answered affirmatively, earlier in the paper.

44 *Law v.Canada (Minister of Employment and Immigration)* [1999] 1 S.C.R. 497 at para. 62, 69, 72, 74

45 D.N. Weisstub, whose *Enquiry on Mental Competency: Final Report* (Toronto: The Enquiry, 1990) at 116, was cited in evidence by the Supreme Court in *Starson v Swayze*. [2003] S.C.J. No. 33 at para. 77, stated: "The tendency to conflate mental illness with lack of capacity, *which occurs to an even greater extent when involuntary commitment is involved*, has deep historical roots, and…attitudes and beliefs have been slow to change. For this reason, *it is particularly important that autonomy and self-determination be given priority when assessing individuals in this group.*" (Emphasis added).

46 There is in general no such thing as global competence or incompetence. In some patients, competence may fluctuate over time, or be present for some decisions but not others. However, overall, many mentally ill patients are competent either all or at least part of the time for all or at least some decisions.

47 Therefore, individuals whose s.7 *Charter* rights to life, liberty or security of the person are to be infringed must receive procedural fairness entitlements, such as a right to an impartial hearing, a right to counsel, etc. This applies to the administration non-consensual treatment to a patient. There may be some procedural protections for security of the person under s.39 (e.g., a Board hearing at the mental hospital, where a substitute decision-maker deliberates on the patient's 'best interests'). However, this may not be enough. As discussed elsewhere, s.39 of IPTA has the potential for a s.7 *Charter* challenge too, although this issue will not be pursued in the paper.

48 *Fleming v. Reid*,[1991] 4 O.R. (3d) 74 at para. 60

49 *Fleming v. Reid*,[1991] 4 O.R. (3d) 74 at para. 39

50 *Fleming v. Reid*,[1991] 4 O.R. (3d) 74 at para. 40

51 *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11, s.1.

52 *R v Oakes*, [1986] 1 S.C.R. 103 at para 69-71, 77; and *R. v. Laba*, [1994] S.C.J. No. 106 at para 79-91.

53 This conclusion is based on several factors: the s.2 subordination of patient self-determination rights (respected only "where possible") to treatment; the overriding effect of s.39 on prior wishes (opposing the usual trends in informed consent); the Act's title (the *Involuntary Psychiatric* Treatment *Act*); and the admission requirement under s.17(e) that, involuntary psychiatric patients lack competence.

54 E.F. Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis*, (Toronto: J. Wiley & Sons, Inc., 1997) at 162.

55 Others echo this view.The Schizophrenia Society of Canada has argued that competent patients` *Charter* liberty rights are violated by allowing them to remain untreated; Schizophrenia Society of Canada, 'Schizophrenia Society disappointed with Supreme Court decision` and sample 'Letter to the Editor' for members' use, online at: www.schizophrenia.ca (dated 11 June 2003). I am indebted to Professor Sheila Wildeman for drawing my attention to this article in her course 'Mental Disability Law' at Dalhousie University Law School. In this distorted view of liberty, untreated psychiatric patients are claimed to have no meaningful liberty; E.F. Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis*, (Toronto: J. Wiley & Sons, Inc., 1997) at 142.

56 Including possible patient suffering, loss of liberty and exclusion due to stigma and involuntary committal, and lost human potential.

57 The urgent societal goals of reducing homelessness, poverty, addictions and criminalization of the mentally ill may also be indirectly assisted, if treatment lets patients gain insight, acquire healthy lifestyle patterns and establish career, educational and social networks for life in the community.

58 E.F. Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis*, (Toronto: J. Wiley & Sons, Inc., 1997) at 172-3

59 K. Millett, *The Loony-Bin Trip* (New York: Simon & Schuster, 1990) at 313.

60 K. Millett, *The Loony-Bin Trip* (New York: Simon & Schuster, 1990) at 311.

61 According to current mainstream scientific consensus, the 'mind' is a product of interactions between the neurons of the brain and other cells. F. Crick, *The Astonishing Hypothesis* (Charles Scribner's Sons: New York, 1994) at 7.

62 Numerous authors have questioned whether human beings in general can be said to possess meaningful free will, autonomy and free choice in our decisions; F. Crick, *The Astonishing Hypothesis* (Charles Scribner's Sons: New York, 1994) at 10, 171, 267-8; R.Tallis, "Why blame me? It was all my brain's fault: the dubious rise of neurolaw," *The Times* (24 October 2007) online: www.timesonline.co.uk/tol/comment/columnists/guest_contributors/article2726643.ehtml. In the specific context of healthcare decisions made by competent patients, Grant Gillett has explored the meaningfulness of informed consent in light of mental factors that appear to undermine truly free choice in healthcare (e.g., framing effects and other unconscious irrational forces directing decisions). He concludes that the deliberation process is not just a facade, and that competent patients do in fact possess meaningful freedom in their medical decisions. This autonomy is exemplified by patients' decision-making within (or in opposition to) the knowledge scaffolding provided by an informed mentor (the healthcare provider or others); G. Gillett, 'Intention, autonomy and brain events,' (2009) 23 *Bioethics* 330 at 336-7.

63 While the lack of scientific understanding of psychiatric treatments may seem concerning, in physical illness, after safety assessments, certain medical treatments or drugs may be routinely used, as Aspirin's active ingredients once were, without a full understanding of their mechanism of function.

64 J.E. Gray, M.A. Shone and P.F. Liddle, *Canadian Mental Health Law and Policy* (Toronto: Butterworths, 2000) at 41.

65 Once termed neuroleptics, the older-style (first-generation) anti-psychotic medications included drugs such as haloperidol (Haldol), used to treat psychotic patients with various diagnoses. There are now also newer `atypical` (or second-generation) anti-psychotic drugs, such as olanzepine (Zyprex). O. Ray and C. Ksir, *Drugs, Society and Human Behaviour* 10th ed. (Boston: McGraw-Hill, 2004) at 225-7. However, the older first-generation drugs still appear to be in use, as discussed infra.

66 The older generation of anti-psychotics worked by blocking dopamine receptors, causing a similar clinical picture to Parkinson's disease, where a deficiency of dopamine ant the dopamine receptors is caused by reduced dopamine production in the brain. Thus as a result of the older anti-psychotic drugs, some 20% of patients suffer Parkinsons-like motor side-effects, including for 2% of patients, tardive dyskinesia, a motor disorder featuring writhing facial movements, drooling, etc. The chance of Parkinsons-like side effects may be reduced either by

administering a second (anti-cholinergic) drug to block motor side-effects, by carefully selecting an (older-style) anti-psychotic drug, or by using atypical anti-psychotic drugs, although the latter possess other concerning side effects. O. Ray and C. Ksir, *Drugs, Society and Human Behaviour* 10th ed. (Boston: McGraw-Hill, 2004) at 227-8.

67 American Psychiatric Association (APA), American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006, (Arlington, VA: American Psychiatric Association, 2006)) at 85; E. Metzger and R. Friendman, "Prolongation of corrected QT interval and *torsades de pointes* cardiac arrhythmia associated with intravenous haloperidol in the medically ill" (1993) 13 *J. Clin. Psychopharmacol*. 85-86; J.E. Tisdale, J.C. Kambe, M.S. Chow and N.S. Yeston, "Effect of haloperidol on ventricular fibrillation threshold in pigs" (1991) 69 *Pharmacol. Toxicol*. 327-9.

68 However, the *APA Practice Guidelines* for 2006 identified haloperidol as still the "anti-psychotic medication of first choice," *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006*, (Arlington, VA: American Psychiatric Association, 2006) at 85.

69 J.I. McKenzie, 'The delicate dance in Canadian mental health policy: balancing equality rights, family rights and community rights,' (2008) 3 *Journal of Ethics in Mental Health* 1 at 1.

70 *Involuntary Psychiatric Treatment Act*, S.N.S., 2005, c.42, s. 2(c)

71 In addition, the s.39 override only applies to *some* mentally ill patients at certain times: those who risk harm to self or others.

72 For example, outdoor grounds privileges.

73 Including an unjustified fear of untreated patients)

74 Some argue that impositions on one`s physical autonomy (via forced psychiatric treatment) restrict not only physical liberty but mental liberty as well. C. Slobogin, *Minding Justice: Laws that Deprive People with Mental Disability of Life and Liberty* (Cambridge, MA: Harvard University Press, 2006) at 222.

75 'Security of the person' will be used interchangeably here with the common law rights to bodily integrity and autonomy.

76 Including gender, age, racial and ethnic characteristics.

77 For instance, clothing, hairstyling, jewellery and cosmetics.

78 Such as diet, exercise, surgical augmentation, and skin piercing or tattooing

79 Accordingly, *Fleming* noted that few intrusions are more extreme than the legislatively enforced administration of mind-altering drugs, affecting this intimate body part.

80 As noted, the s.7 right to security of the person is *only* to be restricted in accordance with the principles of fundamental justice. Yet s.39 of the IPTA appears to restrict security of the person in discriminatory manner, which cannot be in accordance with the principles of fundamental justice. Fundamental justice and discriminatory treatment are diametrically opposed in effect and motive. Thus s.39 seems unlikely to *minimally* impair the s.15 equality right because not only does s.39 *completely* impair a patient`s right to bodily integrity, but it does so on the basis of values *diametrically opposed to* the principles of fundamental justice,

81 The mode of administration of unwanted medication is *not* relevant to whether or not a violation of bodily integrity and autonomy has occurred. Gray suggests that since *injections* of medications are now rarely used in modern Canadian psychiatry, this is acceptable because no force is being used against the patient (presumably implying there is no violation of bodily integrity); J.E. Gray, M.A. Shone and P.F. Liddle, *Canadian Mental Health Law and Policy* (Toronto: Butterworths, 2000) at 196. However, this is a misconception: whether the unwanted drug therapy is oral or by injection, the effect remains the same: the drugs enter the person's body and transit the blood brain barrier, potentially affecting the competent patient's most intimate thoughts in an unwanted manner. Thus, regardless of the route of administration, the patient's right to bodily integrity has been violated, and to the same degree.

82 For example, no competent skin cancer patient, regardless of how life-threatening or treatable their disease, is required to undergo treatment, on the justification that the patient and his potential can be saved, preventing family distress and later costly warehousing. The competent treatment refusal by the *physically* ill is a well-recognized right at law and will ordinarily be respected to avoid legal liability for battery. Comparable respect for competent wishes of the *mentally* ill is required in psychiatric care, in the interests of legal equality.

83 *Fleming v. Reid*,[1991] 4 O.R. (3d) 74 at para. 39.

84 Untreated patients' stays may average twice as long, generating higher costs. J.E. Gray, M.A. Shone and P.F. Liddle, *Canadian Mental Health Law and Policy* (Toronto: Butterworths, 2000) at 204. Some treatment-refusers are hospitalized for much longer—ordered to spend a 12-month period in hospital, 'Professor Starson' had been hospitalized for years by his trial date in 2003; Schizophrenia Society of Canada, 'Schizophrenia Society disappointed with Supreme Court decision`, online at: www.schizophrenia.ca (dated 11 June 2003). Some never return to the community nor fulfil their potential, although medication could make this possible in months.

85 Gray argues that warehousing a treatment-refuser for two years might cost $330,000, while a one-month treatment costs only $15,000, followed by release. J.E. Gray, M.A. Shone and P.F. Liddle, *Canadian Mental Health Law and Policy* (Toronto: Butterworths, 2000) at 206. Yet his estimate omits the need for post-release community supports and medications. Hence the actual cost asymmetry remains unclear.

86 Professor Sheila Wildeman describes *IPTA*`s involuntary treatment as a "combative approach to psychiatric therapy" that "polarizes the therapeutic relationship" and is counterproductive to meaningful treatment; H. Gordon, 'Treatment Act divides mental health advocates` *Nova News Net* (4 November 2005) online at http: http://novnewsnet.ukings.ca/nova_news_3588_6825.html Studies show that treating patients against their will generally results in poorer prognoses; C. Slobogin, *Minding Justice: Laws that Deprive People with Mental Disability of Life and Liberty* (Harvard University Press: Cambridge, MA, 2006) at 245.

87 The Canadian Medical Health Association states: "It cannot be assumed that medical treatment is the only or best option for individuals [with mental illnesses]." Canadian Mental Health Association, 'Informed consent to treatment' online at: www.cmha.ca/bins/print_page.asp?cid=5-33-174&lang=1 (accessed 3 March 2009).

88 *Starson v Swayze*. [2003] S.C.J. No. 33 at para. 46.

89 E.F. Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis*, (Toronto: J. Wiley & Sons, Inc., 1997) at 156.

90 Again, I am grateful to Professor Sheila Wildeman and her course 'Mental Disability Law' at Dalhousie University Law School, for drawing my attention to this emerging trend, described in an undated *Toronto Star* article by H. Henderson, entitled 'Mad Pride', accessed online at: www.mindfreedom.org/mindfreedom/

madpride/Toronto_d.shtml (accessed 30 January 2004).

[91] H. Blume, "Neurodiversity" *The Atlantic* (30 September 1998) online at: www.theatlantic.com/doc/199809u/neurodiversity

[92] Maintaining and encouraging mental differences – neurodiversity-- may be as important as preserving biodiversity, to ensure humanity`s future adaptability and survival: "Who can say what form of [neurological] wiring will prove best?" H. Blume, "Neurodiversity" *The Atlantic* (30 September 1998) online at: www.theatlantic.com/doc/199809u/neurodiversity

[93] E. Saner, "It`s not a disease, it`s a way of life," *The Guardian* online at: www.guardian.co.uk/society/2007/aug07/ health. medicineandhealth

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