

A Right of Appeal Under Ontario's *Health Care Consent Act*: A Paper Victory is No Victory at All

JACLYN GREENBERG*

Ontario's *Health Care Consent Act* enshrines robust procedural protections for people entering the mental health system. One such protection is the automatic right of appeal from a Consent and Capacity Board decision under section 80 of the Act. In tandem with section 18, which states that treatment cannot commence pending final disposition, section 80 ensures that a person's rights to self-determination and bodily integrity are respected. When an individual is found incapable to consent to or refuse treatment and involuntarily hospitalized, they have the right to have the Board review the findings, which is done expeditiously and with the person represented by counsel. However, the process of appealing the Board's confirmation of the findings unleashes a host of complications: the patient-appellant's inability to retain counsel, the hospital's inability to take steps to improve the mental condition that necessitated the finding of incapacity and involuntary status in the first place, and most notably, the indeterminate suspension of the patient-appellant's liberty. In upholding the rights to self-determination and bodily integrity, section 80 leaves a person with little else.

In tracing the problem, as originally outlined by Justice Brown of the Ontario Superior Court of Justice, the author argues that section 80 is more harmful than it is helpful. History proves the necessity for the right to review but a distinction ought to be made between the right to review and the automatic right to appeal. The former guards against abuse of the authority granted by the legislation, while the latter provides legal protection that affords no practical benefit to the individual patient-appellant. The paper discusses Brown J.'s efforts to establish a case management system for CCB appeals, and reviews four cases in light of such efforts. The author relies on the results of these cases and the annual statistics of CCB appeals to argue that efforts to correct the

La Loi sur le consentement aux soins de santé de l'Ontario prévoit de solides protections procédurales pour les personnes qui font affaire au système juridique en matière de santé mentale. Entre autres protections, on note le droit d'appel automatique d'une décision rendue par la Commission de révision du consentement et de la capacité (la Commission) en vertu de l'article 80 de la Loi. Combiné avec l'article 18, qui interdit de commencer un traitement dans l'attente d'une décision, l'article 80 garantit que les droits d'une personne à l'autodétermination et à son intégrité physique seront respectés. Lorsqu'une personne est jugée incapable de donner son consentement ou refuse un traitement et qu'elle est hospitalisée contre son gré, elle est autorisée à faire réviser cette décision par la Commission, selon un procédé accéléré et dans l'intérêt de la personne représentée par un conseiller juridique par l'entremise de l'Aide juridique. Le processus d'appel de la décision rendue par la Commission en vue de maintenir la conclusion entraîne cependant toutes sortes de complications : l'incapacité du patient-appellant à engager les services d'un avocat, l'incapacité de l'hôpital à prendre les mesures adéquates pour améliorer la condition mentale à l'origine de la conclusion d'incapacité et du statut involontaire en premier lieu et plus particulièrement, la suspension pour une durée indéterminée de la liberté du patient-appellant. En confirmant les droits d'une personne à l'autodétermination et à son intégrité physique, l'article 80 laisse finalement peu de chose à cette personne.

En exposant ce problème, comme l'avait à l'origine souligné le juge Brown de la Cour supérieure de justice de l'Ontario, l'auteur fait observer que l'article 80 est davantage source de problèmes que de solutions. L'histoire nous a certes démontré la nécessité de conférer le droit de faire réviser une décision, mais il faudrait établir une distinction entre

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disparity between the way the law is supposed to work and the way it actually works are misplaced. Rather than treat the problem as one of funding issues and the role of counsel, the author suggests amending section 80 so that the automatic right be replaced by leave to appeal. This would place the burden on the justice system, and ensure that a right introduced to safeguard a person's well-being does not eclipse the very thing it seeks to protect.

ce droit et le droit d'appel automatique. Le premier ayant pour objectif de se prémunir contre l'abus du pouvoir octroyé par la législation, tandis que le deuxième confère une protection juridique qui n'accorde aucun avantage concret à la personne en tant que patient-appelant. Dans ce texte, on discute des efforts du juge Brown en vue de créer un système de gestion des cas pour les appels de la Commission et dans cette optique, il passe quatre causes en revue. En se fondant sur les conclusions de ces causes et les statistiques annuelles des appels de la Commission, l'auteur soutient que les efforts déployés pour corriger la disparité entre la manière dont la loi est censée s'appliquer et la façon dont elle fonctionne dans les faits sont malavisés. L'auteur préconise de modifier l'article 80 de façon à remplacer le droit d'appel automatique par un système d'autorisation d'interjeter appel plutôt que de traiter le problème comme étant lié au financement et au rôle du conseiller juridique, comme c'est le cas actuellement. Ce faisant, on placerait le fardeau sur le système de justice et on veillerait ainsi à ce qu'un droit instauré en vue d'assurer le bien-être d'une personne n'ait pas pour effet d'éclipser ce que l'on cherche justement à protéger.

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Unwarranted findings of incapacity severely infringe upon a person's right to self-determination. Nevertheless, in some instances the well-being of patients who lack the capacity to make medical decisions depends upon state intervention.¹

Justice Major in *Starson v Swayze*

I. INTRODUCTION

In 2007, the Chief Justice of the Supreme Court of Canada, Beverley McLachlin, delivered a speech on the challenges the Canadian justice system faces in building a truly just society.² The Chief Justice identified four challenges that threaten the courts' ability to provide a just and efficacious process: access to justice; lengthy trials; delays in the justice system; and dealing with deeply rooted, endemic social problems.³ For mental health consumers—individuals who live with mental illness and who become entangled in the justice system in either civil or forensic contexts—three of the four challenges identified are everyday realities. The Chief Justice told her audience, “[t]he most advanced justice system in the world is a failure if it does not provide justice to the people it is meant to serve.”⁴ The question mental health advocates and practitioners struggle to answer is: what does justice for mental health consumers look like?

1 *Starson v Swayze*, 2003 SCC 32 at para 75, [2003] 1 SCR 722, Major J [*Starson*].

2 Remarks of the The Right Honourable Beverley McLachlin, “The Challenges We Face, speech,” (Remarks delivered at the Empire Club of Canada, Toronto, March 8, 2007.), online: <<http://www.scc-csc.gc.ca/court-cour/ju/spe-dis/bm07-03-08-eng.asp>>.

3 *Ibid.*

4 *Ibid.*

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Currently, Canada's answer has been to move away from a best interests-based reliance on professional discretion towards a rights-based approach.⁵ No longer does a clinician have unfettered discretion when it comes to providing treatment to a mental health consumer who appears to need outside intervention. This article focuses on Ontario mental health law, which has legislated many significant and robust safeguards and procedural protections to ensure that a mental health consumer's liberty, autonomy and integrity are not only respected but prioritized.⁶ The law requires, for instance, that in order to admit a person involuntarily to hospital, he or she must be suffering from a mental condition that is likely to result in harm to himself or herself or others.⁷ The "dangerousness" criteria are considered to be an objective threshold by which a person's right to liberty can be suspended.⁸ Whereas it was once commonplace to simply commit someone when it was believed to be necessary, and the rights of people with mental illnesses were moot, today the law says that the rights of the individual take precedence. Unless those rights are respected insofar as the legal protections demand, no rights-suspending intervention is permitted.

The problem is that there are gaps between the law in theory and the law in practice.⁹ One such gap has come to light in section 80 of the *Health Care Consent Act, 1996 (HCCA)*.¹⁰ This provision establishes a comprehensive appeals process from the Consent and Capacity Board (CCB or the Board), one of Ontario's mental health tribunals.¹¹ The CCB reviews clinicians' determinations that limit the rights of their patients in a civil context. Section 80 enshrines many of the rights articulated in international treaties, jurisprudence and mental health law theory, namely the right to have a finding made against a person reviewed by an independent body and the

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- 5 See Joaquin Zuckerberg, "Mental Health Law and Its Discontents: A Reappraisal of the Canadian Experience" in Bernadette McSherry & Penelope Weller, eds, *Rethinking Rights-Based Mental Health Laws*, eds Bernadette McSherry & Penelope Weller (Portland, OR: Hart Publishing, 2010) [Zuckerberg, "Canadian Experience"]; Aaron A Dhir, "Relationships of Force: Reflections on Law, Psychiatry and Human Rights" (September, 2008) 25 Windsor Rev Legal Soc Issues 103; Lora Patton, "These Regulations Aren't Just Here to Annoy You: The Myth of Statutory Safeguards, Patient Rights and Charter Values in Ontario's Mental Health System" (September, 2008) 25 Windsor Rev Legal Soc Issues 9; Mona Gupta, "All Locked Up with Nowhere to Go: Treatment Refusal in the Involuntary Hospitalised Psychiatric Population in Canada" in Kate Diesfeld & Ian Freckelton, eds, *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment*, (Burlington, VT: Ashgate, 2003).
- 6 I chose to focus on Ontario legislation as that was the legal system that I operated under while working in the Legal Services Department at the Centre for Addiction and Mental Health (CAMH), Canada's largest mental health and addictions teaching hospital.
- 7 *Mental Health Act*, RSO 1990, c M7 at s, ss 15(1)-(1.1), s 20 (1)-(1.1) [MHA].
- 8 See Dhir, *supra* note 5; Zuckerberg, "Canadian Experience", *supra* note 5 at 301.
- 9 See Richard D Schneider, "The Mentally Ill: 'Under-Righted' or 'Under-Lawyered?'" (2008) 25 Windsor Rev Legal Soc Issues 145 at 147; Patton, *supra* note 5 at 11; Dhir, *supra* note 5 at 107.
- 10 SO 1996, c 2, s 80 [HCCA].
- 11 The other mental health tribunal in Ontario is the Ontario Review Board. That tribunal most often determines whether a mental health consumer who has been accused of a criminal offence is fit to stand to trial or, in the instance where he or she has been found Not Criminally Responsible, whether the consumer ought to be released back into the community. This article focuses on the civil context, and thus, discussion of the Review Board or the forensic context generally is outside the scope of this paper.

right to an expeditious review. The problem lies not in the ideas, but in their execution. When mental health consumers appeal decisions from the CCB, most often they are unable to secure counsel and their mental states are such that they are unable to move their appeals forward on their own; their treatments cannot commence pending final disposition, and they are left, in effect, in limbo. The rights of the individual are upheld, but blindly. The right to self-determination is respected but at the expense of one's liberty. The rationale behind re-orienting the law from a professional discretion-based model to a legalism-based approach was to guard against injustice. Considering that justice is not merely a legal concept, but a moral one too, a law that takes a narrow view of rights protection and inhibits treatment and care can hardly be said to satisfy that goal.

In this article, I argue that the automatic right of appeal as set out in section 80 of the *HCCA* is more harmful than it is helpful. First, as argued by CCB lawyer member Lora Patton, by enshrining a right that has no practical execution and no remedy for breach, we “devalue” the underlying fundamental rights—rights enshrined in the *Canadian Charter of Rights and Freedoms*.¹² Second, the “automatic” nature of the right of appeal provides a false belief that reform has corrected the injustices born from the early patriarchal model of mental health law.¹³ Finally, and perhaps most significantly, section 80 undermines efforts at treatment and care for mental health consumers—the very purpose underlying the law's enactment.¹⁴ Although the rights-based approach that underlies the automatic right of appeal seeks to protect the rights of mental health consumers—rights previously ignored and deserving of respect, particularly for so vulnerable a constituency—in the context of the automatic right of appeal, it ultimately undermines a person's rights because some are respected but only at the expense of others.

The article examines the theoretical right to review and the reality on the ground. Part II explores the shift from a best interests-based model to a legalism-based model of mental health law; it examines the impact of classifying the rights of mental health consumers as “human rights” on legislative reform, identifies Ontario's statutory landscape and then outlines the particulars of section 80. Part III then explores the law in practice; it identifies the phenomenon of “warehousing” mental health consumers in hospitals; discusses the case management system for CCB appeals erected by Justice Brown of the Superior Court of Justice; and reviews four mental health consumers' appeals in light of the case management system and in the context of the CCB's statistics on appeals from Board decisions. Finally, in Part IV, the article concludes by calling for section 80 to be amended and, more generally, for a balanced approach to mental health law—an approach that does not prioritize rights at the expense of treatment and well-being.

12 *Supra* note 5 at 13; *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982 (UK)*, 1982, c 11 [*Charter*].

13 See e.g. Dhir, *supra* note 5 at 107-108.

14 *HCCA*, *supra* note 10 at s 1(b).

II. THE RIGHT TO REVIEW

The focus of this article is on the automatic right of appeal in the context of mental health consumers who are found incapable to consent to or refuse treatment and involuntarily hospitalized—specifically, as will be discussed in greater detail in Part III, those persons who seek the right to refuse treatment while being involuntarily hospitalized. There is no debate that the right to refuse treatment is critical—it is the embodiment of the *Charter*-protected right to security of the person. As stated by the Court of Appeal for Ontario in *Malette v Shulman*,¹⁵ “[t]he right to determine what shall be done with one’s own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based.”¹⁶ The challenge, however, is in realizing the limitations of this right in the context of consumers whose well-being is at great risk. Here, I characterize “at great risk” as when a consumer satisfies the criteria, outlined in the *Mental Health Act (MHA)*, to be committed to a hospital involuntarily. That is, he or she is found to be suffering from a mental condition that led him or her to be a danger to himself or herself or others.¹⁷ When mental health consumers satisfy the criteria to be involuntarily hospitalized, the right to refuse treatment takes on a new dimension.

In order to assert one’s right to refuse treatment, one needs to be able to challenge the finding that would override that right before an authoritative body. Contesting a finding to restrict one or more basic rights is a right in itself—the right to review. The right to review plays two critical functions: it serves as a check on the assessing clinician’s rationale for suspending the rights of the mental health consumer and it protects the consumer’s basic rights, as articulated by the *Charter* and international rights documents. The following subsections outline why the right to review is a fundamental and necessary part of any mental health law. First, history shows that unfettered professional discretion undermines a consumer’s autonomy, dignity and integrity. Second, without the right to review, other rights are impossible to assert as the human rights-based jurisprudence shows. Finally, in the case of Ontario’s legislation, the right to review is the most efficient means to ensure that

15 (1990), 72 OR (2d) 417 (CA), 67 DLR (4th) 321 (CA).

16 *Ibid* at 432.

17 The criteria for civil commitment break down into two sets of requirements. The first set, colloquially referred to as “Box A” (for the space they take up on the physical form used to document the certificate of involuntary status), requires that a person must be suffering from a mental condition that is likely to result in “serious bodily harm” to the person or to another person or is likely to result in “serious physical impairment” to the person (*MHA*, *supra* note 7 at, s 15(1)). The second set, referred to as “Box B,” sets a lower substantive threshold, requiring only that it be likely that the person “suffer substantial mental or physical deterioration;” however, there are more procedural requirements to be met under Box B, such as the fact that the person has been declared incapable to consent to treatment, has been treated for the mental condition in the past and has shown clinical improvement (*MHA*, *supra* note 7, s 15(1.1)). For discussions on the dangerousness criteria as appropriate mechanisms to hospitalize someone involuntarily, see Zuckerberg, “Canadian Experience” *supra* note 5 at 301-306; Gupta, *supra* note 5 at 164-166.

the rationale for limiting a consumer's rights can be articulated and justified according to objective criteria.

A. From *Parens Patriae* to Rights-Based Legalism

Historically, courts recognized that it was the responsibility of the state to look after people who were unable to look after themselves, such as those with mental illness.¹⁸ As early as the thirteenth century, English Parliament enacted law enabling the state to take on a *parens patriae* role towards "the property and person of such individuals."¹⁹ By the eighteenth century, Parliament recognized the need to govern that role and imposed regulations on institutions housing the mentally ill.²⁰ Ostensibly, that was the first time it was recognized that caring for persons with mental illness necessitated control over the conditions in which their care was provided. Comparatively, Amy James writes that early efforts at mental health law in Canada "enshrined a patriarchal system of management," where admission, diagnosis, treatment and release were under the control of the Superintendent.²¹ These early conceptions of mental health law were silent on the topic of rights. Rights of the person went unrecognized. The concept of what was "just" for persons with mental illness was the provision of care—care as the state saw fit.

By the mid-twentieth century, mental health laws in countries such as England, the United States and Canada did little except institutionalize trust in professional opinion. The degree of subjectivity that informs psychiatric decision making was problematic. As noted by Larry Gostin, despite situating itself under the scientific basis of medicine, psychiatry operates under "clinical judgment," which relies heavily on "personal intuition and subjective judgments."²² In the 1950s, medical advances, such as the discovery of tranquilizers for the treatment of schizophrenia, inspired optimism about the "curing" power of psychiatry. However, Gostin points to the "unrealistically high expectations" placed on the profession, which in hindsight led to too much trust being afforded to psychiatrists. Despite good intentions today, the profession at the time is associated with power and abuse.²³

That interpretation is largely due to the subjective or "discretionary" authority afforded to psychiatrists. Psychiatrists relied on their expertise and thus, their

18 See Michael L Perlin, *Mental Disability Law: Cases and Materials*, 2d ed (Durham, NC: Carolina Academic Press, 2005) at 3-4 [Perlin]. For an Ontario-based perspective on the evolution of mental health law, see Michael Bay, "The Evolution of Mental Health Law in Ontario" in *Mental Health and Patients' Rights in Ontario: Yesterday, Today and Tomorrow* (Toronto: Queen's Printer, 2003) 14, online: <<http://www.ontla.on.ca/library/repository/mon/22000/283377.pdf>>.

19 Perlin, *supra* note 18 at 4.

20 *Ibid.*

21 Amy James, "Psychiatric Power and Informed Consent in Post-World War II Canada" (2001) 22:4 *Health L Can* 101 at 108.

22 Larry Gostin, "Contemporary Social Historical Perspectives on Mental Health Reform" (1983) 10:1 *JL & Soc'y* 47 at 56 [Gostin, "Perspectives on Reform"].

23 *Ibid* at 55-56.

decision making escaped scrutiny. The laws at the time enshrined reliance on “clinical judgment.” As a result, mental health consumers were subject to discretion and afforded few, if any, protections. Furthermore, early mental health law was seen to support mental health consumers’ committal, prioritizing the collective good at the expense of an individual’s welfare.²⁴ For instance, up until the late 1970s the conflation of involuntary status with capacity was widespread among Canadian jurisdictions.²⁵ The statutory requirement to commit a person was based on a “need for treatment,” and thus, people who did not seek treatment themselves could be hospitalized for the express purpose of coercing treatment.²⁶ Who defined the “need for treatment”? Those who administered it.

Gostin characterizes mental health law “as a pendulum swinging between two opposing schools of thought—legalism and professional discretion.”²⁷ A legalism-based approach rejects discretion-based subjectivity and instead seeks to justify coercive practices based on an assessor’s ability to justify his or her findings in accordance with objective criteria.²⁸ Among other significant influences, the enactment of the *Charter* constitutionalized fundamental rights such as liberty, autonomy and bodily integrity. In one early case, *Lussa v Health Science Centre*,²⁹ a mental health consumer was detained for twenty-one days under Manitoba’s then mental health statute. The consumer was not afforded the opportunity to have the detention reviewed because it was believed she was “mentally disordered” and required treatment. Justice Kroft held that her section 7 and 9 *Charter* rights were violated because the criteria to hospitalize her were too vague and that her rights under section 10 *Charter* were violated because she was not given adequate notice of her rights upon detention.³⁰ Eventually, all provinces amended their mental health legislation to meet objective criteria. Those criteria replaced clinical determinations of patients’ so-called “need for treatment.” Notably, Ontario mental health laws were revised to rely on “established systems of natural justice and process”³¹ before *Lussa* was decided.

The key result borne from the shift to an objective criteria-based model commensurate with the *Charter* was that the state’s ability to have a mental health consumer committed to a psychiatric facility needed to be balanced with obligations

24 *Ibid.*

25 Gupta, *supra* note 5 at 161.

26 *Ibid.*

27 Gostin, “Perspectives on Reform”, *supra* note 22 at 47-48.

28 *Ibid* (“The confrontation should . . . then be on the question of the adequacy of the grounds advanced and not on the basis of presumed expertise” at 56).

29 (1983), 9 CRR 350, 5 CHRR D/2203 (Man QB).

30 *Ibid* at 353-54.

31 Patton, *supra* note 5 at 13. Presumably, Patton refers to the *HCCA*’s predecessor, the *Mental Incompetency Act*, RSO 1990, c M.9, section 4(1) which required that in order for a physician to declare a person “mentally incompetent,” the physician must complete an application, supported by affidavit evidence, to establish beyond a reasonable doubt the person’s mental incompetence. However, some have pointed out that paternalism remained a significant theme in that legislation. See e.g. Patricia Peppin, “Justice and Care: Mental Disability and Sterilization Decisions” (1989-1990) 6 Can Hum Rts YB 65 at 81.

and safeguards to the individual. The *Charter's* “negative rights”—rights that create protection to *be free from* significant kinds of interference—manifested into a number of procedural safeguards for mental health consumers. In Ontario, such safeguards are numerous and designed to be strict.³² The safeguards start with the criteria a clinician must satisfy in order to, for example, admit someone involuntarily to a psychiatric facility or to treat someone against his or her wishes, and extend to review of that clinician’s decision by an independent, expert body.

B. The Right to Review: A Human Right

The advent of the *Charter* marked a turning point for mental health consumers in Canada—it necessitated the shift from discretion-based decision making to objective standards. However, the discussion of a mental health consumer’s *specific* rights—in particular procedural safeguards—began a few years earlier at the European Court of Human Rights (ECHR).

In *Winterwerp v The Netherlands*,³³ a wife made an application for her husband to be committed on an urgent basis to a psychiatric facility. The detention was extended year after year for more than six years.³⁴ The husband, Winterwerp, applied to the public prosecutor to be discharged. On the basis of statements by the medical director of the psychiatric institution where Winterwerp was detained, and statements by Winterwerp himself regarding the misinterpretation of events leading to his detention, the public prosecutor declined to refer the matter to court.³⁵ Pursuant to Article 5(4) of the *Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention)*, the ECHR held:

[I]t is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation, failing which he will not have been afforded ‘the fundamental guarantees of procedure applied in matters of deprivation of liberty’. Mental illness may entail restricting or modifying the manner of exercise of such a right, but it cannot justify impairing the very essence of the right. Indeed, special procedural safeguards may prove called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves.³⁶

32 Patton, *supra* note 5 at 14-15.

33 (1980) 2 EHRR 387, [1979] ECHR 4 (available on BAILII), [*Winterwerp*].

34 *Ibid* at paras 23-28.

35 *Ibid* at paras 30-31.

36 *Ibid* at para 60 [footnotes omitted]. See also *Convention for the Protection of Human Rights and Fundamental Freedoms*, 4 November 1950, 213 UNTS 221, Eur TS 5 (“Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful” at Article 5(4)) [European Convention].

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Winterwerp was an early recognition of the rights owed to persons detained on account of their mental condition. Efforts at reform first focused on enforcing restrictions on those who sought to limit the rights of consumers. Attention was still solely on the decision makers and their judgment, while consumers and their rights remained invisible. *Winterwerp* sparked an evolution—it put the spotlight on consumers, requiring the state to recognize that it has an obligation to them *before* it can uphold any infringement of their rights. It was no longer sufficient to insert professional opinion into legally objective criteria. Post-*Winterwerp*, any suspension of rights was to be justified, and that justification was an entitlement to the individual whose rights were being suspended. Thus, the state's obligation grew to include providing consumers with an independent body they could turn to, that would determine whether the proposed infringement of their rights was justified legally. Many credit the *European Convention* vis-à-vis the ECHR with establishing the importance of procedural safeguards, in particular the necessity of independent systems of review.³⁷

The type of power held by an independent reviewing body was affirmed not long after *Winterwerp*, in *X v United Kingdom*.³⁸ In that case, the ECHR held that a reviewing body, such as a mental health tribunal, was not merely advisory—its decisions were authoritative. “X” had been detained at a secure mental hospital for the criminally insane, but was conditionally discharged for three years. When he was recalled he complained to the ECHR that the recall was unjustified, that he was not promptly given sufficient reasons for his re-detention, and that he had no effective way to challenge the decision.³⁹ The court referred to *Winterwerp*, reiterating that the very nature of the deprivation of liberty necessitates a review of the lawfulness of that deprivation.⁴⁰ The court added, with regard to Article 5(4) of the *European Convention*:

[T]he word ‘court’ is not necessarily to be understood as signifying a court of law of the classic kind... [it] serves to denote –

bodies which exhibit not only common fundamental features, of which the most important is independence of the executive and of the parties to the case, but also the guarantees... of [a] judicial procedure...⁴¹

37 See Joaquin Zuckerberg, “International Human Rights for Mentally Ill Persons: the Ontario Experience” (2007) 30 *Int'l J L & Psychiatry* 512 (the ECHR “is perhaps the most developed body of international law dealing with the rights of the mentally ill” at 513) [Zuckerberg, “International Experience”]; P Weller, “Lost in Translation: Human Rights and Mental Health Law” in B McSherry & P Weller, eds, *Rethinking Rights-based Mental Health Laws* (Portland, OR: Hart Publishing, 2010) 51 at 60; Gostin, “Perspectives on Reform”, *supra* note 22 at 58.

38 (1982) 4 EHRR 188, [1981] ECHR 6 (available on BAILII), [*X v UK*].

39 *Ibid* at para 8.

40 *Ibid* at para 52.

41 *Ibid* at para 53 [footnotes omitted].

Many note that the rights of people with “mental disabilities” came under the umbrella term of “human rights” late.⁴² After all, discussion of mental health consumers’ rights began centuries after the first mental health laws were enacted. That notwithstanding, the ECHR articulated what no other legal body had—that procedural safeguards are required to prevent consumers from having their rights arbitrarily infringed. The importance of an independent system of review, one that is authoritative, and which is procured in a timely manner,⁴³ is now a bedrock principle of mental health law.

International documents provide guidance, some structure and, in those instances where no laws exist, they provide legal coverage. However, they are rarely used in domestic litigation involving mental health consumers.⁴⁴ One reason is because their references to “procedural safeguards and due process protections [are] in ambiguous and general terms.”⁴⁵ International documents, such as the *European Convention*, set standards but do little for the day-to-day operation of mental health law. It is worth noting, for instance, that Winterwerp submitted his application in 1972 and judgment was released in late 1979.

C. Ontario’s Statutory Landscape

Ontario’s mental health laws surpass international standards in respecting the rights of mental health consumers.⁴⁶ The province has multiple pieces of legislation that regulate the mental health sector, particularly the *MHA*, which sets out the procedures and requirements for involuntary committal, and the *HCCA*, which does the same for capacity to consent to or refuse medical treatment.⁴⁷

The various acts that govern mental health law in the province set out a number of procedural safeguards, including the operation of an administrative tribunal—in this case, the CCB. The Board is an administrative tribunal, comprised of a psychiatrist member, a lawyer member, and a “public” member (someone in the community).⁴⁸ All three members review a person’s involuntary status but only

42 Michael L Perlin, “International Human Rights and Comparative Mental Disability Law: The Role of Institutional Psychiatry in the Suppression of Political Dissent” (2006) 39:3 *Isr LR* 69 at 71-72 [Perlin, “Comparative”]. See also Dhir, *supra* note 5 at 104-105.

43 *X v UK*, *supra* note 38 at para 66.

44 See Zuckerberg, “International Experience”, *supra* note 37 at 513.

45 *Ibid.*

46 *Ibid.* For instance, the United Nations’ *Convention on the Rights of Persons with Disabilities*, 12 December 2006, 2515 UNTS 3, Can TS 2010 No 8 [*Disabilities Convention*] stipulates at article 12(4) that a person is entitled to, among other safeguards, “regular review by a competent, independent and impartial authority or judicial body.” There is no mention of the right of appeal, judicial review or similar opportunities to challenge the body that reviews the physician’s finding(s). Compare that with the *HCCA*’s automatic right of appeal, *supra* note 10 at s 80(1).

47 *Ibid.*; *MHA*, *supra* note 7; *Personal Health Information Protection Act*, SO 2004, c 3; *Substitute Decisions Act*, SO 1992, c 30; *Mandatory Blood Testing Act*, 2006, SO 2006, c 26.

48 Consent and Capacity Board, “Annual Report 2011-2012” at 5, online: Consent and Capacity Board <<http://www.ccbboard.on.ca/scripts/english/publications/annualreports.asp>>.documents/annualreport20092010.pdf> [*Annual Report*].

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one—the lawyer member—need review a finding of incapacity.⁴⁹ The CCB's authority spans the statutes noted above.⁵⁰ Ontario mental health law grants robust authority to infringe on the rights of mental health consumers. However, its protections and procedures are equally formidable.⁵¹ Notably, over 80 percent of applications to the CCB involve review of either a person's involuntary status or his or her capacity to consent to or refuse medical treatment.⁵²

Arguably, Ontario is especially rights-focused, even relative to other Canadian provinces.⁵³ For example, the *parens patriae*-rooted concept of best interests is no longer available as a criterion that a clinician can rely on when making a determination that will limit a mental health consumer's rights.⁵⁴ A consumer is entitled to make a conventionally unwise decision regarding his or her medical treatment, so long as the consumer meets the legal definition of capacity.⁵⁵ In *Starson v Swayze*, the Supreme Court of Canada held that the two-pronged legal test for capacity does not require that a person refer to his or her condition as an illness, or in otherwise negative terms, nor is there any emotionally-based evaluation. Instead, the test requires only that a person have the cognitive ability to understand the proposed treatment and the ability to appreciate the consequences of consenting to or refusing treatment.⁵⁶

D. Section 80: The Automatic Right of Appeal

Another significant example of Ontario's faithful orientation towards a rights-based model is the automatic right of appeal. I characterize the right as "automatic" on the basis that it is granted without requiring leave. Decisions by the CCB can be reviewed on a question of law, fact or both.⁵⁷ Section 80 of the *HCCA* creates an entitlement to appeal a decision from the CCB, in addition to the right to review

49 Consent and Capacity Board, "Consent and Capacity Board Rules of Practice," rr 3.1 and 20.1 (15 September 2005), online: Consent and Capacity Board <<http://www.ccboard.on.ca/scripts/english/legal/rulesofpracticehtml.asp>>. D'Arcy Hiltz & Anita Szigeti, *A Guide to Consent and Capacity Law in Ontario* (Markham, Ont: LexisNexis Canada, 2008) at 521. See also *HCCA*, *supra* note 10, s 73(2)(c) for the incapacity hearing requirements for a single member.

50 Consent and Capacity Board, "About Us" (15 September 2005/10 December 2010), online: Consent and Capacity Board <<http://www.ccboard.on.ca/scripts/english/aboutus/index.asp>>.

51 Patton, *supra* note 5 at 12.

52 *Ibid.* Annual Report, *supra* note 48 at 2.

53 Ontario keeps separate legislation for capacity and civil committal. This statement is made on the presumption that it is less prohibitive of one's rights if rights infringements are limited only as needed, as opposed to in a conflated manner. On the other side of the spectrum is British Columbia's *Mental Health Act*, RSBC 1996, c 288, s 31(1) [*BC MHA*] which "deems" involuntary patients incapable to consent to treatment. See *Mental Health Act*, RSBC 1996, c 228 s 31(1).

54 *Starson*, *supra* note 1 at para 76.

55 *Ibid.* See also *Re Koch* (1997), 33 OR (3d) 485, 70 ACWS (3d) 712, (Ont Ct J (Gen Div)) ("[t]he right to be foolish is an incident of living in a free and democratic society" at 512).

56 *Starson*, *supra* note 1 at para 79.

57 *HCCA*, *supra* note 10 at s 80(1).

by the CCB. This automatic right to appeal exceeds international human rights standards.⁵⁸ Whereas international standards and human rights bodies require an independent system of review, Ontario, in effect, provides two.

Section 80 exceeds other Canadian jurisdictions' standards as well. British Columbia and Prince Edward Island do not explicitly mention an appeal to the courts,⁵⁹ although Prince Edward Island allows for the judicial review of a mental health tribunal's decision (which is limited recourse relative to an appeal),⁶⁰ and British Columbia mental health consumers can contest the validity of their involuntary admission via a *habeas corpus* application or by application to the court for discharge from the psychiatric facility.⁶¹ Newfoundland and Labrador and Nova Scotia also narrow the scope of an appeal, permitting a right of appeal only on questions of law.⁶² At the other end of the spectrum, New Brunswick provides no right of appeal to a court.⁶³ The Yukon, the Northwest Territories, Alberta, Manitoba and Saskatchewan all provide the same right of appeal as Ontario.⁶⁴

Among its requirements, section 80 stipulates that: a party must serve and file a notice of appeal within seven days of receipt of the Board's decision;⁶⁵ the CCB must "promptly" serve the parties with a record of the proceedings before the Board, including a transcript of the oral evidence provided;⁶⁶ the appellant

58 See *Disabilities Convention*, *supra* note 46 at art 12(4).

59 See *Halsbury's Laws of Canada*, Mental Health, vol 66, 1st ed, (Markham, Ont: LexisNexis Canada, 2011) at HMN-74, page 201 [*Halsbury's*].

60 See *Mental Health Act*, RSPEI 1988, c M-6.1 28, s 30(12). See also Zuckerberg, "Canadian Experience", *supra* note 5 at 321, n 109. Comparing an appeal and judicial review in the context of a decision of an administrative tribunal may be a distinction without difference. In *Dr. Q v College of Physicians and Surgeons of British Columbia*, 2003 SCC 19 at para 21, [2003] 1 SCR 226 the Supreme Court of Canada held that the standard of review analysis applies to administrative decisions by way of "both application for judicial review and statutory rights of appeal". Indeed, despite the *HCCA* providing the appellate court comprehensive appeal powers typical of an appeal, such as the ability to substitute the Board's decision with its own, the analysis begins with a consideration of the appropriate level of deference to afford the tribunal, as per the standard of review analysis typically associated with judicial review. See *HCCA*, *supra* note 10 at s 80(10) and see e.g. *Scardoni v Hawryluck* (2004), 69 OR (3d) 700 at para 34, 5 ETR (3d) 226.

61 See *Mental Health Act*, RSBC 1996, c 288, s33 (2) and (3) [*BC MHA*]. However, *habeas corpus* applications are considered rare, and usually reserved for situations where the belief is that a finding was made in error. See British Columbia, Ministry of Health, "Guide to the Mental Health Act", (Victoria: British Columbia Ministry of Health, 2005 ed) at 48 < <http://www.health.gov.bc.ca/mhd/mentalhealthact.html>>.

62 See *Mental Health Care and Treatment Act*, SNL 2006, c M-9.1, s 73 [*MHCTA*] and *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, s 79(1) [*IPTA*]. Note that the standard of review for questions of law is correctness, with the result that a mental health tribunal is owed no deference on these grounds, including how it applies its enabling statute. See *Halsbury's*, *supra* note 59 at HMN-73, page 210.

63 See *Mental Health Act*, RSNB, c M-10, s 30.1(5) [*NB MHA*]. However, note that New Brunswick's review boards serve an appellate function, reviewing decisions by a tribunal. Although not a court, the review board's decision effectively provides mental health consumers a second level of review.

64 See *Mental Health Act*, RSY 2002, c 150, s 37(1); *Mental Health Act*, RSNWT 1988, c M-10110, ss 26, 26.1; *Mental Health Act*, RSA 2000, c M-13, s 43(4); *The Mental Health Act*, SM 1998, c 36, CCSM, c M-110, s 36; [*MB MHA*]; *The Mental Health Services Act*, SS 2004, C1984-85-86, c M-13.1, s 36. [*MHSA*].

65 *HCCA*, *supra* note 10 at s 80(2).

66 *Ibid* at s 80(4).

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must deliver a factum within 14 days of receipt of the record⁶⁷ and the respondent must do so within 14 days of receipt of the appellant's factum;⁶⁸ and the court must fix "for the hearing of the appeal at the *earliest date*" possible.⁶⁹ Timeliness is among the most important considerations for a person whose liberty interests have been suspended. The legislative intent is clear—appeals from the CCB are not simply to proceed without delay, they should be heard as quickly as reasonably possible. However, the average time to process an appeal from start to finish is eight months.⁷⁰

Ultimately, Ontario's mental health laws provide for greater protection of rights than many other jurisdictions, domestically and internationally. In theory, the legal safeguards for mental health consumers in Ontario are thoughtful and far-reaching. However, as Part III shows, when the laws and their respective provisions interact in practice, the efficaciousness of these laws becomes suspect.

III. REALITY ON THE GROUND

Despite the automatic right of appeal and the express intent to see that an appeal moves expeditiously toward a final disposition, there are significant barriers to an appeal being heard, let alone reaching its final disposition.⁷¹ Joaquin Zuckerberg, former counsel to the CCB, writes that there are several reasons CCB appeals do not proceed: the matter becomes moot before the court can hear it; the patient exercises the right to have the matter redetermined by the CCB before the court hears the appeal; health practitioners do not pursue the appeal for their own reasons; and, the appellant cannot afford legal counsel.⁷² Regarding the last issue, the majority of consumer-appellants receive some form of financial assistance from the government in exercising their right to review before the CCB.⁷³ At the Board level, this is done namely through legal aid.⁷⁴ However, at the appeal level, legal aid is not available unless an opinion letter from counsel is submitted which speaks to the merits of the appeal.⁷⁵ Information on this "merit letter" is scant. What seems implicit is that Legal Aid Ontario (LAO) will not approve further funding without a lawyer first vouching for the worthiness of the appeal. As will be discussed, issuance of legal aid funding at the appeal level is rare. Intuitively, that means the preparation

67 *Ibid* at s 80(5).

68 *Ibid* at s 80(6).

69 *Ibid*, s 80(8) [emphasis added].

70 Zuckerberg, "Canadian Experience", *supra* note 5 at 321. Comparatively, McLachlin, *supra* note 2 ("[c]ivil appeals in Ontario are now being heard within nine to 12 months of perfection").

71 See Zuckerberg, "Canadian Experience" *supra* note 5 at 321.

72 *Ibid*.

73 See e.g. *Bon Hillier v Milojevic*, 2009 CanLII 70504 at para 14, (Ont Sup Ct) [*Bon Hillier*, Endorsement]. See also Schneider, *supra* note 9 at 148; Dhir, *supra* note 5 at 111; Nyranne Martin, "The Ethical and Practical Advocate: Considerations for Hospital Counsel in the Mental Health Context" (2011) 13:4 RMCHC 37 at 42 [Martin].

74 *Ibid*. See also Dhir, *supra* note 5 at 111 and Schneider, *supra* note 9 at 148.

75 See Zuckerberg, "Canadian Experience", *supra* note 5 at 321.

of “merit letters” is similarly rare. Yet to get to the stage where a “merit letter” is required means that the consumer-appellant has already filed notice of appeal. Who helps the consumer-appellant file such a notice? The counsel who represented the consumer before the Board.⁷⁶ Herein lies the problem.

Upon the Board confirming a clinician’s finding of incapacity, counsel follows his or her duty to inform his or her client of what options are available at that point. The options are either to let the Board’s confirmation of the clinician’s finding stand or appeal. In instances of findings of incapacity, the motivating issue is most often that the mental health consumer is refusing treatment and the physician believes that that refusal is not a “capable” decision. Appealing the Board’s decision is an opportunity to further delay treatment, since treatment cannot begin pending final disposition.⁷⁷ The consumer becomes the appellant because that is his or her right.

This section of the article explores what happens when that right is exercised. In order to appreciate why section 80 further infringes rights, it is first necessary to understand what happens when a mental health consumer who is involuntarily committed disputes his or her finding of incapacity. The “warehousing” effect results—the patient remains detained without treatment and the hospital ceases to play its therapeutic role, thereby forcing it to take on a custodial function. In the circumstance of a consumer who appeals a decision by the Board, the right he or she is exercising is what maintains the status quo in hospital. So long as the consumer’s appeal remains “active,” this holding state remains unchanged, and the ability to therapeutically address the mental deterioration underlying the criteria that led to the infringement of rights is suspended pending the appeal’s conclusion. Furthermore, the right to appeal does not end with perfecting an appeal and appearing before court. At the appellate level, the matters under review are complex and the structure of the proceedings is far more formal than those of the Board hearing. For the right to appeal to be meaningful it requires representation, since, as noted by Justice Brown, for a self-represented consumer-appellant, the ability to put forward his or her appeal in a “cogent, intelligible and persuasive manner”⁷⁸ is unlikely, if not impossible. A consumer can appeal the decision—triggering the further suspension of rights—but unlike a hearing before the Board, there is no system to help the consumer exercise his or her right at court. Thus, as Justice Brown wrote, “[w]ithout proper legal representation, that statutory right of appeal is illusory.”⁷⁹

76 *Cavalier v Ramshaw*, 2010 ONSC 5402, 193 ACWS (3d) 1318 (available on QL) [*Cavalier*, Memo] (“as a matter of practice, those legal aid-funded counsel usually prepare and file the notice of appeal” at para 3(i)),

77 *HCCA*, *supra* note 10 at 10, s 18 (3)(d). However, note the emphasis on *begin*; treatment already commenced may continue pending final disposition.

78 *Bon Hillier v Milojevic*, 2010 ONSC 435 at para 19 (available on QL) [*Bon Hillier*, Reasons].

79 *Ibid.*

A. The “Warehousing” Effect

In the context of appeals of CCB decisions to confirm a finding of incapacity, the discussion must start with the fact that Ontario keeps civil commitment and capacity separate.⁸⁰ When a mental health consumer satisfies the criteria to be involuntarily hospitalized, the right to refuse treatment takes on a new dimension. First, that person’s “risk”—to his or herself, to others or both—has been confirmed by at least two clinicians.⁸¹ Unlike a finding of incapacity, the person’s being “at great risk” has been assessed and confirmed by a second opinion. Second, involuntary admission is indirect confirmation that treatment is needed. As argued by Mona Gupta, “[h]ow can a person be found *capable* of refusing a treatment aimed at reducing dangerousness, having already been determined, albeit indirectly, to be *incapable* of making a decision to continue to remain at large in the community and behave dangerously?”⁸² Third, and of critical importance, the criteria under which the person is admitted involuntarily are unlikely to change without treatment. In other words, the person is unlikely to be discharged from a hospital *unless* treatment is provided.

All that notwithstanding, the Supreme Court of Canada has confirmed a person’s right to make unwise decisions.⁸³ The “strategic” benefit of consenting to treatment in order to be released can be ignored. Alternatively, the mental health consumer may prefer being detained in a hospital rather than risk treatment that poses considerable side effects.⁸⁴ This preference may be particularly cogent for mental health consumers who have a history with treatment and associate that

80 Comparatively, Saskatchewan, Newfoundland & Labrador and Nova Scotia all require that in order for a person to be involuntarily committed that person must be found incapable to consent to treatment. See *MHSA*, *supra* note 64, s 24(2); *MHCTA*, *supra* note 62, s 17(b); *IPTA*, *supra* note 62, s 17. Manitoba’s legislation limits its capacity-based requirement for involuntary admission to admission (as opposed to treatment), placing it closer in line with Ontario’s legislative structure. However, Manitoba states that a person may be involuntarily admitted where that person is incapable to consent to voluntary admission *or* refuses to consent to voluntary admission. See *MB MHA*, *supra* note 64, s 17(1). Perhaps more noteworthy is New Brunswick, which keeps capacity decisions separate from the requirements for involuntary admission. However, where a physician believes that the person is incapable to consent to treatment, is capable but refuses to consent, or is under sixteen, the physician “shall” seek permission to provide treatment without consent. See *NB MHA*, *supra* note 63, ss 8(1)(c), 8.01(2).

81 When someone comes to the hospital, either voluntarily or involuntarily, and there is reason to believe they would benefit from hospitalization, they are admitted on a Form 1, which calls for psychiatric assessment for up to 72 hours. If, after the assessment period, the belief of the benefit of hospitalization remains, a Form 3 must be completed. The Form 3 is notice of admission to the hospital and it must be signed by a physician *other* than the person who signed the Form 1. Even if the physician who signed the Form 1 is the same physician to sign the Form A (declaring the person incapable to consent to or refuse their own treatment), a second physician would be required to corroborate that opinion. This is a procedural safeguard in and of itself. See *MHA*, *supra* note 7 at, s 20(2).

82 *Supra* note 5 at 167 [emphasis in original].

83 *Starson v Swayze*, *supra* note 1.

84 See Larry Gostin, “Compulsory Treatment in Psychiatry: Some Reflections on Self-Determination, Patient Competency and Professional Expertise” (1982) 7 *Poly L Rev* 86 at 88-89 [Gostin, “Compulsory Treatment”] and Dhir, *supra* note 5 at page 110.

experience with negative outcomes (most commonly, in the form of side effects), at the expense of any positive outcomes. Regardless of the “why” behind the decision, the law is such that the consumer may refuse treatment but be committed. Section 19 of the *HCCA* does allow a clinician to bring a motion to seek the court’s authorization to administer treatment prior to final disposition, but the criteria for granting such a motion are stringent and the applications, consequently, are few.⁸⁵ Criteria aside, such a motion may also be unpopular for the damage it stands to do to the therapeutic relationship; after all, how can a clinician build trust with his or her patient when, in response to the patient exercising his or her automatic right of appeal, the clinician takes steps to circumvent that process? The automatic right of appeal threatens the therapeutic relationship because it, in effect, prevents the relationship from being developed. Arguably, section 19 does so by undercutting the very motivation that brought the motion forward, which is to see suffering treated.

Ontario’s legislative structure—to separate the two findings—follows the prevailing belief that capacity is decision-specific and temporal. Ostensibly, consumers can be admitted as involuntary patients on the basis that they are dangers to themselves but they are capable to consent to or refuse treatment with antipsychotic medications. On the one hand, this can be viewed as further respecting the rights of individual, since clinicians need not limit any rights unnecessarily, en route to addressing the real concern. As well, hospitalization can protect an individual from harming himself or herself or others. On the other hand, when a person is hospitalized on an involuntary basis and capably refuses treatment, the criteria by which he or she was admitted are unlikely to change. Viewed another way: if capable, a person can refuse treatment for the condition that necessitated hospitalization in the first place.⁸⁶ This phenomenon, another gap in and of itself, has been referred to by Zuckerberg as “warehousing.”⁸⁷ In effect, a hospital ceases to be a place of treatment and instead it takes on a custodial function. The law simply permits no more to be done.

The description of “warehousing” thus far has presupposed that a person has been found capable to refuse treatment. The point has been made that it is illogical to allow “committed persons” to refuse treatment that would lead to their being discharged.⁸⁸ Despite the incongruity of the possible outcomes associated with separating the two findings, the separation does serve a meaningful role in ensuring that one set of criteria is not conflated with the other. One could see the potential for zealous clinicians to substitute their notions of best interests over objective criteria were the two findings less distinct.

85 *HCCA*, *supra* note 10 at s 19(1); *Cavalier*, *Memo supra* note 76 at paras 14-15. Comparatively, New Brunswick’s mental health legislation allows at section 8.11(1) (c) for treatment to take place where, among other requirements, the reviewing body is “of the opinion that, without the treatment, the involuntary patient would continue to be detained as an involuntary patient with no reasonable prospect of discharge”. See *NB MHA*, *supra* note 63 at ss 8.11(1)(c), 30.1(6)(b), 30.1(6.1)(c).

86 *Gupta*, *supra* note 5 at 167.

87 Zuckerberg, “Canadian Experience”, *supra* note 5 at 307.

88 *Gupta*, *supra* note 5 at 156.

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However, what about the circumstances where a clinician has made both findings *and* both findings are later confirmed by the Board? In those instances, a person's capacity has been reviewed by multiple sources, one of which is an independent quasi-judicial body. When a mental health consumer appeals a decision from the CCB, confirming the finding that he or she is incapable to consent to or refuse treatment, but does not appeal the involuntary decision (as is often the case),⁸⁹ there is little to suggest that the finding of incapacity will be found to be made in error: "empirical research has demonstrated that patients who are sufficiently ill to meet dangerousness criteria for involuntary hospitalization, are usually incapable of making treatment decisions."⁹⁰ It is relevant to return to the requirement of section 18 that treatment cannot begin pending final disposition of appeal.⁹¹ On its own, the provision is the codification of *Mallette v Shulman*, enshrining the right to bodily integrity; however, in operation with section 80, the right to bodily integrity bumps up against the right to liberty, among others. It is the interplay between these two provisions that creates the "warehousing" effect.

It bears repeating that, speaking from a traditional view of rights protection, these requirements respect a consumer's autonomy, dignity and self-preservation. His or her bodily integrity and right to self-determination are not directly at risk. On the other hand, those rights are respected at the expense of the consumer's liberty. Additionally, it has been argued that a person who is hospitalized but not treated stands a greater risk of facing the use of restraints and/or seclusion—even greater affronts to a person's liberty and integrity.⁹² The suspension of a person's rights prior to a Board hearing is finite, but such is not the case at the appeal level. The question must be asked: what of the person's well-being? One of the purposes of the *HCCA* is to facilitate treatment.⁹³ The automatic right of appeal in section 80 undermines that purpose, albeit indirectly.

B. Call for Case Management

Appeals from CCB decisions are usually brought by mental health consumers found incapable of consenting to treatment.⁹⁴ A finding of incapacity is a finding that there is a cognitive deficiency or a disparity between what can be objectively

89 See e.g. *Tran v Ginsberg*, 2011 ONSC 927 (available on QL); *Van Berkum v Geagea*, 2011 ONSC 4326 (available on QL); *Cavalier v Ramshaw*, 2011 ONSC 6009.

90 Gupta, *supra* note 5 at 167.

91 *HCCA*, *supra* note 10 at s 18(3).

92 Gupta, *supra* note 5 at 156-57, 171.

93 *HCCA*, *supra* note 10 at s 1(b). The other purposes of the *Act* are to provide rules governing the consenting of treatment; to promote communication and understanding between health practitioners and mental health consumers; to ensure family members play a significant role when their loved one is found to be incapable; to permit intervention by the Public Guardian & Trustee to intervene where necessary; and, to enhance the autonomy of mental health consumers, for whom treatment is proposed (which explicitly references a right of review, yet is silent on the right of appeal).

94 *Bon Hillier*, Reasons *supra* note 78 at para 17.

understood by the patient and what his or her understanding of his or her own situation is, or both. Proper legal representation at the appeals stage is, practically speaking, a necessity.

In one of his appeal management memoranda,⁹⁵ Justice Brown addressed the problem of a consumer-appellant proceeding without counsel: the person lives with a mental condition which, in effect, paralyzes his or her ability to take the necessary steps to perfect his or her appeal.⁹⁶ Of the steps outlined in section 80 to move the appeal forward, the first two are easily satisfied: submitting a notice of appeal is usually done by the counsel who represented the consumer-appellant in front of the CCB, and the CCB's obligation to provide the transcripts of the hearing and Record of Appeal is efficiently met.⁹⁷ Where the process falls apart, however, is when it comes time for the appellant to submit his or her factum.⁹⁸ Even on an informal basis, the appellant cannot prepare a factum, and without it the appeal process stalls. The court's discretion to extend the time for filing a factum⁹⁹ is good in theory, but in reality it is of no help. Justice Brown observed that "a patient/appellant's inability to file a factum brings the appeal process to a screeching halt."¹⁰⁰

What this means in practical terms is that the appellant is hospitalized indefinitely, in limbo between liberty and treatment, unable to move his appeal forward. Of this legal and medical purgatory, Justice Brown observed:

Based on a number of such cases that I have managed over the past while, the patients' conditions often result in their detention in some sort of secure ward at a treatment facility, sometimes a form of solitary confinement if their condition causes them to endanger the safety of others. Their conditions do not improve; they are unable to move their appeals along to a hearing; so there they sit. Not a pretty picture.¹⁰¹

The memo was not the first time the state of consumer-appellants' limbo-status was addressed. It was first identified by Justice Brown the year before in *Bon Hillier v Milojevic*.¹⁰² In that case he initiated a plan to see that appeals to the Superior Court of Justice from the CCB followed a pre-hearing case management process.¹⁰³ The added judicial oversight came about after Justice Brown learned that CCB appeals were stalling at the point of scheduling the appeal. In order to ensure that

95 *Cavalier*, Memo, *supra* note 76.

96 *Ibid* at para 2.

97 *Ibid* at para 3.

98 *Ibid*.

99 *HCCA*, *supra* note 10 at s 80(8).

100 *Cavalier*, Memo, *supra* note 76 at para 3.

101 *Ibid* at para 5.

102 *Bon Hillier*, Reasons, *supra* note 78.

103 *Ibid* at para 37. See also Zuckberg, "Canadian Experience", *supra* note 5 at 322.

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the court was faithful to the legislative intent behind section 80, Justice Brown laid out a three-piece process to be followed on a “go-forward basis:” first, the parties must obtain a date for the hearing of the appeal so that the “readiness” of the appeal can be assessed; second, either party can seek a case management conference with the appropriate judge at *any* time so as to discuss timetable issues, including the issue of legal representation for the appellant; and third, if the court does not hear of a date being scheduled for a hearing or for a case management conference within 30 days following the filing of the Record of Appeal and transcript by the CCB, the court will set a case conference.¹⁰⁴

The case management system is the court stepping in to determine the consumer-appellant’s ability to move his appeal forward. The key aspect of the system is the court’s discretion to appoint *amicus curiae*, a friend of the court. The court has broad discretion to outline the scope of the role of *amicus*; to date, the role has largely revolved around identifying the pertinent issues at appeal in a way the consumer-appellant is unable to do, such as writing the factum. *Bon Hillier* was the first CCB appeal to receive case management treatment.

In *Bon Hillier*, the self-represented appellant was contesting the finding that he was incapable to manage his own property.¹⁰⁵ Years before he found himself in front of Justice Brown, Bon Hillier was declared by a British Columbia clinician to be “incapable of managing his financial and legal affairs due to cognitive impairment consequent to a traumatic brain injury.”¹⁰⁶ He moved to Ontario, where on subsequent assessment the finding of incapacity was upheld. Bon Hillier contested that decision to name the Public Guardian & Trustee as his substitute decision-maker.¹⁰⁷ A further complication was that Bon Hillier was adamant that he did not want representation at the appeal (nor did he want counsel at the Board hearing).¹⁰⁸ As a result, Bon Hillier found himself in a Catch-22: he wanted to contest the finding that he was incapable of managing his property without representation but could not do so without representation. The reason the question of his capacity to manage his own property arose was the very same reason he was found by Justice Brown to be, in a sense, incapable of progressing his appeal—his mental condition prevented it.

In order to see that Bon Hillier’s right to appeal was meaningfully exercised and that his wish to be self-represented was respected, *amicus* was appointed. The *amicus* appointment was set by Justice Brown:

(i) The court will make an endorsement which provides an outline of the anticipated role of *amicus*, the work expected to be performed

104 *Ibid* at para 38.

105 Nothing in the first endorsement or the ultimate judgment by Justice Brown suggests that Bon Hillier was ever hospitalized for psychiatric reasons.

106 *Ibid* at paras 2-4.

107 When an individual is found to be incapable a substitute decision-maker (SDM) is assigned. The *HCCA* has a hierarchy of who the SDM can be. See *supra* note 10 at s 20.

108 *Bon Hillier*, Reasons, *supra* note 78 at para 10.

by *amicus* prior to and at the hearing of the appeal, the anticipated length of the hearing, and the criteria for *amicus*;

(ii) If the parties have proposed the names of nominees for *amicus* at the case conference, the court may appoint *amicus* at that time and fix the rate of remuneration for *amicus*. The court would inform the [Attorney General of Ontario] of the appointment;

(iii) If the parties have not proposed names of nominees for *amicus*, or if the court wishes additional nominees identified, the court will send a copy of the endorsement to the AGO advising of its intention to appoint *amicus* and request the AGO to seek the assistance of Legal Aid Ontario in identifying competent counsel from its Consent and Capacity panel; and,

(iv) The AGO shall forward the names and qualifications of two or three nominees to the requesting judge who, if satisfied, will then appoint *amicus* and set the rate of remuneration.¹⁰⁹

In August 2010, just shy of two years from the time he was first declared incapable of managing his own property, Bon Hillier's appeal was allowed.¹¹⁰ It is important to note, however, that the matter was referred back to the Board on procedural grounds (with *amicus* to assist in the hearing).¹¹¹ Nothing in the reasons addresses any substantive concerns about the incapacity finding.

The right of appeal legally exists but two factors prevent it from being fully realized: the patient's condition and his inability to qualify for legal aid funding at the appeals level. The case management process, particularly the assignment of *amicus*, corrected those two problems while remaining faithful to the legislative intent to proceed with the appeal expeditiously. It was meant to bridge the gap between the right of appeal and the practical difficulties with exercising that right. By the time *Cavalier v Ramshaw*¹¹² was before Justice Brown a new issue had arisen, putting yet another barrier between the right of appeal in theory and the right of appeal in practice.

The system from which Justice Brown sought to borrow was created by the Court of Appeal for Ontario for appeals from the Ontario Review Board and included two important factors: lawyers appointed as *amicus* were to be chosen from a pool of lawyers experienced in the area and that counsel would be exempt from the requirement to provide a "discretion letter," a letter justifying the need to docket hours that exceed the tariff maximum—for accounts submitted with less than

109 *Ibid* at para 39.

110 *Bon Hillier v Milojevic*, 2010 ONSC 4514 (available on QL).

111 *Ibid*. Unfortunately, there is no published decision from the subsequent Board hearing.

112 *Cavalier*, Memo, *supra* note 76.

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50 hours.¹¹³ After he set out the case management system, Justice Brown learned at the *Bon Hillier* appeal that the Attorney General of Ontario appealed three decisions of the Court's appointment of *amicus* and its setting rates for compensation above the Legal Aid Tariff.¹¹⁴ The case management process quickly showed that consumer-appellants are caught between the courts and the government.¹¹⁵

LAO took the position that the court's appointment of *amicus* was akin to the issuance of a legal aid certificate to represent an individual litigant, which necessarily meant limiting the hours *amicus* could docket for a CCB appeal to 16 and rates of pay to match LAO's current pay structure.¹¹⁶ This cap was set independently of court direction and Justice Brown determined it to be a threat to the case management system altogether; he posited that qualified counsel who would otherwise seek to be appointed as *amicus* would refrain on the basis of the limitations placed on their time.¹¹⁷ Furthermore, Justice Brown characterized *amicus* as comparable to an independent expert, whose assignment and pay is under the purview of the court, rather than counsel with a client.¹¹⁸ In sum, the court argued it has the jurisdiction to appoint *amicus* and set the rate of pay; the government argued otherwise. Despite testimony to the contrary, the government further argued that efforts to raise the cap were unnecessary.¹¹⁹ By April 2011, the argument continued in *Thompson v Ontario (Attorney General)*,¹²⁰ where the Attorney General of Ontario maintained its stance that CCB appeals to the Superior Court offer a "reasonable and effective" way to proceed.¹²¹ In response, Justice Brown wrote "[t]he AGO's submission displays an utter lack of understanding of the 'reality on the ground' facing patient-appellants from CCB decisions."¹²²

113 *Ibid* at paras 14-15.

114 *Bon Hillier*, Reasons, *supra* note 78 at para 48. Hourly rates for *amicus* was addressed extensively in the numerous appeal management memoranda Justice Brown wrote. The issue of hourly rates is not addressed meaningfully here because it is not unique to *amicus* appointed in CCB appeals and thus, is not addressed as a barrier borne by inadequate mental health reform. See Ontario, Ministry of the Attorney General, *Report of the Legal Aid Review 2008* by Michael Trebilcock (Toronto: AGO, 2008), online: <<http://www.attorneygeneral.jus.gov.on.ca/english/about/pubs/>> at iii.

115 Legal Aid Ontario is the body to which consumer-appellants apply to fund their appeals; however at the case management level, it is the Attorney General of Ontario who responds to the court because, although LAO is an independent not-for-profit organization, its funding comes from the government.

116 *Cavalier*, Memo, *supra* note 76 at para 12. For a brief explanation on the rules set out for hours and rates of pay under the *Legal Aid Services Act (LASA)* and its Tariff see *ibid* at paras 11-13. Broadly speaking, what the rules set out therein is that *LASA* and its accompanying regulations determine the rate of pay and the maximum hours allowed per case type (such as preparation of an appeal from the CCB). In contrast, *amicus* appointed for appeals from the Ontario Review Board can docket up to 50 hours for an appeal (*ibid* at para 9[4]). Additionally, in order for *amicus* to be paid for any surplus hours worked she must seek permission in advance. The LAO website states that discretionary increases will only be approved in "exceptional cases" (*ibid* at paras 11-13).

117 *Ibid* at para 9[6].

118 *Ibid* at para 22.

119 *Ibid* at paras 17, 19.

120 *Thompson v Ontario (Attorney General)*, 2011 ONSC 2023, 106 OR (3d) 176.

121 *Ibid* at para 60.

122 *Ibid*.

As will be illustrated in the next section, CCB appeals to the Superior Court are anything but a “reasonable and effective” means to exercise one’s legal rights. The AGO’s position is flawed, especially in light of the fact that a self-represented appellant can only seek counsel funded by LAO once a letter speaking to the merits of his or her appeal has been submitted and approved. It is difficult to square this requirement with the automatic right of appeal in section 80. After all, in the context of a community largely dependent on financial aid, how can an automatic right function without automatic recourse? However, Justice Brown’s contention that it is the government who bears the burden (via LAO and the *LASA*) to correct the problem misses the point. The courts and the government are merely the players, executing their respective legislative authorities and duties. They are the manifestations of the laws—the *HCCA* and *MCA* on the one side, the *LASA* on the other—trying to work in tandem, but unable to be reconciled. It is the rationale underlying the competing legislative intents that needs to be examined where such a conflict exists. In the case of section 80, before advocating that the answer is more money and more counsel, first one must ask whether a right of appeal serves the purpose it was meant to serve. As illustrated by the next section, the answer in this case is no.

C. Many Appeals Reflect One Story: Appellants Languish, Only to have Appeal Dismissed

Of the 51 applications to appeal a CCB decision between April 1, 2009 and March 31, 2010, one appeal was allowed, five were dismissed and eight abandoned.¹²³ Most notably, 37 cases were without information or the case was not yet disposed of by the end of the reporting year.¹²⁴ Stated another way: less than two percent of the appeals were allowed and over 70 percent were somewhere in the ether. Bon Hillier falls into the rare, former category. Bon Hillier’s case is notable not only for the fact that the appeal was allowed, but also because he was adamant about remaining self-represented. As observed by Nyranne Martin, Senior Legal Counsel for the Centre for Addiction in Mental Health,¹²⁵ self-representing in legal proceedings “can be mystifying ... at the best of times. For individuals with mental illness, legal proceedings can be particularly challenging”.¹²⁶

The emergence of the issue of the practical effect of section 80 arose through the court’s concern that CCB appeals were not moving through courts as quickly the legislation demands. Then the related issue of a self-represented consumer-appellant’s ability to effectively argue his or her case came to light. For Bon Hillier,

123 *Supra* note 48 at 15.

124 *Ibid.*

125 CAMH is the largest psychiatric facility in Ontario, and subsequently, is most often the facility that “warehouses” consumer-appellants who appeal their finding of incapacity. Martin represents the clinicians named as the respondents in an appeal.

126 Martin, *supra* note 73 at 42.

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the problem was not that he could not get counsel, it was that he did not want counsel. While it is the right of every individual to represent themselves in legal proceedings—as it is every person's right to make unwise decisions—Bon Hillier was unable to represent his case meaningfully. Moreover, the reason he was not able to do so was the very reason he was found incapable: his mental condition post-brain injury. Of his efforts to challenge the evidence put forward to affirm the finding of his incapacity, the court observed “[they] could have been achieved through cross-examination, or by adducing other evidence to place the [clinician's evidence] in different light. Because of his injury, Mr. Bon Hillier lacked the specialized skills to do either.”¹²⁷ The procedural grounds on which Bon Hillier's appeal was allowed recognized the inherent *incapacity* he had to further his appeal.

A more archetypal example illustrating the issue is the more recently decided *Cavalier v Ramshaw*.¹²⁸ Cavalier is a mental health consumer with psychiatric history dating back to 1989.¹²⁹ In 2004, he faced criminal charges for harassment, and was found unfit to stand trial shortly thereafter.¹³⁰ Pursuant to a Treatment Order by the Ontario Review Board, Cavalier was admitted to hospital and treated. By 2008, he was fit to stand trial.¹³¹ He was subsequently found Not Criminally Responsible and remitted back to hospital, in a minimum security unit.¹³² In June 2009, he was found incapable to consent to treatment, a finding he appealed. As a result, Cavalier remained in hospital, detained, without treatment. Cavalier's mental condition manifested as a psychotic delusion that there is a “widespread media conspiracy to promote extremes of pornography and pedophilia.”¹³³ This psychotic delusion extended to CAMH and his psychiatrist, the Respondent.¹³⁴ Not only did a lack of treatment lead to greater deterioration of his mental health, as well as create greater risk of the need for use of restraints and/or seclusion,¹³⁵ it also put great pressure on the therapeutic relationship between him and his psychiatrist. Martin notes that the clinician-patient relationship—the therapeutic relationship—is “intended to persist long after the involvement of legal counsel has ended.”¹³⁶ Where there is great delay between a Board hearing and final disposition of the appeal (particularly where treatment is suspended or prevented altogether) and where the consumer's mental health manifests with paranoid ideations (a not uncommon symptom), the delay is a significant threat to that relationship, as shown in *Cavalier*. Such a threat ultimately undermines the mental health consumer's well-being.

127 *Bon Hillier*, *supra* note 115 at para 49.

128 *Cavalier v Ramshaw*, 2011 ONSC 6009 at para 23 [*Cavalier*, Reasons].

129 *Ibid* at para 20.

130 *Ibid*.

131 *Ibid* at para 22.

132 *Ibid*.

133 *Ibid* at para 21.

134 *Ibid* at paras 6, 8, 25.

135 *Cavalier*, Memo, *supra* note 76 at para 5.

136 Martin, *supra* note 73 at 41.

Cavalier also illustrates the conundrum of a mental health consumer trying to advocate on his or her own behalf. *Cavalier* believed his counsel at the Board hearing inadequately represented his interests,¹³⁷ although the court found that the basis of that reasoning—that his counsel declined to put forward the issues *Cavalier* himself thought relevant—was without merit.¹³⁸ *Cavalier* believed issues were relevant which his counsel and the court held to be otherwise. Furthermore, when directed by the court to speak to the issues that were potentially under review, specifically where the Board erred, *Cavalier* was unable to respond appropriately. Justice Greer remarked, “I tried unsuccessfully to get [the appellant] to focus on what the Board did say and why he says it erred. I was not successful.”¹³⁹

Likewise, in *Van Berkum v Geagea*¹⁴⁰ the self-represented appellant—who had the same support of *amicus* that *Cavalier* had, as a result of Justice Brown’s case management system—was unable to speak to any legal or factual issues relevant to her appeal.¹⁴¹ *Van Berkum* is a 71-year-old woman with a psychiatry history dating back to the 1970s.¹⁴² In the months leading up to her involuntary admission to hospital in May 2010 (and the finding of her incapacity), she reduced her medication intake. A sharp increase in symptoms followed, including paranoia, delusional thinking, irritability, aggression and threatening behaviour—enough to be admitted involuntarily.¹⁴³ Like *Cavalier*, *Van Berkum* appealed her incapacity but not her involuntary status. After over a year of being warehoused without treatment, the Court dismissed her appeal in July 2011.

A fourth appeal is *Tran v Ginsberg*.¹⁴⁴ In *Tran*, the consumer-appellant was able to retain counsel and the process moved along far faster, reaching final disposition shortly after six months. Yet the result was no different. The appeal was dismissed, but not before the court noted:

Mr. Tran’s position with respect to treatment was not based on reason. It was based on a lack of reason: an inability to recognize or accept the existence of a mental disorder and therefore a failure to understand he would likely continue to endanger himself and others unless treatment was administered.¹⁴⁵

These four cases underscore Martin’s point that legal proceedings are only an instance in a mental health consumer’s overall interaction with the mental health

137 *Cavalier*, Reasons, *supra* note 128 at paras 4, 16, 26.

138 *Ibid* at para 26.

139 *Ibid* at para 25.

140 *Van Berkum*, *supra* note 89.

141 *Ibid* (Justice Stinson observed, “[n]one of her comments, in my respectful view, addressed grounds that are properly the subject of a review of the Decision by way of appeal” at para 21).

142 *Ibid* at para 4.

143 *Ibid* at para 5.

144 *Tran*, *supra* note 89..

145 *Ibid* at para 38.

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system. These consumers were involved in the mental health system well before their appeals and, as confirmed by the final disposition of their appeals (including Bon Hillier), they remain engaged with the system thereafter. A right of review provides the mental health consumer with a system of checks and balances, such that any restriction of rights is free from arbitrary decision-making and is as minimally invasive as possible. The automatic right of appeal, on the other hand, provides no such procedural safeguards. On the contrary, it extends the infringement on liberty with no benefit to the individual's mental condition.

While this is a small sample on which to base arguments, these cases indicate a trend echoed by the CCB's statistics. The statistics reported by the CCB for 2009/2010 are not anomalous.¹⁴⁶ In the CCB's 2008/2009 report, of the 42 notices of appeal brought forward, not a single appeal was allowed and over 75 percent of cases were without information or not yet disposed of.¹⁴⁷ The CCB's 2007/2008 Annual Report provides aggregate statistics for the years 2003 to 2008.¹⁴⁸ Of the 255 total appeals, approximately three percent were allowed and over 50 percent were not yet disposed of or were without information.¹⁴⁹ Unfortunately, the statistics do not break down for that time period. It is therefore premature to conclude the underlying cause for the lower number of "N/A" cases. However, it does seem relevant that the numbers of cases dismissed or abandoned went up significantly over the longer sample period, at over 14 percent and over 30 percent, respectively. One conclusion that can be drawn is that the vast majority of appeals are abandoned or lost track of.

The low success rate and high rate of lost cases is not the only evident trend. The timeliness factor should not be ignored. Although the number of "N/A" cases was significantly lower for the five-year period, it is important to note that more appeals can be heard (or re-counted as abandoned) over a longer period of time. Which is to say that appeals initiated in earlier years were able to reach final disposition before the aggregate period finished. Consider the cases discussed above: Bon Hillier's appeal process was just shy of two years; Cavalier's appeal time was over two years; Van Berkum's case did not reach its final disposition for over a year; and with the help of counsel, Tran's appeal was completed in just over six months.

146 Note that in the CCB's Annual Report for 2010-2011, it provided appeal information according to the calendar year. Due to the fact that the previous year's reporting is according to the CCB's fiscal year, any statistical breakdown for the whole of 2010 would double count some of the appeals reported in the previous report. However, the report reflects the same trend as years past: most appeals remain pending, a significant number of appeals are withdrawn or abandoned, and of those that proceed to court, most are dismissed and, few, if any, are allowed (not a single appeal from the CCB was allowed in 2010 and only one of 63 was allowed in 2011). Also noteworthy is the CCB's fine print, which states that, "appeal outcomes may not correspond to the calendar year the appeal was initially filed". See Consent and Capacity Board, "Annual Report 2010-2011" online: Consent and Capacity Board <<http://www.ccboard.on.ca/>> at 14.

147 Consent and Capacity Board, "Annual Report 2008-2009" at 14 online: Consent and Capacity Board <<http://www.ccboard.on.ca/>>.

148 Consent and Capacity Board, "Annual Report 2007-2008" at 13 online: Consent and Capacity Board <<http://www.ccboard.on.ca/>>.

149 *Ibid.*

Comparatively, the Board can review a finding of incapacity every six months.¹⁵⁰ There is also the opportunity to seek leave from the Board to bring an application to review the finding of incapacity earlier, on the basis that there has been a “material change in circumstances that justifies reconsideration.”¹⁵¹ Reviews of involuntary committal are even more frequent—a renewal of a mental health consumer’s involuntary status triggers a right to a review by the Board. After the 72-hour psychiatric assessment, the first period of commitment lasts two weeks.¹⁵² The first certificate of renewal cannot be for more than one month, the second for not more than two, and the third, and any subsequent renewal for not more than three months.¹⁵³ In the same time that Tran waited for his appeal to be heard—an appeal where there was counsel, an exceptional circumstance—a consumer could have decisions reviewed before the Board multiple times. Furthermore, the *MHA* deems an application to the Board to review a fourth certificate of renewal.¹⁵⁴ That is, there is a guaranteed review of an involuntary certificate *within* 10 months. The worst case scenario for a mental health consumer who is found incapable and held on an involuntary basis is that the consumer’s capacity may be reviewed once every six months and her involuntary status at most once every three. Conceivably, if the consumer’s involuntary status was to change to voluntary (either by the decision of the consumer’s clinician or by the Board), that could constitute a material change and leave could be sought to review the finding of incapacity prior to the six month mark. The consumer would be receiving treatment, which ostensibly would alleviate the mental deterioration underlying the satisfaction of the dangerousness criteria and, thus, encourage re-entry to the community. The consumer’s interests would be represented before the Board by counsel, the Board would be convened within seven days of the application¹⁵⁵ and a decision would be rendered within 24 hours.¹⁵⁶

Part I traced the necessary developments from a best interests-based, professional discretion-oriented model of mental health law to a legalism-based model. In an effort to affirm the rights that were historically trampled on, the right to review was articulated by the highest courts both internationally and domestically. It outlined the advanced efforts made in Ontario, in particular its granting of an “automatic” right of appeal from CCB decisions. What this section illustrated is that the pendulum swung too far, leaving one extreme only to land at another. The automatic right to appeal, as was shown, is a permutation on the right to review and it is one permutation too many.

150 *HCCA*, *supra* note 10 at s 32(5).

151 *Ibid* at s 32(6).

152 *MHA*, *supra* note 7 at s 20(4)(a).

153 *Ibid* at s 20(4)(b).

154 *Ibid* at s 39(4).

155 *HCCA*, *supra* note 10 at s 75(2).

156 *Ibid* at s 75(3).

IV. CONCLUSION

When Justice Brown first outlined his plans to install a case management system for CCB appeals, the inefficacy of section 80 appeared to be an issue of access to justice. Appellants did not qualify for legal aid and without counsel their various mental conditions manifested such that they lacked the ability to progress their appeals on their own. These appellants were doubly marginalized, and thus, especially vulnerable. Justice Brown framed the issue as a need to make the right meaningful and to prevent these persons' right of appeal from being illusory. At the same time, mental health advocates have increasingly called for greater advocacy efforts by the consumer advocate bar, both systemically and on an individual case basis.¹⁵⁷ The underlying message has been: it is the system that is broken and in need of fixing. Little has been said of the law itself.

In Ontario, it is not surprising that the justice system has faced scrutiny while the laws that breathe life into the system have faced little. First, the province's mental health laws are considered advanced in regards to the rights of mental health consumers. Second, mental health law reform has trended heavily towards greater reliance on a legalism-based model. On a narrow reading, Ontario's laws embody the changes called for across the literature—greater respect of rights, greater acknowledgement of the individual's autonomy and the right to self-determination. But such an argument provides a false security that the laws are as they should be, and it does so at the expense of the well-being of the mental health consumer.

The concept of a "paper victory" is well known to the area of mental health law.¹⁵⁸ Section 80 of the *Health Care Consent Act* is a current example of when a law appears to advance the agenda but in reality it does no such thing. The automatic right of appeal is more harmful than it is helpful. In the case of mental health consumers found incapable and admitted to hospital involuntarily—those consumers who most frequently appear before the Board and, thus, the population most likely to appeal their findings—the right to appeal in practice does little to further their rights. In fact, the right operates in such a way that other rights, such as the right to liberty, are further infringed upon.

The automatic right of appeal serves an ideology, and arguably the mental health community at large, but not the individual mental health consumer. The right to be free from bodily interference is fundamental, and it should not be invaded or infringed lightly. However, that threshold is met where a consumer is at great risk to themselves or to others. This point should not be taken to suggest that broader statutory reform of Ontario's mental health laws ought to take place so that a finding

157 See e.g. Schneider, *supra* note 9; Dhir, *supra* note 5; Michael L Perlin, "And My Best Friend, My Doctor/ Won't Even Say What It Is I've Got: The Role and Significance of Counsel in Right to Refuse Treatment Cases" (2005) 42 San Diego L Rev 735 [Perlin, "Role of Counsel"].

158 See generally Michael S Lottman, "Paper Victories and Hard Realities" in Michael S Lottman, ed, *Paper Victories and Hard Realities: The Implementation of the Legal and Constitutional Rights of the Mentally Mental Disabled* (Washington: Health Policy Center, Georgetown University, 1976) 93.

of dangerousness would trigger automatic treatment of the consumer.¹⁵⁹ Rather, it is to say that a doctor's finding that a consumer is a danger to themselves or others sufficient to require involuntary hospitalization *and* the CCB's confirmation of that decision is a strong indicator of the necessity for treatment. Furthermore, our society has said that we will help those who cannot help themselves. Mental health law must necessarily create a system of rights, procedural protection and safeguards for the individual so that such a mandate does not lead to a patriarchal best interests-based system of abuse of authority, as was historically experienced. However, mental health laws are also meant to facilitate treatment and care, to ensure the safety of the individual and the safety of others. The rights movement cannot eclipse these latter goals. For negative or traditional rights to take absolute priority is to treat these types of rights as goals unto themselves, as opposed to being the means to realize broader concepts of justice.

The question to be answered then is if not the automatic right of appeal, then what? An appropriate solution in light of the particular challenges mental health consumers experience is to revise the legislation so that section 80 offers leave to appeal.¹⁶⁰ That means placing minimal requirements on the applicant in

159 British Columbia's statutory scheme follows such a model. See the *BC MHA*, *supra* note 61 at ss 22(2), (3). This paper addresses the procedural safeguards designed to protect against any unlawful limitation of a mental health consumer's rights; it does not investigate the criteria that enable the lawful limitation of rights in the first place. As such, any discussion of broader statutory reform is beyond the scope of this paper.

160 A similar leave requirement exists in the *Immigration and Refugee Procedure Act* for leave to judicial review. See *Immigration and Refugee Protection Act*, SC 2001, c 27 s 72 [*IRPA*]. The leave process under *IRPA* requires, *inter alia*, applicants to first submit a form which outlines the basic reasons for seeking leave to judicial review and later, the submission of an application record, which includes the decision under review, a memorandum of argument and supporting affidavits. See the *Federal Courts Immigration and Refugee Protection Rules*, SOR/93-22, ss 5 and 10. This leave process would not be well-suited to the CCB appeals context. First, its requirements are not so different from the current process outlined in section 80 (and would therefore only serve to add an additional barrier for these patient-appellants to assert their rights, rather than destroy the current barrier before them). Second, the leave requirement under the *IRPA* relates to judicial review, while the leave requirement proposed pertains to an appeal. As stated earlier, the difference between an appeal and judicial review may be of no moment. See text accompanying note 60. However, a court's powers on appeal remain broader in scope than on review, regardless of whether the standard of review analysis is the lens through which the appeal is undertaken, and furthermore, a statute cannot constitutionally block the right of judicial review (*Crevier v Quebec*, [1981] 2 SCR 220, 127 DLR (3d) 1). This leads to the third and critical point, that it must be acknowledged that the *IRPA*'s leave requirement has been strongly criticized for being arbitrary at best, unconstitutional at worst. See e.g. Gerald P Heckman, "Unfinished Business: Baker and the Constitutionality of the Leave and Certification Requirements under the Immigration Act", (2002) 27 Queen's LJ 683, and, most recently, Sean Rehaag, "The Luck of the Draw" (2012) 38:1 Queen's LJ 1 at 31, 36, 38, 50. Heckman argues that the effect of the leave requirement under *IRPA* perpetuates the stereotype that non-citizens file "bogus" claims and are "less worthy of recognition as human beings and members of Canadian society."¹⁶⁰ See Heckman, *supra* note 160 at 734. The rationale behind proposing a leave requirement under the *HCCA* is not to dissuade appeals and protect limited judicial resources, as the *IRPA* requirement aims to do. See Rehaag, *supra* note 160 at 35, quoting John Frecker, former commissioner at the Law Reform Commission. Rather, it stems from the recognition that there is an unqualified need to displace the burden of progressing an appeal from resting atop the shoulders of the mental health consumer. It is thus important to emphasize that I am not suggesting that Ontario adopt any leave structure wholesale, *IRPA* or otherwise. Careful and thoughtful drafting is the only true recourse to avoid further jeopardizing the rights of this vulnerable constituency.

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terms of formal documents necessary to progress the application, providing the courts clear direction on what basis an application will be granted and instituting a low threshold to enable the courts to do so.¹⁶¹ Front-load the consideration of the appeal so that the emphasis on a timely final disposition rests on the system, and not the mental health consumer. Make it a statutory obligation that where leave to appeal is sought, that the court review the matter “at the earliest date possible.” Rather than allow a consumer to submit notice of appeal—only to fall between the cracks, somewhere between legal aid politics and powerless clinicians—consider the merits in advance of moving forward. Furthermore, where leave to appeal is granted, this would serve as confirmation of the “merit” LAO seeks to confirm before providing funding. It would also ensure that the courts remain hands-on throughout the process. With thoughtful drafting, leave to appeal would be a codified version of a case management system, one that bypasses bureaucratic in-fighting and determines the way to proceed on an individualized basis at the outset. Alternatively, where leave is denied, final disposition will result, enabling the appropriate—and necessary—therapeutic efforts to step in.

For those who would worry that this recommendation is tantamount to taking a step “backwards,” three points should be considered. First, the interaction of section 80 and the provisions of the *HCCA* and the *MHA* that deal with findings of incapacity and involuntary status, respectively, illustrate that the rights themselves do not function in harmony just because they seek to substantiate the same values. When a mental health consumer appeals the Board’s confirmation of the finding of incapacity, that person’s right to self-determination is respected but at the expense of that person’s liberty. In such instances, where rights cannot co-exist in any true fashion, there needs to be a principled way to prioritize them.

Second, many mental health advocates argue that negative rights are an outdated ambition, and that positive rights—such as the right to housing in the community—should predominate.¹⁶² The mental health community is increasingly focused on building systems that support a mental health consumer out in the community. What can be under-recognized is that this is the shared goal of mental health practitioners, consumers and advocates alike. As Martin points out, practitioners and consumers seek the same outcome—to see the consumer function in the community; where their opinions diverge is deciding the most appropriate route

161 For instance, the *IRPA* threshold for granting leave for judicial review is that the applicant shows that she has an arguable case. See *ibid* at 36. Stated differently, only those applications which are bound to fail should be denied. This test is criticized for being unclear and leading to arbitrary decision-making. Clear guidelines that outline when an application will be deemed to meet the threshold could avoid such a problem.

162 See e.g. Julio Arboleda-Florez, “Who do hospitals need: more good doctors or more good lawyers?” in *CrossCurrents* (Spring, 2004) online: Centre for Addiction and Mental Health <http://www.camh.net/Publications/Cross_Currents> (“[t]he new challenges in mental health law are to ensure that minimum legal entitlements such as a home, a job and a friend... not be denied to mental patients”). Also see generally *Rethinking Rights-Based Mental Health Laws*, Bernadette McSherry & Penelope Weller, eds, (Portland, OR: Hart Publishing, 2010).

to get there.¹⁶³ To realize on this emerging set of ambitions necessarily requires a broader interpretation of what it means to respect rights. If a consumer has rights but not the mental state to appreciate them, nor the cognitive ability to exercise them, then further investigation to correct this seems an obvious next step.

Third, it is important to also investigate what the right of appeal sets out to achieve. The right of appeal is the right to have a court review questions of law or fact or both. It is a formalized legal process. The literature suggests that the mental health community, generally speaking, seeks the purveyance of rights as a means to address the many complex legal, medical and socio-economic issues that pervade the mental health system. This paper does not suggest that the legal system is ill-equipped to address such issues; what it does is suggest that the right of appeal is not the vehicle to achieve such aims. For those who point to the continued abuse of power by clinicians, the right of appeal is neither the most efficient means to address medical abuses, nor the most effective. If the concern is over medical malpractice, then professional disciplinary boards are better equipped to review that charge. If the concern is that the profession of psychiatry remains a blunt object to deal with a delicate, complex circumstance, then it is the medical community who must take responsibility and see to it that changes reflect modern understanding. For those who argue that the Board is itself a conservative body, reticent to challenge a physician's finding, then advocate for more comprehensive training for Board members. The robustness of the automatic right of appeal does not guard against injustice; it merely provides the cover that justice is being done.

Those arguments for legal reform to section 80 are not to suggest that there are no systems-based issues to be resolved. It is beyond the scope of this paper to address what the justice system may do to improve how it responds to the particular needs of mental health consumers. However, two quick recommendations in context of the issues addressed can be made. First, that a mental health consumer can rely on counsel to submit a notice of appeal on their behalf but then cannot obtain funding to retain counsel for the actual appeal is a gulf that cannot continue. LAO ought to recognize that so long as the right to appeal exists, then the merit of the appeal lies in the existence of the right. If the "merit" is not found on substantive grounds, then it must be recognized as a procedural protection afforded to this vulnerable constituency and funding provided. Second, as argued by Dhir, consumer advocates need to acclimatize themselves to their client base.¹⁶⁴ Not only does that mean becoming fluent in pharmacology and psychiatric diagnostics as Dhir rightly contends,¹⁶⁵ but it extends to developing a competency for how to proceed when the question of a client's capacity to instruct counsel exists.¹⁶⁶ More generally,

163 See e.g. Martin, *supra* note 73 ("[clinician and patient] are likely to want to see the patient out of hospital and moving forward in his or her life" at 41).

164 *Supra* note 5 at 110-111.

165 *Ibid* at 110.

166 See generally Diana A Romano, "The Legal Advocate and the Questionably Competent Client in the Context of Poverty Law Clinic" 35:4 Osgoode Hall LJ 737.

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I would echo Michael Perlin's argument that patient counsel needs to reorient their views of their clients lest they poison their efforts—and undermine the clients' rights and well-being—from the get go.¹⁶⁷

Where perhaps I diverge from the literature on the topic is in my acknowledgment that treatment, including hospitalization, is a tool to counteract marginalization, isolation and second-class citizenry. Those efforts may at one time have been a tool to sustain oppression, and there are examples of this remaining so in institutions around the world, and in the rarer domestic case.¹⁶⁸ However, Ontario clinicians generally are cognizant of the power at their hands and do not treat such power lightly.¹⁶⁹ Moreover, leave to appeal (as opposed to a right to appeal) would not lessen the safeguards in place; it would simply allow final disposition, and thus treatment as deemed necessary, to be reached more quickly. Gostin writes that “perhaps no other body of law...has undergone as many fundamental changes in approach and philosophy as mental health law.”¹⁷⁰ That in mind, amendment to a single provision should stand for the proposition that mental health laws should necessarily be as flexible as the area of psychiatry is fluid, and nothing more.

When Chief Justice McLachlin addressed her audience on the fourth issue that challenges the building of a truly just society—dealing with endemic social problems—she told an anecdote about speaking with a police chief. She asked him what his biggest problem was, expecting him to complain about “all those judges who pronounce on rights.” Instead, he replied, “mental illness.”¹⁷¹ Negative or protective rights are not the end-goal and perhaps as a legal community we have treated them as such. We would be wise to remember that these rights enable our well-being, they do not provide it. The Chief Justice of Canada spoke about the efforts on the forensic side of the mental health law system to divert consumers away from the criminal justice system and towards the mental health care system. Of the creation of mental health courts—which she described (quoting Brian Lennox) as “addressing ... the real rather than the apparent causes”—she credited the creative solution of adapting the “criminal law court procedures to better meet the realities of endemic social problems and better serve the public.”¹⁷² The civil side, too, requires such solutions. In the case of section 80, the answer must be: first the law, then the system.

167 Perlin, “Role of Counsel”, *supra* note 157 at 738, 750-755. Justice RD Schneider of Toronto's Mental Health Court and Canadian mental health advocates Aaron Dhir, Mercedes Perez and Anita Szigeti have also made this point.

168 See e.g. Perlin, “Comparative”, *supra* note 42.

169 For instance, as part of their mandatory core curriculum, psychiatry residents at the University of Toronto take an intensive, multi-session workshop on the legal requirements and considerations for civil commitment and capacity, as well the expectations for a CCB hearing. The course is taught by Nyranne Martin, Senior Legal Counsel, CAMH, and Dr. Justin Geagea, a psychiatrist at CAMH. See e.g. Core Curriculum—Revision Proposals, online: University of Toronto <<http://postgrad.utpsychiatry.ca>>.

170 Gostin, *supra* note 22 at 48.

171 McLachlin, *supra* note 2.

172 *Ibid.*