Brian's Law – A Compassionate Tyranny?

by David Barker

> *Speak out for those who cannot speak,*
> *for the rights of all the destitute.*[1]
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> - Proverbs 31:8

Proverbs 31:8 provides a scriptural basis for radical theologies that politicize faith. For example, Oscar Romero relied upon these words when speaking for the poor of El Salvador and he used his pulpit as a platform from which to air the grievances of the disenfranchised.[2] In the Matthew's Beatitudes, Jesus adds a refinement: "Blessed are the poor in spirit, for theirs is the kingdom of heaven."[3] My interest lies with the "poor in spirit" of a particular sort - the mentally ill. In some circumstances, members of this group cannot speak, and so are placed outside the decision-making process which determines their futures. Surrogate decision-making for the mentally ill is a potentially wide-ranging subject, and so I shall give my exploration some focus by considering the application of Community Treatment Orders [CTO's] in Ontario. I shall begin by offering some background to the legislation which enables the implementation of CTO's. Then I shall consider the theoretical question of how we justify such legislation. All surrogate decision-making is an exception to an exception. That is, in a liberal

[1] The Scripture quotations contained herein are from the New Revised Standard Version Bible, copyright © 1989 by the Division of Christian Education of the National Council of the Churches of Christ in the U.S.A., and are used by permission. All rights reserved.
[2] "With this people it is not hard to be a good shepherd. They are a people that impel to their service us who have been called to defend their rights and to be their voice." Bruderhof Communities; available from http://www.bruderhof.com/articles/OptionForPoor.htm; Internet; accessed December 11, 2004.
[3] Matt 5:3 (underlining added).

democracy, constitutionally entrenched rights represent a class of exceptions to the state's otherwise complete legislative freedom. This class of exceptions is viewed as fundamental. However, CTO's and other forms of surrogate decision-making *prima facie* violate those entrenched rights. This violation cannot be treated lightly, and must be supported by sound justifications. Finally, I shall offer some reflections on (what I regard as) an astonishing absence of religious input on a matter which, at least on one interpretation, lies at the very heart of faith concerns. Mental health may be described as the clinical face of the human spirit, and so belongs as much within the care of the pastor or rabbi or imam as it does within the care of the therapist or psychiatrist.

Brian's Law[4]

Brian's Law, a series of amendments to Ontario's Mental Health Act, was proclaimed in force on December 1, 2000.[5] It bears the name of a popular Ottawa sportscaster, Brian Smith, who was killed by an untreated schizophrenic. At his inquest, the coroner's jury made recommendations which were influential in both the drafting and enactment of the legislation.[6] As one commentator has pointed out, the practice of naming a law for a victim of violence (New York's comparable legislation is called "Kendra's Law") associates the purpose of the law with prevention of violence. This is an unwarranted entrenchment of stigma associated with mental illness, as there is no evidence to support the assertion that CTO's have any impact upon the incidence of

[4] Bill 68, An Act, in memory of Brian Smith, to amend the Mental Health Act and the Health Care Consent Act, 1996.
[5] R.S.O. 1990, C. M.7. See Appendix "A" for the relevant provisions.
[6] Ontario Ministry of Solicitor General Verdict of Coroner's Jury on the Inquest into the Death of Brian Smith, Nov., 1997

violence among the mentally ill.[7] For our purposes, Brian's Law raises two points of interest. First, it broadens involuntary admission criteria for mental health patients so as to include "mental deterioration where the person has a history of successful treatment."[8] Second, it introduces a specific form of involuntary treatment – the CTO. In Ontario, involuntary treatment of mental illness was originally based upon "need for treatment" criteria.[9] In 1978, the test became more stringent by requiring an apprehension of physical dangerousness.[10] On its face, Brian's Law appears to return involuntary admission criteria to a more open-ended standard. Traditional justification for involuntary admission looks to two sometimes-competing considerations: 1) protection of the community (police power); and 2) protection of the patient from the consequences of mental illness (*parens patriae* power).[11] Based upon the history of involuntary admission criteria in Ontario, it would appear that Ontario legislators have vacillated in their valuation of these two considerations.[12]

Although new to Ontario, the CTO is not a new idea. Various outpatient committal regimes have been available in some American jurisdictions for almost thirty years and were first introduced in Canada (in Saskatchewan) in 1995.[13] There are two principal models which govern the delivery of mandatory outpatient mental health services: diversionary and preventive. A diversionary CTO requires that the patient meet the jurisdiction's inpatient committal criteria, whereas a preventive CTO is less

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[7] Richard O'Reilly, "Why Are Community Treatment Orders Controversial?" Can J Psychiatry 2004;49: 579 - 584 at 582.
[8] R.S.O. 1990, C. M.7 as am., s. 20(1.1) See Appendix "B" for full text.
[9] Mental Health Act, S.O. 1967, c. 51, s. 13(2)(a) authorized involuntary admission where the patient would "require further hospitalization in the interests of his own safety or the safety of others."
[10] R.S.O. 1980, c. 262, s. 14
[11] John E. Gray, Margaret A. Shone and Peter F. Liddle. eds., Canadian Mental Health Law and Policy (Toronto: Butterworths, 2000), 102.
[12] See Health Care Consent Act, 1996, S.O. 1996, c. 2 for current committal criteria.
[13] O'Reilly RL, Brooks SA, Chaimowitz GA, et al., Mandatory outpatient treatment. CPA Position Paper 2003-43. Ottawa: Canadian Psychiatric Association; 2003.

stringent insofar as it is designed to prevent a deterioration to the jurisdiction's inpatient committal criteria. Both Saskatchewan and Ontario incorporate elements of both models in their respective regimes. In Ontario, patients can only be placed on a CTO if they both a) meet the inpatient committal criteria, and b) have been a patient in a psychiatric facility on two or more occasions or for a cumulative period of thirty days within the previous three years.

Two final comments round out this introduction to the CTO. First, the Supreme Court of Canada recently considered the involuntary committal provisions as amended by Brian's Law.[14] An Ontario Consent and Capacity Review Board had confirmed an involuntary committal arranged by the respondent's attending physician. On appeals to the Superior Court, Ontario Court of Appeal and Supreme Court of Canada, the courts consistently overruled the Board's decision. Among other things, the Supreme Court found (6-3) that the Review Board was statutorily restricted to a consideration of the respondent's capacity and could not adjudicate upon the wisdom of the respondent's treatment decision. This case may have had a chilling effect upon subsequent findings of incapacity generally and upon CTO's specifically. Clearly, in the ongoing debate about the state's role in relation to mental health patients, this decision places the Supreme Court in opposition to a full-blown *parens patriae* conception.

The second comment relates to semantics. In a troubling use of language that has arisen, surprisingly, from among mental health advocates, mental health patients are frequently referred to as mental health "consumers."[15] The motivation may well be to

[14] Starson v. Swayze, [2003] 1 S.C.R. 722.

[15] For example, the first question of the "FAQ" link on the web site for the Mood Disorders Association of Ontario asks: "What written information is available for consumer/survivors and families?" Mood Disorders Association of Ontario, available at http://65.110.68.8/mdao.asp?mc=FAQ; Internet; accessed December 11, 2004. Or: "I will be visiting Brampton on Thursday, December 2nd. I am scheduled to meet a number of consumers and a representative

shift attention away from a disease model of mental "illness" and the paternalism that such a model can attract, but recasting the mentally ill as economic actors in a marketplace of potential mental states implies a degree of choice which the mentally ill do not enjoy. The one matter over which no sufferer will ever admit a choice is the matter of whether or not to suffer from mental illness in the first instance. Moreover, an economic metaphor of mental illness is just as susceptible of paternalism in the hands of economists as in the hands of benevolent statesmen. Nevertheless, this usage suggests a distaste for – and desire to escape from – a particular understanding of mental health. And so, throughout this paper, I shall assume that paternalism alone is unacceptable from the point of view of a sufferer. If paternalism is to have a place at all in this discussion, it must be coupled with something more – compassion or empathy or an intimate concern (perhaps by reason of lived experience) or spiritual solidarity.
Let us proceed then to examine several models which may assist us in our consideration of various interests in their relationship to those whose mental health has so deteriorated that it suggests a need to invoke some form of surrogate decision-making regime.

Public Reason, Conjecture, and Sincerity

In "The Idea of Public Reason Revisited,"[16] John Rawls tries to accommodate plurality within constitutionally democratic government. Individual citizens, and associations of citizens, each possess comprehensive doctrines which, if permitted to direct public life, would place these citizens in direct conflict with other citizens who possess competing or contradictory comprehensive doctrines. Prompted by a duty of

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of a family group." Michael Bay, "Community Treatment Orders: Ontario Legislated Review, CTO Project Update Blog" Saturday, November 27, 2004; http://www.ctoproject.ca/id11.html; Internet; accessed on December 13, 2004.
[16] John Rawls, "The Idea of Public Reason Revisited," in The Law of Peoples (Cambridge: Harvard University Press, 1999)

civility, which is mediated by the principle of reciprocity, individuals subordinate their respective comprehensive doctrines to public reason. Public reason is one of the constitutive elements of a deliberative democracy and as such represents a procedure rather than a political state; it demands ongoing negotiation. There are a number of conditions which must be satisfied before public reason can flourish, and it is the necessity of these conditions which raises the question whether Rawls' conception of public reason is capable of accommodating a surrogate decision-making regime. The conditions which concern us are as follows:

1) public reason occurs amongst free and equal citizens;[17]

2) the deliberative democracy in which public reason occurs is populated by a citizenry which is educated both in matters of constitutional government and of specific issues.[18]

First, those who satisfy statutory committal criteria cannot be understood as "free and equal" within a deliberative democracy. Indeed, Rawls' conception of qualified participants may be even more restrictive. In answering the objection that people cannot help but argue from their comprehensive doctrines, he ascribes to reasonable and rational citizens two moral powers – "the capacity for a conception of justice and the capacity for a conception of the good."[19] It is difficult to imagine how those contemplated by Brian's Law would possess either moral power. Second, by definition (but not always in fact), those who lack mental capacity cannot be educated in any sense which would thereby permit them to participate meaningfully in the democratic process.

At first glance, it would appear that Rawls account of public reason creates no space for those subject to CTO's. In fact, at the very outset of his paper, he places in

[17] Rawls 133.
[18] Rawls 139.
[19] Rawls 171, note 84.

opposition to the idea of public reason as motivated by comprehensive doctrines the spectre of "unreasonable doctrines."[20] Perhaps the CTO may be characterized as a social safety-valve for diverting from political discourse "unreasonable doctrines" of a particular sort – beliefs articulated by the mentally ill. Nevertheless, throughout his paper, Rawls consistently envisions public reason as occurring within a constitutional democracy. The words "constitutional" and "democratic" appear together in each of the first three paragraphs. To the extent that political theory conceives of constitutionality in the democratic process as directed at protections which transcend strict democratic principles (e.g. inalienable rights), then it would appear that public reason may accommodate such protections. Rawls makes explicit, albeit brief statements, which support this reading.

In his discussion of discursive modes aimed at public justification of decisions based upon public reason, Rawls writes of "conjecture:"[21]

> [W]e argue from what we believe, or conjecture, are other people's basic doctrines, religious or secular, and try to show them that, despite what they might think, they can still endorse a reasonable political conception that can provide a basis for public reasons.

This suggests that a statute, such as Brian's Law, can be justified if Ontario's legislature can faithfully assert that in deliberating upon its provisions, it engaged in a structured form of empathy. Although some might greet this suggestion with cynicism, certainly within the Canadian political scene, compassionate and empathetic conversation about

[20] Rawls 131, fn 3: "Of course, every society also contains numerous unreasonable doctrines."
[21] Rawls 155-6.

mental health issues is gaining wider acceptance and credibility.[22] In fact, during the third reading of Brian's Law, Mr. Brad Clark (Stoney Creek) read into the record the statement of a prominent politician which had been taken during the public consultation process. The statement was not a partisan political opinion; it was intensely personal.[23] Rawls cautions that conjecture must be sincere and not manipulative. Unfortunately, he does not elaborate upon this, and so we are left to create for ourselves criteria for assessing the sincerity of conjecture. Is it legitimate to ask: how sincere were Ontario's legislators as they debated Brian's Law? If one criterion is the recourse to heartfelt and empathetic public consultation, then I believe their conjecture was sincere. However, other features of the debate are troubling. For example, Mr. Clark acknowledged that opinions on the issue are disparate and often irreconcilable and he viewed his role, not as mediating to resolution, but as striking a balance between individual civil rights and

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[22] For example, since the suicide of his son in 1995, former federal finance minister, Michael Wilson has become a passionate and vocal advocate of mental health concerns. See Julia Nunes & Scott Simmie, Beyond Crazy (Toronto: McClelland & Stewart, 2002), 33 - 41.

[23] I'd like to read into the record again from the hearings.

"Our youngest son became seriously ill with schizophrenia in 1985. Over the next 12 years he was admitted to hospital a dozen times and spend [sic] a third of his time as a psychiatric patient, either in Ottawa hospitals or at Brockville. We faced countless obstacles, many of them stemming from the Ontario mental health law, in securing appropriate care for our son. We are fortunate that today he has his own apartment, has daily assistance with medication, and this support is succeeding in keeping him [out] of hospital. Nonetheless, we cannot help feeling the 12 years our son spent going in and out of the hospital, the revolving door, could have been drastically reduced or even eliminated if legislation like Bill 68 had been in force.

"Our story is typical of many families where someone in the family begins to show the symptoms of schizophrenia. At first we thought our son was just suffering from adolescent growing pains. A psychiatrist who saw him regularly for a year failed to identify his illness. It took three years.

"Then what? Under our Mental Health Act, our son was considered well enough to leave hospital, though his illness was not yet under control." He continually had problems to the point where he was living in a rooming house in Toronto, and ended up trying to get to Pennsylvania, where an alert border guard at the United States border stopped him. "I should say that because of our son's condition, we could not, while we were both working, leave him in the house on his own.... The security risks were too great."

"The individual I'm talking about who spoke was Michael Cassidy, the former leader of the New Democratic Party."

Legislative Assembly of Ontario, Hansard, (L075A - Tue 20 Jun 2000), available at http://www.ontla.on.ca/hansard/house_debates/37_parl/session1/L075A.htm#P597_126564; Internet; accessed December 11, 2004.

social values - in particular, the duty to help fellow citizens who need treatment and concerns for public safety. Couching his comments in terms of striking a balance allowed Mr. Clark to mitigate a sentiment which Mrs. Claudette Boyer (Ottawa-Vanier) later made explicit when she repeatedly referred to the people affected by Brian's Law as the "mentally challenged." This phrase smacks of paternalism. The phrase "mentally challenged" has been adopted to replace the politically incorrect "mentally retarded" and denotes an individual who suffers a cognitive impairment.[24] There is no necessary correlation between mental illness and cognitive impairment. In fact, in the case of those who suffer from illnesses such as schizophrenia, which fall under the broad description of psychotic disorders, it is the treatment rather than the illness which often causes cognitive impairment. Similarly, anecdotal accounts repeatedly illustrate that many of our most influential historical figures have suffered from debilitating affective disorders.[25] More disturbing is what appears to be a complete misconception of Bill 68's operation. Mrs. Lyn McLeod (Thunder Bay-Atikokan) stated: "[T]he intent of the bill is to take a significant step forward in having people with serious mental illness access treatment sooner …. " However, in striking the balance which Mr. Clark invoked, Brian's Law was structured to provide CTO's only to individuals who have an established history within the mental health system. In other words, individuals enjoy earlier access to mental health services (assuming a community infrastructure exists to deliver them) so long as they satisfy diagnostic criteria which can be determined only if such individuals are already monitored by mental health professionals; it provides no new measures to identify and treat the very individuals who prompted the legislation in

[24] It is beyond the scope of this paper to consider the complexities attached to the term "cognitive impairment," but it should be noted that this is no less problematic than "mentally retarded." Its definition is not neutral, but rather has been formulated within a politically charged context.
[25] See my account of Abraham Lincoln, below, note 26.

the first instance – undiagnosed sufferers who have no contact with the mental health system.

These comments from the third reading of Brian's Law illustrate the plurality of views brought to a debate even where there is consensus as to its outcome.[26] Nor do all of those views suggest sincerity. Given that Rawls writes as heir to a long utilitarian tradition, it is difficult to understand how he could conceive of sincerity without tying it to the outcome of the deliberative process. His commentary upon the school prayer issue is instructive in this regard, for he makes it clear that public reason has nothing to say about specific political institutions or policies, but rather, is concerned about the kinds of reasons used to justify "laws and policies that invoke the coercive powers of government concerning fundamental political questions."[27] I confess that I find the idea of sincerity appealing because it injects deeply moral considerations into the deliberative process, but Rawls leaves me to imagine, on my own account, what shape this might take in concrete political deliberation. Certainly, in the debate that preceded Brian's Law, the variation in justifications casts a shadow upon the question of sincerity in that particular context.

Another brief statement appears to support the view that the idea(l) of public reason can accommodate the introduction of legislation affecting people who are excluded from the deliberative process. In addressing potential objections to his proposal, Rawls cites the 1858 debates between Abraham Lincoln[28] and Stephen

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[26] In fact, the motion to enact Brian's Law was carried 82 – 10. Although not a consensus, Bill 68 was addressed on a non-partisan basis. Legislative Assembly of Ontario, Hansard, (L075A - Tue 20 Jun 2000), available at http://www.ontla.on.ca/hansard/house_debates/37_parl/session1/L075A.htm#P597_126564; Internet; accessed December 11, 2004.

[27] Rawls 165 – 6.

[28] It is fortuitous (or maybe not) that Abraham Lincoln is now acknowledged to have suffered from recurrent episodes of major depression. Consider this excerpt from a letter to his law partner dated January, 1841: "I am now the most miserable man living. If what I feel were equally distributed to the whole human family, there would be not one cheerful face on earth. Whether I shall ever be better, I cannot tell. I awfully forebode I shall not. To

Douglas.[29] He answers the concern that a strict application of public reason would preclude Lincoln's position since it was based upon a privately held comprehensive doctrine of moral and religious content. By promoting the equal enjoyment of fundamental constitutional liberties, Lincoln's arguments were aimed at facilitating the conditions in which public reason could flourish, and were therefore, in themselves, reasonable. Nevertheless, at the time of the Lincoln/Douglas debates, it was impossible for blacks to participate in the deliberative process which would determine their future as citizens within a constitutional democracy. Lincoln's strategy was to define them into the process and thereby accord them the rights concomitant with citizenship. However, he could not do this from within the existing political structures of 1858. He (and his constituents) had to engage in a "sincere" imaginative effort at political empathy, deciding, as whites, what was in the best interests of blacks without reference to their status as citizens (because they had none in many states).

The Lincoln/Douglas debates provide an inexact model of how one might reasonably speak for those who have no voice. Lincoln sought to confer rights upon a group of people for their own good, whereas Brian's Law removes rights from a group of people for their own good. Both contexts for the application of public reason demand a measure of empathy, but the latter context invites more cautious procedures and a higher threshold of justification.

A final word about sincerity: one means of engaging sincerity is the consultation of those directly affected. In the case of CTO's, this occurs in two contexts – during community consultation prior to drafting proposed legislation (I shall discuss this below), and at the time of particular decisions to implement CTO's. One method of

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remain as I am is impossible. I must die or be better it appears to me." Quoted in Julia Nunes & Scott Simmie, Beyond Crazy (Toronto: McClelland & Stewart, 2002), 42.

[29] Rawls 174.

"consultation" which raises interesting possibilities is the Ulysses contract. For virtually everyone, mental health exists on an ever-changing continuum. In all but the most extreme cases, sufferers have enjoyed extended periods of good mental health and can expect to do so again in the future. Thus, it is possible to canvas individuals who, by reason of history, can expect to experience periods when they are appropriate candidates for CTO's. Previously developed advance directives or Ulysses contracts can be used as consent to treatment at times when an individual lacks the capacity to consent to treatment. This is contemplated in the context both of consent to treatment[30] and refusal of treatment.[31] Admittedly, there is a practical limitation to the use of this form of consultation. Richard O'Reilly suggests that such arrangements are difficult to make in the case of those who suffer from a chronic mental illness associated with lack of insight and early onset, as is typical of schizophrenia.[32] (Recall that it was an untreated schizophrenic who killed Brian Smith.) Unfortunately, research suggests that it is precisely this population that benefits most from CTO's and other outpatient treatment regimes.[33]

Comparative Ethics

In his case study of the Mackenzie Valley Pipeline Debate, Roger Hutchinson offers an approach to clarification of ethical issues that seeks to provide an alternative to those modes of discourse (variously referred to as foundational, positivist or imperialist)

[30] O'Reilly 581.
[31] Gray, Shone and Liddle 229 – 230.
[32] O'Reilly 581 – 2.
[33] Marvin S. Swartz and Jeffrey W. Swanson, "Involuntary Outpatient Commitment, Community Treatment Orders, and Assisted Outpatient Treatment: What's in the Data?" Can J Psychiatry 2004;49: 585-591.

which seek to bring closure to debate or to preclude the possibility of debate altogether.[34] This is a process, and as such, seeks to accommodate both those, on the one hand, who have narratives to share and who have strongly held convictions arising from such narratives, and those, on the other hand, who have empirical data to present. It is a process which recognizes that even though a participant in a debate may validate her position by reference to objective claims, nevertheless, her motivation for participating may be convictions which are just as strongly held as the participant who speaks in religious or ethical terms. Thus, the first step in Hutchinson's method "involves noticing the auras of approval or disapproval which hover over the specific claims and arguments presented by each side." In his analysis of the Mackenzie Valley Pipeline debate, Hutchinson notes areas of factual disagreement and interpretation of data. Nevertheless, the presentation of facts had little impact upon the debate, because different groups had declared their positions before relevant studies were ever completed. It was these positions, and not empirical evidence, which determined the language used by competing participants. And so we move to a second stage of analysis which works to ethical clarification by looking to the values which motivate competing interests. The purpose is not to set values in conflict with one another, but rather, to delineate with precision the scope of the conflict. Revealing regions of conflict can operate to reduce conflict because it has the salutary effect of revealing regions of agreement as well. In his third stage of analysis, Hutchinson engages competing interests at a post-ethical or foundational level of clarification by examining "metaphors, images, symbols, sacred texts and authoritative traditions."

[34] Roger Hutchinson, "Comparative Ethics and the Mackenzie Valley Pipeline Debate," Toronto Journal of Theology 1,2(Fall 1985):240-260.

In the context of the Mackenzie Valley Pipeline debate, church and business interests viewed themselves as mutually irreconcilable. However, even at the level of factual debate, it became apparent that competing claims could not be understood in isolation of underlying ethical consideration. For example, ethical concerns determined what counted as a relevant factual claim. A second stage analysis revealed competing ethical models - deontological and utilitarian - which shed light upon differences in language and goals. Interestingly, at the post-ethical stage of analysis, it became apparent that church and business interests looked to similar sources to justify their divergent positions. For example, the United Church of Canada took an official position in opposition to the Mackenzie Valley Pipeline, while many of the business leaders who advocated the project were members of the United Church of Canada. Clearly, there was a wide swath of overlapping values.

Hutchinson's article provides a useful methodology which may well be adaptable to Rawls' conception of public reason. Hutchinson offers a concrete example (along with theoretical commentary) of how competing interests can promote conditions which accommodate public reason in order to secure the common good. In particular, his three levels of clarification look like a roadmap for honouring what Rawls describes as "the proviso." Rawls allows that any person or association can engage in public conversation grounded upon comprehensive doctrines, can even publicly declare such comprehensive doctrines, so long as the actions grounded upon those doctrines can also be supported by "proper political reasons."[35] In fact, Rawls suggests that a vital constitutional democracy demands that its citizens openly share their comprehensive doctrines as they engage in political debate. Only then can citizens fully honour their duty of civility.[36]

[35] Rawls 152.
[36] Rawls 153 - 4.

At the level of factual clarification, Hutchinson shows how interpretations of an issue differ depending upon whether the facts which describe the issue are viewed through the lens of rights or of responsibilities. Facts are never neutral. But we can never understand why this is so unless we are prepared to reveal the (sometimes unperceived) assumptions which determine their often idiosyncratic interpretations. Here, I have alluded to an issue that does not appear (at least, not explicitly) in either Rawls or Hutchinson – there may be occasions when it is impossible to declare one's comprehensive doctrine or, in the language of Hutchinson, one's "foundational convictions." There are many reasons why this might be the case. However, because we are dealing with papers that address problems of public conversation, I shall offer a reason which is public (social) in nature. It may be the case that one's comprehensive doctrine is hegemonaic. That is, the assumptions which determine a given mode of discourse are so deeply embedded that it appears that one's discourse is not chosen, but arises naturally, as if from a source independent of historically contingent factors. Although the influences which determine a discourse may, in fact, be historically contingent, they nevertheless appear to be deontological. An hegemony never reveals itself *in medius res*. Nevertheless, hegemonies do exist, for they emerge with the passage of time.

I shall offer two examples of hegemonies which appear to have dissolved with time. The first is sweeping in scope; the second is local, restricted to the practice of psychiatry. The first is the notion of the *corpus Christianum*, an idea of a unified institutional religion which dominated western Europe and northern Africa for a thousand years. Protestants tend to view the Reformation as a spiritual (r)evolution in the history of Christianity that dismantled the idea of the *corpus Christianum*. However, five hundred years after the Reformation took hold in Germany, we recognize many

historically contingent (and secular) factors at play: the invention of the printing press, the rise of nationalism and the resulting political fragmentation of western Europe, a new empiricism brought about by men like Copernicus, Galileo and Bacon, the social, spiritual and economic impact of bubonic plague, smallpox and syphilis, to name only a few. Today, at least from a Protestant point of view, the idea of a *corpus Christianum* appears naïve. The second example relates to assumptions regarding appropriate treatment of psychoses. When antipsychotic medications were first developed, psychiatrists prescribed them without reservation, assuming that the symptoms had to be eradicated whatever the cost.[37] However, such assumptions no longer obtain, perhaps as part of a wider and emergent post-modern suspicion of western science and its optimistic vision of progress (the very science which Copernicus, Galileo and Bacon helped to establish). Now, psychiatrists are more likely to entertain refusals to take antipsychotic medication because it is no longer apparent that concomitant side effects are preferable to hearing voices.[38] These examples illustrate that assumptions which guide our political life are sometimes so deeply embedded that we cannot identify them, much less share them, when we are in the midst of conversation. This poses a practical impediment to the methodology recommended by both Rawls and Hutchinson. In addition, it begs the question: if we lack sufficient insight to identify those things which ground our own views, how can we claim authority to understand the best interests of those whom we seek to help?

[37] Paul de Kruif, best known for his book, The Microbe Hunters, provides an enthusiastic endorsement of the "new science" of psychiatry and its pharmacological tools in A Man Against Insanity (London: Arrow Books Ltd., 1958).
[38] O'Reilly 582.

Those Without a Voice – Abortion

Abortion may be regarded as the paradigm of vulnerability. The foetus is utterly powerless to determine its own future. And so, debate around the issue of abortion suggests fertile ground to explore the matter of surrogate decision-making. It is useful to note points of similarity between the concerns for a foetus and for a person suffering from serious mental illness. Here is a brief (incomplete) list:

1) Under our current legal regime, neither is accorded full status as a person. In the case of a foetus, the Supreme Court of Canada has made it clear that a foetus has no rights as a person.[39] And, as noted above, upon a determination that a person lacks mental capacity, the subject's rights are significantly curtailed. As a result, in both concerns, competing interests are more likely to articulate rights-based arguments in metaphysical or spiritual terms. Rights-based arguments are addressed in legal terms only as part of focused attempts to lobby for legislative change.
2) Proponents of abortion rest their primary argument upon the absolute sovereignty of a woman over her body. In the same way, mental health advocates assert that a sufferer's wishes regarding treatment plans must trump all other concerns. Many treatment plans are medically invasive (e.g. medication, electro-convulsive therapy and deep brain stimulation) and so a right to refuse treatment arises from the same principles as a claim to personal sovereignty.
3) Right-to-life advocates look to the ineffable wonder of the soul and argue that, because we cannot say when a foetus acquires a spiritual dimension, therefore we must follow the most conservative course and proceed on the assumption that a foetus is a person

[39] Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.), [1997] 3 S.C.R. 925.

from the instant of conception. Treatment of the mentally ill raises similar considerations. This issue presented itself more forcefully before the advent of antipsychotic pharmaceuticals when lobotomies were routinely administered to relieve the suffering of the severely ill. This involved the deliberate and imprecise destruction of tissue in the brain's frontal lobes, and the result was an irrevocable change in behaviour. While this change granted many a return to reality, their new reality was emotionally barren.[40] In spite of a move to less invasive treatments, the issue continues to dog mental health professionals.[41]

In addition to the three similarities noted above, there is one important difference: the possibility of consultation, both in the process of developing general policy, and in the process of applying policy to specific cases. It is impossible to consult representative foetuses in policy deliberations, and it is impossible to consult an individual foetus when deciding to terminate a pregnancy. However, it is <u>always</u> possible to engage in consultation with mental health sufferers during policy deliberations, and, even when formulating an individual treatment plan, coherent input is usually available.

In her discussion of the papal encyclicals, *Veritatis splendor* and *Evangelium vitae*, Jean Porter points to the dangers inherent in the Vatican's call for a return to a "'bracing' defense of the absoluteness of the moral law."[42] A call to dialogue seems disingenuous when coupled to any claim which purports to be absolute. Such a claim presupposes

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[40] On Dr. Jack Ferguson's decision, in 1954, to terminate his psychosurgery practice, Paul de Kruif writes: "Lobotomies could reverse chronic, advanced insanity. They also destroyed what's most glorious about human beings – irreversibly. The greatest psychosurgeon in the world … could not put back what his merciful ice-pick had taken away. The fateful sweep of the ice-pick cuts the fibres connecting the front lobes of the brain with the thalamus. This causes a particular nucleus of brain cells in the so-called powerhouse of emotions, the thalamus, to dengenerate [sic]. Permanently." de Kruif 116 – 7.

[41] Neurologist Oliver Sacks has made a career of documenting patients, seemingly and irretrievably less than human who, usually by accident, demonstrate that a whole person has been living deep within. See, for example, Oliver Sacks, <u>An Anthropologist On Mars</u> (Toronto: Vintage Canada, 1995).

[42] Jean Porter, "Moral Reasoning, Authority, and Community in *Veritatis Splendor*," *The Annual of the Society of Christian Ethics*, 1995, 203.

both the possibility of certainty, and the knowledge of that certainty's content. Thus, conversation about such a claim is limited to persuasion; dialogue is impossible. Porter points out that the encyclicals go beyond the statement of a moral position; they judge those who hold an opposing position.

Evangelium Vitae confirms the absolute wrongness of abortion. It does this syllogistically by classifying abortion as the taking of human life. Murder is the taking of human life. Therefore abortion is a form of murder. Since murder is categorically wrong, therefore abortion is categorically wrong. Porter's critique follows two strategies. First, she suggests that because a rule which is applied to differing facts will produce differing outcomes, it is necessary to evaluate the rule in light of the rule's underlying purpose. This approach is the kernel from which Victor Hugo crafted his masterpiece, Les Miserables: a categorical prohibition against theft fails to capture the circumstances of a man who must steal a loaf of bread in order to feed his family. If we view the purpose of the prohibition as the promotion of social order, then the prohibition should be ignored where its enforcement would undermine that purpose. In the case of Hugo's novel, strict enforcement of the prohibition against theft would further entrench a corrupt social order. Applied to abortion, one would begin by considering the purpose of a rule prohibiting abortion. For example, such a rule might be founded upon a conception of the sanctity of human life. On such an understanding, it is possible to imagine scenarios which would not only justify, but might in fact demand an abortion. If, for example, continuation of a pregnancy would produce, as a guaranteed outcome, the death of both woman and foetus, then abortion would best serve a principle which recognizes the sanctity of life. However, most decisions regarding abortion are made with imperfect knowledge as to outcomes, and the relative interests of all concerned cannot be accurately evaluated. Even so, Porter suggests that, where there exists a

rational basis for an alternative application of a moral precept, then conversation is not merely recommended; it is essential in order to map out the territory occupied by "difficult questions."

Porter's second strategy involves a recognition that, at each stage of a rule's enforcement, one is engaged in matters of judgment which are irreducible to strictly codified rules. It is not clear how we decide that the taking of human life in this particular instance qualifies as murder. Are all acts of killing murderous? Anglo-Canadian jurisprudence requires that we examine the intentions of the killer before making our determination. Even the biblical prohibition (Ex 20:13) is ambiguous since the Hebrew word may be translated as either "murder" or "kill." Indeed, the prohibition could not have applied to all killings because capital punishment and killings during warfare were authorized in ancient Israel. On what does the prohibition's absoluteness rest? Again, we look to an assertion regarding the sanctity of life. And again, we can rationally imagine instances in which it may be claimed that killing is justifiable on that basis.

If we accept that we are nothing more than automatons whose behaviour can be judged by a finely calibrated complex of rules (like an expert systems algorithm), then we deny ourselves the very thing which accords us dignity: the power to discern for ourselves, however imperfectly, the difference between right and wrong.

Porter concludes her paper with an observation which is worth setting out here:

> The acknowledgement that people can share moral commitments, and yet disagree deeply and in good faith on the implications of these commitments in concrete cases, is one of the necessary presuppositions for public civility.

Her comment is suggestive of the Rawlsian approach. The acknowledgment of moral commitments resembles Rawls' call to share comprehensive doctrines so that we can treat our interlocutors with sincerity. And her reference to "public civility" is reminiscent of the Rawlsian "duty of civility." Mutual acknowledgment and public civility are conditions necessary for the promotion of meaningful dialogue, and in these matters, Porter shares much with both Rawls and Hutchinson.

Let us direct Porter's reflections towards Brian's Law and the implementation of CTO's. Porter laments the rhetoric of *Evangelium vitae* where it speaks of the modern world's "culture of death." This characterization of modern moral sensibilities effectively terminates dialogue before it can even begin. I question whether a similar rhetoric has entered the debate regarding appropriate treatment of the mentally ill. It is the rhetoric of good intentions. Brian's Law is about "whom we're trying to help."[43] It is about ensuring "that people with serious mental illness get the care they need."[44] It is also about managing dangerous people.[45] As noted above, Brian's Law was enacted by an overwhelming majority. Indeed, I am hard-pressed to find any dissenting voices. The Canadian Civil Liberties Association made submissions to the Ontario legislative committee on Brian's Law, signaling a note of caution, but its own web site makes scant

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[43] Mr. Brad Clark (Stoney-Creek): "I think I'd like to try and put this bill in perspective, if I may. For me it hasn't been about the law per se but about whom we're trying to help. It has been about the people who are suffering from serious mental illness. It has been about the people who commit suicide, who are victimized as a result of their mental illness, who become violent as a result of their mental illness, who suffer greatly as a result of their mental illness. That's whom this bill is about. That's whom we're trying to help." Legislative Assembly of Ontario, Hansard, (L075A - Tue 20 Jun 2000), available at http://www.ontla.on.ca/hansard/house_debates/37_parl/session1/L075A.htm#P597_126564; Internet; accessed December 11, 2004.

[44] "Mental Health Act Amendments: Questions and Answers," Ontario Ministry of Health and Long-Term Care, http://www.health.gov.on.ca/english/public/pub/mental/faq.html; Internet; accessed December 13, 2004.

[45] "At the inquest into Brian's death, the jury recommended a comprehensive review of Ontario's mental health legislation and the introduction of community-based treatment programs to ensure that people with serious mental illness who pose a danger to themselves or others get the treatment they need. Today we are introducing legislation to fulfill those recommendations … " Elizabeth Witmer, Selected Hansard, April 25, 2000, available at http://www.oma.org/hansards/apr2000.htm; Internet; accessed December 13, 2004.

reference to the submission.[46] When an amendment is so obviously in the best interests of "consumers" and society alike, who could possibly find the matter objectionable? In fact, so pervasive is the rhetoric of good intentions, that it is difficult to discern that it is, after all, rhetoric. Identifying it as such is like trying to see a shadow on a black wall.

But let us imagine, briefly, that we are embroiled in a heated debate about CTO's. And let us imagine that we have adopted Porter's strategies for ensuring meaningful dialogue. First, what is the underlying reason(s) for a legislated response like Brian's Law? At the time of its enactment, members of Ontario's legislature reached across party lines and joined hands, citing a duty to help those who suffer from serious mental illness and a duty to protect the public from dangerous and unpredictable behaviour. Legislators claimed that the amendments represented a balance between these two competing interests. However, it was simultaneously suggested that both duties spring from the same source: protection of the vulnerable from victimization. In fact, in her testimony, Alana Kainz (Brian Smith's widow) made this sentiment explicit when she stated that there was not one victim, but two, when Jeffery Arenburg shot her husband.[47] With respect, for anyone of theological commitment, such a claim is untenable since it effectively types God as a sadistic sociopath (assuming there is no one besides God who can be blamed for inflicting Jeffrey Arenburg with schizophrenia). If victimization cannot serve as a point of commonality between these two interests, perhaps we can broaden the underlying reason to encompass concerns for the vulnerable. Was Brian Smith vulnerable? It cannot be said that he was uniquely vulnerable. Nevertheless, his death may have been an instance of a social (statistical?) vulnerability. What kind of risk

[46] Canadian Civil Liberties Association, "CCLA attacks proposed changes to Ontario's mental health laws," available at http://www.ccla.org/news/mentalhealth.shtml; Internet; accessed December 13, 2004.
[47] Mrs. Lyn McLeod (Thunder Bay-Atikokan), Legislative Assembly of Ontario, Hansard, (L075A - Tue 20 Jun 2000), available at http://www.ontla.on.ca/hansard/house_debates/37_parl/session1/L075A.htm#P597_126564; Internet; accessed December 13, 2004.

assessment would be necessary in order to calculate his vulnerability? Whose expertise would count in this assessment? Psychiatric? Actuarial? Theological? It is unclear that we even understand the meaning of the word "vulnerable." It is conceivable that only through an assessment of vulnerability would we arrive at a definition of the subject of our assessment.

This takes us to Porter's second strategy: a systematic revelation of subjective adjudication lying beneath a veneer of certitude. Indeed, we can see how free the rein is even when we attempt to define the fundamental purpose of Brian's Law. Moreso than in the case of abortion, it is arguable that mental health legislation is fraught with issues that demand the exercise of judgment and that it generates a corresponding anxiety as occasions for judgment skirt around the "borderline cases." For example, how does a qualified practitioner decide that a patient meets the committal criteria? When does a threat of bodily harm become "serious"?[48] What symptoms delimit the threshold of seriousness?[49] And how does the current committal criteria differ from earlier legislation which required that a threat of "serious physical impairment of the person" be "imminent?"[50] Even if we could clearly articulate a precise definition of "serious" or of "imminent," we would still have to apply our precise definition on a case-by-case basis, and so we would still have to exercise judgment.

One argument which has been used to justify more open-ended mental health laws is that it empowers practitioners to exercise prophylactic measures which ultimately save lives. It is not clear, however, that public policy supports such a rationale. In the context of criminal law, recent high-profile wrongful conviction cases

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[48] Mental Health Act, R.S.O. 1990, C. M.7, s. 15.

[49] I pose this question while acutely aware of two violent incidents which have recently occurred in Toronto. Both involved mothers, Andrea Labbe and Leah Marie Mindach, who committed homicides before committing suicide, taking five lives in all. Both involved serious and undetected mental health issues.

[50] Mental Health Act, R.S.O. 1990, C. M.7, ss. 15(1)(f) & (1.1)(f).

have attracted debate in balancing the same values which are at stake in our discussion. But in the criminal context, the prophylactic argument has been used in the opposite direction. We prize personal freedom too highly, and so we would rather acquit a guilty man than incarcerate an innocent, regardless of the potential danger we unleash upon a vulnerable public. Why is freedom valorized in one situation and not in the other? I do not wish to pursue this matter in its intricacies. The point, as Porter suggests, is that one can disagree – rationally and in good faith. Our concern here is not for the content, not for an enumeration and evaluation of all the points of disagreement; but rather, for an acknowledgment that the debate is not closed. The issues under debate are volatile. At every level – physical, psychological and spiritual – our understanding of mental health is forced to revise itself on an almost daily basis. This becomes all too obvious when we read the books of Paul de Kruif, for example, written nearly fifty years ago. And so we must also continue to hone our laws governing the treatment of the mentally ill while, at the same time, we hone our skills in the exercise of good judgment.

Concluding Reflections

It is instructive to review the list of witnesses who testified before the legislative committee in May, 2000 before Brian's Law was passed.[51] This list includes medical practitioners and professional organizations, advocacy groups, legal service providers, and individuals. Absent from the list is input from representatives of faith-based organizations. At an institutional level, mental health issues do not appear to attract concern. This disturbs me. It leads me to inquire whether the stigmatization associated with mental illness has found its way even into our places of worship. And so I wish to

[51] Legislative Assembly of Ontario. Library, "Bill 68, Brian's Law (Mental Health Legislative Reform), 2000", available at http://gateway.ontla.on.ca/library/bills/68371.htm; accessed on December 14, 2004.

conclude by reflecting upon whether or not faith-based input is warranted when deliberating upon a legal regime for treatment of those who suffer from serious mental illness. First, I think it appropriate to indicate that I am not a neutral commentator. In the language of Rawls, I write from the perspective of a specific comprehensive doctrine, and undoubtedly, it colours my views, perhaps in ways I do not even suspect. I write from the perspective of a liberal Protestant denomination and of a mental health "consumer." Consequently, this is not merely a paper, but also a signal "from within the storm." It serves as an illustration of a statement I made above: the mentally ill can always be consulted. I would go further and say that the mentally ill must always be consulted, not only through advocacy groups, but also through direct discussion with sufferers. Mental illness does not respect the indicia of identity; it afflicts its sufferers without regard to age, gender, race, religion, sexual orientation, socioeconomic status, nationality, and (most importantly for the purposes of consultation) intellectual ability. When measured against many of these indicia, I am viewed as a person of privilege, and so my personal experience of mental illness has never been marked by stigma, but rather, by a feeling of being ignored. Nevertheless, because of the privilege I enjoy, I have a sense of myself as impressed with a trust to ensure that I do participate in this continuing dialogue, to give voice, not merely to my personal concerns, but more importantly, to the concerns of those who cannot speak on their own account.

It is an easy matter to ground my sense of duty. After all, I am an insider and therefore motivated by self-interest. And experience gives me a measure of authority: I know what I am talking about. At the same time, experience strips me of authority: the presumption lies against me; my voice is heard, but with suspicion; my credibility is called into question. Perhaps this is where faith communities can enter into the conversation. Perhaps they can serve as mediators between private experience lived and

public deliberation. Traditionally, faith communities have served as havens from the hostile "outside" world. It is not accidental that places of worship are called sanctuaries. It is in the context of sanctuary that the mentally ill can feel at ease. Most mainstream Canadian faith communities profess both a spiritual and practical attitude of acceptance and non-judgmental concern. This allies itself with current therapeutic practices. In fact, the nexus between faith and mental wellness is well documented.[52] Religious organizations are well placed both to identify and to attend to the needs of the mentally ill. Among other things, they provide points of social contact, continuity between gaps in treatment, and opportunities to engage in meaningful activities. Advocacy seems to follow as a natural consequence.

Why, then, is faith-based advocacy of mental health issues so sporadic, and all but absent from expressions of "official" concern? Lacking empirical evidence, I can only speculate. I suspect that the anxiety which attends personal contact among individuals also affects the behaviour of religious institutions. In addition, there are factors which make religious institutions more resistant to changes in attitude where mental health is concerned. For example, there are numerous biblical references to major mental health disorders and these entrench negative typing of the mentally ill. It is difficult to set aside powerful images first given to us in our childhood. For me, one such image comes from the stories of Jesus casting out demons.[53] For a Christian, nothing can be more alienating than identifying with a being whom Jesus rejects. I do not anticipate a revision or deletion of this text in the near future. Nevertheless, an accompanying commentary in plain language would help those of us whose behaviour is sometimes "demonic." Perhaps before religious institutions can assume an advocacy role, they must first initiate

[52] See, for example: Marilyn Baetz, David B. Larson, Gene Marcoux, et al., "Canadian Psychiatric Inpatient Religious Commitment: An Association With Mental Health" Can J Psychiatry 2002;47: 159 - 166.
[53] Matt 8:28-34; Mark 5:1-20; 9:38-41; Luke 8:26-39; 9:49-50.

an internal and continuing dialogue on how to think about, and more urgently, how to care for some of the most vulnerable among us.

Appendix A

Community treatment order

33.1 (1) A physician may issue or renew a community treatment order with respect to a person for a purpose described in subsection (3) if the criteria set out in subsection (4) are met. 2000, c. 9, s. 15.

Same

(2) The community treatment order must be in the prescribed form. 2000, c. 9, s. 15.

Purposes

(3) The purpose of a community treatment order is to provide a person who suffers from a serious mental disorder with a comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility. Without limiting the generality of the foregoing, a purpose is to provide such a plan for a person who, as a result of his or her serious mental disorder, experiences this pattern: The person is admitted to a psychiatric facility where his or her condition is usually stabilized; after being released from the facility, the person often stops the treatment or care and supervision; the person's condition changes and, as a result, the person must be re-admitted to a psychiatric facility. 2000, c. 9, s. 15.

Criteria for order

(4) A physician may issue or renew a community treatment order under this section if,

(a) during the previous three-year period, the person,

(i) has been a patient in a psychiatric facility on two or more separate occasions or for a cumulative period of 30 days or more during that three-year period, or

(ii) has been the subject of a previous community treatment order under this section;

(b) the person or his or her substitute decision-maker, the physician who is considering issuing or renewing the community treatment order and any other health practitioner or person involved in the person's treatment or care and supervision have developed a community treatment plan for the person;

(c) within the 72-hour period before entering into the community treatment plan, the physician has examined the person and is of the opinion, based on the examination and any other relevant facts communicated to the physician, that,

(i) the person is suffering from mental disorder such that he or she needs continuing treatment or care and continuing supervision while living in the community,

(ii) the person meets the criteria for the completion of an application for psychiatric assessment under subsection 15 (1) or (1.1) where the person is not currently a patient in a psychiatric facility,

(iii) if the person does not receive continuing treatment or care and continuing supervision while living in the community, he or she is likely, because of mental disorder, to cause serious bodily harm to himself or herself or to another person or to suffer substantial mental or physical deterioration of the person or serious physical impairment of the person,

(iv) the person is able to comply with the community treatment plan contained in the community treatment order, and

(v) the treatment or care and supervision required under the terms of the community treatment order are available in the community;

(d) the physician has consulted with the health practitioners or other persons proposed to be named in the community treatment plan;

(e) subject to subsection (5), the physician is satisfied that the person subject to the order and his or her substitute decision-maker, if any, have consulted with a rights adviser and have been advised of their legal rights; and

(f) the person or his or her substitute decision-maker consents to the community treatment plan in accordance with the rules for consent under the Health Care Consent Act, 1996. 2000, c. 9, s. 15.

Exception

(5) Clause (4) (e) does not apply to the person subject to the order if the person himself or herself refuses to consult with a rights adviser and the rights adviser so informs the physician. 2000, c. 9, s. 15.

Content of order

(6) A community treatment order shall indicate,

(a) the date of the examination referred to in clause (4) (c);

(b) the facts on which the physician formed the opinion referred to in clause (4) (c);

(c) a description of the community treatment plan referred to in clause (4) (b); and

(d) an undertaking by the person to comply with his or her obligations as set out in subsection (9) or an undertaking by the person's substitute decision-maker to use his or her best efforts to ensure that the person complies with those obligations. 2000, c. 9, s. 15.

Protection from liability, substitute decision-maker

(7) The substitute decision-maker who, in good faith, uses his or her best efforts to ensure the person's compliance and believes, on reasonable grounds, that the person is in compliance is not liable for any default or neglect of the person in complying. 2000, c. 9, s. 15.

Legal advice

(8) The person who is being considered for a community treatment order, or who is subject to such an order, and that person's substitute decision-maker, if any, have a right to retain and instruct counsel and to be informed of that right. 2000, c. 9, s. 15.

Obligations of person

(9) If a person or his or her substitute decision-maker consents to a community treatment plan under this section, the person shall,

(a) attend appointments with the physician who issued or renewed the community treatment order, or with any other health practitioner or other person referred to in the community treatment plan, at the times and places scheduled from time to time; and

(b) comply with the community treatment plan described in the community treatment order. 2000, c. 9, s. 15.

To whom copies of order and plan to be given

(10) The physician who issues or renews a community treatment order under this section shall ensure that a copy of the order, including the community treatment plan, is given to,

(a) the person, along with a notice that he or she has a right to a hearing before the Board under section 39.1;

(b) the person's substitute decision-maker, where applicable;

(c) the officer in charge, where applicable; and

(d) any other health practitioner or other person named in the community treatment plan. 2000, c. 9, s. 15.

Expiry of order

(11) A community treatment order expires six months after the day it is made unless,

(a) it is renewed in accordance with subsection (12); or

(b) it is terminated earlier in accordance with section 33.2, 33.3 or 33.4. 2000, c. 9, s. 15.

Renewals

(12) A community treatment order may be renewed for a period of six months at any time before its expiry and within one month after its expiry. 2000, c. 9, s. 15.

Subsequent plans

(13) Upon the expiry or termination of a community treatment order, the parties may enter into a subsequent community treatment plan if the criteria set out in subsection (4) are met. 2000, c. 9, s. 15.

Early termination of order pursuant to request

33.2 (1) At the request of a person who is subject to a community treatment order or of his or her substitute decision-maker, the physician who issued or renewed the order shall review the person's condition to determine if the person is able to continue to live in the community without being subject to the order. 2000, c. 9, s. 15.

Same

(2) If the physician determines, upon reviewing the person's condition, that the circumstances described in subclauses 33.1 (4) (c) (i), (ii) and (iii) no longer exist, the physician shall,

(a) terminate the community treatment order;

(b) notify the person that he or she may live in the community without being subject to the community treatment order; and

(c) notify the persons referred to in clauses 33.1 (10) (b), (c) and (d) that the community treatment order has been terminated. 2000, c. 9, s. 15.

Early termination of order for failure to comply

33.3 (1) If a physician who issued or renewed a community treatment order has reasonable cause to believe that the person subject to the order has failed to comply with his or her obligations under subsection 33.1 (9), the physician may, subject to subsection (2), issue an order for examination of the person in the prescribed form. 2000, c. 9, s. 15.

Conditions for issuing order for examination

(2) The physician shall not issue an order for examination under subsection (1) unless,

(a) he or she has reasonable cause to believe that the criteria set out in subclauses 33.1 (4) (c) (i), (ii) and (iii) continue to be met; and

(b) reasonable efforts have been made to,

(i) locate the person,

(ii) inform the person of the failure to comply or, if the person is incapable within the meaning of the Health Care Consent Act, 1996, inform the person's substitute decision-maker of the failure,

(iii) inform the person or the substitute decision-maker of the possibility that the physician may issue an order for examination and of the possible consequences, and

(iv) provide assistance to the person to comply with the terms of the order. 2000, c. 9, s. 15.

Return to physician

(3) An order for examination issued under subsection (1) is sufficient authority, for 30 days after it is issued, for a police officer to take the person named in it into custody and then promptly to the physician who issued the order. 2000, c. 9, s. 15.

Assessment on return

(4) The physician shall promptly examine the person to determine whether,

(a) the physician should make an application for a psychiatric assessment of the person under section 15;

(b) the physician should issue another community treatment order where the person, or his or her substitute decision-maker, consents to the community treatment plan; or

(c) the person should be released without being subject to a community treatment order. 2000, c. 9, s. 15.

Early termination of order on withdrawal of consent

33.4 (1) A person who is subject to a community treatment order, or his or her substitute decision-maker, may withdraw his or her consent to the community treatment plan by giving the physician who issued or renewed the order a notice of intention to withdraw consent. 2000, c. 9, s. 15.

Duty of physician

(2) Within 72 hours after receipt of the notice, the physician shall review the person's condition to determine if the person is able to continue to live in the community without being subject to the order. 2000, c. 9, s. 15.

Order for examination

(3) If the person subject to the community treatment order fails to permit the physician to review his or her condition, the physician may, within the 72-hour period, issue in the prescribed form an order for examination of the person if he or she has reasonable cause to believe that the criteria set out in subclauses 33.1 (4) (c) (i), (ii) and (iii) continue to be met. 2000, c. 9, s. 15.

Return to physician

(4) An order for examination issued under subsection (3) is sufficient authority, for 30 days after it is issued, for a police officer to take the person named in it into custody and then promptly to the physician who issued the order. 2000, c. 9, s. 15.

Assessment on return

(5) The physician shall promptly examine the person to determine whether,

(a) the physician should make an application for a psychiatric assessment of the person under section 15;

(b) the physician should issue another community treatment order where the person, or his or her substitute decision-maker, consents to the community treatment plan; or

(c) the person should be released without being subject to a community treatment order. 2000, c. 9, s. 15.

Accountability

33.5 (1) A physician who issues or renews a community treatment order, or a physician who is appointed under subsection (2), is responsible for the general supervision and management of the order. 2000, c. 9, s. 15.

Appointment of other physician

(2) If the physician who issues or renews a community treatment order is absent or, for any other reason, is unable to carry out his or her responsibilities under subsection (1) or under section 33.2, 33.3 or 33.4, the physician may appoint another physician to act in his or her place, with the consent of that physician. 2000, c. 9, s. 15.

Responsibility, named providers

(3) A person who agrees to provide treatment or care and supervision under a community treatment plan shall indicate his or her agreement in the plan and is responsible for providing the treatment or care and supervision in accordance with the plan. 2000, c. 9, s. 15.

Responsibility of other persons

(4) All persons named in a community treatment plan, including the person subject to the plan and the person's substitute decision-maker, if any, are responsible for implementing the plan to the extent indicated in it. 2000, c. 9, s. 15.

Protection from liability, issuing physician

33.6 (1) If the physician who issues or renews a community treatment order or a physician appointed under subsection 33.5 (2) believes, on reasonable grounds and in good faith, that the persons who are responsible for providing treatment or care and supervision under a community treatment plan are doing so in accordance with the plan, the physician is not liable for any default or neglect by those persons in providing the treatment or care and supervision. 2000, c. 9, s. 15.

Same, other persons involved in treatment

(2) If a person who is responsible for providing an aspect of treatment or care and supervision under a community treatment plan believes, on reasonable grounds and in good faith, that a person who is responsible for providing another aspect of treatment or care and supervision under the plan is doing so in accordance with the plan, the person is not liable for any default or neglect by that person in providing that aspect of treatment or care and supervision. 2000, c. 9, s. 15.

Same, physician

(3) If a person who is responsible for providing an aspect of treatment or care and supervision under a community treatment plan believes, on reasonable grounds and in good faith, that the physician who issued or renewed the community treatment order or a physician appointed under subsection 33.5 (2) is providing treatment or care and supervision in accordance with the plan, the person is not liable for any default or neglect by the physician in providing the treatment or care and supervision. 2000, c. 9, s. 15.

Reports

(4) The physician who issues or renews a community treatment order or a physician appointed under subsection 33.5 (2) may require reports on the condition of the person subject to the order from the persons who are responsible for providing treatment or care and supervision under the community treatment plan. 2000, c. 9, s. 15.

Community treatment plans

33.7 A community treatment plan shall contain at least the following:

1. A plan of treatment for the person subject to the community treatment order.

2. Any conditions relating to the treatment or care and supervision of the person.

3. The obligations of the person subject to the community treatment order.

4. The obligations of the substitute decision-maker, if any.

5. The name of the physician, if any, who has agreed to accept responsibility for the general supervision and management of the community treatment order under subsection 33.5 (2).

6. The names of all persons or organizations who have agreed to provide treatment or care and supervision under the community treatment plan and their obligations under the plan. 2000, c. 9, s. 15.

No limitation

33.8 Nothing in sections 33.1 to 33.7 prevents a physician, a justice of the peace or a police officer from taking any of the actions that they may take under section 15, 16, 17 or 20. 2000, c. 9, s. 15.

Review

33.9 (1) The Minister shall establish a process to review the following matters:

1. The reasons that community treatment orders were or were not used during the review period.

2. The effectiveness of community treatment orders during the review period.

3. Methods used to evaluate the outcome of any treatment used under community treatment orders. 2000, c. 9, s. 15.

First review

(2) The first review must be undertaken during the third year after the date on which subsection 33.1 (1) comes into force. 2000, c. 9, s. 15.

Subsequent reviews

(3) A review must be completed every five years after the first review is completed. 2000, c. 9, s. 15.

Report

(4) The Minister shall make available to the public for inspection the written report of the person conducting each review. 2000, c. 9, s. 15.

Appendix B

Mental Health Act, R.S.O. 1990, C. M.7 as am., s. 20(1.1)

Conditions for involuntary admission

(1.1) The attending physician shall complete a certificate of involuntary admission or a certificate of renewal if, after examining the patient, he or she is of the opinion that the patient,

(a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person;

(b) has shown clinical improvement as a result of the treatment;

(c) is suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment;

(e) has been found incapable, within the meaning of the Health Care Consent Act, 1996, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained; and

(f) is not suitable for admission or continuation as an informal or voluntary patient. 2000, c. 9, s. 7 (2).