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JURISDICTION OF MENTAL HEALTH TRIBUNALS TO PROVIDE POSITIVE REMEDIES: APPLICATION, CHALLENGES, AND PROSPECTS

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Modern mental health legislation protects the civil rights of the mentally ill by limiting the scope of permissible state interference with an individual's autonomy. It also generally sets up mental health tribunals in charge of reviewing compliance with parts of the legislation. However, the legislation does not generally address the right to adequate mental health care. The latter (or its lack thereof) has increasingly become a source of debate among scholars and policy makers. The right to adequate care is increasingly being seen as the sine qua non of the civil rights of the mentally ill. This article explores recent Canadian jurisprudence dealing with the power of administrative tribunals to address constitutional and quasi-constitutional claims, and questions whether such power could give rise to a claim for adequate health care before mental health tribunals. It argues that, subject to some limited circumstances where mental tribunals have been given certain discretion to factor adequate care into their decisions, the recent Canadian jurisprudence does not significantly modify the limited remedies available before mental health tribunals.

La législation moderne en matière de santé mentale protège les droits civils des personnes atteintes de maladies mentales en limitant la portée de l'ingérence étatique sur leur autonomie individuelle. Cette législation établit également des tribunaux administratifs chargés de faire respecter certains de ses propres éléments statuaires. Toutefois, la législation ne traite généralement pas du droit d'accès à des services de santé mentale adéquat. Ce droit (ou plutôt, son omission) est progressivement devenu une source de débat parmi les universitaires et les acteurs gouvernementaux. Le droit à des soins adéquats est de plus en plus perçu comme étant la condition *sine qua non* des droits civils des personnes atteintes de maladies mentales. Cet article examine la jurisprudence canadienne portant sur le pouvoir des tribunaux administratifs à statuer sur les revendications constitutionnelles et quasi constitutionnelles, et s'interroge plus particulièrement à savoir si un tel pouvoir pourrait mener à une revendication devant les tribunaux administratifs en matière d'accès aux soins de santé mentale. L'auteur maintient que, à l'exception de certaines circonstances où les tribunaux ont pu se prévaloir de leur discrétion pour prendre en compte l'accès aux soins dans le contexte de leurs décisions, la jurisprudence canadienne ne modifie pas de manière significative les recours limités devant les tribunaux de santé mentale.

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Introduction

Most modern mental health legislation provides for some sort of review body to oversee decisions to admit persons involuntarily into psychiatric facilities, to review findings of incapacity to consent to medical treatment, and/or to issue community treatment orders (CTO). This review body often takes the shape of an independent mental health tribunal (MHT)[1] charged with the role of ensuring that an individual's autonomy is only limited according to the substantive and procedural requirements established by law.

This article questions whether these tribunals have or should have a wider role than the one traditionally assigned to them. The recent jurisprudence from the Supreme Court of Canada (SCC) regarding the jurisdiction of administrative agencies to entertain constitutional and quasi-constitutional challenges provides an interesting opportunity to review this question. What are the effects of such jurisprudence on the work of MHTs and on their use as a forum to adjudicate questions concerning the adequacy of health care provided? This is not only an academic question but also a question of access to justice, as MHTs are invariably the only adjudicative body, in terms of monitoring compliance with mental health legislation, to which the mentally ill have access.

This article begins by providing a brief overview of constitutional jurisprudence in the context of Canadian mental health legislation, which has been limited to litigation over the boundaries of legitimate state action and has not addressed the right to adequate care. It then turns to the recent SCC decisions that address the authority of administrative agencies to deal with constitutional and quasi-constitutional claims.

Part V introduces the debate surrounding the right to adequate health care in the context of mental health legislation. It then considers a number of potential constitutional and quasi-constitutional claims to adequate health care that could be made before MHTs and highlights some of the legal barriers these claims face. It concludes that, subject to some limited circumstances where tribunals have been given limited discretion to factor adequate care into their decisions, the recent Canadian jurisprudence will not significantly affect the limited jurisdiction of MHTs.

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[1] For the purposes of this article, I define MHTs as administrative tribunals/agencies with the authority to adjudicate over civil and not forensic patients, mainly with jurisdiction over reviews of involuntary admission, findings of incapacity to consent to treatment and community treatment orders (CTOs). In federal systems, these tribunals are generally established by provincial (Canada) or state (Australia) legislation.

I. The *Canadian Charter of Rights and Freedoms*

The *Canadian Charter of Rights and Freedoms*,[2] part of Canada's Constitution, came into force in 1982. The text outlines political and civil rights that apply to the actions of all levels of government. Canadian courts have the power to strike down legislation that conflicts with *Charter* rights. In terms of mental health legislation, the most pertinent sections are: section 7 ("the right to life, liberty and security of the person"), section 9 ("the right not to be arbitrarily detained or imprisoned"), section 10 (the right, upon arrest or detention, to legal counsel and to *habeas corpus* recourse), section 12 (the right not to be subjected to cruel and unusual punishment), and section 15 (the right to equality). These rights are generally subject to the limitations clause (section 1), which allows governments to justify certain infringements of rights.

A number of provincial mental health laws have been challenged on the basis of constitutional incompatibility. This litigation has only dealt with alleged breaches of negative rights. Early on, the courts upheld the constitutionality of Ontario's mental health legislation.[3] The administration of treatment without the patient's consent and against his or her will, for instance, was found not to violate section 7 of the *Charter* because the framework erected under the mental health legislation was in accordance with the principles of fundamental justice.[4] Nor was an MHT's admission and reliance on hearsay evidence considered to violate the *Charter*.[5]

The courts, however, struck down legislative provisions dealing with involuntary committal in Manitoba because the provisions did not narrowly define those persons with respect to whom they could be properly invoked and did not specifically prescribe the conditions under which a

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2 *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*].

3 *Re Azhar and Anderson* (1985), 33 ACWS (2d) 521 (Ont Dist Ct), Locke J (the patient's section 7 *Charter* right to security of the person was not violated and neither was his section 9 right not to be arbitrarily detained. Similarly, there was no violation of the patient's rights under section 12 of the *Charter*—the medical treatment used was neither cruel nor unusual).

4 *Howlett v Karunaratne* (1988), 64 OR (2d) 418 at 432, 438, 9 ACWS (3d) 218 (Ont Dist Ct) (the court further held that the *Mental Health Act*, RSO 1980, c 262, as amended by SO 1987, c 37 [*OMHA 1980*] did not violate the appellant's rights under sections 12 and 15(1) of the *Charter*, and that limitations imposed on *Charter* rights would nevertheless be upheld under section 1 of the *Charter*).

5 See *Dayday v MacEwan* (1987), 62 OR (2d) 588 at 596-97, 7 ACWS (3d) 208 (Ont Dist Ct) (the stringent legislative time requirements for holding hearings allowed for the use of hearsay evidence in the interest of expediency).

person could be detained.[6] The amended legislation, which included a test for involuntary admissions that listed "dangerousness" as a criterion,[7] was subsequently upheld by the court.[8] Dangerousness, however, is not the only permissible criterion for involuntary committal. Courts have held that the criterion of protection of the patient or others, for instance, involves the notion of harm and is thus not so vague as to constitute a breach of section 7 of the *Charter*.[9]

More recently, courts have held that the test for determining a patient's capacity to consent to treatment under Ontario mental health legislation is not unconstitutionally vague,[10] and that the legislation does not infringe the *Charter* by permitting the administration of treatment to be forced on involuntary incapable persons[11] and the civil committal of cer-

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6 See *Thwaites v Health Sciences Centre Psychiatric Facility* (1988), 48 DLR (4th) 338, 51 Man R (2d) 196 (CA) [*Thwaites*]. Pursuant to the *Mental Health Act* (RSM 1987, c M110, ss 15(1), 15(3) [*MBMHA*]), persons could be detained for medical examination when "suspected or believed to be in need of examination and treatment in a psychiatric facility," and they could be compulsorily admitted to such a facility when a single medical practitioner was of the opinion that they should be so confined. The provisions did not include a dangerousness standard. "Mental disorder" and related terms were broadly defined and included a wide range of illnesses and disorders, many of which did not require compulsory examination or admission.

7 Manitoba's regime was amended to include an objective standard for compulsory admissions of general application with a specific requirement for a finding of mental disorder. Compulsory admission was only authorized when a mental disorder met the objective statutory criteria. Although this amendment pre-dated the decision in *Thwaites* (*supra* note 6) it had not yet been proclaimed. See *MBMHA*, *supra* note 6, s 16(1), as amended by *An Act to Amend the Mental Health Act*, SM 1987-88, c 56, s 7(2).

8 *Bobbie v Health Sciences Centre* (1988), [1989] 2 WWR 153, 56 Man R (2d) 208, (QB) (the court held that an application of the legislative test of "likelihood of serious harm" resulting in deprivation of liberty did not contravene the principles of fundamental justice protected by section 7 of the *Charter*).

9 See *McCorkell v Riverview Hospital Review Panel*, 104 DLR (4th) 391 at 417-20, [1993] 8 WWR 169 (BCSC) (assessing the constitutionality of British Columbia's *Mental Health Act*).

10 *D'Almeida v Barron*, 2010 ONCA 564, 103 OR (3d) 250.

11 See *T (SM) v Abouelnasr* (2008), 171 CRR (2d) 344, 166 ACWS (3d) 569 (Ont Sup Ct); *Fleming v Reid* (1991), 4 OR (3d) 74, 82 DLR (4th) 298 (Ont CA), Robins JA [*Fleming* cited to OR]. "I would further declare ss. 35a and 35(2)(*b*)(ii) of the *Mental Health Act* inoperative insofar as these sections purport to empower the review board to authorize the psychiatric treatment of incompetent patients involuntarily confined in psychiatric facilities contrary to the refusal of the patient's substitute decision-maker to consent to such treatment on the basis of the patient's prior competent wishes" (*ibid* at 96). Therefore, if an involuntary incapable patient does not express prior competent refusal, the administration of treatment may be forced.

tain sexual offenders at the end of their sentences.[12]

The *Charter* has also been invoked in the context of advance directives. In this regard, provisions of Ontario's *Mental Health Act* that permitted the province's mental health tribunal to override the competent wishes of incapable patients and the decisions of their substitute decision makers, without providing recourse to a hearing to determine why the patient's wishes should not be honoured, were found to violate the right to security of the person under section 7 of the *Charter*.[13]

Finally, the judiciary has, in the context of *Charter* challenges, commented on the scope of patients' right not to incriminate themselves[14] and their right to be informed of their right to counsel.[15]

II. Jurisdiction of Mental Health Tribunals to Assess the Constitutional Validity of Legislation

The power to assess the constitutionality of legislation derives from section 52 of the *Constitution Act, 1982*.[16] In the past, administrative tribunals that had jurisdiction—whether express or implied—to decide questions of law arising under a legislative provision were presumed to have concomitant jurisdiction to decide the constitutional validity of that provi-

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[12] See *Penetanguishene Mental Health Centre v Stock* (1994), 116 DLR (4th) 550, 49 ACWS (3d) 157 (Ont Gen Div); *Starnaman v Penetanguishene Mental Health Centre* (1995), 24 OR (3d) 701, 83 OAC 95.

[13] *Fleming*, *supra* note 11.

[14] See *CW v Mental Health Review Board (Man)*, 95 Man R (2d) 153 at 157, 8 WWR 761, (CA) (in *obiter dicta*, the court noted that the board may interview the patient to help board members formulate their own opinions as to the patient's mental condition, but that it would be unthinkable that a board, inquiring as to whether there were sufficient grounds on which to detain a patient involuntarily, would threaten the patient with a loss of liberty for failure to answer questions).

[15] See *Chandrasena v McDougald* (5 October 1989), Ottawa-Carleton 32824/89 (Ont Dist Ct) (available on QL) [*Chandrasena*] (a patient subjected to an application for psychiatric assessment in Ontario must be advised of his or her right to counsel). The *Charter* issue was moot in this case, because the *Charter* right of detained persons to counsel was separately contained in sections 30(a)(1)(c) and 30(a)(1)(e) of the *OMHA 1980* (*supra* note 4). See also *B(C) v Sawadsky* (2006), 82 OR (3d) 661, 216 OAC 105 (dismissing an action for false imprisonment, unreasonable search and seizure, and breach of the rights to liberty, to counsel, and to be advised of the right to obtain counsel, contrary to sections 7, 8, 9, and 10 of the *Charter*). The court confirmed the lower court's decision, which held that the plaintiff was informed in writing of her right to retain counsel. The question of whether section 10(b) of the *Charter* imposes additional obligations to advise patients of their right to counsel and/or to facilitate contact with counsel was not decided.

[16] *Constitution Act, 1982*, s 52, being Schedule B to the *Canada Act* (UK), 1982, c 11 [*Constitution*].

sion. In *Cooper v. Canada*, however, the SCC suggested that it would not be easy to make a finding of implied jurisdiction.[17] This, in effect, created a presumption of lack of jurisdiction to consider the constitutionality of legislation for those boards that lacked express jurisdiction, including most, if not all, MHTs in Canada.

The SCC reversed this approach in *Nova Scotia (Workers' Compensation Board) v. Martin; Nova Scotia (Workers' Compensation Board) v. Laseur*,[18] shifting to a presumption of jurisdiction, so long as the tribunal in question has express or implied power to deal with questions of law.[19] The Court further held that "[t]his presumption may only be rebutted by showing that the legislature clearly intended to exclude *Charter* issues from the tribunal's authority over questions of law."[20]

The decision in *Martin* was bound to give rise to a constitutional challenge under section 52. In the context of MHTs, this occurred in *Ontario (Attorney General) v. Jane Patient*,[21] where the respondent patient had challenged the constitutional validity of Ontario legislative provisions dealing with CTOs. According to the Ontario *Mental Health Act*, "[t]he purpose of a community treatment order is to provide a person who suffers from a serious mental disorder with a comprehensive plan of commu-

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17 *Cooper v Canada (Human Rights Commission)*, [1996] 3 SCR 854 at 890-92, 140 DLR (4th) 193 (a tribunal's jurisdiction to deal with questions of law involving its enabling legislation—the so-called "limited" questions of law—would not suffice for a finding of implied jurisdiction. Courts in the post-*Cooper* era will only find implied jurisdiction if a tribunal has jurisdiction to deal with questions of law not involving its enabling legislation—the so-called "general" questions of law).

18 2003 SCC 54 at paras 3, 30, [2003] 2 SCR 504 [*Martin*].

19 Implied jurisdiction must be discerned by looking at the statute as a whole. Relevant factors include the statutory mandate of the tribunal and whether deciding questions of law is necessary to fulfilling this mandate effectively; the interaction of the tribunal with other elements of the administrative system; whether the tribunal is adjudicative in nature; and practical considerations, including the tribunal's capacity to consider questions of law. Practical considerations, however, cannot override a clear implication from the statute itself. See e.g. *Parkhill Bedding & Furniture Ltd v International Molders & Foundry Workers Union of North America, Local 174* (1961), 26 DLR (2d) 589 at 591-92, 34 WWR 13 (Man CA); *McLeod v Egan*, [1975] 1 SCR 517, 46 DLR (3d) 150 [*McLeod*]; *CTV Television Network Ltd v Canada (Copyright Board)*, [1993] 2 FCR 115 at 123, 99 DLR (4th) 216 (CA).

20 *Martin, supra* note 18 at para 3. Some commentators have called this approach somewhat disingenuous, as most administrative tribunals have the power and the duty to determine the constitutional validity of any law that is necessary for carrying out their statutory mandate. A tribunal cannot operate without interpreting what its jurisdiction is. See e.g. Robert W Macaulay & James LH Sprague, *Practice and Procedure Before Administrative Tribunals*, loose-leaf (consulted on 17 September 2011), vol 3 (Toronto: Carswell, 2004) at 23.21-22.

21 (2005), 250 DLR (4th) 697, 194 OAC 331 (Sup Ct (Div Ct)) [*Jane Patient*].

nity-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility."[22] On judicial review from a decision of the Consent and Capacity Board (CCB), Ontario's MHT, the court held that the board did not have jurisdiction to determine the constitutional validity of the CTO provisions in its enabling legislation[23] because this legislation did not give the board jurisdiction to consider questions of law (specifically, constitutional challenges); this was evidenced by the fact-intensive nature of the board's typical inquiries and the strict statutory timelines imposed on its proceedings.[24] Importantly, the court was of the opinion that, even assuming that the board did have implied jurisdiction to determine questions of law, the presumption that the board had jurisdiction to adjudicate *Charter* challenges with respect to those questions of law was rebutted because the strict statutory time limits under which the board was required to conduct hearings and render decisions made consideration of *Charter* challenges unrealistic.[25] The court also expressed some concern about having a potential majority of nonlegal members deciding *Charter* issues.[26]

A. *Did* Jane Patient *Apply Only to the Challenged Community Treatment Order Provisions?*

The decision in *Jane Patient* arguably applied only to the impugned CTO sections of the Ontario *Mental Health Act*[27] and left open potential section 52 challenges of other provisions of the legislation. Nevertheless, the court's comments regarding the strict statutory limits on the CCB pertain to the tribunal's institutional constraints and are equally applicable to other decisions under the jurisdiction of the CCB (and other Canadian MHTs).[28] The court's analysis is of particular relevance to reviews of

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22 *Mental Health Act*, RSO 1990, c M.7, as amended by SO 2000, c 9, s 33.1(3) [*OMHA 1990*].

23 *Ibid*; *Health Care Consent Act*, SO 1996, c 2 [*HCCA*].

24 *Jane Patient*, *supra* note 21. However, the test in *Martin* requires only that the tribunal have the power to determine questions of law (*supra* note 18 at para 51).

25 See *OMHA 1990*, *supra* note 22, s 39.1(6) (mandating the CCB to "promptly review" CTOs); *HCCA*, *supra* note 23, ss 75, 80 (providing for particularly short time frames for the CCB to schedule hearings and render decisions, and for appeals from those decisions to be filed).

26 See *OMHA 1990*, *supra* note 22, s 39.1(9) (establishing that parties to CTO reviews by the CCB must include the ordering physician, the patient, and any third person specified by the CCB).

27 *Ibid*, ss 33.1, 33.3, 33.7.

28 Although *Jane Patient* is only a first instance decision that is not binding on other provinces, the comments made by the court could equally apply to other MHTs with similar time constraints.

involuntary admission as it appeared to endorse the rationale behind *Re C(J)*, which held that the legislature intended to limit the mandate of the psychiatric review board (a predecessor of the CCB) to a factual inquiry of whether the statutory conditions for involuntary admission were met.[29]

The issue of whether *Jane Patient* had implications beyond the CTO provisions in question quickly became moot. Subsequent to the release of the decision, the legislation was amended to preclude the CCB from deciding the constitutional validity of an act or regulation.[30] A similar approach has been taken in British Columbia, where the Mental Health Review Board is barred from exercising jurisdiction over "constitutional questions".[31] The question of whether other Canadian MHTs have authority to deal with the constitutional validity of legislation has not yet been litigated.

III. Remedial Power under Section 24(1) of the *Charter*

Jane Patient addressed whether the CCB had the power to decide the constitutionality of legislation under section 52 of the *Charter*, but not whether the board had a remedial power under section 24(1). The latter may apply to a situation where the law itself is constitutional, but where the actions taken by a health practitioner pursuant to that law violate the *Charter* rights of a patient.

An administrative tribunal that is found to be a "court of competent jurisdiction" has authority to provide *Charter* remedies under section 24(1). Historically, an administrative tribunal was a "court of competent jurisdiction" under section 24(1) of the *Charter* if it had jurisdiction over the person and the subject matter, and was able to grant the remedy sought.[32] This approach was modified in *R. v. Conway*,[33] where the SCC

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29 *Re C(J)* (1992), 3 Admin LR (2d) 223 at 236, 33 ACWS (3d) 150 (Ont Gen Div) [*Re C(J)*].

30 *HCCA*, *supra* note 23, s 70.1(1), as amended by *Good Government Act, 2006*, SO 2006, c 19, Schedule L, s 2.

31 See *Mental Health Act*, RSBC 1996, c 288, as amended by SBC 2004, c 45, s 24.2 [*BCMHA*]; *Administrative Tribunals Act*, SBC 2004, c 45, s 44 [*BCATA*] (together, these two provisions removed the jurisdiction of British Columbia MHTs to deal with "constitutional questions"). Other British Columbia tribunals can hear constitutional questions other than *Charter* ones (for example, federal-provincial conflicts) (*ibid*, s 45). In practice deciding *ultra vires* questions may sometimes be unavoidable for any tribunal, even one that has no jurisdiction over constitutional questions of any nature, as it may be simply necessary to reach a decision.

32 See *R v Mills*, [1986] 1 SCR 863 at 955, 29 DLR (4th) 161; *Cuddy Chicks Ltd v Ontario (Labour Relations Board)*, [1991] 2 SCR 5 at 14, 81 DLR (4th) 121; *Douglas/Kwantlen Faculty Assn v Douglas College*, [1990] 3 SCR 570 at 595, 77 DLR (4th) 94.

33 *R v Conway*, 2010 SCC 22, [2010] 1 SCR 765 [*Conway*].

held that when a *Charter* remedy is sought from an administrative tribunal, whether the tribunal is one of "competent jurisdiction" under section 24(1) depends on whether it is authorized to decide questions of law.[34]

Whether an MHT has remedial jurisdiction under section 24(1) was first addressed in Ontario in *Chandrasena*.[35] The Ontario psychiatric review board was found not to be a "court of competent jurisdiction" for the purposes of section 24(1), though the court did not elaborate on the reasons for this finding. This issue was revisited and fully addressed in *Re C(J)*.[36] The physician in this case appealed the psychiatric review board's decision to rescind a certificate of involuntary admission, but he abandoned the appeal before it was heard and proceeded to have the patient recommitted as an involuntary patient.[37]

Thereafter, the patient again applied to the psychiatric review board to review his continuing status as an involuntary patient.[38] The board ruled that it had jurisdiction to consider whether the actions of the hospital had infringed the patient's rights under sections 7 and 9 of the *Charter*. It also ruled that it was a "court of competent jurisdiction" in terms of section 24(1) of the *Charter*. The board proceeded to hold that the hospital had violated the *Charter* and abused the processes of the board in abandoning an appeal that it knew it could not win and in instead proceeding to have the patient recommitted under the provisions of the Ontario *Mental Health Act*. As a result, the board made some procedural rulings but did not grant the patient the remedy he was seeking—namely, a stay of the certificate of involuntary committal. The decision was reversed on appeal.[39] The court relied on the deleterious effects to the tribunal's ability to perform its intended function (such as time constraints, workload, and the tribunal's expertise and ability to compile a record) in determining that the board did not have jurisdiction to deal with *Charter* issues or to grant *Charter* relief.[40]

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34 The *Conway* decision is analyzed further below.

35 *Supra* note 15.

36 *Supra* note 29.

37 The psychiatrist in chief explained that, on reviewing the file, he was not at all sure that the hospital would win the appeal and, as a result, he had acted to prevent the release into the community of a person whom he regarded as dangerous. *C.f. OMHA 1990*, *supra* note 22, s 48(6) (allowing a physician to extend a discontinued certificate of involuntary admission by motion to the court).

38 *Re C(J)*, *supra* note 29.

39 *Ibid*.

40 See also *Re P* (21 November 2008), Oshawa TO-08-2990, 2008 CanLII 65731 (Ont Consent and Capacity Board) (CCB refusing to grant *Charter* relief under section 24 of the *Charter* because of the failure to notify patient of his involuntary admission and to pro-

The question of whether administrative tribunals may administer remedies under section 24(1) of the *Charter* was recently reviewed by the SCC in *Conway*.[41] Seeking relief under section 24(1), Conway applied to the Ontario Review Board (ORB) for an absolute discharge, a direction that the hospital provide specific treatment, and some other remedies, alleging breaches of a number of sections of the *Charter*. Such review boards are tribunals established under Canada's *Criminal Code* that review the status of every person who has been found to be not criminally responsible or unfit to stand trial for criminal offences on account of a mental disorder.[42] The ORB concluded that it had no *Charter* jurisdiction in light of its enabling legislation and function, and with regard to its own past rulings and the rulings of other review boards confirming these boards' lack of section 24(1) jurisdiction. The Ontario Court of Appeal, by a two to one margin, confirmed that the ORB lacked jurisdiction to hear *Charter* applications or to grant *Charter* remedies under section 24(1).[43] On further appeal, the SCC determined that the ORB had remedial jurisdiction under section 24(1).[44] It also expanded upon the wider issue of the relationship between the *Charter*, its remedial provisions, and administrative tribunals generally.

The SCC characterized as "unhelpful" the previous practice of asking every tribunal from which a *Charter* remedy was sought whether it was "competent" to grant a particular remedy within the meaning of section 24(1):

> The question instead should be institutional: Does this particular tribunal have the jurisdiction to grant *Charter* remedies generally? The result of this question will flow from whether the tribunal has the power to decide *questions of law*. If it does, and *if Charter jurisdiction has not been excluded by statute*, the tribunal will have the jurisdiction to grant *Charter* remedies in relation to *Charter* issues *arising in the course of carrying out its statutory mandate* (*Cuddy Chicks* trilogy; *Martin*). A tribunal which has the jurisdiction to grant *Charter* remedies is a court of competent jurisdiction. The tribunal must then decide, given this jurisdiction, *whether it can grant the particular remedy sought based on its statutory mandate*. The

vide him with a rights adviser on the basis that the board was not a "court of competent jurisdiction").

41 *Supra* note 33.

42 *Criminal Code*, RSC 1985, c C-46, ss 672.38-672.4 (outlining the establishment of review boards and guidelines for their composition). The ORB is made up of lawyers, psychiatrists, psychologists, and members of the public.

43 *R v Conway*, 2008 ONCA 326, 90 OR (3d) 335.

44 *Conway*, *supra* note 33.

> answer to this question will depend on legislative intent, as discerned from the tribunal's statutory mandate (the *Mills* cases).[45]

In finding that the ORB had the power to decide questions of law, the SCC relied heavily on the provisions of the *Criminal Code*, which provide that any party may appeal an ORB's disposition on questions of law, fact, or mixed fact and law. Interestingly, the court in *Jane Patient* had rejected this very same argument when reviewing the similar appeal provisions for CCB decisions.[46] Unfortunately, in *Conway* the SCC did not address *Jane Patient* in its reasoning, though post-*Conway* case law has confirmed that the appeal provisions of a tribunal may be determinative in answering whether a tribunal has the authority to deal with questions of law.[47]

The decisions of the Court in *Martin*[48] and *Tranchemontagne*[49] have "gradually expanded the approach to the scope of the *Charter* and its relationship with administrative tribunals," with *Conway* being "an attempt to consolidate the results of that expansion."[50] It is hard to avoid the conclusion that *Conway* has, by implication, overturned the view of the court in *Jane Patient*—namely, that appeal provisions are not determinative of a tribunal's power to deal with questions of law. Since legislation in Ontario and several other Canadian provinces provides similar grounds for appeal from decisions of MHTs,[51] it therefore appears that at least those Canadian MHTs that have not been previously found to be courts of competent jurisdiction may be found to have the authority to decide questions of law.

A. Legislative Intent to Exclude Charter *Jurisdiction*

The SCC also characterized the *function* of the ORB as follows:

> The Board is a quasi-judicial body with significant authority over a vulnerable population … [and it was established] as a specialized statutory tribunal with *ongoing supervisory jurisdiction* over the

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45 *Conway*, *supra* note 33 at para 22 [emphasis added].

46 *Supra* note 21.

47 *Carrier Sekani Tribal Council v British Columbia (Utilities Commission)*, 2009 BCCA 67 at para 40, 89 BCLR (4th) 298.

48 *Supra* note 18.

49 *Tranchemontagne v Ontario (Director, Disability Support Program)*, 2006 SCC 14, [2006] 1 SCR 513 [*Tranchemontagne*].

50 *Conway*, *supra* note 33 at para 23.

51 See e.g. *OMHA 1990*, *supra* note 22, s 48(1); *Mental Health Act,* RSY 2002, c 150, s 37; *The Mental Health and Consequential Amendments Act,* SM 1998, c 36, s 59(1); *An Act Respecting Mental Health Care and Treatment,* SNL 2006, c M-9.1, s 73(1); *Involuntary Psychiatric Treatment Act,* SNS 2005, c 42, s 79(1).

> treatment, assessment, detention and discharge of those accused who have been found not criminally responsible by reason of mental disorder.[52]

On this basis, the SCC held that there was no support for the notion that Parliament intended to withdraw *Charter* jurisdiction from the scope of the ORB's mandate.

Provincial MHTs have different functions than review boards constituted under the *Criminal Code*. The former do not have "ongoing supervisory jurisdiction over the treatment, assessment, detention and discharge" of patients appearing before them. Rather, they review decisions made by health practitioners at specific points in time. It is therefore unclear to what extent a court would deem the legislative functions of an MHT to be similar to the ones of a review board in terms of intention to exclude the *Charter*.

As discussed above, some Canadian jurisdictions, such as British Columbia, have explicit limitation clauses that bar tribunals from entertaining constitutional questions, thus expressing a clear intention to exclude any *Charter* claims. Less clear are provisions such as section 70.1 of Ontario's *HCCA*, which precludes the CCB from deciding the "constitutional validity of an Act or a regulation."[53] Although this amounts to a clear intention to exclude section 52 jurisdiction, it may not amount to a clear intent to withdraw this tribunal's remedial power under section 24(1).

This issue could be argued in one of two ways. First, if the legislature did not want an adjudicative agency to deal with the constitutional validity of an act, it surely, impliedly, did not want it to be dealing with other constitutional matters such as section 24(1). As discussed below, however, this rejection-by-implication argument was rejected by the majority of the SCC in *Tranchemontagne*,[54] a case in which the Court addressed the jurisdiction of adjudicative agencies over quasi-constitutional legislation. The majority in *Tranchemontagne* distinguished between questions of law under the *Charter* and under provincial human rights codes. This distinction is harder to make when comparing questions of law arising from section 52 and section 24(1), as these are of the same nature.

In the alternative, the express reference to constitutional validity may mean that the legislature assumed that an administrative tribunal such as the CCB had full *Charter*/constitutional jurisdiction, and only found it necessary to exclude the constitutional validity aspect. According to this

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[52] *Conway*, *supra* note 33 at para 84 [emphasis added].

[53] *Supra* note 23.

[54] *Supra* note 49.

interpretation, the power to grant remedies under section 24(1) and under the common law remains.[55] Courts may adopt this narrow interpretation of provisions with similar wording to section 70.1 of the Ontario *HCCA* and find that the tribunal still has authority to provide a remedy under section 24(1). This alternative interpretation is in line with the developing jurisprudence of the SCC, as reflected in *Martin* and *Tranchemontagne*.

B. A Tribunal's Jurisdiction over Remedies

Assuming neither the legislation nor the function of an MHT clearly withdraws section 24(1) jurisdiction, the SCC in *Conway* affirmed:

> [T]he remaining question is whether the tribunal can grant the particular remedy sought, given the relevant statutory scheme. Answering this question is necessarily an exercise in discerning legislative intent. On this approach, what will always be at issue is whether the remedy sought is the kind of remedy that the legislature intended would fit within the statutory framework of the particular tribunal. Relevant considerations in discerning legislative intent will include those that have guided the courts in past cases, such as the tribunal's statutory mandate, structure and function.[56]

Considering the scope and nature of the ORB's statutory mandate and functions, the Court noted the requirements of section 672.54 of the *Criminal Code*, and the four enumerated statutory criteria: the need to protect the public from dangerous persons; the patient's mental condition; the reintegration of the patient into society; and the patient's other needs.

The Court found that the ORB had a "necessarily broad" discretion to consider a large range of evidence in order to fulfill this mandate.[57] After noting that the ORB could not grant an absolute discharge to an individual who remained a significant threat to the safety of the public and that a disposition may not include any conditions that prescribe or impose treatment on a non-criminally responsible accused, the Court concluded that, subject to these limits,[58] the content of the conditions included in a disposition was at the ORB's discretion:

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55 I thank James Sprague for his comments on this issue.

56 *Supra* note 33 at para 82 [footnote omitted].

57 *Ibid* at para 90.

58 Left somewhat in flux was the situation as it related to some of the subsidiary *Charter* claims made by Conway, in relation to his complaint about being housed near a construction site, which had not yet been determined by the ORB. Other alleged violations of Conway's *Charter* rights related to unfair treatment by staff and the hospital's failure to provide an atmosphere that was free of threats of attack and attacks by other patients, and free of racism.

> In this way, the Board has the statutory tools to supervise the treatment and detention of dangerous [not criminally responsible (NCR)] patients in a responsive, Charter-compliant fashion and has a broad power to attach flexible, individualized, creative conditions to the discharge and detention orders it devises for dangerous NCR patients.[59]

The terms and conditions imposed by review boards when making dispositions may, therefore, include ordering governments to supply community housing when ordering a conditional discharge,[60] ordering certain living conditions for forensic in-patients, or setting up timelines for the transfer of forensic patients to lower-security facilities. Some of the conditions may be deemed a limited way to give effect to forms of entitlement. In contrast with review boards, most MHTs have no power to impose terms or conditions. Rather, their jurisdiction is generally restricted to confirming decisions to civilly commit a person and findings of incapacity to consent to medical treatment. *Conway*'s application to the work of most MHTs appears, therefore, to be of limited scope.

C. Charter *Jurisdiction Does Not Allow Tribunals to Grant New Remedies*

The narrow effect of *Conway* regarding the work of MHTs is also supported by the fact that Conway's appeal was ultimately dismissed because he was not entitled to the particular *Charter* remedies he sought. Administrative tribunals cannot order treatment or other remedies beyond the agency's statutory power (for example, costs, injunctions, damages, etc.). The *Conway* decision appears to turn, as such decisions always do, on the remedies available to the claimant as defined in the statute. The test for jurisdiction to grant a remedy was not changed by *Conway*: if the legislature or Parliament did not intend that a tribunal have a certain remedial power, section 24(1) of the *Charter* does not give that tribunal anything more. An individual before an administrative tribunal is not entitled to receive a remedy not contemplated by the legislation, *Charter* violation or not.

IV. The Application of Human Rights Codes

As discussed above, *Charter* jurisprudence in Canada neither recognizes a positive duty to provide adequate health care, nor does it give MHTs any remedial powers they have not been granted by legislation. In addition to the *Charter*, individuals can avail themselves of the protection

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[59] *Conway*, *supra* note 33 at para 94.

[60] Cristin Schmitz, "Top Court 'Merges' Admin Law's Three 'Discrete Universes'", *The Lawyers Weekly* 30:8 (25 June 2010) 3.

provided by human rights legislation. Both federal and provincial human rights codes address discrimination on certain prescribed grounds, including "mental disorder" and "mental impairment".[61] One example is Ontario's *Human Rights Code*, which upholds the right to equal treatment "with respect to services, goods and facilities."[62] A person with a mental disability could potentially advance a claim to adequate treatment on the basis of discrimination in the provision of goods, services, and facilities.

Thus, claims under human rights codes encompass a broader conception of rights than the *Charter* does. The various human rights codes also differ from section 15 of the *Charter* in that they provide protection against discrimination[63] by individuals in the private sector; the *Charter's* equality rights provision only extends to the actions of governments. The remedy for a provision that is found to breach human rights legislation is a declaration of inapplicability rather than a finding of invalidity under the *Charter*.[64]

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61 See e.g. *Human Rights Code,* RSO 1990, c H.19, s 10(1) [*Ontario Code*]; *Canadian Human Rights Act*, RSC 1985, c H-6, s 3 (prohibiting discrimination on the basis of "disability").

62 *Ontario Code*, *supra* note 61, s 1.

63 The term "discrimination" is not defined in either the *Ontario Code* (*ibid*) or section 15 of the *Charter* (*supra* note 2) but has been developed in *R v Kapp*, 2008 SCC 41 at para 17, [2008] 2 SCR 483 (the test to be applied for determining whether discrimination exists has two steps: (1) "Does the law create a distinction based on an enumerated or analogous ground?"; and (2) "Does the distinction create a disadvantage by perpetuating prejudice or stereotyping?"). See also *Ontario (Director, Disability Support Program) v Tranchemontagne,* 2010 ONCA 593, 102 OR (3d) 97 (the test in *Kapp* applies equally to both the *Charter* and human rights legislation).

64 If an MHT were found to have the authority to apply human rights legislation, a party alleging discrimination based on mental disorder or mental impairment would presumably choose to raise this issue before the MHT and then decide whether to proceed before a human rights tribunal. Ontario human rights legislation permits concurrent applications before an adjudicative agency and the provincial Human Rights Tribunal (HRT) with respect to the same human rights issue. Pursuant to the *Ontario Code* the HRT has the power to defer a hearing until the matter has been concluded by another tribunal (*supra* note 61, s 45). See e.g. *Pando v Colleges of Applied Arts and Technology Pension Plan*, 2009 HRTO 59 (available on CanLII), [2009] OHRTD No 59 (QL).

If an application is deferred, applicants may reactivate their application if the HRT considers the human rights claim has not been appropriately dealt with by the other tribunal (Human Rights Tribunal of Ontario, *Rules of Procedure*, r 14.3-14.4). For a more thorough discussion of the Ontario HRT's concurrent jurisdiction, see Mary Cornish, Fay Faraday & Jo-Anne Pickel, *Enforcing Human Rights in Ontario* (Aurora: Cartwright Group, 2009) at 107-17.

In the British Columbia context, see *British Columbia (Workers' Compensation Board) v British Columbia (Human Rights Tribunal)*, 2010 BCCA 77, 2 BCLR (5th) 274. In this case, the British Columbia Court of Appeal held that the British Columbia Human Rights Tribunal (BCHRT) had the discretion to reject all or part of a human

The authority of adjudicative agencies to deal with human rights legislation was addressed in the aforementioned *Tranchemontagne* decision.[65] This case involved two individuals who challenged a finding that, although their circumstances satisfied the definition of "disability" under the *Ontario Disability Support Program Act*, *1997*,[66] they were ineligible for benefits under that act because their disabling condition was substance abuse. They argued that this exclusion violated the *Ontario Code*.

The Social Benefits Tribunal (SBT) found that it did not have jurisdiction to consider whether a section of the act was inapplicable by virtue of the *Ontario Code*. The SCC applied the analysis in *Martin* (subsequently reiterated in *Conway*) and found that the SBT was a tribunal empowered to decide questions of law and was therefore presumed to have the power to look beyond its enabling statutes to apply the whole law to a matter properly before it. The majority of the Court therefore held that the SBT had jurisdiction to consider the *Ontario Code*. *Tranchemontagne* confirms that administrative tribunals with authority to decide questions of law must give effect to the primacy of human rights legislation over ordinary legislation.[67]

As discussed above, the SCC in *Tranchemontagne* split with respect to the effects of certain amendments to the SBT's enabling legislation which,

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rights complaint if it believed that the substance of the complaint, or that part of the complaint, had been appropriately dealt with in another proceeding before another agency pursuant to the *Human Rights Code*, RSBC 1996, c 210, ss 25(1), 27(1)(f) [*BC Code*]. By reason of the express legislative direction in section 27(1) (*ibid*) it was open to the BCHRT to allow the same complainants who had lost before the Workers' Compensation Board review division to argue the same point before the BCHRT. In doing so, the BCHRT was not sitting on appeal from the decision of the review decision. This is a significant issue because proceedings before most MHTs will invariably take place and conclude within a short period of time, given the tight statutory timelines under which they operate (for example, the CCB must begin its hearings within seven days of an application being received and decisions must be rendered within one day after the hearing ends, pursuant to section 75 of the *HCCA*, *supra* note 23). These short timelines in effect render most human rights proceedings moot. Additionally, the costs associated with human rights proceeding can make them prohibitive (although making human right claims before MHTs may also result in protracted and expensive litigation).

65 *Supra* note 49.

66 Being Schedule B to the *Social Assistance Reform Act*, SO 1997, c 25 [*ODSPA*].

67 See also Raj Anand & Mark Edelstein, "The Tribunal Application of the *Human Rights Code*: *Tranchemontagne* and Beyond" (Paper delivered at the Six-Minute Administrative Lawyer Conference, Law Society of Upper Canada, 23 February 2010), [unpublished] (arguing that *Tranchemontagne*, *supra* note 49, should not be seen as groundbreaking as the Supreme Court of Canada had already established in *McLeod*, *supra* note 19, that administrative tribunals can and must apply broader law where necessary). For similar reasons, *Conway* (*supra* note 33) should not be considered groundbreaking.

similarly to the CCB, prohibited the SBT from considering the constitutional validity of any act or regulation. The majority of the Court held that this statutory prohibition did not in itself preclude the application of human rights legislation, as issues arising under human rights codes belong to a different category of questions of law than do *Charter*-related issues.[68]

Furthermore, the minority in *Tranchemontagne* used the test in *Martin* to find that "practical considerations" indicated the legislature's intention that the SBT not consider legal questions regarding the validity of a statute.[69] These practical considerations were similar to the grounds used in *Re C(J)* and *Jane Patient*, which included the tribunal's institutional characteristics and the inappropriateness of the SBT deciding such complex, time-consuming legal issues. The SBT's hearings are informal, private, and brief. The SBT was meant to provide an efficient, effective, and quick process. Imposing human rights legislation compliance hearings on it would inevitably have had an impact on its ability to assist the disabled community in a timely way, as indeed happened when the case was sent back to the SBT for reconsideration.[70] The proceedings before the CCB were also significantly delayed in the case of *Jane Patient*.[71]

The comments expressed by the minority regarding the SBT are applicable to MHTs, whose human rights code jurisdiction has not been expressly removed. Human rights litigation before MHTs will also affect the efficient, effective, and speedy adjudication of matters. Whether claims for adequate care, founded on human rights legislation, will be invoked before MHTs remains to be seen.[72] The uncertainty regarding a mental

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68 *Tranchemontagne*, *supra* note 49. The majority distinguished between the power to invalidate legislation and its authority to apply a provincial human rights code. However, the minority held that the prohibition to consider the constitutional validity of legislation meant the legislature intended to preclude the SBT from deciding questions of the operability of a provision as a consequence of the application of the *Ontario Code* (*supra* note 61), as both the *Ontario Code* and the *Charter* were of a similar nature.

The case was sent back to the SBT to rule on the applicability of section 5(2) of the *ODSPA* (*supra* note 66). The tribunal concluded that the respondents were persons with a disability and were entitled to income support under the *ODSPA*, irrespective of section 5(2). It decided that this section was discriminatory and inconsistent with the *Ontario Code*. The decision of the SBT was upheld on appeal by Ontario's Superior Court of Justice in *Ontario (Director, Disability Support Program) v Tranchemontagne* (2009), 95 OR (3d) 327, 250 OAC 23 (Sup Ct (Div Ct)).

69 *Tranchemontagne*, *supra* note 49.

70 It is interesting to note and perhaps puzzling that none of the judges in *Conway* (*supra* note 33) disclosed a similar concern with the impact that section 24(1) arguments may have on tribunal proceedings.

71 *Supra* note 21.

72 Another point that awaits a legal answer is how *Tranchemontagne* (*supra* note 49) affects the jurisdiction of MHTs, such as the British Columbia Mental Health Review

health tribunal's power to hear a *Charter* or human rights claim creates a difficult predicament for someone trying to advance such arguments. A party may choose not to raise the latter before an MHT to avoid delays and to obtain a speedy resolution of his or her claim. However, the party then runs the risk of not being able to raise such a claim before a reviewing court, lest the court decline jurisdiction because the appellant did not exhaust all recourse to tribunals. One would expect the courts to take a lenient view in cases in which the party was self-represented at the tribunal level. A party with legal representation will, however, be forced to make a strategic choice.

On this point, it is worth noting that an individual making a claim under human rights legislation will have to show unjustified discrimination between the provision of services for the mentally ill and the physically ill (or some other comparator group).[73] This may be an insurmountable barrier that requires proving that the person with the mental disability is seeking access to *existing* government benefits.[74] For example, a claim to appropriate community housing, residential, or treatment facilities may fail if no such service is provided to a comparator group.[75] Thus, limited or non-existent government funding may by itself create an additional legal barrier for a person arguing for entitlement to a health benefit under a human rights code. Alternative arguments could be made on the basis of discrimination between individuals suffering different types of mental disorder; for example, if health services available to the mentally ill were not available to the complainant or only offered to a specific gender or age group.

Board, that were given discretion to decline jurisdiction to apply a *Human Rights Code*. See *BCATA*, *supra* note 31, s 46 (specifying which of this province's administrative tribunals have jurisdiction to deal with complaints based on alleged violations of the *Human Rights Code*); *BCMHA*, *supra* note 31, s 24.2, as amended by SBC 2007, c 14, s 46 (giving the Mental Health Review Board the discretion to decline jurisdiction to apply the *BC Code*, *supra* note 64).

73 *New Brunswick v Human Rights Commission (NB)*, 2010 NBCA 40, 360 NBR (2d) 283 [*Human Rights Commission (NB)*]. A comparator group is necessary to determine whether a *prima facie* case of discrimination has been established. Equality is an inescapably "comparative concept": *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143 at 164, 56 DLR (4th) 1. See also *Martin, supra* note 18; *University of British Columbia v Berg*, [1993] 2 SCR 353, 102 DLR (4th) 665.

74 The principles for the determination of an appropriate comparator group were discussed by Chief Justice McLachlin in *Auton (Guardian* ad litem *of) v British Columbia (Attorney General)*, 2004 SCC 78 at paras 48-62, [2004] 3 SCR 657 [*Auton*].

75 *Human Rights Commission (NB)*, *supra* note 73.

V. Potential Claims before Mental Health Tribunals to Advance Rights to Adequate Care

The absence of legal provisions addressing the right to adequate health care for the mentally ill continues to be identified as one of the main shortcomings of modern mental health legislation:

> Any contemporary model of mental health law (including rights protections) must surely be judged mainly by how well it engages with these new patterns of service, and the degradation of service quality and resourcing often associated with contemporary delivery of community mental health services. It is here that current models of mental health adjudication, and any wider human rights laws, are most found wanting. ... [However], [o]verseas experience in Canada or the United Kingdom demonstrates that the omission of positive ("economic and social") rights, such as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", renders human rights laws of little assistance in leveraging access to treatment services or resources.[76]

The call for a more holistic vision of mental health care can find its theoretical underpinning in the work of Henry Shue and other scholars who have long argued for a model of basic rights that would include corresponding duties.[77] For Shue, those duties take three essential forms: to avoid deprivation, to protect from deprivation, and to aid the deprived. All of these duties must be performed to guarantee that a basic right, such as a right to physical security, is respected. The first form can be considered

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[76] Terry Carney, "Involuntary Mental Health Treatment Laws: The 'Rights' and the Wrongs of Competing Models?" in Bernadette McSherry & Penelope Weller, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010) 257 at 264-65 [footnotes omitted]. Similar claims have been made specifically about the Canadian context, see e.g. H Archibald Kaiser, "Canadian Mental Heath Law: The Slow Process of Redirecting the Ship of State" (2009) 17 Health LJ 139. But see, in the international law context, *International Covenant on Economic, Social and Cultural Rights,* 16 December 1966, 993 UNTS 3, art 12(1), Can TS 1976 No 46, (entered into force 3 January 1976, accession by Canada 19 May 1976) [*ICESCR*]; *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, GA Res 46/119, UNGAOR, 46th Sess, Supp No 49, UN Doc A/RES/46/119, (1991) 188 at 190 [*UN Mental Health Principles*] (principle 8(1): "[e]very patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons"). The right to appropriate mental health care, being a positive right requiring more proactive governmental intervention for its attainment, is by far the most controversial of mental health rights.

[77] Henry Shue, *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy*, 2d ed (Princeton, NJ: Princeton University Press, 1996). But see Rose's critique of the use of the rights discourse as an appropriate way for obtaining resources for the mentally ill: Nikolas Rose, "Unreasonable Rights: Mental Illness and the Limits of the Law" (1985) 12:2 JL & Soc'y 199.

a negative duty, which is reflected in the provisions of most mental health legislation and in the traditional review role of MHTs. The second and third duties require state action to ensure access to adequate health care for the mentally ill. In other words, the second and third obligations owed to those deprived of their liberty mean they should actually get the care and treatment needed.[78]

This wider conceptualization of rights, which encompasses reciprocity, appears to be reflected in international human rights instruments such as the *Universal Declaration of Human Rights*;[79] the *International Covenant on Economic, Social and Cultural Rights*;[80] the *UN Mental Health Principles*;[81] and the *Convention on the Rights of Persons with Disabilities*.[82]

This raises a question as to the appropriate legal forum for making such claims. As seen from the review above, the Canadian court system has not proven to be an effective arena for deciding claims by the mentally ill for adequate care. This is not surprising in light of the historical reluctance of the judiciary to recognize constitutional health claims in general,[83] as confirmed in *Auton*,[84] and reinforced by the minority opinion in

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78 Brenda Hale, "The Human Rights Act and Mental Health Law: Has it Helped?" (2007) Journal of Mental Health Law 7 at 17. See also Nigel Eastman, "Mental Health Law: Civil Liberties and the Principle of Reciprocity" (1994) 308 Brit Med J 43.

79 GA Res 217(III), UNGAOR, 3d Sess, Supp No 13, UN Doc A/810, (1948) 71.

80 *Supra* note 76.

81 *Supra* note 76, principle 17(2).

82 GA Res 61/611, UNGAOR, 61st Sess, Supp No 49, UN Doc A/RES/61/106, (2007) 2. There are a number of positive clauses in the convention that require governments to provide access to "community support services", "habilitation and rehabilitation services", "awareness-raising" measures, and other "public health programmes". These may become an important tool for those who seek further funding for certain areas of health care dealing with the mentally ill. See generally Arlene S Kanter, "The Promise and Challenge of the United Nations Convention on the Rights of Persons with Disabilities" (2007) 34:2 Syracuse J Int'l L & Com 287.

83 Martha Jackman, "Section 7 of the Charter and Health-Care Spending" in Gregory P Marchildon, Tom McIntosh & Pierre-Gerlier Forest, eds, *The Fiscal Sustainability of Health Care in Canada: Romanov Papers, Volume 1* (Toronto: University of Toronto Press, 2004) 110; Martha Jackman, "The Right to Participate in Health Care and Health Resource Allocation Decisions Under Section 7 of the *Canadian Charter*" (1995-1996) 4:2 Health Law Review 3.

84 *Auton*, *supra* note 74 (holding that British Columbia's non-inclusion of autism treatment within the provincial medicare system did not violate section 15 of the *Charter*). For a general discussion of *Auton* and its legal implications, see Martha Jackman, "Health Care and Equality: Is there a Cure?" (2007) 15 Health LJ 87.

Chaoulli.[85] These decisions in effect reaffirmed the lack of a constitutional right to health care in Canada, although the minority opinion in *Chaoulli* also supports the principle of reciprocity by making it clear that access to health care falls under section 7 of the *Charter*.[86] This may bolster an argument in favour of an MHT's discretionary, positive, remedial role when interpreting legislation according to *Charter* values. An MHT's decision must be made consistently with the *Charter* and its values.[87] As the SCC acknowledged in *Conway*, by heeding the submissions of the parties and by trying to ascertain with some precision the least onerous and least restrictive disposition in their normal operation, both review boards and MHTs may already be addressing areas where the *Charter* and clinical practice could be said to overlap. *Charter* considerations may in many cases already be accounted for as tribunals aim to arrive at a decision that impinges "on [the claimant's] liberty rights as minimally as possible, having regard to the particular circumstances of each case,"[88] and which makes the liberty of the person a major preoccupation.[89]

In other words, the remedial provisions of a tribunal may already provide it with the statutory tools to craft a decision in a responsive, *Charter*-compliant fashion without the need to avail itself of a *Charter* or human rights remedy. Tribunals "must act consistently with the *Charter* and its values when exercising their statutory functions."[90] In the words of the SCC:

> [I]t may well be that the substance of Mr. Conway's complaint ... can be fully addressed within the framework of the Board's statutory mandate and the exercise of its discretion in accordance with *Charter* values. If that is what the Board ultimately concludes to be the case, resort to s. 24(1) of the *Charter* may not add either to the

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85 *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 SCR 791 [*Chaoulli*] (holding that provincial restrictions on private health funding violated the Quebec and Canadian charters).

86 *Ibid* at paras 34, 100. For a more general discussion, see generally Lorne Sossin, "Towards a Two-Tier Constitution? The Poverty of Health Rights" in Colleen M Flood, Kent Roach & Lorne Sossin, eds, *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 161; Martha Jackman, "'The Last Line of Defence for [Which?] Citizens': Accountability, Equality, and the Right to Health in *Chaoulli*" (2006) 44:2 Osgoode Hall LJ 349.

87 *Re GJ* (23 July 2010), 2010 CanLII 47505, 2010 CarswellOnt 6073 (WL Can) (Ont Consent and Capacity Board) (a delay in scheduling a transfer hearing did not warrant the board ordering the transfer of the patient).

88 *Winko v British Columbia (Forensic Psychiatric Institute)*, [1999] 2 SCR 625 at 645, 175 DLR (4th) 193.

89 See generally *Penetanguishene Mental Health Centre v Ontario (Attorney General)*, 2004 SCC 20, [2004] 1 SCR 498 [*Penetanguishene*].

90 *Conway*, *supra* note 33 at para 78.

> Board's capacity to address the substance of the complaint or to provide appropriate redress.[91]

The section below explores some potential areas in which an MHT may use *Charter* values to further the right to adequate health care.

A. Ordering, Recommending, or Reviewing Treatment and the Surrounding Conditions

A tribunal's review of the appropriateness of the treatment proposed to an individual appearing before an MHT may be necessary to their function of preventing an unjustified deprivation of liberty or physical integrity.[92] It can lead health services to rethink their priorities and to reallocate their resources in order to give effect to these various tribunal orders. The purposes of the statutory scheme may then be used to advance provision of the best possible care in the least restrictive environment.[93] Nevertheless, without careful control, there is a risk that an MHT may overstep its jurisdiction and be challenged as encroaching on the clinical decision making of health care workers:[94] as discussed before, physicians cannot be ordered to follow a specific treatment plan in a way that is contrary to their ethical obligations and professional judgment.[95]

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[91] *Ibid* at para 103. *Charter* values can be equally applied to a tribunal's procedural (as opposed to substantive) rulings in terms of ensuring fair procedure without the need to consider *Charter* jurisdiction. See e.g. *R v S(N)*, 2010 ONCA 670, 102 OR (3d) 161 (a preliminary inquiry judge must take the *Charter* into account when deciding whether a woman must be forced to remove her niqab when testifying). The jurisdiction of preliminary inquiry judges (who had been previously found not to constitute a court of competent jurisdiction) to consider the *Charter* did not come from section 24(1), but rather from the application of *Charter* values to a question of fair procedure in the courtroom, over which the preliminary inquiry judge had a statutory power.

[92] See Genevra Richardson & David Machin, "Doctors on Tribunals: A Confusion of Roles" (2000) 176:2 British Journal of Psychiatry 110. "The tribunal has to determine a legal question, but it is a legal question set in a health-care context and dependent for its interpretation on a clinical opinion. Thus, an examination of the statutory criteria can lead almost inexorably to a wider discussion of the patient's care and future plans" (*ibid* at 113).

[93] Terry Carney, David Tait & Fleur Beaupert, "*Pushing the Boundaries: Realising Rights Through Mental Health Tribunal Processes?"* (2008) 30:2 Sydney L Rev 329 at 331, n 7 (discussing the objects of the *Mental Health Act* 2007 (NSW)).

[94] *Ibid* at 355.

[95] *British Columbia (AG) v Astaforoff*, [1983] 6 WWR 322, 47 BCLR 217 (SC); *Rotaru v Vancouver General Hospital Intensive Care Unit*, 2008 BCSC 318 (available on CanLII). In the UK context, see *Re R* (1991), [1992] Fam 11 at 26, [1991] 4 All ER 177 (CA); *Re J* (1990), [1991] Fam 33 at 41, [1990] 3 All ER 930 (CA); *Re J* (1992), [1992] 4 All ER 614 at 622-23, [1992] 3 WLR 507.

Not surprisingly, Canadian MHTs have been granted the power to make only nonbinding recommendations "respecting the treatment or care of a patient"[96] or where a violation of a patient's rights has been determined.[97] Some foreign jurisdictions have given MHTs the authority to make nonbinding recommendations regarding a course of treatment, including the power to order the revision of treatment plans in certain circumstances[98] and to order a psychiatrist to make a CTO or to vary a CTO.[99]

While nonbinding recommendations may potentially lead to the reconsideration of a course of treatment or to changes in hospital policy, noncompliance with such recommendations has no legal consequences. Thus, these examples are quite limited in scope. This is more evident when contrasted with the authority to impose binding conditions that review boards have in Canada. In *Mazzei*, the SCC recognized that review boards could issue binding conditions regarding the *supervision* of a patient (but could not prescribe or impose treatment) given their supervisory role and discretion to impose conditions when making orders under section 672.54 of the *Criminal Code*.[100] Although the distinction between making supervisory orders regarding treatment and making orders prescribing treatment is not always easy to draw, the SCC appears to be taking an approach that balances the need to allow deference to the opinion of health professionals with the need to ensure the purposes of the legislation are met. It could be argued that perhaps some of the purposes of mental health legislation are similar to the ones pertaining to review boards and may therefore support a broader role for MHTs.[101] Nevertheless, *Mazzei* would not apply to MHTs given their different role and their lack of power to impose conditions, as discussed above. Left with no source of jurisdic-

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96 See e.g. *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, s 68(2) (providing that the MHT, in reviewing involuntary admissions, has the authority to "make such recommendations to the [health facility's] chief executive officer as it sees fit respecting the treatment or care of a patient").

97 See e.g. *Mental Health Care and Treatment Act*, SNL 2006, c M-9.1, ss 72(1)(c), 72(2).

98 *Mental Health Act 1986* (Vic), s 35A gives the state's MHT the power to review patients' treatment plans as part of the conduct of every review of the patients' involuntary admission. See also section 19A, which gives the MHT the power to order the revision of treatment plans that fail to meet the statutory requirements or are not capable of being implemented. The MHT does not have the power to make treatment decisions. Nor can physicians be ordered to follow a specific treatment in a way that is contrary to their ethical obligations and professional judgment.

99 *Ibid*, ss 36(4), 36C(3)(a).

100 *Mazzei v British Columbia (Director of Adult Forensic Psychiatric Services)*, 2006 SCC 7 at para 31, [2006] 1 SCR 326 [*Mazzei*].

101 See e.g. *HCCA*, *supra* note 23, s 1.

tion to issue binding conditions regarding supervision or to make any type of recommendation, some MHTs may attempt to scrutinize treatment through the subtle persuasion of medical practitioners appearing before MHTs.[102]

In sum, neither a breach of *Charter* rights nor discrimination in the provision of services under the *Ontario Code* would give an MHT jurisdiction to provide a remedy not contemplated by its statutory authority. Thus, MHTs are likely to continue to refuse to entertain requests to order treatment following *Conway*.[103] For example, in *Re A.* the CCB has held that it has no jurisdiction to assess the placement of a fifteen-year-old involuntary in a psychiatric intensive care unit.[104] The CCB also found it had no jurisdiction to attach treatment conditions to its decision confirming a minor's involuntary admission where no local adolescent psychiatric unit was available and where transferring the patient to such a unit out of town was not in the minor's best interests because she would be separated from her mother and community supports.[105]

A more nuanced question is whether an MHT could review the conditions in a CTO that allegedly discriminate against the patient, either under the *Charter* or under human rights legislation (assuming the tribunal has jurisdiction to deal with one or both these grounds). Terms included in CTOs sometimes go beyond what is traditionally deemed to be medical treatment and may include housing, socializing arrangements, and even travel restrictions.[106]

Legislation protecting civil rights in other jurisdictions has been interpreted to allow restrictions on housing or socializing conditions in

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[102] Carney, Tait & Beaupert, *supra* note 93.

[103] As the SCC commented in the context of review boards, allowing administrative tribunals to interfere with hospitals' treatment plans and practices would be inappropriate (*Mazzei*, *supra* note 100 at para 31). In *Conway*, the Court emphasized that "[t]he authority to make treatment decisions lies exclusively within the mandate of provincial health authorities in charge of the hospital where [a not criminally responsible] patient is detained" (*supra* note 33 at para 100).

[104] (6 April 2005), 2005 CanLII 12686, 2005 CarswellOnt8592 (WL Can) (Ont Consent and Capacity Board). The CCB noted that this was not a desirable environment for the patient but that the alternative options (the general psychiatric ward or the pediatric ward) were equally unsuitable.

[105] *Re AC* (23 February 2005), 2005 CanLII 7115, 2005 CarswellOnt 8616 (WL Can) (Ont Consent and Capacity Board).

[106] Anita Gibbs, John Dawson & Richard Mullen, "Community Treatment Orders for People with Serious Mental Illness: A New Zealand Study" (2006) 36:7 British Journal of Social Work 1085 at 1093.

CTOs.[107] In Ontario, the CCB has held that it has no jurisdiction to review these types of conditions if they can be characterized as "treatment". This principle applied to the terms of a CTO that required the patient "to have any visitors to his residence pre-approved by his landlord" or by the treatment team.[108] In another case, the CCB held that it had no jurisdiction to review the terms of a Community Treatment Plan (CTP) drafted under a CTO because the CTP itself constituted treatment; in the alternative, the CCB held that the CTP's identification of treatment as "all oral/injectable psychiatric medication" was not too vague, but rather ensured flexibility for some treatment changes.[109] The CCB has also found housing arrangements contained in CTOs to be in accordance with the overarching principles of the *Charter*;[110] this ensures that CTOs may function as comprehensive and effective treatment tools. Such an interpretation has been found, in turn, to be less of an affront to a person's dignity and to be closer to the purposes of the governing legislation, as it is less restrictive than admission to a psychiatric facility.[111] The underlying assumption holds that care in the community provides a higher degree of respect for individual liberty and autonomy than care in an institutional setting.[112]

This does not preclude a successful *Charter* or human rights challenge to the conditions of a specific CTO. An MHT may find that specific terms discriminate against the patient, or constitute an unreasonable affront to the patient's dignity or *Charter* rights, when the terms subject to the challenge can be separated from the CTO without impairing its overall effectiveness.[113] Striking down those terms would support the least restrictive principle that governs most modern mental health legislation, and would be in accordance with a *Charter* analysis.

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107 Mary Donnelly, "Community-Based Care and Compulsion: What Role for Human Rights?" (2008) 15 Journal of Law and Medicine 782.

108 *Re K* (6 February 2008), 2008 CanLII 10213, 2008 CarswellOnt 1339 (WL Can) (Ont Consent and Capacity Board).

109 *Re JP* (31 August 2010), 2010 CanLII 55559, 2010 CarswellOnt 7302 (WL Can) (Ont Consent and Capacity Board).

110 *Re MBG* (7 July 2003), 2003 CanLII 14360, 2003 CarswellOnt 8190 (WL Can) (Ont Consent and Capacity Board).

111 *Ibid*.

112 Donnelly, *supra* note 107.

113 *Ibid* (discussing potential challenges to arbitrary CTO terms in the context of the European human rights system).

B. Lack of Community Accommodation Leading to Involuntary Admission

Evidence before MHTs sometimes discloses that an involuntary patient would be able to manage in the community if appropriate accommodation and treatment were available. In other words, the patient would not need to be committed but for the lack of resources in the community;[114] committing such a patient conflicts with the least restrictive principle underlying modern mental health legislation. For example, there has been some judicial commentary supporting the Ontario MHT's discretion to decide whether to confirm civil committal, even when the criteria for involuntary admission are met,[115] though the scope and application of this discretion remain unclear.[116] Therefore, an MHT could be faced with a re-

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[114] See e.g. *Re BF* (4 March 2008), 2008 CanLII 14522, 2008 CarswellOnt 1870 (WL Can) (Ont Consent and Capacity Board) (confirming a patient's involuntary admission on the basis of the limited housing options after release from the psychiatric facility, which would not "provide the stability ... required to minimize the impact of [the patient's] mental disorder, or to increase the possibility of compliance with medication in the community"); *R (H) v Secretary of State for the Home Department*, [2003] UKHL 59 at para 28, [2004] 2 AC 253 (confirming the committal of a patient who had been granted a conditional discharge but for whom the community agencies did not make the arrangements necessary to meet the conditions of discharge).

[115] *Capano v Centre for Addiction & Mental Health*, 2010 ONSC 1687 at para 37, 4 Admin LR (5th) 147. For example, in *Re SS* (22 July 2003), 2003 CanLII 17067, 2003 CarswellOnt 8380 (WL Can) (Ont Consent and Capacity Board), an individual had been involuntary detained for three years after a judge placed a conditional sentence on him, requiring that he live at the facility. At the end of the two-year sentence, he was certified and remained certified under the *OMHA 1990*, *supra* note 22. His attending physician was unsuccessful in finding an appropriate group home for him. The CCB considered exercising its discretion not to confirm the certificate based on "the absence of any attempt to relocate [the patient] to a less restrictive setting." Through perhaps puzzling reasoning, the panel held that it was entitled to consider the lack of community resources as justification for continuing the patient's involuntary admission; however, it held that it was also entitled to consider the lack of discharge planning as justification for refusing to continue the patient's involuntary detention, and it refused to exercise its discretion.

Likewise, in *Re FH* (12 March 2010), 2010 CanLII 15626, 2010 CarswellOnt 2059 (WL Can) (Ont Consent and Capacity Board), the CCB indicated that a factor to be considered in deciding "whether to execute discretion ... is the likelihood and degree of potential seriousness of the harm if the patient is discharged." The CCB therefore refused to use its discretion in this case, owing to "the likelihood of serious harm should [the patient] be prematurely discharged."

[116] The Ontario MHT's discretion has been criticized in *Re JW* (18 March 2005), 2005 CanLII 7114, 2005 CarswellOnt 8706 (WL Can) (Ont Consent and Capacity Board):

> Given the finding, without which the supposed discretion cannot arise, namely, that all of the prerequisites of the *Act* are met at the time of the hearing, what legitimate purposes might the release of such a patient serve? Is that release meant to punish those responsible for the triggering circumstance? Is it to compensate the patient? Is it to protect him or her? Clearly, to release a patient who is certifiable is not an appropriate method of reproof for

quest to refuse to confirm the civil committal of a patient in the case where committal is the result of an allocation of services and facilities that discriminates against the mentally ill under human rights legislation or the *Charter*. It is, however, unlikely that an MHT would exercise its discretion to release an involuntary patient who is likely to cause harm to himself or another person.[117]

C. Transferring Patients

Conway recognized that review boards were able to influence clinical decision making when ordering a patient's transfer to a health facility, pursuant to their power to impose terms and conditions. Until recently, MHTs had no statutory power to order transfers of patients, at least not without the consent of the receiving facility.[118] The recent amendments to Ontario's *Mental Health Act*, which allow a facility or patient to apply to the CCB for an order transferring the patient to another psychiatric facility, revisit the scope of authority given to MHTs in terms of clinical decision making.[119] In effect, Ontario's MHT has been given the authority to

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> the collateral conduct of others of which a panel happens to disapprove. Surely, to turn out into the street, contrary to his or her best interests, a person who is sick and/or dangerous enough to warrant certification can hardly be viewed as compensatory. If it is suggested that the discretion exists as a means to protect the patient from abusive conduct, it may be pointed out that, depending on its nature and severity, such abuse would appear to fall within the domain of criminal law, or of human rights law, or of civil liability. As such, it is the business not of the Board, but of the police and/or of the patient and his or her counsel.
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> ...
>
> For these reasons, we are of the view that the apparent discretion provided by the use of the word "may" in s.41.(2) is hollow, and that we have no true discretion to decide to *not* confirm.

117 *Re EP* (26 November 2010), 2010 CanLII 68913, 2010 Carswell Ont 9620 (WL Can) (Ont Consent and Capacity Board) (declining to exercise discretion to release a patient who had once been detained against her will for several days without legal justification).

118 See e.g. *J v V*, [1995] ACTSC 66 (available on AustLII) (holding that the Mental Health Tribunal of the Australian Capital Territory must give prior approval to initiate a period of compulsory treatment lasting up to six months pursuant to the *Mental Health (Treatment and Care) Act 1994* (ACT), ss 28, 36). Such orders are not location-specific and may involve treatment in either a hospital or community setting. See also *ibid*, ss 32(2), 32(3) (whereby the supervising psychiatrist decides a person's place of residence once an involuntary treatment order has been made by the tribunal).

119 *OMHA 1990*, *supra* note 22, s 39.2(2), as amended by *Creating the Foundation for Jobs and Growth Act, 2010*, SO 2010, c 1, Schedule 17, s 4 (providing that a transfer application may be made when a fourth certificate of renewal is completed with respect to an

decide the place and level of security under which some patients will be receiving treatment. This is a significant decision-making power, which breaks with the traditional role of MHTs as enforcers of negative rights, in that it not only deals with the fundamental liberty right of the patient but is inextricably linked to his or her prognosis and reintegration into society. In a similar vein to review boards, which have been found to have the authority to include express terms relating to interim custody and discretionary privileges pending transfer of a patient detained in a psychiatric facility,[120] the power to transfer requires MHTs to share responsibility for co-managing hospital resources when called on to adjudicate a transfer request.

Theoretically, patients in a high-security health facility could make a human rights claim because they cannot be transferred to lower-security environments because of the underfunding of the latter and because forensic patients are generally given priority, in effect precluding the involuntary patients from access to the "cascade" system that is otherwise available. Furthermore, the right to access the patient's family and to socialize in general, and the availability (or lack thereof) of cultural, religious, or language services are arguably factors that the CCB could consider in making a transfer application.[121]

The power to transfer appears to be a promising tool to further the right to adequate health care of mentally ill patients appearing before MHTs. Its potential, however, does not derive from constitutional or quasi-constitutional sources of law but from the lawmaker's decision to give such jurisdiction to the tribunal in question.

It is uncertain whether similar transfer provisions will be replicated in other jurisdictions, and if so, what the extent of the discretion given to the tribunal to impose any terms and conditions on the transfer will be. However, it is clear that the power to order a transfer may open the door to seeking remedies addressing a patient's right to adequate mental health care.

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involuntary patient and after the completion of every subsequent fourth certificate of renewal). But see *Mental Health Services Act,* SS 1984-85-86, c M-13.1, s 34(2), as amended by *The Mental Health Services Amendment Act, 1996,* SS 1996, c 17, s 9, allowing a patient in Saskatchewan to review—but not request—an order for the transfer of an involuntary patient from an in-patient facility to any other in-patient facility.

120 See *Penetanguishene*, *supra* note 89. In the context of delays in transferring forensic patients following Ontario review board dispositions, see *Orru v Penetanguishene Mental Health Centre* (2004), 126 CRR (2d) 182, 2004 CanLII 48886 (Ont Sup Ct).

121 *Ibid.*

Conclusion

The recent SCC jurisprudence appears to "judicialize" the role of administrative tribunals by recognizing their authority to apply constitutional and quasi-constitutional law. However, MHTs are creatures of statute, and the remedies they can award are limited to their jurisdiction.[122] *Martin*, *Tranchemontagne*, and *Conway* underscore the jurisdictional limitations of administrative tribunals. In fact, these cases support a cautious approach toward expanding the jurisdiction of tribunals.[123]

The jurisprudence of the SCC also highlights the inherent institutional limitations of adjudicative agencies and the unreasonable expectations placed on them. Adjudicative agencies are institutionally ill-equipped to deal with constitutional or quasi-constitutional legislation. The expectation that unrepresented parties before MHTs may raise human rights or *Charter* claims is unrealistic, as is the prospect that tribunal members may do so. This creates legal uncertainties regarding the right of parties to raise such arguments at an appellate level. There is also concern that allowing tribunals to raise such issues of their own accord may affect the fairness of the proceedings.[124] To the lack of institutional resources and expertise one must add the risk of losing sight of the purpose for which both the tribunal and the applicable legislation were created. Providing a speedy and accessible forum for adjudication, one of the foundations upon which most modern mental health legislation and MHTs are established, is impacted by long, protracted, and complex proceedings. Paradoxically, this runs contrary to international human rights standards requiring a speedy review of the decision to restrict the rights of a mentally ill person,[125] as was made evident by the dissent in *Tranchemontagne*:

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[122] A potential exception can be found in the Australian Capital Territory's *Human Rights Act 2004* (ACT), ss 18(7), 23, which expressly includes, among the recognized human rights, a right to compensation for unlawful arrest or detention and for wrongful conviction.

[123] See *British Columbia Maritime Employers Ass'n and ILWU*, 150 CLRBR (2d) 224 at paras 53-59, [2007] CIRB 397; *Jacobs Catalytic Ltd v International Brotherhood of Electrical Workers, Local 353*, 2009 ONCA 749 at para 18, 98 OR (3d) 677; *Clement v Varga* (16 May 2006), [2006] ORHTD 39 at paras 22-23; *Tenants v MF Arnsby Property Management Ltd* (5 June 2006), [2006] ORHTD 60 at para 40; *Haig v Ontario (Director, Ministry of the Environment)* (1 October 2008), 2008 CarswellOnt 7655 (WL Can) at para 62 (Ont Environmental Review Tribunal).

[124] Anand & Edelstein, *supra* note 67.

[125] See *UN Mental Health Principles, supra* note 76 (providing that an initial review of involuntary admission is to take place "as soon as possible" at principle 17(2)). See also *Convention for the Protection of Human Rights and Fundamental Freedoms,* 4 November 1950, 213 UNTS 221 at 227, art 5(4), Eur TS 5 (providing that persons deprived of their liberty are entitled to speedy review of the decision to detain them).

> Imposing Code compliance hearings on the SBT will similarly and inevitably impact its ability to assist the disabled community it was established to benefit in a timely way. It will be difficult to explain to the thousands of disabled individuals waiting for their appeals to be heard—many without any interim support—that there is any public benefit in the SBT hearing a complex, lengthy, and inevitably delaying jurisprudential issue with no precedential value. That is the real access issue in this case.[126]

Furthering positive rights or entitlements via the use of the *Charter* or human rights legislation before MHTs also raises concerns that administrative tribunals may become de facto resource-allocation agencies, a role they were not originally intended to fulfill. It can also result in privileging the claims for entitlement of certain parties over similar or stronger claims of other individuals:

> For a court to order improved conditions or set specified standards according to which an institution ought to be run, or for a court to demand that a state authority establish certain provisions in order not to infringe the constitutional rights of its citizens for treatment in "least restrictive" settings, effectively constitutes a legal arrogation of discretion in choices as to allocation of funds amongst competing priorities.[127]

These issues highlight the limitations of rights- or entitlement-based strategies in providing authoritative solutions. The language of rights lends itself to different and contradictory claims. The prioritization of each claim is therefore a source of continuing debate, one for which various societies have given dissimilar responses at different points in time.

Nevertheless, MHTs are still the most common legal forum available for the mentally ill to raise constitutional and quasi-constitutional challenges that may result in advancing a right to adequate health care. Furthering access to justice in this context creates a dilemma that has no easy resolution. In the context of review boards, the SCC has attempted to reach a compromise by acknowledging their supervisory role and power to impose conditions regarding supervision. Barring statutory amendments, this option is not available for provincial MHTs, which are only left with the power to interpret legislation in accordance with *Charter* values and to make *nonbinding* recommendations dealing with treatment and other

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[126] *Supra* note 49 at para 91.

[127] Rose, *supra* note 77 at 213. See also Terry Carney & David Tait, *The Adult Guardianship Experiment: Tribunals and Popular Justice* (Sydney: The Federation Press, 1997) at 146, 178-79; David Tait, Terry Carney & Kirsten Deane, *A Ticket to Services or a Transfer of Rights?: Young People and Guardianship* (Hobart: National Clearinghouse for Youth Studies, 1995); Terry Carney & David Tait, "Caught Between Two Systems? Guardianship and Young People with a Disability" (1997) 20:1 Int'l J L & Psychiatry 141 at 153, 158.

matters, such as hospital policies and CTOs. The latter functions correspond to a model that incorporates both adjudicative functions and the powers of a commission of inquiry.[128] It is a model that can influence the provision of adequate health care; the model should be carefully delineated with due regard to the rights and responsibilities of health practitioners, to avoid the risk of administrative agencies becoming de facto executive agencies or losing their authority, or both. The power to order the transfer of patients given to Ontario's MHT may also become a further tool to advance claims to adequate health care.

> It remains to be seen whether the practices and powers described above mark a new trend toward a greater and different role for MHTs, or whether these will remain isolated examples arising from the need to deal with particular regional concerns or conditions. What is certain is that legislative action continues to be essential for a comprehensive re-examination of the role and jurisdiction of MHTs and any reprioritization of the rights of the mentally ill.

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[128] Most Canadian MHTs already give their own members similar powers to the ones given to commissioners appointed under provincial public inquiries legislation.