



Principles Underlying Mental Health Legislation

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Introduction

According to the World Health Organization, the fundamental aim of mental health legislation is, “to protect, promote and improve the lives and mental well-being of citizens.”² Mental health legislation provides the legal framework required to ensure that the public and individuals with mental illness are afforded protection from the consequences of untreated mental illness. Mental health legislation must balance the interests of an individual suffering from mental illness with the interests of society, but it must also balance the conflicting interests of the individual who suffers from mental illness. A person has a right to liberty, autonomy and procedural fairness, but they also have the right to receive protection and medical treatment necessary to prevent them from experiencing serious harm.

In Canada, mental health legislation falls under provincial jurisdiction. In some Canadian jurisdictions, consent and

capacity provisions that are used to ensure appropriate treatment for people with severe impairment of decision-making capacity, are also considered under the rubric of mental health legislation, whereas other jurisdictions have consent and capacity legislation that is not specific to mental illness. Whether consent and capacity legislation is separate from, or integrated with, mental health legislation, it is critical to the functioning of mental health legislation. This paper will use the term “mental health legislation” to encompass involuntary hospitalization as a result of civil commitment; mandatory outpatient treatment, including community treatment orders and leave provisions; and consent and capacity decision-making legislation. The paper will not specifically consider the principles associated with the provisions of the criminal code relating to criminal responsibility, fitness to stand trial or criminal code review boards, although many of the same principles apply.

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In some countries, mental health legislation outlines standards for mental health services. This type of service legislation can play an important role in improving access to mental health care. For example, service legislation may be designed to ensure that underserved areas or specific populations receive the necessary level of resources. While the Canadian Psychiatric Association (CPA) recognizes the potential benefits of this type of service legislation, it is an approach that has not been adopted in most Canadian jurisdictions and will not be considered in this paper. It is important to note that service legislation does not obviate the need for legislation authorizing involuntary hospitalization and treatment.

Mental health legislation is not static and as it evolves, it must consider advances in medical science, changes in the service system and developing conceptions of human rights. Since the publication in 2010 of the previous CPA position paper on the principles of mental health legislation¹ there have been advances in these areas that have prompted the present update. The CPA has developed this position paper in order to inform psychiatrists, lawmakers and the general public of the position of the CPA on mental health legislation and the principles that underpin it. Psychiatrists should be aware of these principles, not only in their day-to-day practice, but also when asked for advice on the development or revision of mental health legislation in jurisdictions in which they practice.

Principles

Reciprocity

Involuntary hospitalization results in a loss of liberty for an individual who, in most instances, has not committed a crime. Restrictions on individual liberty or the autonomy to make treatment decisions must result in a benefit to the individual who is subject to those restrictions. The primary benefit to an individual who is hospitalized against their wishes is that they are protected from harm and receive treatment for their mental illness. When a person is involuntarily hospitalized, the costs of the treatment the individual receives should be paid for by the state and the treatment should be consistent with recognized best clinical practices.

Least Restrictive and Least Intrusive

Wherever possible, care and treatment should be provided to individuals with mental illness without resorting to the use of compulsory powers. However, in cases in which this is not possible, individuals who are subject to mental health legislation should be provided with the necessary care and treatment in the least invasive manner and in the least restrictive

environment that is compatible with the delivery of safe and effective care and treatment, while considering the safety of the individual or others. This principle is often articulated as the “least restrictive alternative.”³ However, it is important to add a rider indicating that the intervention is the “least restrictive alternative that is viable.” It is often possible to identify approaches that are less restrictive but unsuitable for an individual who requires treatment and ongoing supervision.

Appropriate Procedural Safeguards

The legal standards governing involuntary admission and treatment without a person’s consent should be clearly defined in the legislation and individuals subject to these legal provisions must be provided with appropriate procedural safeguards. These procedural safeguards must be easily accessed and available in a timely fashion to the person or, when appropriate, to the person’s family or substitute decision-maker.

Procedural safeguards should generally include, but not be limited to: provision of rights information; the right to retain counsel; the right to an independent review of committal, or a finding of incapacity; and appropriate review by the courts. These safeguards must be uniformly available and therefore the state must provide counsel for an indigent individual.

Right to Treatment

All citizens have the right to access publicly funded treatment. This right is no less compelling for individuals with psychiatric illnesses than it is for those with medical illnesses. Lack of resources sometimes limits access to physical and mental health services. However, for many people with severe mental illness, impaired appreciation of the need for treatment—an intrinsic component of their illness—is the primary barrier to their accessing essential health care. Access to treatment must not be denied to a defined group in society. Thus, access to psychiatric treatment should not be denied to a person simply because that person does not have the capacity to recognize their illness. Capacity may be impaired by primary cognitive deficits, for example, in dementia, or by deficits in the ability to appreciate the existence of an illness or the likely consequences of treatment or lack of treatment, as often happens in psychotic illness.

While the CPA recognizes that health-care resources are not limitless, there should be special considerations for people who are hospitalized involuntarily or who are required to follow a plan of treatment in the community. Society restricts the liberty of these individuals and, in some cases, compels them to take specific treatments. In these circumstances, treatment should not be constrained

by limited resources, and the best available medical and nonmedical treatments should be provided.

Timely Treatment

The right to treatment is meaningless if the treatment is not provided in a timely fashion. Delayed access to medical treatment increases the risk of morbidity and mortality. The same is true for psychiatric treatment. As already noted, a legal review of involuntary hospitalization and findings of incapacity is an essential safeguard. However, this review must be available in a manner that does not unnecessarily prolong a person's involuntary detention in hospital or unnecessarily delay the initiation of appropriate psychiatric treatment.

In the 1970s and 1980s, many North American jurisdictions introduced legislation that required that a person must pose a risk of physical harm to themselves or others before the person could be involuntarily hospitalized.⁴ This restrictive approach prevented many people with severe illnesses, who were not dangerous, from receiving beneficial treatment in hospital. The failure to provide treatment in turn resulted in unnecessary homelessness, criminalization, and deaths in situations where these people continued to deteriorate to a point where they were suicidal or unable to provide the basics for life or, in a smaller number of cases, where they acted violently towards others.⁵ Many jurisdictions subsequently amended their legislation to allow involuntary hospitalization to prevent substantial mental or physical deterioration in addition to preventing physical harm. This approach is consistent with research that indicates that delay in initiating treatment for psychotic illnesses is associated with impairment of the long-term prognosis of those illnesses.⁶

Compliance with the Charter of Rights and Freedoms

Mental health legislation must incorporate the rights laid out in the Charter of Rights and Freedoms.⁷ For example, the Charter, section 7, states "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." It is important to note that the courts have found that involuntary admission does not breach this right when it is made in accordance with the principles of fundamental justice.

Compliance with International Human Rights Conventions to Which Canada is a Signatory

Canadian mental health legislation has been influenced by various United Nations (UN) conventions and principles,

including the *Principles for the Treatment of Persons With Mental Illness and the Improvement of Mental Health Care*.⁸ In 2010, Canada signed the *UN Convention on the Rights of Persons With Disabilities* (CRPD).⁹ The CRPD commits signatory countries to ensure that people with disabilities are able to fully integrate into society through needed accommodations and that the legal rights of disabled individuals can be exercised.

The UN formed the CRPD Committee to oversee the interpretation and implementation of the CRPD. The interpretation of the Convention by the CRPD Committee and the direction the CRPD Committee has given to signatory countries has been controversial.¹⁰ The CPA does not share the CRPD Committee's interpretation that elements in the Convention require the abolition of involuntary hospitalization, involuntary treatment, findings of unfitness to stand trial or of lack of criminal responsibility due to a mental illness.¹¹ The abolition of these statutes would be contrary to many of the principles outlined in this paper, such as the right to treatment. It is possible that some of these matters will be decided by the courts.

Consistent with Scientific Evidence

The development of effective antipsychotics, antidepressants and mood-stabilizing medications has greatly improved the treatment of severe psychiatric illnesses. Rapid progress in the neurosciences holds the promise of further advances. However, some people with mental illness do not show clinical improvement when treated with currently available medications, or they develop intolerable side effects which limit the use of these treatments. A realistic appraisal of the effectiveness of available psychiatric treatments for different disorders is important when developing and implementing mental health legislation.

Aspects of mental health legislation itself should also be studied to determine their effects on various clinical and liberty outcomes, and this information should be used to guide the development of legislation.

Compatible with Professional Standards

There should be no dissonance between mental health legislation and professional standards of care. Psychiatrists should be able to practice ethically. Government should consult with professional bodies when drafting or amending mental health legislation to ensure that the legislation allows mental health professionals to follow the standards outlined by their licensing authorities and provincial and national associations.

Nondiscrimination

Mental health legislation should be drafted and exercised without discrimination based on physical disability, age, gender, sexual orientation, language, religion, ethnic background or social status.

Understanding behavioural and societal norms, and differentiating psychiatric pathology from societal diversity, is a critical aspect of psychiatric assessment, care and treatment. It is essential to recognize the values and beliefs of individuals, their extended family and their community. Detention or treatment provisions in mental health legislation should allow for care that respects a person's individual qualities, abilities and background. Those developing and administering mental health legislation should ensure that the powers of the legislation do not cause, or exacerbate, inequity in the assessment, treatment and care of people suffering from psychiatric disorders.

Participation of Stakeholders

When drafting or amending mental health legislation, those who have been, or are likely to be, subject to its provisions should be consulted. The same principle applies to the oversight of the day-to-day application of the legislation. It is important to bear in mind that some individuals with the most severe types of mental illness experience chronic decision-making incapacity. Family caregivers often provide long-term care for these individuals and are critical stakeholders who should also be consulted on the development and implementation of mental health legislation.

Privacy of Personal Health Information

The right to privacy is a fundamental value in democratic societies. Apart from exceptional circumstances, people receiving health care have a right to keep their health information confidential.

This information should not be disclosed to third parties without the person's consent. People receiving treatment for mental illness, including involuntarily hospitalized patients maintain this right. However, because mental illness can sometimes impair the capacity to make decisions about the release of personal health information, a legal mechanism must be in place to allow this capacity to be assessed and, where necessary, to transfer responsibility to consent to the release of information to others.

A person's right to privacy is not absolute and there are situations in which confidentiality may be justifiably

breached. These include situations when there is a life-threatening emergency or when failure to disclose would likely result in harm to the patient or others. In many jurisdictions, the circumstances under which a person's health information can be disclosed are defined in law.

Legislation should allow clinicians, and any therapeutic services involved in the care of an individual, to share information necessary for the care and treatment of the individual. When clinicians and therapeutic services rely on such implied consent, they should only share information that is necessary for the individual's care and treatment.

Other Important Legislation Issues

Purpose of Civil Commitment

Is the primary purpose of civil commitment to limit harm through detention or to ensure that people receive treatment? This is probably the most contentious question relating to mental health legislation. The opposing principles can be stated as follows:

No capable person should receive treatment over their objection even when involuntarily hospitalized.

Or:

When the state takes away a person's freedom because of the effects of a mental illness, the state assumes a responsibility to provide the treatment necessary to ameliorate the effects of that illness and thereby provide the person a realistic prospect of regaining freedom.

The issues underlying this question have been expanded in a CPA discussion paper.¹² The CPA notes that democratic jurisdictions have adopted each of these approaches and that it does not seem possible to privilege one approach over the other.

However, if a jurisdiction adopts a model permitting treatment refusal by an involuntarily hospitalized but capable patient, it is essential that the legislation is written in a manner that will ensure that the person is truly capable of deciding to forgo treatment, especially if that treatment is required for the person to regain their freedom. Research has shown that without standard psychiatric treatment, most involuntarily hospitalized patients will be detained for a prolonged or indefinite period.^{13,14}

Advance Directives and Involuntary Hospitalization

Some jurisdictions accept an involuntarily detained individual's capable, contemporaneous wish to refuse

treatment but refuse to accept as binding an incompetent individual's previously executed advance directive to refuse treatment.

An advance directive allows an individual who is legally capable of making treatment decisions to state their treatment preferences if they were to become incapable in the future. Advance directives differ from contemporaneous treatment decisions in several important ways. First, the person making an advance directive often makes decisions about future treatment without knowledge of pertinent facts and thus these decisions may not be fully informed. Second, any doubt about a person's contemporaneous capacity can be resolved by careful re-examination, including assessment by review boards or courts. In contrast, it can be very difficult to retrospectively determine a person's capacity at the time the person executed an advance directive. Finally, unlike contemporaneous decisions made when capable, which can be changed at any time, once a person becomes incapable, he or she cannot change their advance directive.

In some jurisdictions, a person can make an advance directive not to take psychiatric treatment, even if he or she is involuntarily hospitalized. However, that person cannot make an advance directive not to be hospitalized. Thus, if the person loses capacity to make treatment decisions and is hospitalized involuntarily they cannot change their directive in order to accept treatment. Without treatment, this person may face life-long detention in hospital.

This risk of indeterminate detention can be lessened in several ways. One is to ensure that the person is actually capable of making the treatment decision and understands the implications of the advance directive at the time they execute the directive. To achieve this, some jurisdictions require that a lawyer or health professional attest that, at the time the advance directive is executed, the person is capable and understands the full implications of the directive.

Alternative approaches, used in some Canadian jurisdictions, are not to accept advance directives for involuntary patients or, alternatively, not to accept these directives as binding if they endanger the patient's or another person's health or safety.

Summary

People who have a serious mental illness that results in a significant risk of harm and an impaired appreciation

of the need for treatment must have access to health care facilitated through mental health legislation. The vulnerability of these individuals also requires stringent protection of their civil rights. The CPA recommends that the 12 principles outlined above should guide the development of mental health legislation.

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