Chapter 18

Legal and Ethical Dimensions of Dual Diagnosis

Patricia Peppin

Learning Objectives

Readers will be able to:

1. Describe how law develops and changes;
2. Develop an awareness of ethical dimensions underlying laws affecting people with dual diagnoses;
3. Identify key legal issues arising out of a dual diagnosis; and
4. Consider how law applies to particular situations involving persons with dual diagnoses

Introduction

This chapter introduces you to a range of legal and ethical issues that can arise when an individual is diagnosed with a psychiatric disorder and a developmental disability. The first section provides a brief discussion of the way law develops, to provide a context for the following discussion. In the second section, the values that underlie the law are examined. The concept of equality is used as a lens to examine the disadvantaged position of dually diagnosed individuals in society. The third section considers how to construct an understanding of dual diagnosis, through examining theories of discrimination.

The final section analyses specific legal consequences particularly applicable to persons with dual diagnosis. The chapter has been designed to give you a general sense of these legal issues. Because law changes, and because any specific situation may raise other issues, legal advice should be sought to deal with specific cases.

Interpreting Law

Law comes from a variety of sources in Canadian society. It is important to understand the sources of law to appreciate how law changes over time, and how law reform is achieved in a legitimate way. This is particularly important for the study of the law's application to people with dual diagnoses because their needs and problems have the potential to bring them into closer contact with law than many others in society.

Laws result from authoritative decision-making by legitimate actors within the three branches of government - the legislative branch, the judiciary, and the executive. Judge-made law is referred to as "common law". Law has the potential to restrain activities, as it does when criminal activities are successfully deterred. This role of law in setting boundaries for action rests on the authoritative nature of law, and on the mechanisms for enforcing its prohibitions. Law's second role is to enable activities. The certainty of law and its enforceability make it possible for people to arrange their affairs.

Values, Law and Dual Diagnosis

1. Values

Law is based on values, and we need to determine what those values are if we are to understand the law. Certain values are reflected in laws, while other values lie outside the range of particular laws.

Writers in the field of bioethics have identified four ethical principles of importance to decision-making in this field. They are: *autonomy, benefeasance (creating benefit), non-malfeasance (not doing harm), and justice*. (Beauchamp & Walters, 1989). Similar values are sometimes given different names, and somewhat different meanings, in different areas of the law, such as tort law, criminal law and the Canadian Charter of Rights and Freedoms. These similar terms are indicated in the following list:

- autonomy/liberty/freedom of conscience and religion
- benefeasance/best interests/protection
- non-malfeasance/avoiding harm/physical inviolability/ security of the person
- equality/substantive justice/formal justice

Some of the values listed above are fundamental human rights. Human rights apply to everyone in society, and can be seen as an expression of the rights and freedoms that exist because of our basic humanity. Each is based on the idea that every individual is entitled to certain basic rights and freedoms, and that these rights and freedoms should be protected through law. Some rights are also collective or group rights. Rights are expressed and protected through the Canadian Charter of Rights and Freedoms in the Canadian constitution, through human rights legislation, and through applicable international law and the Universal Declaration of Human Rights, proclaimed by the United Nations in 1948.

The values listed above also form the basis for legal protections through other types of law. Tort law provides a means for people whose interests have been violated through wrongful acts to seek compensation. Tort law is also intended to deter wrongdoing. For example, if a person intentionally touches another person without consent, that is considered a battery. The fact that a lawsuit can be brought means that the person whose bodily integrity was infringed can be compensated. As well, we hope that such wrongful behaviour will be deterred by the possibility of a legal action.

Conflicts about values may arise in many health and social services areas, and these conflicts are familiar to people working in these areas. One such conflict occurs when care providers' attempts to protect individuals come into conflict with that individual's right to autonomy and physical inviolability. Preventing and deterring harm to third parties, which is a purpose underlying the criminal justice system as well as the tort system, is a value that may well conflict with the individual's fundamental freedoms, including the Charter section 7 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". All Charter rights are also subject to limitation since government may justify the rights limitation as being reasonable in a free and democratic society. Achieving one value may be impossible without diminishing another value.

2. Equality

The equality section of the Charter provides that every individual has the right to equality without discrimination on the basis of mental or physical disability, and other grounds. Each of the two conditions making up a dual diagnosis - psychiatric and developmental disability – could be found to come within the category of mental disability. The cases that have been decided under the equality section of the Charter indicate that inequality may be found in conditions of disadvantage, which are indicated by historic disadvantage, stereotyping, and prejudice.

Equality is defined broadly in Canadian law so that it deals with the effects of action and not only the intent. Formal equality protects procedural rights such as the right to be treated equally before and under the law. Equality of effects means that the result of the behaviour should itself not be unequal. For instance, individuals in wheelchairs who could enter a theatre only by means of stairs would have equal opportunity in a formal sense, but would not have achieved equality in terms of effects until they could reach the top of the stairs. Adverse effects interpretation provides greater protection for substantive rights. Anti-discrimination legislation and the Charter both provide vital support for the respect and dignity to which all people are entitled, and for the right to be free from discrimination (Rioux & Frazee, 1999).

If we use the “lens” of equality to look at the situation of persons with a dual diagnosis, we find many signs of inequality.

Mental incompetence

Until recently in most Canadian provinces, a judicial declaration that a person was mentally incompetent had far-reaching consequences. This was a global and all-embracing determination. The mentally incompetent person was placed in the custody of a guardian, and lost the right to make key personal and/or financial decisions. Essentially, the individual lost the status of an adult in law. As a result of changes in legislation in some provinces, including Ontario, persons with limitations of mental capacity in some areas of their lives can be declared incompetent for these tasks, but may be considered to remain competent for other tasks. For example, persons with capacity in one area of personal care may continue to make those decisions while having decisions about another area, where they are incapable, made by a substitute decision-maker. The parens patriae (literally, parent of the fatherland) jurisdiction arises in the court on the declaration on mental incompetency. It has epitomized paternalism, containing the elements of custody and control along with the elements of responsibility and caring. The parens patriae jurisdiction has important benefits for individuals lacking mental capacity, but it is only recently that it has been tempered by respect for the individuals' rights, and an acknowledgement that its application must be limited to appropriate areas. The changes in the Ontario Health Care Consent Act and Substitute Decisions Act resulted from a lengthy process that included much consideration of the rights of people with mental disabilities.

Institutionalization

Institutionalization was similarly two-edged, providing the opportunity for benefits in the care and support unavailable elsewhere, while also creating the significant disadvantages inherent in a closed environment. Recognition of the potential for abuse in a closed environment (Dykeman, 1999) and increasing awareness of the detrimental effects of isolation from communities' patterns of life (Wolfensberger, 1972; Radford & Park, 1999), has led to downsizing of institutions and massive movements of developmentally disabled individuals from large and medium-sized institutions into group homes, smaller institutions and family settings. The deinstitutionalization and normalization movement has been an attempt to create a living environment in the community that would enhance opportunities for normalization and development of their individual potential.

Persons with developmental disabilities who have left large institutions in Ontario to move to forms of community residence have had considerably better residential options than persons leaving psychiatric facilities, where a laissez-faire attitude has prevailed (Simmons, 1990; Drassinower & Levine, 1995). Those who have both conditions should, in theory, have options available in either system, but their history is more likely to illustrate the gaps in the social service system for members of this population, an inability to provide service to deal with all aspects of the condition, and the way mental health and developmental disability services have been organized from a bureaucratic standpoint.

Reproduction and sexuality

Controls on reproductive and sexual life were most clearly indicated by the eugenics legislation in force in Alberta and British Columbia, enacted in 1928 and 1933 and in force until 1972 and 1973 respectively. In the 44 years during which the Alberta statute provided authority for eugenic sterilization, authorization was given for 2,822 people to be sterilized, and many of these people had not yet reached puberty (Robertson, Appendix to Muir v. Alberta, 1996). The Alberta legislation distinguished after 1933 between psychotic persons whose consent to sterilization was required, and "mentally defective" persons whose consent was not required. Women who were considered mentally disabled were targetted by the legislation, since they were seen as the source of feeblemindedness

(Goundry, 1994; Simmons, 1982). Other groups considered socially undesirable were also targeted, including poor people and immigrants from minority cultural groups (Robertson, Muir Appendix, 1996). The case of Muir v. Alberta led to compensation for her forced sterilization, a decision that had been based on faulty grounds, and one that had failed to apply the statute or follow government procedures. Leilani Muir's case, although not typical of those situations where decisions about people were made in accordance with the statute, led the way for others who had been sterilized to secure compensation.

The Eve decision by the Supreme Court of Canada declared that the Court would not use the parens patriae jurisdiction to authorize a non-therapeutic sterilization for contraceptive reasons for a person mentally incapable of deciding to have such a procedure herself (Peppin, 1989 - 1990). The Court was conscious of the history of control of persons with mental disabilities through control of reproduction, and in particular the atrocities committed by the Nazis. The Court made its decision not to authorize contraceptive sterilization on the basis of her rights, and disapproved of limiting the bodily integrity of the mentally incapable woman, of limiting the right to procreate, and of using a procedure that was intrusive, irreversible and non-therapeutic, to which she could not consent herself. Although the decision has been praised for its stance on behalf of the rights of mentally disabled individuals, it has also been soundly criticized for fundamental failures, including its failure to take sufficient account of her best interests, as involving the possible desirability of contraceptive sterilization, as required under the parens patriae jurisdiction (Re F, 1987, H.L.; Shone, 1987; Peppin, 1989 - 1990; Olesen, 1994). The Ontario legislation on consent to treatment leaves this decision intact by stating that the legislation does not apply to an authorization of sterilization that is not medically necessary. With a long-term contraceptive option available now, in the form of Depo Provera, the precise legal issues faced in the Eve case have become less pressing clinically, although the criteria used by the Supreme Court of Canada are still relevant to "non-therapeutic" procedures in general. The equality section of the Charter, which was not applied to the Eve case because the equality section was not in force when the case began, would presumably be available for consideration in any subsequent litigation in this area.

Sexuality and sexual violence

Research indicates that the level of violence, including sexual violence, against women with disabilities is high (Goundry, 1994). Sexuality is subject to control, and becomes a matter of some concern in institutional settings, particularly where non-consensual behaviour constituting battery or abuse may take place (McSherry & Somerville, 1998; Mossman, Perlin & Dorfman, 1997). Such non-consensual activity may be perpetrated by residents or by care providers. McCreary and Thompson have outlined the close relationship between being abused and becoming a perpetrator of a sexual offence (1999). The prevalence of childhood sexual abuse among women psychiatric patients is a significant related issue (Dykeman, 1999).

Stereotyping

Stereotyping and stigma are still conditions of life for persons with developmental disabilities. The trial judge in the Muir case stated that the damage of being sterilized was aggravated by her wrongful stigmatization as a moron or high-grade mental defective, which led to humiliation on a daily basis in her relations with family, friends and employers. Interestingly, the stigmatization was wrongful in her case because the province had failed to follow its own statutory requirement, practices and procedures when it institutionalized her and sterilized her. Such stigma continues today for those who are perceived to have a disability, and a current example can be found easily in the conversations of some children, teenagers and adults who use terms for mental disabilities as casual indicators of low regard.

Constructing an understanding of dual diagnosis

The academic literature on disability distinguishes between the physical impairment and the social construction of disability. Impairment does not necessarily produce powerlessness, stereotyping, prejudice, and a condition of disadvantage. Disability is seen as a concept with multiple dimensions expressed bodily, personally and socially (Bickenbach, 1993). The context within which a person with a disability experiences his/her life includes the social construction of disability - that is, the way members of the culture view a person with a disability, including that person herself or himself. As we seek to understand the situation of people with dual disabilities, hearing their experiences and voices is vital. As Goundry (1994) has noted, “women with disabilities have identified a number of broad social issues as particularly relevant to their lives and have described the systemic barriers which undermine their equality aspirations. Violence, self-image, reproduction, parenting, employment, poverty, and sexuality are among those issues which have a particular meaning(s) for many women with disabilities – meaning(s) that are just beginning to be articulated in the literature” (Goundry, 1994, p. 1).

In a biological context, attempts are being made to develop an understanding of dual diagnosis within an ethical framework that is increasingly affected by developments in our understanding of biology. As genetic innovations increase our understanding of the human body and its development, it seems that society needs to be reminded of the limitations of scientific understanding. Reducing human behaviour to genes, and expecting genes to provide answers to human difference are two “worrying” aspects of this process (Lippman, 1993). Although genetics and biochemistry are contributing to our understanding of disabilities, genes are not solely determinative of the person’s life.

In a social context, a response to an individual’s need based simply on consideration of his/her best interests is insufficient if it fails to consider the social order that produces the condition of disadvantage experienced by the individual. If a legal or psychiatric theory focuses on individual behaviour while excluding the social context within which the behaviour has developed, it can be considered deficient. The capacity of an individual to engage in autonomous decision-making needs to be seen in the context of society, including its structure of political inequality (Edelman, 1980; Weinberg, 1988; Minow, 1990; Sherwin, 1992).

The social structures themselves need to be challenged, and the power and rights that characterize human relationships should be the focus (Minow, 1990; Duclos (now Iyer), 1993; Razack, 1994). For example, Sherene Razack (1994) has analyzed sexual violence against girls and women with developmental disabilities. She has argued that the relations need to be seen as social arrangements that constitute groups differently as dominant and subordinate, and that these constructions interact across social dimensions of gender, disability and age.

In a psychological context, when more than one condition of inequality and disadvantage is present, such as developmental disability and mental illness, the interplay may occur in complex ways. The disabilities may reinforce one another, may lead in different directions, or may simply be added together to make the effect greater. When considering the nature of inequality and discrimination, it is important to take this analytical step of considering how the conditions interact. When an individual has a dual diagnosis, the other reinforcing or alleviating conditions, such as his/her gender, race, age, sexual orientation, may have an effect on his/her social and legal situation. Any one of these factors may reduce or enhance the power of an individual in relation to other individuals with similar conditions (Razack, 1994).

Legal issues affecting people with dual diagnoses

Specific legal issues may arise as a consequence of a person with a developmental disability also having a diagnosis of psychiatric disorder. The range of issues that might arise for any individual includes: *access to services; right to decide about treatment and substitute decision-making for persons mentally incapable of making a decision; exposure to violence and abuse; violence committed by the individual directed at him/herself or others; involuntary commitment; restraints; and participation in experimentation and research.* This is not an all-inclusive list, and the focus is particularly on key issues in the areas of personal care and social service.

1. Access to services

The problem of inadequate service is experienced by dually diagnosed individuals who have difficulty obtaining treatment suitable to both conditions. This may occur when they "fall between" two service systems, such as those of the Ministries of Health and Long Term Care and Community and Social Services. Similarly, an individual who has come into conflict with the law may be incarcerated in a provincial or federal institution, where specialist care may or may not be available.

Negligence law requires that individuals who owe a duty of care to another person meet a standard of care. Failure to meet the standard of care for a treatment amounts to negligence and this leads to liability when harm of a foreseeable type has been caused by the negligence. This raises the question of how the standard of care is to be determined, and how it is to be maintained in service settings. This is a particularly complex question because the dual diagnosis area has few practitioners, and because multiple caregivers are often involved. One American study examined the treatment and social support services provided to persons with dual diagnoses, and found the level of service delivery insufficient, citing evidence of excessive drug therapy, including drug therapy where the diagnosis did not warrant it (Thomas, 1994). Similar areas of concern have been identified across Ontario. Increased awareness of these issues by professionals and caregivers will hopefully improve their conditions under which persons with developmental disability are treated in the mental health sector.

In the recent case of <u>Eldridge v. British Columbia</u> (1997), the Supreme Court of Canada decided that an authority's decision not to fund sign language interpreters in hospitals constituted discrimination on the basis of disability because deaf persons were unable to benefit equally from the health care services available to everyone, and that this constituted a denial of plaintiffs' equality rights under the Charter. This decision on access to services is likely to be of considerable significance to people with disabilities.

2. Right to decide about treatment

The Health Care Consent Act and Substitute Decisions Act govern health care treatment decision-making in Ontario. Treatment is defined broadly in the Act, and the kinds of health practitioners who may provide treatment are also broadly determined, based principally on a selection of those professions currently regulated under the health professions regulatory legislation in Ontario. A valid treatment decision is one that is informed, voluntary, made by a capable person or their substitute decision-maker, and one made without fraud or misrepresentation. People are presumed to be capable, and it is only when there are reasonable grounds to believe otherwise that capacity is assessed. The determinative factor of mental capacity is assessed on the basis of the ability to understand the information relevant to the decision, and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of decision. Both cognitive abilities must be present for an individual to be considered mentally capable. Capacity is assessed at a particular time with respect to a particular decision.

Guardians may be appointed by a court to act for individuals who are mentally incapable with respect to personal care matters or financial matters or both. A guardian may be appointed for one or more areas of personal care decision-making in which the individual has been found incapable, while that person retains authority to make decisions over all the other areas. Court-appointed guardians are required to act in accordance with principles outlined in the legislation.

Persons with developmental disabilities who are incapable of making treatment decisions are able to have substitute decision-makers make treatment decisions for them. Substitute decision-makers (SDMs) are listed in rank order in the legislation and generally the highest person on the list who is available, willing, old enough and mentally capable is the substitute decision-maker for that treatment decision. A guardian authorized to make treatment decisions is at the top of the list, followed by an attorney for personal care authorized to make treatment decisions under a power of attorney for personal care, and then a representative appointed by the Consent and Capacity Board, a spouse or partner, a parent or 16+ child, access parent in the situation where one parent has custody, a sibling, and finally another relative (by blood, marriage or adoption). If there is no person available and willing to act as substitute decision-maker, the Public Guardian and Trustee, a public official, must be the substitute decision-maker. This is an important provision for long-institutionalized and older persons with disabilities, ensuring that they will not be without services even though no one associated with them is available to act as substitute decision-maker. The Public Guardian and Trustee must also act as decision-maker if equally entitled substitute decision-makers fail to reach an agreement on a decision.

The decision made by the substitute decision-maker must be made in accordance with the principles set out in the <u>Health Care Consent Act</u>. The substitute decision-maker must decide on the basis of a wish made by the person when capable of doing so and when at least 16 years of age. This prior capable 16+ wish must be followed by the SDM as long as it is not impossible to carry out. If there is no such prior capable 16+ wish, then the SDM must decide on the basis of the best interests of the mentally incapable person. In determining the best interests, the Act requires that the SDM consider the following: (i) the values and beliefs the individual held when capable, on the basis of which he/she would make this decision; (ii) his/her incapable wishes; (iii) risk-benefit factors including likely improvement with the proposed treatment, prevention or slowing of deterioration; and whether a less restrictive or intrusive treatment would be as beneficial, and the risk-benefit calculation. The basic principle for substitute decision-making may be expressed as: wishes, or if none, then best interests. Requiring the decision to be made on the basis of the individual's wish, and outlining best interests criteria that incorporate aspects of the individual's values and context are important protections for the individual's autonomy.

Another way in which autonomy is protected is through recognition of the power of attorney for personal care. Individuals who are capable of doing so may make out a power of attorney for personal care, naming their own substitute decision-makers in the event of subsequent incapacity. Wishes may also be expressed in this formal document, if the person is capable of making that particular decision.

Procedural rights are also found in the legislation, including rights of appeal to the Consent and Capacity Board, and from it to the courts. Rights advice is an important part of any system affecting individual rights, such as the mental health system of involuntary commitment and community treatment orders, and the health care decision-making scheme. Unless people subject to the law are made aware of their rights, the rights are meaningless. Similarly, substitute decision-makers acting on behalf of individuals with a mental incapacity must also be made aware of their responsibilities. Without this knowledge, they may unwittingly fail to respect the autonomy or best interests of the individual. *"Advocacy, protection, and representation of people with dual diagnoses require heightened understanding of this population and their rights because such people experience difficulty in understanding the legal mechanisms available to assert their rights"* (Bersoff, Glass & Blain, 1994, p. 60). Rights advisers are provided in psychiatric facilities in Ontario, including public hospitals with psychiatric wards. Health practitioners proposing treatments have obligations to inform individuals of their rights under the health care consent legislation, in accordance with norms set by their professions, and also have an obligation to inform substitute decision-makers of their responsibilities and the bases (outlined above) on which they are legally required to make substitute decisions (A.M. v. Benes, 1999, Ont. C.A.). The Canadian Charter of Rights and Freedoms applies to statutes.

3. Crisis situations

Violence by others toward a person with developmental disability, self-injurious behaviour and violence to others by these persons, are all serious occurrences that have legal dimensions. Emergency situations, requiring quick treatment to prevent serious bodily harm or severe suffering, are dealt with under specific sections of the Health Care Consent Act.

Violence and abuse directed towards vulnerable adults, such as the dually diagnosed, was one concern of government that led to the changes in the legislation governing consent to treatment and substitute decision-making. The Substitute Decisions Act contains an important provision that applies when it is suspected that an apparently incapable individual is being abused or neglected. When an allegation is made that a person is or may be suffering "serious adverse effects", possibly because of mental incapacity, the Public Guardian and Trustee (PGT) is required to investigate. Serious adverse effects are defined for this part of the Act as serious illness or injury, or deprivation of liberty or personal security. Such an investigation may lead to an order of temporary guardianship, naming the PGT as temporary guardian, and could involve apprehending and removing the person.

This mechanism has been designed to bring to the attention of a public official those situations of abuse, neglect and self-injurious behaviour to which mental incapacity is contributing. In these instances, the PGT is given a right of entry, subject to certain conditions, in order to determine whether the person is incapable, and to assess the situation in which adverse effects may be taking place. Only in these limited circumstances is it permissible to intervene.

In considering the appropriate course of action in a crisis situation, the question of whether a common law duty of care exists must be answered. Institutions have been held to have a duty of care to the individual, a duty to make the environment safe for other patients (Stewart v. Extendicare Ltd.), and a duty to control and supervise psychiatric patients so as to prevent harm to third parties in the hospital (Lawson v. Wellesley Hospital), or to third parties outside the institution who have a sufficient relationship of proximity, and are "exposed to a risk of danger because of the nature of the patient" (Wenden v. Trikha, 1991, p. 157). Health professionals who have established a relationship with the person will owe him or her a duty of care (Picard & Robertson, 1996). Other care providers may also owe duties. The responsibility of a physician is to use the reasonable degree of skill, care and knowledge ordinarily possessed by professionals in that context. Specialists, such as psychiatrists, are held to the standard of specialists, as are non-specialists who hold themselves out as having that degree of expertise. A court may find that the standard of care should be higher than the professional standard in situations "fraught with obvious risk" (ter Neuzen v. Korn, 1995).

The above-mentioned situations constitute crises. In a crisis situation, an assessment by a treating psychiatrist would include consideration of the potential for harmful behaviour and ways to manage it. If steps are proposed to limit the behaviour of an individual engaging in conduct dangerous to others – such as fire-setting or sexually aggressive behaviour - it is important to ask what steps have been taken to reduce the danger, including those taken to prevent any precipitating events to such violence. If there is reason to believe that the risk is not under control, it would be appropriate to ask the nature of the obligations owed to the individual by the psychiatrist and any institution, and what duty and standard of care applies in relation to members of the community where the person lives.

In considering the elements of risk to others and to the individual, it is important to give weight to the individual's own perspective, including his/her understanding of the situation, and whether he/she would be willing to warn others as a means of minimizing risk. In some circumstances, a court may find that a duty to warn others is required of the treating professional. When engaging in long-term planning, it would be important to consider the effect of any alternatives on the person's opportunity to participate in making a community living experience work. The area of crisis management is one where it is particularly important to obtain legal advice.

The duty to control another person arises in tort law as an aspect of the duty of care. When a duty of care exists, or when a special relationship gives rise to this duty to protect or control, then a court will require that a certain standard of care be met, in order to prevent harm from arising to the individual or to another person. For example, innkeepers are required not to keep serving alcohol to patrons past a certain point of inebriation, in order to prevent the customers from harming themselves or third parties such as other drivers. A common law duty to restrain or confine a person when immediate action is needed to prevent serious bodily harm to them or others is not affected by the Health Care Consent Act.

Duties to restrain or control come into conflict with rights to physical inviolability and security of the person, in addition to individuals' autonomy rights, all of which receive protection in tort law and under the Canadian Charter of Rights and Freedoms. Such steps to confine or restrain a person must be reasonable and legally authorized (Conway v. Fleming, 1999).

Section 12 of the Charter prohibits "cruel and unusual treatment or punishment". This section, it has been argued, might apply to the legislation permitting decisions authorizing intrusive measures such as electro convulsive therapy, contingent electric shock, and other such aversive therapies (Kaiser, 1986; Weagant & Griffiths, 1988) Statutes and institutional guidelines also reflect this interplay of rights. For example, any government guidelines on behaviour modification, physical or chemical restraint, would have important implications for the range of actions permissible or required. Further considerations are whether such an intrusive measure meets the standard of care of the profession, and whether an informed decision has been made.

Whether intrusive procedures can be seen as therapeutic is a controversial issue. Weagant and Griffiths (1988) have asked if the particular aversive conditioning measure known as contingent electric shock can be a treatment when it is a punishment used in a crisis situation. On this basis, the authors suggest that the limitation on non-therapeutic procedures directed to mentally incapable persons stated by the Supreme Court of Canada in the Eve case would apply to contingent electric shock, so that it would be available only on the consent of the individual. Further, they suggest that sections 12 and 7 of the Charter provide strong bases for preventing contingent electric shock from being used on a non-consenting person.

A new Ontario statute is intended to reduce the use of physical and chemical restraints and monitoring devices used to prevent serious bodily harm. The *Patient Restraints Minimization Law* (2001) was introduced as a private member's bill by former Health Minister, Frances Lankin, who had found that her 88 year-old mother had been placed in restraints in hospital, even though the family had stated that they wished no restraints to be used (Priest, 2001). Researchers interviewed by the Toronto *Globe and Mail* indicated that Canada is among the highest users of restraints and that restraints can be misused when they are used to solve staffing problems or when other alternatives exist or when they themselves cause injuries (Priest, 2001).

The stated purposes of the Act are to minimize the use of restraints and to encourage hospitals and facilities to use alternative less controlling methods whenever possible when they find it necessary to use restraints to prevent serious bodily harm to a patient or others. Regulations to the new Act will provide the details necessary to implement the legislation. To "restrain" means "to place the person under control by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the person's physical and mental condition". The Act also governs the use of monitoring devices to prevent serious bodily harm to the person or others. It applies to public and licensed private hospitals and to facilities and organizations set out in the regulations, although it doesn't apply where the Mental Health Act applies to the use of restraints on patients or other people in psychiatric facilities.

Only physicians and others specified in the regulations may order restraint, confinement or monitoring devices. The use of restraints, confinement or monitoring devices by a hospital or facility must meet the criteria in the Act or come within the common law duty of a caregiver to confine or restrain when immediate action is necessary to prevent serious bodily harm to the person or others. The statutory criteria that authorize the use fall into two categories – enhancing freedom/giving greater enjoyment of life or preventing serious bodily harm. In either case, its use must be necessary to prevent serious bodily harm to the person or another and any regulatory criteria must have been met. In the case of enhancing freedom or life enjoyment, the restraints much achieve this purpose and a plan of treatment to which consent has been given must authorize its use. Hospitals and facilities have duties to establish and comply with policies, including policies to encourage less controlling alternatives, to monitor patients and to provide staff training.

In an examination of dually diagnosed individuals and "forcible administration of psychoactive medication to involuntarily committed and voluntarily admitted mental patients outside of the criminal justice system", it was found that American courts examining the issue gave weight to the safety of state hospitals, particularly when the patient was incapable (Bersoff, Glass & Blain, 1994). The authors recommended that psychological treatments that are less intrusive, such as group therapies and token economies, should, in order to avoid judicial scrutiny under the U.S. constitution, be used for treatment and for the safety of those staff and patients in the institution, and that they not be used for punitive motives.

Psychiatric treatment and community treatment orders

The provincial Government has enacted revisions to the Mental Health Act (in force, Dec. 1, 2000) that have been described as an attempt to balance individual and social needs, rights and responsibilities (Witmer, 2000). Health Minister Elizabeth Witmer has also drawn on the deinstitutionalization movement as a rationale for creating community treatment orders.

The Mental Health Act criteria for application for psychiatric assessment and involuntary admission have been relaxed by removing the requirement that the threatened danger be "imminent". The Mental Health Act criteria for a physician's application for a psychiatric assessment require that a physician's examination produce reasonable cause to believe one of threatened or attempted bodily harm to the self, violent behaviour or causing fear of bodily harm to another, or lack of competence to care for the self, plus apparent mental disorder likely to result in serious bodily harm to the person or such harm to another or serious physical impairment of the person.

Involuntary commitment requires determination of the mental disorder plus one of the resulting predictions unless the person is in the custody of a psychiatric facility, and that the person not be suitable as an informal or voluntary patient. The amended legislation makes it easier to send an individual to a psychiatric facility for a psychiatric examination. Involuntary commitment has become mandatory if the criteria are met, rather than permissible. This means that physicians no longer possess discretion at this point. It is possible to have a person psychiatrically assessed and involuntarily committed if he/she has been treated in the past for an illness likely to cause serious effects if untreated, if the following other factors exist: a) clinical improvement has resulted, b) the mental disorder is the same, c) serious effects (serious bodily harm, deterioration or impairment) are likely to be caused by his/her condition, d) he/she is mentally incapable of consenting to treatment in a psychiatric facility and his/her substitute decision-maker consents, and e) in the case of commitment, informal or voluntary admission is not suitable.

In these circumstances, a physician may make a “community treatment order” (CTO), provided that a number of additional criteria are met. These criteria are: the need for continuing treatment or care and supervision in the community; past commitment within a certain period or a CTO; an examination within the past 72 hours, on the basis of which the criteria for an application for psychiatric assessment have been met; serious bodily effects predicted to result from an absence of such treatment/care and supervision; the ability to comply with the CTO; a plan; and consultation. The individual or his/her substitute decision-maker must have consented to the CTO, and rights advice must have been provided or refused. The Act states that the individual must comply with the order and attend appointments with the physician.

The Health Care Consent Act applies to community treatment orders in addition to treatments generally. Prior *expressed* capable adult wishes will still prevail when they are clear, but the individual with no expressed prior capable wishes will be subject to the best interests determination of the substitute decision-maker. There are several areas in this Act that may be challenged by counsel using the protections of rights of the Charter. These include: a) preference for treatment, b) application of duress in the form of required compliance with treatment c) the threat of re-commitment to a psychiatric facility, and d) its relaxation of the standard for involuntary psychiatric assessment. The difficult questions related to implementation of this policy change have yet to be addressed, including provision of sufficient community resources to carry it out.

Experimentation and research

Research on human subjects in Canada is governed by a network of laws and guidelines. The common law requires that researchers meet the “full and frank disclosure” standard, while negligence law applies to the design, authorization and conduct of such research. The Tri-Council Policy Statement was adopted by the three federally funded research councils to apply to research funded by them. The TCPS, which has the status only of a statement and not the status of law, is interpreted and applied by Research Ethics Boards in the institutions, which are responsible for the review of research protocols in accordance with legal and ethical standards. One deficiency of this system is the lack of accreditation of REBs. Under a new federal regulation, the federal government has authority to inspect clinical trials of prescription drugs to ensure the protection of human subjects and compliance with established standards. As well, the role of REBs is recognized. The TCPS states that persons should not be prevented, purely on the basis of mental capacity, from participating in research that is potentially beneficial to them or to their group. This statement marks the change from a view of research as potentially harmful to a recognition of the research participation as having benefits, including early access to experimental drugs.

Conclusion

In this chapter, the legal and ethical aspects of dual diagnosis have been considered. The issue of equality has been examined in particular detail, with some discussion of how equality is to be determined when two conditions of mental disability coincide. This intersection affects their position in the constitutional sphere and in Canadian society, since both conditions have a history of social stigma, physical invasions, and lack of power. Following this, an overview was given of specific legal consequences of dual diagnosis.

Future professionals in the fields of health and social services have a need to understand the law applying to their professional service and to the situations of clients. Success in implementing any law depends on whether health care practitioners understand the law and apply it. We also need to hear more from people with such diagnoses so that we can all learn more about the effects of law on their lives.

Do You Know?

1. What situations could be changed so that people with dual diagnoses can achieve greater equality?
2. In what situations involving people with dual diagnoses do fundamental rights come into conflict?
3. Describe three situations in which a dually diagnosed person would be affected by the law. Outline how the law would apply to those situations.

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