Law Reform Commission of Canada

Commission de réforme du droit du Canada

PROTECTION OF LIFE

behaviour alteration and the criminal law

Working Paper 43

KF
384
ZA2
.L37/W
no. 43
c. 3

Canada

BIBLIOTHÈQUE JUSTICE LIBRARY
3 0163 00090523 2

KF 384 ZA2 .L37/W no.43
c.3
Law Reform Commission of
Canada.
Behaviour alteration and the
criminal law

DEPT. OF JUSTICE
MIN DE LA JUSTICE

AOUT
AUG 2 6 2003

LIBRARY BIBLIOTHÈQUE
CANADA

Reports and Working Papers of the Law Reform Commission of Canada

Reports to Parliament

1. *Evidence* (December 19, 1975)
2. *Guidelines — Dispositions and Sentences in the Criminal Process** (February 6, 1976)
3. *Our Criminal Law* (March 25, 1976)
4. *Expropriation** (April 8, 1976)
5. *Mental Disorder in the Criminal Process** (April 13, 1976)
6. *Family Law** (May 4, 1976)
7. *Sunday Observance** (May 19, 1976)
8. *The Exigibility to Attachment of Remuneration Payable by the Crown in Right of Canada** (December 19, 1977)
9. *Criminal Procedure — Part I: Miscellaneous Amendments** (February 23, 1978)
10. *Sexual Offences** (November 29, 1978)
11. *The Cheque: Some Modernization** (March 8, 1979)
12. *Theft and Fraud** (March 16, 1979)
13. *Advisory and Investigatory Commissions** (April 8, 1980)
14. *Judicial Review and the Federal Court** (April 25, 1980)
15. *Criteria for the Determination of Death* (April 8, 1981)
16. *The Jury* (July 28, 1982)
17. *Contempt of Court** (August 18, 1982)
18. *Obtaining Reasons before Applying for Judicial Scrutiny — Immigration Appeal Board* (December 16, 1982)
19. *Writs of Assistance and Telewarrants* (July 22, 1983)
20. *Euthanasia, Aiding Suicide and Cessation of Treatment* (October 11, 1983)
21. *Investigative Tests: Alcohol, Drugs and Driving Offences* (November 10, 1983)
22. *Disclosure by the Prosecution* (June 15, 1984)
23. *Questioning Suspects* (November 19, 1984)
24. *Search and Seizure* (March 22, 1985)
25. *Obtaining Forensic Evidence* (June 12, 1985)
26. *Independent Administrative Agencies: A Framework for Decision Making* (October 1985)

Working Papers

1. *The Family Court** (1974)
2. *The Meaning of Guilt: Strict Liability** (1974)
3. *The Principles of Sentencing and Dispositions** (1974)
4. *Discovery** (1974)
5. *Restitution and Compensation** (1974)
6. *Fines** (1974)
7. *Diversion** (1975)
8. *Family Property** (1975)
9. *Expropriation** (1975)
10. *Limits of Criminal Law: Obscenity: A Test Case* (1975)
11. *Imprisonment and Release** (1975)
12. *Maintenance on Divorce** (1975)
13. *Divorce** (1975)
14. *The Criminal Process and Mental Disorder** (1975)
15. *Criminal Procedure: Control of the Process** (1975)
16. *Criminal Responsibility for Group Action** (1976)
17. *Commissions of Inquiry: A New Act** (1977)
18. *Federal Court: Judicial Review** (1977)
19. *Theft and Fraud: Offences* (1977)
20. *Contempt of Court: Offences against the Administration of Justice* (1977)
21. *Payment by Credit Transfer* (1978)
22. *Sexual Offences** (1978)
23. *Criteria for the Determination of Death** (1979)
24. *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons* (1979)
25. *Independent Administrative Agencies* (1980)
26. *Medical Treatment and Criminal Law* (1980)
27. *The Jury in Criminal Trials** (1980)
28. *Euthanasia, Aiding Suicide and Cessation of Treatment* (1982)
29. *The General Part: Liability and Defences* (1982)
30. *Police Powers: Search and Seizure in Criminal Law Enforcement** (1983)
31. *Damage to Property: Vandalism* (1984)
32. *Questioning Suspects* (1984)
33. *Homicide* (1984)
34. *Investigative Tests* (1984)
35. *Defamatory Libel* (1984)
36. *Damage to Property: Arson* (1984)
37. *Extraterritorial Jurisdiction* (1984)
38. *Assault* (1985)
39. *Post-seizure Procedures* (1985)
40. *The Legal Status of the Federal Administration* (1985)
41. *Arrest* (1985)
42. *Bigamy* (1985)

The Commission has also published over seventy Study Papers on various aspects of law. If you wish a copy of our catalogue of publications, please write to: Law Reform Commission of Canada, 130 Albert Street, Ottawa, Ontario K1A 0L6, or Suite 310, Place du Canada, Montréal, Québec H3B 2N2.

* Out of print. Available in many libraries.

BEHAVIOUR ALTERATION AND THE CRIMINAL LAW

Available by mail free of charge from:

Law Reform Commission of Canada
130 Albert St., 7th Floor
Ottawa, Canada
K1A 0L6

or

Suite 310
Place du Canada
Montréal, Québec
H3B 2N2

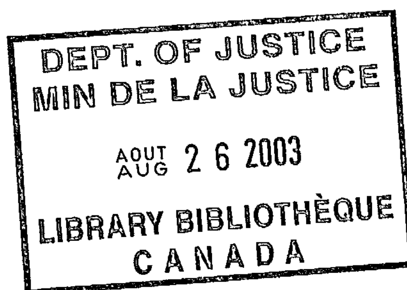
© Law Reform Commission of Canada 1985
Catalogue No. J32-1/43-1985
ISBN 0-662-53857-9

Law Reform Commission
of Canada

Working Paper 43

BEHAVIOUR ALTERATION AND THE CRIMINAL LAW

1985



DEPT. OF JUSTICE
MIN DE LA JUSTICE
AOUT AUG 2 6 2003
LIBRARY BIBLIOTHÈQUE
CANADA

Notice

This Working Paper presents the views of the Commission at this time. The Commission's final views will be presented later in its Report to the Minister of Justice and Parliament, when the Commission has taken into account comments received in the meantime from the public.

The Commission would be grateful, therefore, if all comments could be sent in writing to:

Secretary
Law Reform Commission of Canada
130 Albert Street
Ottawa, Canada
K1A 0L6

Commission

Mr. Justice Allen M. Linden, President
Mr. Gilles Létourneau, Vice-President*
Ms. Louise Lemelin, Q.C., Commissioner
Mr. Alan D. Reid, Q.C., Commissioner**
Mr. Joseph Maingot, Q.C., Commissioner
Mr. John Frecker, Commissioner*

Secretary

Jean Côté, B.A., B.Ph., LL.B.

Co-ordinator, Protection of Life Project

Edward W. Keyserlingk, B.A., B.Th., L.Th., L.S.S., LL.M., Ph.D.

Principal Researcher

Jean-Louis Baudouin, Q.C., B.A., B.C.L., D.J., D.E.S.

* Was not a member of the Commission when this document was approved.
** Was a member of the Commission when this document was approved.

Principal Consultants

Gerry A. Ferguson, B.A., LL.B., LL.M.
Lucinda Vandervort, B.A. (Hons.), M.A., Ph.D., LL.B., LL.M.

Consultants

F. C. R. Chalke, M.D., F.R.C.P.
D. Craigen, M.B.Ch.B., D.P.M., M.R.C.Psych.
J. Dillon, B.A., LL.B.
T. V. Hogan, Ph. D., F.C.P.A.
R. Martin, Ph.D.
P.-A. Meilleur, B.A., B.Ph., M.D., L.M.C.C., C.S.P.Q.
M. Rioux, B.A., M.A.
R. B. Sklar, B.S., LL.B., LL.M.
M. A. Somerville, A.U.A. (Pharm.), LL.B., D.C.L.
R. P. Swinson, M.D., F.R.C.P.(C), F.R.C.Psych., D.P.M.
R. E. Turner, M.D., F.A.P.A., F.R.C.P.(C), F.R.C.P.Psych.
H. Yarosky, B.A., B.C.L.

Table of Contents

INTRODUCTION 1

CHAPTER ONE: The Techniques 5

I. Psychological Techniques 6

A. Psychotherapies 6

1) Individual and Group Therapies 6
2) Milieu Therapy 7

B. Behavioural Therapies 7

1) Positive Reinforcement 8
2) Negative Reinforcement 8
3) Desensitization 9

II. Physiological Techniques 9

A. Drug Treatment 10

B. Electroconvulsive Therapy 11

C. Electrical Stimulation of the Brain 12

D. Psychosurgery 12

E. Castration 13

CHAPTER TWO: Issues and Responses in Present Law 15

I. The Autonomy of the Person: The Problem of the Nonconsensual Administration of Behaviour Alteration Techniques 15

A. Personal Autonomy in a Psychological Context 15

B. Nonconsensual Administration of Psychiatric Treatment................ 18

II. The Principle of the Inviolability of the Person and the Protection of Psychological Integrity 24

A. Inviolability of the Person in a Psychological Context 24

B. Present Legal Protection 26

III. The Use of Behaviour Alteration Techniques as a Sanction or Method of Social Control within the Context of Criminal Law 28

A. Criminal Sanction 29

B. Social Control... 31

CHAPTER THREE: Possible Reforms 35

I. Protection of Incompetents 35

II. Affirmation of the Protection of Psychological Integrity................... 38

III. Using Behaviour Alteration Techniques as a Sanction or Method of Social Control 42

BIBLIOGRAPHY 44

Introduction

Human behaviour is extremely complex. It constantly evolves, and is shaped by the experiences of life and many external factors, conscious or unconscious. Persons have always considered themselves capable of influencing the behaviour of others. Behaviour control and modification techniques are numerous and varied. Family and school education for example, undoubtedly influence the formation of a child's personality and the behaviour to be adopted as an adult. The cultural milieu in which an individual lives and develops also has an impact on behaviour.

In modern times, technology has given human behaviour modification a claim to a certain degree of scientific authority. Subliminal advertising, to cite a well-known example, can unconsciously alter individual habits. On another level, some medical, psychological and psychiatric treatments are used on a daily basis against mental illness and to promote a return to "normal" behaviour. Their goal is to modify human behaviour, and restore psychological stability and peace of mind.

Modern medical and psychiatric technology applied to human behaviour has raised difficult issues. For example, some therapeutic techniques are associated with a certain degree of apparent violence. As we will note in this Paper, aversion and electroconvulsive therapy have been challenged because of physical constraints on the patient. Others, such as psychosurgery, are challenged because of their irreversible characteristics and still others, such as certain forms of drug treatment, because of permanent secondary effects. Yet, on a theoretical level, once medically and scientifically approved, these techniques are *per se* neither good nor bad. They only become good or bad, acceptable or unacceptable, by the imbalance that may exist between risk and benefit, by the degree of their intrusiveness or by the unacceptable reasons for which they may be used. When used to relieve someone from an affliction that prevents the leading of a normal life, they constitute a form of genuine medical treatment, subject like all other treatments to conditions prescribed by law. Used on the other hand to ensure political control by suppressing dissident or marginal opinions, they would become unacceptable in a democratic society.

It would be possible, albeit ambitious, to analyse all the techniques that can influence or modify human behaviour. Several studies have already addressed that question from different points of view. The aims of this Paper are considerably more modest and restrained. First of all, it is confined to the field of the more commonly used psychological, behavioural or medical techniques. Experimental techniques, or those seeking behavioural results by means of education, environmental modification and

advertising, are excluded. This study is part of the Commission's Protection of Life Project, and should be read together with the other Papers previously published by the Commission. It is the natural follow-up of certain studies already published on medical treatment and the criminal law, and on the cessation and refusal of treatment. In a number of respects, it is related to Working Paper 24 entitled *Sterilization — Implications for Mentally Retarded and Mentally Ill Persons* and to the Study Paper *Consent to Medical Care*. Like these Papers, it too deals with the measures required to ensure legitimacy of decision making for those unable to decide for themselves. It also draws upon the recent document prepared by the Department of Justice entitled The Mental Disorder Project. Finally, it considers some general problems of bioethics and social behaviour, some of which have already been addressed in the Commission's Study Paper entitled *Sanctity of Life and Quality of Life in the Context of Ethics, Medicine and Law*.

It is not our intention to deal with all of the ethical, social and legal problems raised by these techniques, but only with a limited number of issues. The Commission's principal function is, broadly speaking, the reform of existing federal law. Within federal law, the criminal law is of exceptional importance, and is the special focus of this Paper.

Why isolate these techniques? Why not simply apply to them the general rules already delineated by the Commission in the field of medical treatment? We feel these techniques deserve special consideration for several reasons.

First, though present legislation is certainly not perfect, it nevertheless offers adequate protection against assaults on human physical integrity. But, as we shall see, the situation is otherwise regarding psychological integrity. The law provides only a limited protection by means of specific guarantees limited to particular cases. It is therefore appropriate to question the adequacy of such protection.

Secondly, in the majority of cases such techniques are used on persons having a diminished ability to provide consent. The law takes great care to ensure that the ordinary patient provides a full and informed consent to treatment. In psychiatric cases, difficulties are greater as a strong link of dependence exists between the patient and the therapist. Special precautions must be taken and present legal mechanisms critically appraised to ensure adequate protection against nonconsensual treatment.

There is a third reason for focusing on behavioural techniques in this Paper. One of the purposes of criminal law is to sanction unacceptable conduct in the hope that punishment will discourage both commission of the act and its repetition. In this context, sentencing also purports to change human behaviour. If science can change human behaviour in a more effective way than classic forms of punishment (imprisonment, for example) two clear options appear. Society may, at first, offer the accused a choice between "punishment" and "treatment", for example, between life imprisonment and castration. But is this a legally and morally legitimate option? Society may later be

tempted to go further, to suppress that choice, and to simply and directly impose "treatment" as a substitute for punishment. The line between therapy and punishment would disappear as a result. Let us suppose hypothetically that someday a technique of psychosurgery is discovered which is effective, without risk, painless, which would eliminate tendencies towards physical violence yet leave the intellectual and emotional abilities, and the personality traits untouched. Would it not then be legitimate for society initially to encourage, and even to force, certain categories of individuals whose repeated acts of violence have harmed other citizens, to submit to this kind of surgery? At present, the question may seem academic. But the underlying problem is not.

Finally, these techniques can also be used as a means of social control, for the well-being of the individual himself, that of society, or the two combined. Witness the recent use of psychiatric drugs which provide very effective alteration of some behaviour and psychotic states. Without necessarily curing the disease they at least allow patients to escape spending the rest of their lives in psychiatric hospitals, as in the previous century. Adequate medication of lithium salts or tricyclic antidepressants enables patients to function and live in society within their own milieu, and lead as normal a life as possible.

On the other hand, when other interests take precedence over those of the individual, the use of these techniques may create dramatic and shocking situations. Non-democratic states can (and do) use them as a method of social control. They are then no longer applied only to the mentally ill, but also to those whom the authorities consider marginal or political dissidents. These techniques are thereby diverted from their original function and used for political or ideological purposes to the detriment of individual rights and freedoms. As in the case of torture applied by medical means, they constitute a grotesque caricature of medical science.

The prospects of this Orwellian vision becoming a reality in Canada are small. Yet, watchfulness is necessary. On a much smaller scale, certain marginal groups with low profile and insufficient political impact are exposed to the risk referred to above, without necessarily any deliberate intention to so expose them.

Consequently, the Commission believes that behaviour modification by medical techniques merits an independent study within the context of its work on the protection of life and the reform of criminal law.

Despite the self-imposed limits mentioned above, the subject remains large and difficult. It necessarily bears on criminal law, prison law, health law and human rights, all of which to one degree or another are not only within federal jurisdiction but also provincial. To provide a comprehensive and accurate picture, it is therefore necessary to comment on certain aspects of provincial law. The emphasis in this Paper is, however, on criminal law and human rights. Furthermore, the recommendations themselves involve only those fields which are clearly within the legislative competence of the government of Canada.

To facilitate the understanding of the text that follows, two preliminary observations must be made. First of all, this Paper attempts to steer clear of the "free will-determinism" debate. Some maintain that human beings are entirely controlled by social factors, and therefore that individual freedom is artificial if not non-existent. They conclude that there is no real option between social control and free choice, but rather one between a diffused, erratic social control and one that is organized and productive. The theory of determinism, as elaborated and defended by Skinner for example, totally rejects the possibility that human beings can make truly free decisions. This paper takes the opposite position. Law in general, and criminal law in particular, are based on a different premise. We shall therefore postulate that man is free, can change and that human behaviour is not only the predetermined consequence of social factors. Yet we do recognize the influence of these factors on the exercise of free will.

Secondly, from time to time we will refer to the extremely complex and controversial notions of "normal" and "abnormal" human behaviour. The "normality" of any given behaviour is neither universal nor static. To some extent, it depends on the setting. An act committed in one country may seem perfectly "normal", and yet be labelled "abnormal" in another. The concept of normality also depends on the period in time. What might have been considered "abnormal" in the previous century may very well conform to modern-day standards. Finally, the very act of qualifying a certain type of behaviour as "normal" or "abnormal" implies, communally or individually, a complex value-judgment which draws on notions of acceptability and tolerance, and can vary considerably depending on the circumstances. We will use these terms without offering any precise definition, fully aware of the difficulties they raise, on the assumption that "normality" is basically what is so recognized at a specific time and place by those who have the task of making such a value-judgment.

Considering these factors, the limits of its mandate, and the special nature of the problems raised by behaviour alteration techniques, the Commission has chosen to address three questions:

1) Do present laws provide sufficient protection against involuntary or nonconsensual administration of behaviour alteration treatments?

2) Should psychological integrity be protected by the *Criminal Code*, as physical integrity already is?

3) Should the law legitimate the use of these techniques for purposes of criminal sanction and as a method of social control?

CHAPTER ONE

The Techniques

To facilitate the understanding of this study and to crystallize the issues, it would be useful in this first part to briefly and succinctly describe a certain number of techniques that are commonly used to alter human behaviour.

The classification of the various techniques is complex, and itself the subject of scientific controversy. Indeed, all classifications are somewhat arbitrary. The one adopted by the Commission should not be considered to be an endorsement of certain schools of thought on the subject. The basis of the selection is principally that of promoting a better understanding and greater access to the description of these techniques. Moreover, from the multitude of available techniques, only a limited number have been selected, namely those which appear to be most frequently used and best known to the public.

Behaviour alteration techniques may be artificially separated into two main groups. The first comprises those that attempt to influence the psychology or the mind of the person without medical or surgical intervention. This first group includes the different forms of psychotherapy whose basic mechanism is verbal communication between one or several people and a therapist. Their aim is to provide persons with a better comprehension of their feelings, their reactions, their thought processes and, therefore, their behaviour. This group also includes what is known as behavioural therapies. They all derive from the premise that human behaviour is the result of training. The understanding of the mechanisms of the learning process makes it possible to help the person eliminate or change a behaviour that he considers undesirable and, by means of training, to sometimes substitute a desired behaviour for the undesired one.

The learning of such substitute behaviour may be accomplished for example by using a reward system. On a theoretical level, it is the same principle as used in the education of young children. Results may also be obtained by means of sanctions when an unpleasant or painful stimulus is administered to prevent repetition of undesired conduct. Aversion therapy relies on this procedure.

The second group is made up of techniques which attempt to change human behaviour by direct medical or surgical intervention on the human body. Unlike the first group, they all have as a dominant characteristic a physiological intervention. Examples include the treatment of mental illness with drugs or medication, or by psychosurgery, the latter being a procedure by which brain centres associated with certain behaviour are surgically destroyed.

This dualistic classification is not totally scientific. Nor is it, by any means, watertight. Aversion therapy may for instance use as its sanction, a physiological intervention, such as the ingestion of a drug. Furthermore, this classification does not allow for the fact that within each group, and even each technique, there exist substantial variations which are difficult, if not impossible, to describe within the limited scope of this Paper.

In addition, it has the disadvantage of looking at each technique in isolation from the others. Reality is otherwise, and some of these techniques are frequently combined within a specific treatment programme. For example, patients treated by psychotherapy frequently receive at the same time antianxiety or antidepressant medication.

Finally, humans are extremely complex beings, and the dichotomy between psychological and physical aspects is largely artificial. It is sometimes impossible to know for sure whether a given conduct can be related exclusively to physical or psychological factors, a combination of both, or even a combination of the two and of external factors such as his environment.

In the pages that follow, the reader must constantly bear in mind that our description of the primary behaviour alteration techniques has been greatly simplified. Each one is, in reality, scientifically far more complex than its simple description in this Paper would suggest. The reader should also remember that these descriptions are not exhaustive. We have felt it necessary to make certain choices in the light of the particular purpose of this Paper. No inferences should be drawn from the fact that some techniques are only summarily mentioned, and others not at all.

I. Psychological Techniques

This first group consists of techniques that attempt to alter behaviour without direct physical intervention. Its two major categories are psychotherapies and behavioural therapies.

A. Psychotherapies

1) Individual and Group Therapies

Psychotherapy is probably the behavioural technique best known to the public. However, it would be inaccurate to think that psychotherapy in general is synonymous with Freudian psychoanalysis. Actually, there are more that one hundred forms of individual and group psychotherapy.

Common to all psychotherapies is the professional relationship established between patient and therapist. The former communicates his thoughts, ideas and feelings to the latter. The patient thus is brought to gradually understand his feelings and his reactions

by reliving and verbalizing them, and to acquire a deeper insight into his own behaviour. The therapy aims at eliminating states of anxiety or distress, and allowing the patient through improved self-knowledge to develop his personality in a positive direction.

Psychotherapy may be practised either in a group or individually, and may take a variety of forms. In individual therapy, the patient is required to attend a certain number of sessions lasting from thirty minutes to one hour, from one to five times a week. Treatment may be expensive if not covered by medicare, and may extend from a period of several weeks to a few years.

Group therapy is often undertaken in circumstances where a shortage of therapists makes individual therapy impossible. Nevertheless, group therapy is not only a substitute measure, but a distinct technique with its own advantages. It allows participants to improve their standing within a group, to find their own role within it, and to earn the group's support and psychological acceptance.

Psychotherapy, in a variety of forms, is widely used in Canada. Group therapy, considering its greater availability and the fact that it requires no specialized equipment, is common in psychiatric hospitals, detention centres and Canadian prisons. Participation is essentially voluntary. It is a treatment which, in its classical form, is relatively free of danger or of a high degree of intrusion even if it may create a strong link of dependency.

2) Milieu Therapy

Milieu therapy essentially involves manipulation of the person's environment to effect a change in his behaviour. It is based on the principle that change cannot be obtained solely through relatively brief individual or group sessions, and that continuing efforts must be made within the very milieu in which the person evolves.

In milieu therapy, several people must be actively and continuously involved. Consequently, in a psychiatric institution, a genuine therapeutic community must be established. Physicians, therapists, nurses, administrators and support staff are all considered active agents for change. This technique is principally used in closed settings, where it is possible to create a full and durable support environment.

B. Behavioural Therapies

We will examine briefly three particular forms of behavioural therapy. All of them are based, to one degree or another, on the idea of learning a new behaviour and of "unlearning" what is deemed a negative behaviour.

1) Positive Reinforcement

Positive reinforcement is based on rewards associated with a particular form of behaviour. Behaviour that is considered good for the person is encouraged. Each time it is repeated, the subject is rewarded. Alternatively, the reward is withdrawn in the event of negative behaviour. In a very general sense, it is akin to the primary education system of the young child offered candy if he behaves and threatened with the loss of dessert if he doesn't. The system is therefore based on a psychological inducement to adopt a given behaviour and to abandon another.

Rewards can vary greatly. In a prison environment, for example, they may consist in granting certain privileges (visiting rights, leaves of absence) or extras (the prospect of getting tobacco or supplementary food). The "token economy" system is yet another example of positive reinforcement that has often been used in prisons. The inmate who respects certain predefined standards of behaviour is promoted according to a hierarchy of ranks and grades. Each promotion brings a series of advantages for that prisoner. Techniques of positive reinforcement are frequently employed in hospital and correctional settings. Their degree of intrusion is generally considered acceptable.

2) Negative Reinforcement

Negative reinforcement, contrary to positive reinforcement, is based on the concept of punishment rather than reward. Inducement is replaced with retribution. The technique associates undesirable behaviour with the appearance of unpleasant stimuli. In theory, the repetitive process is designed to encourage the person to link the sanction with his conduct and cause him to abandon it, even when the actual threat of the unpleasant stimulus has disappeared.

Unpleasant stimuli vary. They may, for example, consist of mild electric shocks. Certain drugs, such as apomodine and anectine, have sometimes been used in American prisons. Administered when behavioural rules are broken, these drugs induce vomiting, a sensation of suffocation similar to that of a drowning person, and feelings of terror associated with imminent death.

When the sanction is physical, negative reinforcement raises the issue of physical assault. This has made it subject to controversy. To date it appears to have been rarely used alone, but rather in conjunction with other techniques.

In Canada, negative reinforcement has been frequently employed in the treatment of alcoholism and what is considered abnormal sexual behaviour. It has also been applied in other countries to help cure tobacco addiction, drug abuse, shoplifting, paedophilia, etc. There are certain problems associated with the reversibility of its short-term effects.

3) Desensitization

Desensitization techniques are used to treat certain forms of phobias and anxieties. Generally, they attempt to weaken the link the individual makes between his distress and the situation or the stimulus producing it, and to develop an anxiety-free response. The patient is gradually enabled to replace the anxiety-ridden reaction when exposed to the stimulus in question with one that is free of anxiety. For instance, a person who is terrified of crowds gradually learns to master this phobia, and substitute a normal reaction for the pathological one generated when in contact with a crowd.

The desensitization technique can take a variety of forms. Systematic desensitization is based on a gradual learning of relaxation. The patient is asked to imagine the very first step in the appearance of the phobia or anxiety-producing situation. In our example, he would try to imagine himself entering a crowd. At the same time he is taught to loosen up and relax. The experiment is repeated until he is able either to imagine the entire situation without distress or phobia, or at least to face up to it.

Another technique, known as total immersion, consists in placing the subject in phobic situations for long periods of time, either by allowing him to confront directly the real situation or by using pictures to provoke the anxiety. The patient has no possibility of escaping, and begins to realize that the trauma associated with the situation is not objective, or that its grounds are considerably weaker than imagined. The hoped-for result is the elimination or the mitigation of the anxiety or phobia.

These techniques have been used in Canada to treat certain neuroses and phobias such as fear of heights or of crowds. They are also used occasionally to cure stuttering, hyperactivity and impotence. They do not involve high risk.

To conclude this description of so-called ''psychological'' techniques, we must repeat that it is far from complete. There is a vast specialized literature that the reader may consult profitably for further information on the subject.

II. Physiological Techniques

Techniques falling within this second category attempt to modify human behaviour by a direct physiological intervention on the person. They are closer to medical treatment in the strict sense of the term. We will describe some of the classical forms of drug treatment, electroconvulsive therapy, electrical stimulation of the brain, psychosurgery and castration.

A. Drug Treatment

The discovery in the early 1950s of complex chemicals for the treatment of symptoms and certain effects of known mental disorders, created a genuine revolution in psychiatry. Since then, research on new drugs has made very significant progress. Drug treatment is presently one of the most common techniques for human behaviour alteration. The development of this form of treatment has considerably reduced the need to institutionalize patients by providing control of the most acute symptoms of their disease, and thereby allowing them to maintain an acceptable level of social activity.

Relationships between physical illness and mental illness are numerous and complex. A strictly physical affliction (for example, an hormonal imbalance or certain tumours) may have a significant psychological impact and seriously affect human behaviour. Conversely, some mental illnesses may have quite specific physiological consequences. It is therefore not surprising that drug treatment used for purely physical or psychological disorders may have secondary psychological effects in the first case or physical effects in the second, and repercussions to one extent or another on the patient's general state. This interaction between the physical and the psychological deserves special attention in the case of drug treatment.

Three types of drugs are most frequently used for human behaviour alteration. Psychotropic drugs, such as chlorpromazine, are helpful in certain types of schizophrenic or paranoid psychoses. They suppress or relieve the most acute symptoms of the disease, reduce or eliminate hospitalization, and facilitate social reintegration. On the other hand, they can have serious side-effects when taken for prolonged periods. Current research does not yet permit a reliable determination of the permanent and cumulative impact on the health of regular users.

Antidepressants are used mainly for the treatment of temporary or prolonged depression. They facilitate a reduction of hospitalization and relieve or suppress certain symptoms thereby permitting the use of other treatments (e.g., psychotherapy) to cure the patient or at least provide prolonged relief.

The third group is known as "antianxiety" drugs, more commonly referred to as mild tranquilizers. They are used against anxiety attached to stress or certain types of psychological disorders. Like the others, they may serve to facilitate other forms of therapy, or be combined directly with them. Like the other two categories, they produce more or less pronounced side-effects, depending on the person, the type of drug and the dosage. In addition, some may induce psychological or physiological dependence lasting for certain periods of time. They are widely used.

Another series of drugs or medication that does not fit directly into any one of the above mentioned may also affect human behaviour. Scopolamine and sodium amytal (popularly, but not correctly, known as truth serum) eliminate human defence mechanisms, and reduce the ability to speak against one's will. More recently, lithium salts

and tricyclic drugs have provided substantial progress in the treatment of certain forms of depression and various mental disorders. Finally, drugs or medication that are sometimes used in negative conditioning also fall within this category.

Treatment by drugs has made extremely important progress in the last several years. Its use, sometimes routine, raises ethical and legal problems, especially in relation to the right of a mentally ill person to refuse treatment, and to the legal mechanisms protecting persons against their unwarranted administration. Furthermore, as recent studies tend to show, some of these drugs used over lengthy periods, may have long-term and even damaging effects on the body and the nervous system.

This technique will no doubt continue to improve. Serious efforts are presently being made to reduce the long-lasting side-effects of these drugs and provide the ability to direct the chemical compounds to specific areas of the brain.

B. Electroconvulsive Therapy

Bilateral or unilateral electroconvulsive therapy (popularly known as "shock treatment") is the passing of an electric current of a defined intensity through the brain. The current provokes a convulsion similar to an epileptic seizure. In fact, the technique was discovered through observation of epileptic patients, who are virtually never afflicted with psychosis. Clinicians deduced that epileptics were naturally protected against this form of illness.

Electroconvulsive therapy is administered in hospitals with a number of medical safeguards in order to reduce the unpleasant effect on the patient. The major such safeguards are anaesthesia, administration of muscular relaxants and oxygen. Its operation on the human brain is still not well understood by scientists. Medical literature does indicate that the technique is useful in certain types of mental disorders, notably severe depression.

Electroconvulsive treatment has been frequently used in the United States and Canada, especially prior to the discovery of the principal drugs which now constitute the clinical basis of drug treatment. It has enjoyed a certain revival in recent years, when drug treatment is not indicated or ineffective.

Owing possibly to the way it was originally administered, this form of treatment continues to be the subject of lively controversy in the United States, Canada and other countries. A certain number of doctors, former patients and members of the public do not hesitate to call it an experimental technique, to warn of its side-effects and to point out the availability of less dangerous and traumatizing substitute techniques. Others note that selective use is beneficial to certain types of patients who do not respond to other forms of treatment. This technique has been, and continues to be, used in Canadian psychiatric institutions.

C. Electrical Stimulation of the Brain

Often classified as a particular form of psychosurgery, this treatment consists in surgically inserting electrodes in certain parts of the brain, and stimulating them to produce a given form of conduct. The technique is based on the principle that specific zones of the brain can be related to certain types of behaviour and that electric stimuli can provoke specific appropriate responses.

Experiments with this technique on animals and humans have been conducted in the United States for many years. We know of no example of treatment using this technique in Canada. It appears to be still largely experimental.

D. Psychosurgery

Psychosurgery is the destruction or isolation of certain parts of the human brain, despite the fact they are healthy and not afflicted with any type of pathology, with a view to modifying the patient's behaviour. An important distinction must be made between psychosurgery and neurosurgery. Neurosurgery sets out to eliminate parts of the brain affected with illness or pathology. Such is the case with an operation to treat an epileptic lesion, or one to remove a tumour. Brain operations conducted to suppress pain, when it cannot be controlled by other known means, are also generally classified as neurosurgery.

Psychosurgery's underlying hypothesis is the linking of particular places in the human brain with the control of various behaviours. It raises ethical and legal issues. On the one hand, psychosurgery provokes irreversible destruction of nerve cells which do not regenerate. On the other hand, it destroys organically healthy human tissues which show no signs of pathology. As yet there is little scientific evidence either of the effectiveness of psychosurgery in humans or of the predictability of its results.

The experimental character of this technique and its relative lack of success attracted the attention of the American government. As a result the (U.S.) *National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research* studied this procedure in detail. It recommended that psychosurgery be approached with great reservation. It is, nevertheless, still sometimes practised in the United States and Great Britain. A literature search indicates that it does not seem to have been used widely in Canada since 1973.

Frontal lobotomy, a particular form of psychosurgery, was widely used both in the United States and Canada until the beginning of the 1960s. By means of a special surgical instrument, certain parts of the frontal cortex were sectioned and neurologically isolated. Observations indicated that the operation produced an improvement in violent

or aggressive behaviour. The technique now appears to have been completely abandoned for two reasons. First, it sometimes caused serious and irreversible side-effects, notably a clear deterioration of intellectual capacity. Secondly, the availability of drug treatment, which gives better results, has brought an end to the technique, at least for the present time.

E. Castration

Castration may be either surgical or chemical. Surgical removal of the testicles causes the complete elimination of testosterone hormone in the blood. It considerably reduces or even totally suppresses sexual drive.

Chemical castration is accomplished by administration of certain recently discovered drugs (cyproterone, provera). These substances reduce the level of testosterone and produce effects similar to those of surgical castration. Its effects are however reversible and cease when the drug is not administered for a certain period of time.

There is considerable disagreement among specialists about the real effects of castration on male behaviour. Some believe its effects are not proven since reduction of sexual drive does not change sexual preferences. Others hold the contrary view and consider that castration (notably chemical castration) remains the best possible treatment for certain forms of undesirable sexual behaviour and greatly reduces violent tendencies.

These two forms of castration have already been used on sexual delinquents, notably paedophiles, in countries such as Denmark, Sweden and Germany. To the best of our knowledge it has not been practised in Canada, though an inmate did once petition an Ontario court to authorize his own castration. The court refused the request.[1]

These are some of the principal techniques that may be used to alter human behaviour. This description, even if summary, nevertheless permits a certain number of preliminary observations.

First of all, theoretically speaking, none of these techniques are, in and of themselves, unacceptable or intolerable. Yet the consequences and the possible effects of their administration must always be taken into consideration. A fundamental principle of medical law requires an acceptable proportionality between risk and benefit. Thus, where two techniques provide an equivalent result, the technique that has the lowest degree of risk and intrusion must always be preferred. For example, if the foreseeable and desired results in both cases are identical, a reversible drug treatment with no

1. *R.* v. *Williams*, unreported, 15 January 1976, Supreme Court of Ontario. See also "Where We Have No Law", *The Globe and Mail*, 15 January 1976, p. 4; "Court Has No Power to Order Castration" *The Globe and Mail*, 16 January 1976, p. 7.

serious side-effects is preferable to psychosurgery, which is not reversible and may have negative and permanent side-effects. Second, it also appears that some techniques are more intrusive than others. Such is the case when psychosurgery or castration are compared with positive reinforcement. Third, while some techniques are irreversible, there are others where the patient may stop treatment at any time without any permanent effects.

Fourth, even though all techniques have, or may have, side-effects, the seriousness of these side-effects varies greatly. Fifth, and finally, many of these techniques are still at the stage of scientific experimentation or experimental therapy. Others, on the contrary, have now been medically and scientifically accepted.

CHAPTER TWO

Issues and Responses in Present Law

Problems of behaviour control and alteration techniques must be examined within the perspective of the Commission's mandate, which is that of recommending changes in Canadian law. The reader should not therefore expect a thorough discussion of all the issues that these techniques may raise in a society such as ours, but only of those that relate to potential legislative or judicial intervention.

The very number of these problems requires clear identification of those which will be the subject of our analysis. This analysis can be made at two different levels. The first is that of the fundamental principles which form the very basis of present legal rules. It thus becomes necessary to evaluate the impact of these techniques both on the principle of the autonomy of the person and on that of the inviolability of the human body.

On a more specific level (that of the concrete application of the rules of law), we must also consider the wisdom of providing psychological integrity with the same legal protection as is currently provided for physical integrity. Finally, if such techniques can serve as mechanisms of social control in the broad sense of the term, we must ask what limits the law should place upon them and how these limits can best be translated into legislation.

I. The Autonomy of the Person: The Problem of the Nonconsensual Administration of Behaviour Alteration Techniques

A. Personal Autonomy in a Psychological Context

The notion of personal autonomy is fundamental. The Commission has already stressed its importance in several documents. It has no intention of repeating here the analysis already made, but only of examining it in the light of potential problems raised by the use of behaviour alteration techniques.

In a general sense, the person's autonomy means the affirmation of one's right to self-determination, the manifestation of one's freedom to decide. Autonomy is consequently of particular importance, and its preservation by the law all the more critical

when the decision is made by, and concerns, that person. Therefore the Commission formally affirmed the principle of autonomy over one's body when it recommended, as it did and does, that every competent person should have the right to refuse medical treatment, even when such refusal may lead to his death or a continuation of his illness.

This principle not only includes the right to make decisions pro or con a course of action, but also has another facet. If persons are truly autonomous, recognition of the right not to have the decisions of others imposed upon them against their will must also be granted. It is in the name of autonomy that a person's protection against imposed medical treatment is recognized. This right however is not absolute. The legislator may sometimes, in the name of public good or of the related rights of others, limit or restrict it to varying degrees.

Personal autonomy includes the right to ''choose'', on the one hand, and the right to ''refuse'', on the other. Within the context of physical integrity, these two aspects include the right to choose between different types of medical treatments, the right to decide not to be treated, and the right to refuse a treatment imposed by others which has not been freely consented to.

Within the context of behaviour alteration, these two freedoms raise particular problems that require a brief analysis. First, behaviour alteration techniques are not, in and of themselves, a threat to a person's freedom of choice and, thus, to his autonomy. Some claim, somewhat hastily, that these techniques inevitably constrain autonomy. Nothing could be more inaccurate. The everyday use of psychological and behavioural techniques is, on the contrary, aimed at restoring or enhancing individual autonomy and ability to make significant choices. The mentally ill person suffering from a serious psychosis has a limited degree of autonomy, curtailing his ability to make choices. Drug treatment for example can provide a partial or full cure for an illness, or at least mitigate its effects and restore the ability and the capacity to make personal decisions. However, we should not give way to paternalism, striving at all costs to improve the lot of others. That is why, in principle, wide scope must be left to the person's wishes and initiative.

Second, freedom of choice and freedom of refusal in matters of psychiatry are fluid and contingent notions. Fluid, because they often fall outside a truly objective standard. There are degrees of autonomy linked to individual considerations and imperatives. Consequently, it is true to say that a person with liberty enjoys, in general, a greater degree of autonomy than a prisoner. Yet, between a free man in perfect mental health and a free man suffering from acute schizophrenia, the difference is considerable, just as it is between a prisoner sentenced to life imprisonment and the one serving only a few months.

They are contingent notions because the autonomy of any person's decision making depends on an interaction of factors drawn from his education, his milieu and his environment, all of which directly influence the expression of individual freedom and are not prone to any form of strict scientific measurement. Determinists challenge notions

of autonomy and freedom on this basis. It should be recognized that these notions are not always very clear and, to a large extent, depend on individual factors and conditions. However, the basic underlying values deserve legal protection.

Freedom of choice implies the right to accept or refuse the administration of any of these techniques, and to select a particular one. It implies, as for any other form of treatment, an informed consent. It also raises, as with any other treatment, the issue of the right to refuse treatment. Nevertheless, certain differences distinguish behaviour alteration from purely physiological medical techniques.

In the first place, those who decide to undergo such treatments usually belong to a group of persons which suffers, to one degree or another, from a mental disorder suppressing or diminishing capacity to consent. The thorny issue of substituted consent arises most frequently and acutely within the context of psychiatric techniques. The question was recently addressed by the courts. A father sought an injunction against a psychiatric hospital to force it to provide his daughter with a certain type of treatment, and to allow him the right to choose her therapy and medication. The Québec Superior Court, while recognizing the father's right to be constantly informed of his daughter's treatment, denied the request. It held that, in the particular circumstances of the case, only the institution had the necessary expertise to decide the best type of treatment.[2]

Secondly, these techniques may sometimes be used to eliminate or restrain a person's judgment and his freedom to make an informed choice. This raises the problem of the nontherapeutic use of these techniques. It is possible with certain drugs to provoke precise pathological reactions in the person, to reduce his will and completely or partially deprive him of his ability to make judgments. The problem is clearly then their abusive application and not the techniques themselves.

Thirdly, a specific aspect of these techniques is their ability to induce a behavioural change in a patient despite his wish to resist such a change. This is the classic case of assault on the mind by an organized and scientific brainwashing procedure. Here again the limits of strict therapeutic use are breached and one is in the domain of ''re-education'', ''punishment'' or ''social conditioning''.

The person's freedom to resist the use of these techniques raises other issues related to the administration of the treatment. Is it legitimate to use them on a person, without his consent, when the behaviour to be corrected constitutes an immediate danger for himself or others? Is it legitimate to conduct the treatment only with the consent of the spouse or next of kin, or of the legally designated curator or guardian? Should society respect an individual's refusal to submit to these techniques, when the effect of such refusal may be a potential threat to the individual's life or health, or that of others?

---

2. *Arnold Carsley* v. *Centre hospitalier Douglas*, unreported, 27 July 1983, Québec Superior Court, no. 500-05-008783-837.

This brief analysis of some of the major difficulties raised by the principle of individual autonomy in the context of these techniques, demonstrates that the problem is indeed complex. It is necessary at this point to examine how the law can contribute certain reforms.

B. Nonconsensual Administration of Psychiatric Treatment

Before the question of nonconsensual administration of psychiatric or behavioural techniques is addressed, it is important to exclude the problem of experimentation. That issue is the subject of a separate Commission study now under way. Here we are exclusively concerned with medical treatment in the strict sense of the term.

Treatment of mental illness and disorders has made great progress since the last century. The person who suffers from mental illness is no longer dispatched to a prison-like asylum, totally abandoned and isolated from the rest of society. Today that person is more likely to be considered a patient, hospitalization tends to be relatively brief, and a particular effort is placed on the control of symptoms to allow for rapid reintegration into society.

For several years, however, problems related to consent to psychiatric treatment have stimulated much judicial consideration. Several important American and Canadian cases have attempted to define the rights of involuntary psychiatric patients with regard to therapeutic interventions without consent, as well as their right to refuse treatment.

In the United States especially, psychiatry in its broadest sense has been the subject of strong attacks by former patients, lawyers, civil libertarians, and by a mixed group to whom the label of "antipsychiatry" has been given. It is important to examine the basis of these attacks in order to help us appreciate their validity and to facilitate a critical evaluation of the present state of the law.

These critics question the truly free and voluntary nature of the administration of psychiatric treatment, and the effective participation of the institutionalized person in therapeutic decisions concerning himself. Physicians are criticized (often on the basis of extreme examples of glaring abuse) for denying the patient any real choice in the administration of treatment once the law has declared the patient to be incompetent. Once legal incapacity has been found, it is claimed that everything takes place as if the patient had nothing more to say in the administration of therapy. This contrasts with the situation of the nonpsychiatric patient who may, at any time, obtain relevant information, discuss the pros and cons of proposed medical procedures and even demand that they be stopped. The mentally ill patient is thus deprived of true freedom of choice because previously classified as incompetent.

This loss of freedom has two important consequences. First, the patient's decisions are not respected, or are bypassed, on the assumption that they are the product of a mental process incapable of making them. That patient is thereby in danger of receiving treatment against his will. Secondly, the decision to ignore the patient's wishes has the practical effect of freeing the therapist from the general legal obligation to inform his patient. Information is normally provided specifically to enable the patient to exercise an informed consent, something that one who is incompetent, in this view, cannot really do.

It is also argued that the danger of imposed treatment is all the greater when certain techniques are used which provoke intellectual confusion and further reduce the ability to make decisions. This criticism generally is accompanied by a demand for supplementary, impartial and independent mechanisms of control.

Finally, the critics deplore the fact that refusal of treatment is often considered a priori to be unreasonable, and even as a symptom of the presumed impossibility to give a valid consent. Yet the reasonableness of a refusal to be treated is not the problem. Even an unreasonable decision must be respected if the person making it has the capacity to understand the nature and consequences of his act. One may consider unreasonable, for example, the decision by an adult Jehovah's Witness to refuse a blood transfusion. Yet this decision must be respected despite its serious consequences. There is probably a tendency to show less respect for a decision to interrupt treatment taken by a psychiatric patient because there is a readiness to presume a causal connection between refusal and incompetence. Refusal is often considered unreasonable in itself and the very evidence of the patient's incapacity to provide a valid consent.

These critical observations have some merit. The somewhat dualistic distinction between competent and incompetent persons, between voluntary and involuntary patients is surely open to criticism. If these occasionally arbitrary classifications are used to automatically deprive the patient of the right to make any decisions regarding his own body and health, the possibilities of abuse become evident. The capacity to decide, in this context, must be evaluated with extreme caution. A judicial or administrative declaration of incompetence, or a commitment, should not automatically constitute legal justification for completely ignoring the wishes of the patient.

Two related notions are sometimes confused by the present legal system and should be more clearly distinguished: legal competence, in the large sense of the term, and the ability to consent. For some time, in most legal systems, a finding of incompetence by an administrative or judicial decision carried not only a denial of the right to administer property, but also of all rights to make decisions affecting physical or mental health. Many fundamental rights were probably easily abused or ignored by this system. If one adds to this the fact that it was often in practice difficult to have that finding revised, it is easy to understand why under the old system to be found incompetent was indeed a decision with serious consequences. The curator, tutor or guardian decided on his own, without consultation, "what was in the best interest" of the patient without

really trying to determine if the latter's perception of this interest was identical or similar. In this paternalistic model the patient's refusal of what may have been objectively beneficial treatment could in practice be easily ignored "for his own good".

The Law Reform Commission already expressed some views on this question when it considered the problem of sterilization of mentally handicapped persons. In its Working Paper 24, page 77, it made the following comments concerning sterilization:

> There is nothing *inherent* in mental handicap, however, that prevents a person from providing competent consent to a sterilization. If a mentally handicapped person requests that sterilization be performed, and it is established that he or she understands the nature of the procedure and its consequences and is under no duress to undergo the sterilization, then that person should have the right to exercise or withhold his or her consent. The existence or degree of handicap should not be a relevant issue. In such a case the use of third party consent or the refusal to provide the sterilization denies such persons a right normally accorded to others.

We believe that these remarks state principles that are applicable to the techniques discussed in the present document.

Legal mechanisms for the protection of incompetent persons have now changed thanks to the gradual enlightenment of both society and the legislator. It is impossible here to study in detail all the relevant legislation and case-law. However, as the problem remains important for law and criminal policy, it is appropriate to make some brief comments on certain aspects.

The person's first and most important guarantee is the right, in principle, not to be subjected to psychiatric treatment in an arbitrary manner and without consent. Indeed any treatment, excluding cases of emergency and necessity, must remain an act to which consent is freely given. At present, federal and provincial laws do provide some protection against possible abuse.

A study of the *Criminal Code*'s application in this respect would be redundant, given the thorough analysis undertaken by the Commission in its Working Paper 26, *Medical Treatment and Criminal Law*. In that document, the Commission recommended that the *Criminal Code* recognize the right of every competent individual to refuse treatment or to demand its interruption, thus affirming the autonomy of the person regarding decisions affecting one's own body. On the other hand, at the time Working Paper 26 was written the *Canadian Charter of Rights and Freedoms* did not yet exist. A close examination of the Charter suggests that it does strongly reinforce the psychiatric patient's autonomy and right to self-determination. Section 7 of the Charter protects the right to liberty and security of the person and requires that any encroachment upon these rights be done in accordance with principles of fundamental justice. Because the Charter's application is not confined to criminal law, we believe that an institutionalized person or one who is subjected to psychiatric treatment without the observing of these standards, could invoke this provision and benefit from greater protection against arbitrary detention. The Charter should also protect the person who is committed without having had the opportunity to defend himself against that process, allowing him to rebut

evidence and present his own version of the facts. "Fundamental justice" is a sufficiently large concept to permit the judge to question, for example, the process and the methods employed to declare a patient legally incompetent and to authorize a non-consensual psychiatric treatment. As we note below, the protection against cruel and unusual treatments (section 12) is also applicable.

In addition, section 9 protects against arbitrary detention, and section 10 provides the right to determine the validity of a detention by *habeas corpus*. The Commission believes that these sections allow the involuntary psychiatric patient to argue that he is being illegally held against his will and to demand his release. The Charter has an extremely significant impact on the rights of psychiatric patients because it clearly reaffirms that a declaration of incompetence does not eliminate what it recognizes as fundamental rights.

At the provincial level there exists a variety of judicial or administrative mechanisms such as regional boards of review aimed at preventing arbitrary detention, ensuring that the incompetency procedures respect fundamental rights, and permitting periodic revision of the legal status of incompetence. Without going into details, it should be mentioned that the majority of provincial statutes allow the patient to demand a review of his case by an independent body. The remedy of *habeas corpus*, the traditional guardian of a persons's freedoms, also remains available.

A second type of protection is that which allows the psychiatric patient to refuse treatment, even when he has been declared legally incompetent. To clearly identify the various possibilities, we will refer to some examples, though they might be somewhat misleading. No two perfectly identical situations exist, and it is always important to focus upon the particular facts of each individual case. These examples are therefore only meant to serve as illustrations.

The first is the case of a person completely deprived by his mental disability, either temporarily or permanently, of the ability both to understand what is happening to him and to exercise a rational and informed judgment. The case is analogous to that of the highway accident victim brought unconscious to a hospital emergency ward. As the Commission has already affirmed elsewhere, in such circumstances the presumption must be in favour of life and health. Medical authorities should have the right to provide treatment and should not have to presume that if that person were conscious, he would refuse treatment. Should a physician be accused of assault in these circumstances, he has a valid defence under the existing criminal law. The same is true under tort law.

This principle was recently reaffirmed by courts. In one case, the authorities of a centre for the criminally insane sought a declaratory judgment to allow them to treat a psychotic patient against his will. This patient had threatened the Premier of Québec, and had refused all treatment on the grounds it was a political plot to stifle his freedom of expression. Satisfied with evidence that the patient was genuinely suffering from paranoid schizophrenia, and convinced that the absence of treatment would only lead

to a deterioration of his condition, the court acted in *parens patriae*, substituting its decision for that of the patient, and authorized the petitioner to proceed with treatment, even by force.[3]

The procedures designed for the protection of these rights can be, however, as important as the rights themselves. After a critical study of those already existing, it seems to us essential that these procedures be made more uniform.

A second example involves the person who has preserved some awareness and contact with the outside world, but shows signs of conduct dangerous either to himself or others. An instance would be that of the acute psychotic who threatens the life of his next of kin. Given the present state of the law it is doubtful that treatment can be administered to the patient without his consent. Yet procedures can be undertaken for finding of incompetency and institutionalization, and the ordinary measures taken to protect his life and that of others.

A third situation is probably the most common. It is the case of the person with a mental disorder who is no immediate danger to himself or others. The danger could occur however if his decision to refuse or to interrupt treatment is respected. Legally, the problem is to determine if his decision is truly free and informed, in other words, the result of a valid act of will. Nonconsensual administration of treatment could, on the one hand, be justified in the name of the potential risk to the safety of others and of the repetitive character of the behaviour. On the other hand, it is also possible to respect the patient's decision (the present law seems to be to this effect), but demand in return hospitalization so as to prevent the possible negative consequences of this decision on others. At present, the law appears to offer no clear and fully satisfactory response, largely in view of society's changing attitudes towards the mentally ill.

Our final example is that of the patient who refuses therapy, as in the preceding case, but poses no threat either to himself or others. We believe his decision should always be respected, provided he has been properly informed. In the absence of other circumstances, treatment without consent constitutes a criminal act and a civil tort.

Incompetence is principally within the ambit of provincial law, which by means of various statutes provides for the protection of those incompetent, and the procedures and system governing voluntary or involuntary patients. A brief review of the approach taken by various provincial statutes regarding the right of psychiatric patients to refuse treatment seems pertinent. It indicates that approaches and responses to the problem are as yet far from being uniform.

Provincial mental health legislation can be divided into four groups. A first group explicitly provides for the detention and nonconsensual treatment of the psychiatric patient hospitalized in the interest of his own safety or that of others. Newfoundland's statute law falls in this first category. Subsection 6(1) of the province's *Mental Health Act, 1971* (S.N. 1971, c. 80) states the following:

3. *Institut Philippe Pinel de Montréal* v. *Dion*, [1983] C.S. 438.

> ...Any person, who in the opinion of a physician is suffering from mental disorder to such a degree that the person requires hospitalization in the interests of his own safety, safety to others or safety to property, may *without his consent* be admitted to, detained within *and treated* at a treatment facility. [Emphasis added]

The mental health legislation of British Columbia, Manitoba, Saskatchewan, New Brunswick and Alberta comprise a second group. Each of these statutes differs from the others in a number of respects which cannot be noted here. However, all have a common characteristic. To one degree or another, they appear to recognize "implicitly" that the hospitalized involuntary patient does not have the right to refuse treatment. Some provinces explicitly recognize this right only for the voluntary patient. Logically, where there is explicit recognition of that right only for the voluntary patient, one is entitled to conclude that it is not extended even implicitly to the involuntary patient. For example, the *Manitoba Mental Health Act* (R.S.M. 1970, c. M110, s. 8(4), as amended by S.M. 1980, c. 62, s. 17), provides as follows:

> Where a patient is a *non-compulsory patient*, no treatment shall be given to the patient if the patient objects to the treatment. [Emphasis added]

Admittedly, differing and even contradictory interpretations are possible as to the exact scope of the right to refuse treatment in this class of legislation.

The laws of Ontario and Nova Scotia comprise a third group. Both provinces explicitly acknowledge the right of the hospitalized patient to refuse treatment. Nova Scotia's statute states that the ability to consent to treatment is to be determined by the psychiatrist. If this is not done, the patient is presumed to have the ability to consent to treatment, even when hospitalized. Ontario's legislation (*Mental Health Act*, R.S.O. 1980, c. 262, s. 1(*g*)) takes the same approach, but adds a precise and interesting definition of the term "mentally competent", namely

> means a person having the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent;...

The fourth group consists of those statutes that do not address the question directly or indirectly. Such is the case with the ordinances of the Yukon and Northwest Territories and the legislation of Prince Edward Island. Québec has a unique system of "cure fermée". Its laws make no direct reference to refusal of treatment, although a procedure to revise involuntary commitment is provided for.

Three main trends emerge from this brief analysis. First, genuine respect for the person can only exist if the law respects both his consent to treatment and his participation in it. For such important decisions as those dealing with life and health, the law must insist on respect for the person's choices, and steer clear of imposing treatment without consent except in emergency or situations involving imminent danger. The widely accepted presumption that an individual is presumed to be competent, unless declared otherwise, must be maintained intact.

Second, consent must not be considered to have been given once and for all for all future eventualities. Consent must be understood as a continuous process. Because it was obtained at the start of treatment, this does not justify the continuation of treatment despite a patient's subsequent reservations, objections or refusals. The problem of establishing withdrawal of consent during treatment is of course difficult. Nevertheless, procedures and forms for such withdrawal are available in hospitals. They appear to fulfil their purpose, even if no serious study of their real effectiveness in psychiatric cases is yet available.

Third, contemporary law is beginning to delineate better between legal competence and ability to consent, or between legal incompetence and incapacity in fact. These notions must be clearly distinguished. A person who is judicially or administratively declared to be incompetent should nevertheless retain some ability to participate in decisions concerning medical activities, even when hospitalized. At least, such a patient should have rapid access to a review of the incompetence verdict. A declaration of incompetence should not be a way of denying the patient's participation in decision making, and of systematically ignoring his choices.

II. The Principle of the Inviolability of the Person and the Protection of Psychological Integrity

A. Inviolability of the Person in a Psychological Context

The notion of inviolability of the person is closely related to other concepts already studied by the Commission, notably that of the sanctity of life, a notion explored in detail in the Study Paper, *Sanctity of Life or Quality of Life*. This notion has also been examined in the context of physical assaults in Working Papers 26 entitled *Medical Treatment and Criminal Law*, and 28, *Euthanasia, Aiding Suicide and Cessation of Treatment*.

To ensure the protection of the person, all laws, whether federal or provincial, require that informed and free consent be given before any treatment is undertaken. Article 19 of the Québec *Civil Code* clearly reflects this principle by stating that "the human person is inviolable. No one may cause harm to the person of another without his consent or without being authorized by law to do so." The law also recognizes the right of the person to surrender this inviolability. This happens, for example, when consent is given to a surgical operation. Without consent the act would be an assault under the law. The law also permits certain interferences that are not consensual. For example, in the case of contagious disease, where there is a risk of contaminating others, a physician may be authorized by a health official to take medical action over the person's refusal to be treated. Provincial legislation contains a number of examples of such authorizations designed to protect public health.

The person's right to physical integrity is recognized by law as fundamental even if the degree and quality of protection may vary. In a democratic society such as ours, great emphasis is placed on a person's freedom from interference. Cases where the law authorizes interference with personal integrity are rare, even exceptional, and are always precisely defined. Courts generally interpret these exceptions in a restrictive manner in order to ensure the fullest possible exercise of a person's freedom.

The concept of the inviolability of the person is discussed and analyzed most frequently in the context of physical infringements. Under the *Criminal Code*, persons are protected from assault, homicide, or acts of negligence likely to endanger this integrity. Civil law, as well, protects this principle. Tort rules give the victim of an illegal and unconsented-to assault a right to monetary compensation for the harm suffered. Courts evaluate incapacity in monetary terms, whether the incapacity is temporary or permanent, total or partial, and apply a cost to the consequences of the injury.

A human being is not however only a physical entity. Persons not only have bodies, but also are intellectual, spiritual and emotional entities. Up to now these other non-corporeal dimensions of the person have been less protected by the legal system. Examples of protection against attacks on the psychological integrity in case-law or in legislation are quite rare. They nevertheless exist and their very existence is evidence that the law does acknowledge psychological integrity as a value deserving protection in the name of the principle of the inviolability of the person.

In some cases, assaults on psychological integrity are the result of an assault against physical integrity. The problem of sanction, if it arises, can in such cases be resolved by the rules relating to the protection of physical integrity. Thus the performance of psychosurgery against the wishes of a competent patient would undoubtedly constitute an assault and a civil tort. There are other cases, however, where this interference is not predicated on a violation of physical integrity. In such cases the law appears to be generally unsure of its response. It is doubtful that present criminal law contains any disposition prohibiting the unconscious and involuntary psychological conditioning of a person by subliminal advertising. Nor is it certain that the law could adequately react to the veritable psychological imprisonment or brain-washing of people who have become victims of certain cults or sects.

Legal protection against psychological interference thus remains limited and specific. The *Criminal Code* contains only a few examples of this type of protection, such as crimes of extortion, blackmail and intimidation. Usually, however, the protection in these cases is only indirect since the main thrust of the offence seems to be to prevent physical assault or interference against property or goods. On the other hand, section 688 of the *Criminal Code* provides an exception. This provision, dealing with dangerous offenders, contains an explicit reference to the "physical or mental well-being" of the person and to the "severe psychological damage" which could be inflicted.

Civil law, on the other hand, does react more effectively to damage resulting from an attack on the psychological integrity of the person. It provides compensation for moral damages, alienation of affection, and pain and suffering, even where there is no

direct and specific material injury. The *Divorce Act* similarly admits mental cruelty as a valid cause for the dissolution of marriage. Finally, various federal and provincial laws protecting special groups such as children against abuse are other examples. These laws allow removal of a child from the care of a person who represents a psychological threat to that child.

We conclude that under present law, the principle of the inviolability of the person is not restricted to physical integrity alone, but also extends, although in a much more limited way, to psychological integrity. This partial protection may at first glance seem insufficient. But before taking the law to task, one should first clearly identify the degree of protection our society "should" provide, and then determine if a truly effective protection is legally possible.

B. Present Legal Protection

In contrast to the protection of physical integrity, an examination of provincial, federal, international and foreign laws reveals a lack of systematic and organized protection of psychological integrity. As we will note later, protection of psychological integrity poses for law difficult problems of evidence. It is relatively easy to establish material and tangible evidence of physical assault on a person and to present it to a court. On the contrary, it is difficult and sometimes impossible to establish the impact of psychological interference, or even its relationship to certain physical symptoms, in a way consonant with the legal rules of evidence.

On the international legislative scene, a certain number of documents indirectly relate to this question. *The United Nations Charter*, *The Universal Declaration of Human Rights*, and the *International Covenant on Civil and Political Rights* all recognize such fundamental rights as the rights to life, liberty and to refuse to be the subject of experimentation. These rights however are not precisely defined. Arbitrary detention, for example, would probably be seen as an infringement on fundamental freedom and thus be protected. Similarly, physical abuse or humiliating and degrading punishments would surely fall within the ambit of these texts. What is not certain, however, is that situations involving psychological interference in the absence of physical assault would fall within their scope.

International medical "Codes" of ethics furnish another example of partial protection. These texts, formulated by the international community, establish the main norms of what is judged humanly acceptable. As with all international documents, their moral value is widely recognized in medical and scientific communities. *The Nuremberg Code*, *The Declarations of Geneva*, *Helsinki*, *Tokyo* and the *Hawaii Declaration of The World Psychiatric Association* reject all forms of human experimentation performed without consent, attempt to establish limits regarding acceptable medical treatment and reaffirm rules relating to competency, freedom of consent and the informing about risks.

Closer to our preoccupations here, however, are certain international texts relating to the protection of children. Important consideration is given by them to the idea that a child has the right to a harmonious development of his personality and therefore should be protected not only from physical dangers but also from psychological harm. The *Declaration of the Rights of the Child* proclaimed by the United Nations on 20 November 1959, states ten main principles, each of which clearly exemplifies this theme in various terms. For example, the right to develop "physically, mentally, morally, ... in a healthy and normal manner;" the right to grow "in an atmosphere of affection and of moral and material security;" etc.

In Canada, the strongest legislative protection is without doubt contained in the *Canadian Charter of Rights and Freedoms*. Section 7 provides that everyone has the right to life, liberty and security. In the Commission's view, the wording of this section is broad enough to ensure protection of psychological integrity. An assault against psychological integrity can destroy or interfere with the liberty and security of the person and constitutes a direct attack on the fundamental rights recognized by that document.

Section 12 on the other hand guarantees to each citizen of Canada protection against "any cruel and unusual treatment". Because this Charter is new, it is probably too soon to confirm with any certainty the legal interpretation it will be given. Nevertheless, the terms used by the legislator, and the general meaning of the word "treatment" provide every reason to believe that this text would protect the psychiatric patient from any unusual or experimental therapy or one representing a serious risk to health or life. In the United States, similar, if not identical, terms have been given a wide judicial interpretation and have provided extensive protection for a person's interests. The Commission believes that a similar line of thought will guide the interpretation of the Charter sections.

The *Criminal Code* contains a variety of provisions relating to the protection of the person. But, as already indicated, with few exceptions these almost exclusively seek to prevent physical or material injuries (deprivation of physical freedom, assaults, etc.). To become a criminal act, assault must either be directed against the human body or must cause bodily harm. Indirectly, however, the *Code* acknowledges the importance of effects other than physical in the creation of offences. This is apparent in paragraph 49(*a*) (an act intended to alarm Her Majesty), in paragraph 205(5)(*d*), (wilfully frightening a child or sick person to death). This recognition is however limited since section 211 states that apart from the exception provided for in paragraph 205(5)(*d*), one cannot commit homicide by means only of influence on the mind. Already mentioned examples of extortion, intimidation, and dangerous offenders are cases where the criminal law does recognize psychological injury. Provisions protecting one from defamation can also be placed in this category as they tend to prohibit indirect interference with the personality rights of the victim. Laws protecting children from sexual abuse also recognize this element of psychological assault.

Provincial laws also contain provisions to protect a person's psychological integrity. The already considered statutes concerning the protection of the mentally ill constitute

the most striking example. Those providing protection for children against abuse provide another illustration.

Lastly, our research into the legislation of some other countries indicates that, at present, there is not a single legal system in the world which gives the same protection to psychological integrity as it does to physical integrity.

One must therefore turn to case-law. The civil law of Québec and the common law of the other Canadian provinces have long recognized moral damages, even distinct from physical assaults. The author of a delict or a tort must compensate his victim for psychological harm caused by his fault or negligence. Courts have awarded damages for attacks on reputation in cases of defamation, even where no direct economic or material damage was suffered. Other well-known examples are damages granted for loss of enjoyment of life, loss of moral support, false imprisonment and loss of consortium. These rules are not peculiar to Canada. They are also found in the majority of other legal systems.

In the United States, no doubt owing to greater use of these behavioural techniques, courts have more frequently tackled problems related to the legitimacy and legality of these techniques and the need for protection against psychological intrusion. The recognition of a "right of privacy" constitutes one of the basic tenets of the law. In the case of psychosurgery, American courts have also decided that the First Amendment of the Constitution could serve as the basis for the protection of the individual on the grounds that freedom of speech and expression guaranteed by this text would be seriously impaired if, as a result of such a behavioural technique, the right to freely generate ideas were to disappear.

Traditional law, both statutory and case law, affords no general protection against attacks on psychological integrity as it clearly does against attacks on physical integrity. Although particular kinds of acts causing psychological harm are sanctioned under the law, this has not led to the formulation of rules with universal scope. It is probable however that this attitude will be changed by the provisions of the *Canadian Charter of Rights and Freedoms*. In principle, criminal law should directly prohibit violations of this recognized and protected value. Should the *Criminal Code* contain an offence, parallel to that of (physical) assault, to prohibit injury to the psychological integrity of a person? Is it possible, however, to overcome the very difficult problems posed by evidence of this kind of interference?

III. The Use of Behaviour Alteration Techniques as a Sanction or Method of Social Control within the Context of Criminal Law

One can easily imagine, with the help of examples already available from other countries, a society in which these techniques would be used to ensure strict compliance with the rule of law. In our system, when the law forbids certain types of behaviour

and imposes a sanction on an offender, it does not completely suppress that person's freedom of choice. This statement is in fact of considerable importance. The driver of a vehicle is free to consume alcohol. However, in the interest of safety, impaired driving is forbidden by law. The law goes still further: police can use a breathalyzer device to determine the degree of intoxication. The driver nevertheless remains free to continue drinking and refuse to submit to the test, even if this leads to a penalty. Sanctions applied for breaching the law do not in principle go so far as to completely suppress freedom of choice.

Again, when society punishes a citizen for criminal behaviour, it allows the offender, after the administration of the sentence, the "freedom" to break the law again. Once the sentence has been served, the offender is "free" to commit the same crime again, if he is ready to face the consequences. There are however countries which limit this other form of freedom in which a recidivist can be condemned not just to prison, but to involuntary treatment and various forms of behaviour conditioning. The goal then is to permanently suppress undesirable behaviour and to substitute in its place behaviour conforming more closely to an "ideal" social model. Many of the techniques previously described thus pose a problem when used as methods of social control. The difference separating the classical form of punishment from punishment using these techniques is that in the first instance, once the sentence is served, the person regains his freedom of choice, whereas in the second case, this freedom of choice is itself eliminated against the person's will. The legitimacy of the use of these techniques as sanctions for criminal acts is a real question for a democratic society. That same society should also question its motives when it attempts to use them as a method of social control.

A. Criminal Sanction

The use of behaviour alteration techniques as penalties assumes, on the part of the state, the right to impose treatment without the consent of the person for whom it is intended. At present there is no such right in our society. The systematic or even occasional use of these methods as a penalty for the perpetration of a criminal or antisocial act, without the consent of the individual, is inadmissible and should be firmly rejected. It would be contrary to the basic principles of a democratic society. It would suppress decisional autonomy, reduce the person to a simple object and, without any doubt, open the door to the serious potential for abuse. On a strictly legal level, it would be contrary to a set of international principles to which Canada adheres and, on a national level, to the *Canadian Charter of Rights and Freedoms*. The question remains however whether it remains possible to impose them in an indirect way through certain programmes or structures.

At a conceptual level, the distinction between the notions of treatment and punishment is sometimes blurred. Sometimes an apparent punishment is made an integral part of treatment. A good example in certain behavioural therapies is the use of negative

reinforcement, in the form of denying the patient, because of bad behaviour, the right to a visit or recreation or another privilege. This can be analyzed both as a form of punishment and as an integral part of the treatment. Criminal law should not prohibit these acts, because they are elements of the administration of treatment, considered beneficial, and given with the actual or substituted consent of the person, providing the treatment conforms to the general conditions imposed by law. On the other hand, punishment which involves a serious assault on physical integrity, or which is unreasonable in view of the goal sought by the therapy, should not be tolerated. Any act, even if it may be perceived by the person as a punishment, must conform to the norms already established by law, (that is, an intervention must be beneficial to the person, reasonable in nature, and provided only after obtaining informed consent).

A second situation is where treatment is given within the general framework of the administration of the punishment. This is the case where psychological or psychiatric treatment is given to a person serving a sentence for an offence. The problem in this case is to ensure that the prisoner's acceptance of the treatment is truly free and voluntary. Such treatment should be provided in a free and voluntary manner and not form part of a punishment or reduction of sentence. On a scientific level, there would be reason to doubt the efficacy of therapy based solely on these motives.

Some will argue that although a prisoner can satisfy the requirement of "informed" consent, the voluntary character of the act is suspect. The prisoner is in a coercive situation. He has no control over his movements and cannot exercise his initiative. It is argued therefore that a prisoner cannot in reality give valid consent. To ensure full protection for this class of citizen and prevent abuse, it is sometimes argued that prisoners should not have access to behavioural treatment.

The well-known *Kaimowitz* case in the United States illustrates this claim. A person was detained in a psychiatric hospital following a rape and murder. He signed a form consenting to psychosurgery intended to reduce, if not eliminate, his aggressive tendencies. This form of surgery, largely experimental, would have allowed scientific comparison with results obtained by another treatment by means of drugs. The *Kaimowitz* court, in spite of the prisoner's consent and the fact that the procedure was given approval by a scientific committee, concluded that such an operation on a patient detained against his will was contrary to the First Amendment of the United States Constitution. It stated that this kind of intervention was illegal because it was contrary to the "right to privacy of the mind."[4]

This position, apart from any discussion of the intrinsic merits of psychosurgery, appears to us too extreme. First, it is difficult to generalize and to conclude that a person incarcerated is thereby always incapable of giving valid consent. In the usual hospital setting, a patient may be in a somewhat similar situation when the doctor

4. *Kaimowitz* v. *Department of Mental Health*, 42 U.S.L.W. 2063 (Circ. Ct. Wayne County, Michigan, 1973). See also J. R. Mason, "*Kaimowitz* v. *Department of Mental Health*: A Right to Be Free of Experimental Surgery" (1974), 54 *Boston Law Review* 301.

explains that a cure to a serious illness cannot be achieved unless he consents to a particular operation. That patient's choice is then limited and the pressure on him can be very powerful. Nevertheless, no one would dream of preventing that patient access to surgery. Refusing access by prisoners to techniques which might be helpful would surely deprive a number of them of any possibility of progressing towards social rehabilitation.

The Commission believes on the contrary that the solution lies in the mechanisms used for ensuring informed and voluntary consent. It must be kept in mind, as noted in the Commission's Study Paper *Consent to Medical Care* at page 95, the law should a priori consider consent given by a prisoner as suspect. It should then impose additional conditions to ensure the free and voluntary character of that consent. Treatment should always be easily accessible to the individual but should never be indirectly imposed. Nor should it be linked to favours, or reductions of sentences or other privileges. The principle of proportionality between benefits and risks should also be scrupulously respected. The single consideration should always be the improvement of the condition of the prisoner.

In the Commission's view, the mere existence of difficulties relating to a prisoner's consent is not sufficient reason for systematically eliminating psychological treatment programmes from the institutional milieu. It is, on the contrary, a valid reason for recommending the development of a series of ethical rules. These rules would concern not only problems connected with obtaining consent, but also those relating to confidentiality of professional relationships, and the role of the therapist when interacting with prison or parole authorities.

The Commission therefore believes that a clear distinction must be established between treatment and punishment. Psychological treatment should never be conceived of, or imposed as, punishment for a violation of criminal law rules. In the case of prisoners, the administration of treatment should also be clearly dissociated from punishment in order to ensure that, as much as possible, it is provided according to essentially the same conditions which apply outside prisons. The ethical rules in this respect must be reinforced.

B. Social Control

Outside the limited context of prison and punishment, the state could resort to psychiatric and behavioural techniques with a wider objective of the preventive social control of delinquency. At the present time a certain form of this type of control is exercised in cases of mental disorder, that is when the act can be related to mental instability. Again, it is necessary to go further by determining the legitimate degree of recourse to these techniques as a method of prevention.

A first potential use of these techniques could be made before, and as an alternative to, a trial. A police officer will use a certain degree of discretionary power when faced with bizarre delinquent behaviour suggesting a lack of sanity. If he believes that the offender is suffering from mental or behavioural problems, he can decide not to issue a complaint and use the powers given to him by federal and provincial law to direct the person to a health care institution better equipped to deal with him. This is a good example of what is known as "diversion". In this manner the delinquent is directed to a health care institution rather than to the criminal law system.

If the police have already brought a complaint, the Crown can then use its discretionary power and require the individual to submit to a psychiatric examination before deciding whether or not he should be charged. The Crown can suspend or drop the charges upon obtaining a consent to submit to psychiatric care either as an out-patient or as an institutionalized patient. Some of the treatment techniques already described can then be used as a means of treatment.

A second possible use of these techniques could be made when, according to section 542 and subsection 543(6), the accused is declared unfit to stand trial by reason of insanity or found not guilty for the same reason. The accused is then placed in the care of the lieutenant governor at his "pleasure". Usually he is placed in a psychiatric institution and can be set free if the treatment is successful. Regular review by members of review boards is prescribed by provincial legislation. Within the institution, psychiatric and behavioural techniques can be used to control the individual judged unfit and attempt to provide a cure allowing him to return to society.

The third use of the psychiatric and behavioural techniques may be made at the point of sentencing and during imprisonment. As regards sentencing, paragraph 663(2)(*h*) of the *Criminal Code* is currently used by courts to require the accused to voluntarily submit to psychiatric treatment. The court then issues a probation order setting out the particular conditions of the treatment to ensure according to the text, "the good conduct of the accused". Technically speaking, a literal interpretation of this section does not appear to require the consent of the accused. In practice however, the accused is either given a choice between a probation order or a prison sentence, or consents freely to the suggested regime. The court can also sentence the accused and include in the sentence specific recommendations for appropriate treatment. The Law Reform Commission of Canada in its Working Paper 14 suggested the adoption of the British hospital order which allows a court, under certain conditions, to authorize the accused to serve all or part of his sentence in a psychiatric institution.

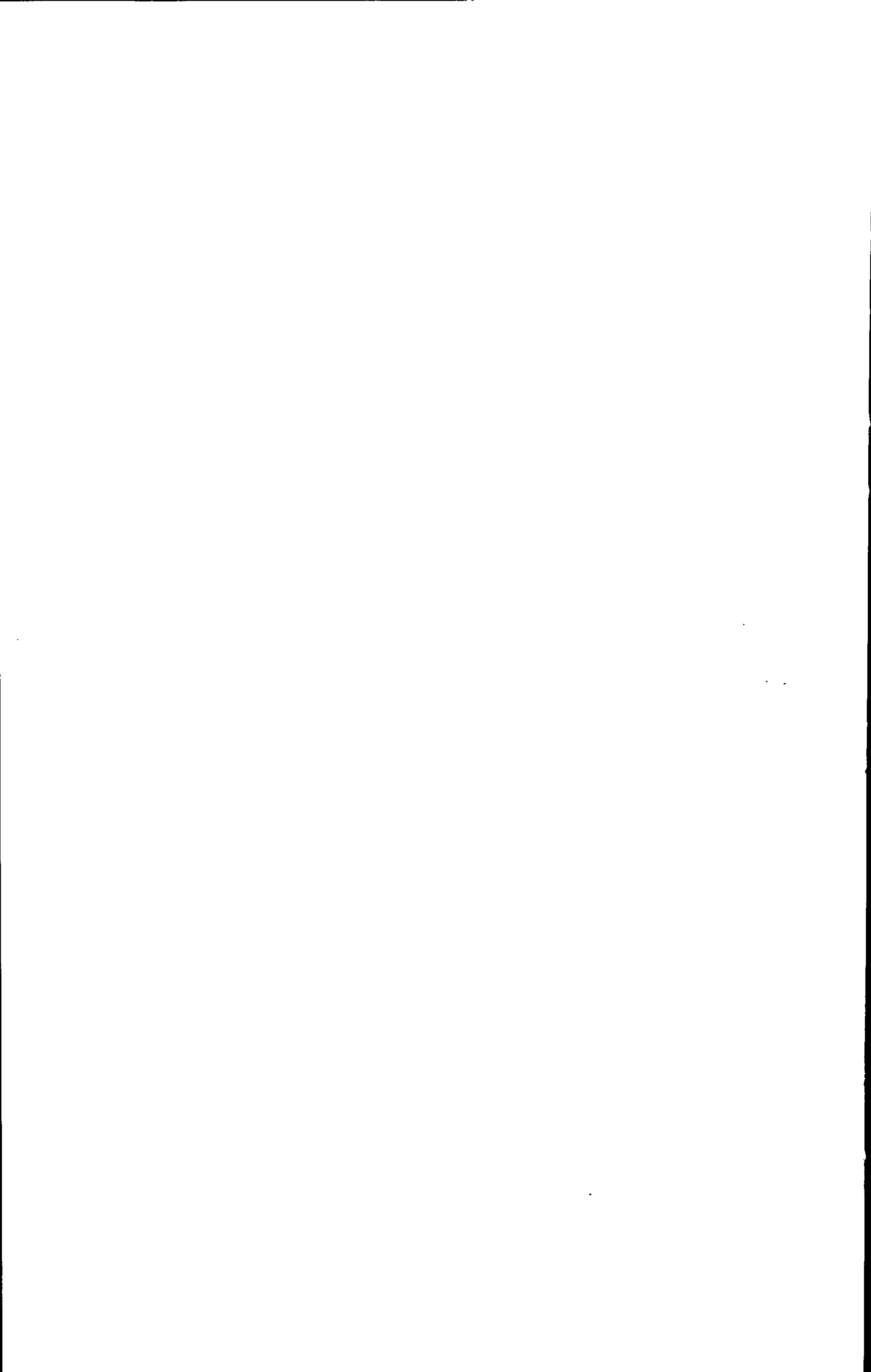
A fourth and last possible use of these techniques as a method for social control takes place in the prison environment. Treatment services are available in the prison itself or in outside institutions. Here again the view of our legal system is that these techniques can only be used on a voluntary basis. Regulations and directives of the penitentiary administration do not allow the use of these techniques outside the therapeutic context, for instance as a way of controlling the prison inmates.

Present law therefore limits the use of these techniques as a method of social control because they are exclusively restricted to the context of the treatment of mental disorders. Subject to what was already noted about the differences between treatment and punishment or treatment and control, the goal of treatment must always be the well-being of the person and not the assuring of social order.

On a more general level of criminal policy however, a legal system could be tempted to link the release of a prisoner to submission to treatment. Or, going a step further, it could force the accused to submit to it only for the purpose of preventing future criminal behaviour. The Commission believes that this practice, even if provided with every possible safeguard at the structural and procedural level, is unacceptable. First it would undermine the fundamental principle of individual freedom. It would also imply that the concept of "delinquency" can be defined in a precise manner. It would undoubtedly lead to an arbitrary and therefore unacceptable interference of the state in the private lives of its citizens.

As well, the judicial and scientific communities agree that the predictability of the social dangerousness of a person is at best vague and at worst quite impossible to determine. To deprive a person of his freedom on the basis of a simple guess is impossible to justify. The right to participate in psychological therapy as defined in our study should always be free and voluntary, or be the object of substituted consent when the interested party is truly incapable of expressing informed consent. Every precaution should be taken to ensure that consent, given on behalf of another, is based on considerations of the well-being of the patient and the protection of society. Substituted consent should always be given with a strict therapeutic goal in mind.

In conclusion, recourse to these techniques for purposes of treatment and rehabilitation in a prison milieu or reintegration into society should not be prohibited only because it is impossible to guarantee the completely voluntary character of the consent. Caution must always be exercised, and additional precautions taken, to ensure that consent, when given, is fully informed and eliminate coercion as much as possible as well as strengthen the mechanisms for ensuring voluntary and informed consent.



CHAPTER THREE

Possible Reforms

In the closing paragraph of the introduction to this document three main questions were raised as fundamental to any eventual reforms. They were:

1) Do present laws provide sufficient protection against involuntary or nonconsensual administration of behaviour alteration treatments?

2) Should criminal law protect psychological integrity in the same way it already protects physical integrity?

3) Should the law make legitimate the use of these techniques as punishment or as a method of social control?

Present law already deals with some aspects of these questions, but leaves others unanswered. It thus becomes necessary to provide more precise responses.

I. Protection of Incompetents

The first issue we examined was the present legal protection of the incompetent individual against treatment administered without consent. The law, we noted, affirms the general rule that patient consent is required for psychiatric treatment as it is for any other medical treatment. However, the practical application of this rule involves real difficulties. There is a tendency to presume that some patients suffering from a mental disturbance are never able to understand the situation well enough to give valid consent.

The Commission, in its Working Paper 28 and in its Report 20, presented a number of recommendations dealing with the right to refuse treatment or to have it stopped. These recommendations were made within the context of physiological treatment. But in the Commission's view those proposals are equally applicable to psychological and psychiatric treatment. Respect for a person's right to autonomy includes the right of that person to control the development of his personality. Just as there is no right to impose ordinary medical treatment except under exceptional circumstances, so, in the Commission's view, must be respected the principle that access to psychiatric treatment should be free and voluntary.

There are three exceptions to this general rule. The first is when the conduct presents a danger to the life or health of that person or others. An example is that of the person suffering from a psychotic episode who threatens to take his life or that of another. Protection of the life and health of others must take precedence over an absolute right to autonomy. This case, as far as protection of third parties is concerned, is basically the same as that of the person who is suffering from a contagious disease but refuses to be treated and on whom treatment can be imposed.

The second exception, which is actually another illustration of the first, is that of the patient totally incapable of taking care of himself. In this case nonconsensual treatment is legitimate if done to save the patient's life. This exception can be justified on grounds of the best interest of the patient himself and his absolute incapacity to assure his survival. It is akin to that of the unconscious patient brought to the emergency ward. Treatment should be given even if consent is impossible to obtain.

The third exception is that of the involuntarily hospitalized patient who has lucid intervals. This is by far the most sensitive situation. One would want to be certain that there can be no irregularity in the finding of incompetency and no possible mistake in the diagnosis. Irregularities and diagnostic errors can of course occur. The solution then is to reform the procedures and methods used to determine incompetence and of the periodic review of that finding.

Should a patient properly institutionalized nevertheless have the right to refuse treatment? Should treatment be given without necessarily obtaining consent? As the Commission has tried to emphasize in this Paper, any answer to this question is predicated upon two rules of policy which serve as a basis for legislation. We repeat them once more to underline their importance.

The first is that incompetence should never be taken to imply the complete deprivation of the person's rights, and more specifically, the right to refuse treatment. Incompetence merely indicates that during a certain period, because of a mental disturbance, a person was unable to make decisions concerning himself. It does not follow that during that time any kind of treatment can be administered nor does it exempt the therapist from determining the patient's wishes and providing needed information.

The second rule is that consent to treatment, especially treatment of behavioural disorders, should always be seen as applying only to the present condition of the patient. The purpose of treatment must be to try and help the patient regain his decision-making capacity. Procedures must therefore be devised by law that can ensure a constant observation of the mental state of the person, in order to preserve his rights and promote the earliest possible return to consensual therapy.

With these two reservations, the Commission believes that this third exception should be recognized by law. If the patient is found to be incapable of making decisions, it should be possible to administer treatment. However, the Commission believes that this third exception must be interpreted restrictively and accompanied by concrete measures of protecting the rights of that incompetent person.

At the time these lines are written, an unknown factor remains. No one knows with any certainty how courts will interpret the *Canadian Charter of Rights and Freedoms* in relation to the rights of the mentally handicapped. Yet, as we have emphasized several times in this present work, the Commission believes that a basis for such intervention already exists. There is no doubt that the Charter is dedicated to the protection of the individual against cruel and unusual treatment or treatment not freely consented to. It is anticipated that a certain number of laws dealing with the notion of procedures related to determinations of incompetence will be challenged in the courts for that reason. Therefore, in order to eliminate any doubt, the Commission considers that the proposals it already expressed regarding treatment in general, and the proposal that the *Criminal Code* acknowledge the right to refuse treatment and the right not to have treatment imposed, should also apply to psychiatric treatment.

The Commission therefore recommends that the criminal law affirm the right of a psychiatric patient not to be treated against his will, and to have treatment already under way stopped, with the reservation of the usual exceptions already acknowledged by law, that is, in cases of emergency or where the absence of treatment creates a serious risk for the life and safety of the patient or others.

The Commission also reiterates Recommendation R-3(2) of its 1976 Report entitled *Mental Disorder in the Criminal Process* which proposal reads in part:

> A mentally disordered person is entitled to the same procedural fairness and should benefit from the same protections of personal liberty as any other person. In this regard extreme caution should be exercised before there is any deprivation of personal liberty in the form of a psychiatric examination or treatment.

The Commission believes that the Charter responds directly and adequately to these preoccupations.

The Commission notes however the lack of uniformity presently existing between provincial laws dealing with incompetency proceedings and the protection of the rights of the incompetent. Some brief comments will therefore be made here, followed by a specific recommendation.

In view of the Charter and the general principles of our law, the Commission believes that legislation concerning declarations of incompetence and the treatment of mentally handicapped persons should set out in a clear and unequivocal manner the minimal rules for the protection of human rights. Due process of law should be scrupulously observed and the law should insist upon procedural and evidentiary guarantees to minimize the risk of error. Legislation should also provide mechanisms for the incompetent person to request, at any time, a review of the finding of incompetency, and by which the person's wishes in treatment matters will be respected once well enough to express them freely. We emphasize once more the importance of dissociating legal from factual incapacity, and the importance of not necessarily waiving the right of that person to consent to, or at least approve of, the treatment solely on the ground that at one time that person had been declared legally incompetent.

Lastly, the Commission considers it necessary for all legislation permitting the nonconsensual treatment of a committed patient to specify the circumstances under which it can be administered, and define the protective measures which will apply, thereby ensuring a permanent control of the individual over decisions concerning his own person. These rules, in different degrees, can be found in all the provincial mental health statutes. Nevertheless, as we have seen, there are important variations in the way some of them are expressed and a number of regrettable imprecisions in terms of the protection of human rights, suggesting the need for greater uniformity.

How, practically speaking, can this goal be achieved? Legislation dealing with matters of incompetency generally fall within the purview of the provinces. The Commission does not have the power to make recommendations at the provincial level. Whatever their respective merits, the fact remains that there is great disparity between the various provincial laws. This is regrettable because it follows that, in terms of psychiatric therapy, Canadians are being treated substantially differently from province to province despite fundamental social values common to the whole of our country. The Commission also observes that these differences may have a practical impact on the way fundamental rights of the person are respected.

Consequently the Commission recommends that under the auspices of such organizations as the Uniform Law Conference, which has already done some work on this question, a particular commitment be undertaken to adapt the various statutes to the rights recognized by the Charter and, wherever possible, provide uniformity in matters of the administration of treatment, and protection of the fundamental rights of the mentally incompetent patient.

II. Affirmation of the Protection of Psychological Integrity

As we have seen, the present protection of psychological integrity is limited. As we have also noted, this hesitancy of law is not so much occasioned by principle as by practical difficulties. It is not, in other words, in the name of a fundamental principle that the law does not provide for psychological integrity similar to that it grants to physical integrity. From the perspective of reform, it is appropriate to examine whether or not at least some degree of that protection is possible.

Criminal law could easily intervene by acknowledging the analogy between the notions of physical integrity and psychological integrity. It would be possible and interesting to take the major sections of the *Criminal Code* protecting physical integrity and add to them a provision protecting psychological integrity as well. Theoretically, these would be sections 197, 202, 204, 208, 209, 211, 212, 213, 215, 228, 229, 231(1) and 245. If this were done, a complete and universal legal protection for the person would be assured.

The problem however is not at the level of principles, but resides in the practical application of the rules. This is apparent in the present state of both law and the behavioural sciences. Whereas assaults on physical integrity can generally be easily established, this is not always the case with interferences with psychological integrity. It is in effect relatively easy to prove an attack on physical integrity, if not with certitude, at least to a reasonable degree. The reason is that a comparison can readily be made between the previous physical condition and the new condition produced by the assault. The law has a measure, a standard of reference to relate the two events (the act and the result) by a sufficient causal link. The important question for certain offences is to determine whether the attack by the accused actually caused physical damages or death. Psychological assault, on the other hand, cannot be measured with the same precision. How could one prove that the alleged illegal act of psychological aggression actually caused the result evidenced by the condition of the "victim"?

Persons are constantly subjected to various influences. Behaviour is determined by negative and positive experiences, both present ones and earlier ones. Education, family, social milieu, and environment all have a difficult-to-assess impact on the psychology of the person. In addition, this impact is not direct but represents the sum of all these factors and the complex product of their interaction. It therefore becomes particularly difficult for law to isolate a single factor or even a group of factors as having caused or contributed in a significant way to assaulting the psychological integrity of a given person. How would it be possible to know with at least reasonable certainty, that a given psychological assault has really had the impact on the person that someone might claim it has had? Such an assault could be measured when there is some physical evidence of the violent impact. Lacking such physical manifestation, and when it is not possible to relate a given act to particular psychological consequences, normally there can only be hypothesis, not certitude or even probability.

Criminal law, from a legislative policy point of view, must use moderation. It should not create useless offences which interfere with individual freedom or reduce traditional standards of proof and procedures, or safeguards of individual freedom. Medical knowledge of the human mind is not yet sufficiently advanced to predict, with a degree of certainty acceptable to criminal law, the causal connection between a given act or series of acts and its impact on the psychology of a person. To set up a general offence penalizing this type of interference is to risk either reducing it to a dead letter in practice or raising insurmountable problems of interpretation.

One could argue that an answer can be provided by lowering the standards of evidence required to determine guilt. It could be declared sufficient, for example, in cases of interference with psychological integrity, to use the rule of preponderance of evidence and not that of proof beyond a reasonable doubt. The Commission is firmly opposed to this approach. The weakening of the fundamental safeguards of our criminal law system cannot be allowed merely to facilitate the criminalization of a conduct whose effects remain so problematic.

Our analysis however is to be understood within the present context and in the light of the current state of the art of the behavioural sciences. It remains possible that science in the future will succeed in isolating more precisely factors determiming behaviour, and will provide a scientific way of measuring their impact and thus demonstrate direct causal relations between the act and the effect in cases where the psychological interference is not manifested in a corresponding loss of physical integrity. Should that development come to pass, there would be nothing to oppose the legislative affirmation of a general protection of psychological integrity.

Does this mean that law should not provide any protection for psychological integrity? Clearly, the answer must be in the negative. For one thing, certain forms of assault on this integrity are already covered in instances when the acts also constitute physical assaults. For another, certain groups more susceptible to negative influences (particularly children) are already protected under federal or provincial law. Civil law also contains mechanisms providing compensation for permanent or temporary loss of psychological integrity and even sometimes for its prevention.

At the criminal law level, in principle nothing stands in the way of a formal recognition of psychological integrity. As already noted however, because of the problems of proof we do not believe that it is advisable in practice to add a general offence to the *Criminal Code*. Nor should sections 197 (the need to furnish materials essential to life), 202 and 204 (criminal negligence), 208, 209, 212, 213, 215 (murder and homicide), 228 (deliberately causing bodily harm), be widened in scope to include the protection of psychological integrity. The reason, once again, is not at the level of principles. The Commission continues to believe that psychological integrity deserves legal protection. The only obstacle relates to the present criminal law system. As noted above, the difficulties of proof of psychological assault could only be overcome if the present standards were lowered, which the Commission does not intend to propose. Nevertheless, the Commission believes it is still possible and urgent to extend protection to psychological integrity in a limited number of cases.

Section 211 of the *Criminal Code* provides that, except in the death of a child or an ill person caused by a deliberate attempt to frighten that person to death, death caused by influence on the mind is not homicide. One can see the reasons why the legislator created an exception favouring these two types of victims thought to be weaker and more susceptible to negative influence. Nevertheless, the total exclusion of the possibility of otherwise committing homicide by influencing the mind seems unjustified today. Retaining the section appears to be incompatible with present scientific knowledge, since it is surely possible to condition a person to the point that it will provoke death. It is also incompatible with the Commission's position on the subject of aiding suicide. It is difficult to see how a person who psychologically conditions someone and directly provokes his death would not be held responsible for the act, since the same deliberate manipulation with a view to inciting the victim to commit suicide is already an offence under section 224. It is impossible to justify the difference between these offences at a level of legislative policy. The Commission therefore reaffirms the proposal it made in its Working Paper 33 entitled *Homicide* in which it recommended the deletion of section 211.

It will perhaps be objected that this change in the law risks opening the door to abuses. That possibility is extremely unlikely. The Commission believes that instances of homicide by influence on the mind will be rare, and that the proof of causality would be difficult to establish. Nevertheless, if evidence is effectively supplied to the trier of fact, the Commission does not see why the person who committed the act should not be found guilty. **Consequently the Commission recommends the total abolition of the provisions of section 211 of the *Criminal Code*.**

Section 229 of the *Criminal Code* deals with the administration of poisons and noxious substances. Paragraph (*a*) provides for a severe jail sentence if the poison endangered the life of the victim or caused bodily harm. A study of case-law shows that this offence is very seldom prosecuted. In its Working Paper entitled *Assault*, the Commission reached the conclusion that this provision should be deleted within the context of physical assault. This kind of act can be prosecuted under the proposed provisions of the *Code* dealing with harming, attempted harming or endangering life and bodily integrity. However, in the proposed new *Code*, it will be necessary to deal in this section, or elsewhere, with the possibility of the administration of a drug or a noxious substance which does not harm the body but is given in order to cause a psychological change in the person. The Commission considers that at both moral and legal levels no distinction should be made between a person who administers a substance in order to cause bodily harm (for example by destroying or damaging a human organ) and a person who administers a substance to cause temporary or permanent psychological damage.

The Commission recommends that the administration of a drug or a noxious substance with a view to causing psychological harm to a person be made a criminal offence by a general or specific text in the new *Criminal Code*. The general exception concerning treatment is sufficient to cover the administration of drugs for therapeutic purposes as the Commission maintained in Working Paper 28.

Finally, in the same line of thought, the Commission considers that a similar amendment can be made to section 231 concerning "traps" contributing to bodily harm. A hypothetical example will illustrate the probably rare situation that this amendment would cover. It would apply to a person who is aware of the precarious state of mental health of another and of that person's morbid or irrational fear of a particular thing, and arranges some form of trap or device with the sole intention of inducing his victim into a type of permanent mental disability. It seems to the Commission yet another instance where the expression "bodily harm" alone does not cover cases such as this. In our view they are morally and legally reprehensible and merit prohibition and sanction by the *Criminal Code*.

In consequence, the Commission recommends that subsection 231(1) be amended by adding at the beginning, following the words "bodily harm" the expression "or psychological harm", and by adding at the end of the same section the same expression following the words "bodily harm" and before the words "to persons". The revised Criminal Code should also prohibit such acts which result from gross criminal negligence.

The revised subsection 231(1) would be as follows:

> Every one who, with intent to cause death or bodily harm or psychological harm to persons, whether ascertained or not, sets or causes to be set or placed a trap, device or other thing whatsoever that is likely to cause death, or bodily harm or psychological harm to persons is guilty of an indictable offence and is liable to imprisonment for five years.

III. Using Behaviour Alteration Techniques as a Sanction or Method of Social Control

We wish to reiterate here the principle already implicitly and explicitly affirmed in this Paper: no medical treatment, no psychiatric or behaviour alteration technique should be used as a punishment for an act judged socially wrong.

It would be inconceivable for treatment to be diverted from its original goal which is the relief or cure of the person and use it instead as punishment. However, as we have insisted throughout this Paper, treatment in certain circumstances may not only serve the interests of particular individuals, but also those of society. Curing behavioural problems not only benefits the incarcerated individual, but also society as a whole. But are social interests sufficient justification to impose it?

The Commission is of the view that, in matters of sentencing, the first consideration must remain that of choosing measures that are both just and equitable for the individual and protective of society against violent behaviour dangerous to its members. The role of psychiatric treatment, though important, must remain secondary and not influence the duration of sentence. To make a direct link between sentencing and psychiatric treatment is to fall into a trap leading to confusion between treatment and punishment. It also seems to us contrary to section 15 of the Charter which imposes equality and forbids discrimination based upon mental or physical handicaps.

Another problem that we examined is that of the consent of the prisoner to psychiatric treatment. We emphasized two particular difficulties in this respect. The first is that of determining whether it is legal to impose psychiatric treatment against the will of the person. The second is to ensure that the prisoner's consent is truly an act of free will, that it is informed and that it is voluntarily given.

From a penitentiary policy and sentencing point of view, the Commission judges it important to reaffirm that the prisoner should have as much right to psychological treatment as to medical and physiological treatment. Once sentenced, the accused should have access to social and medical services comparable to those offered to the ordinary citizen.

Regarding the first difficulty, namely the question of forced psychological treatment on the prisoner, the Commission continues to profess the principle it has affirmed many

times reflecting one which has a respect for the individual. **Except in cases of emergency, or when the individual is completely unable to give consent, psychiatric treatment should never be undertaken without the patient's express authorization.**

The second difficulty raises an important legal issue. The Commission considers that no one should be prevented from participating in treatment programmes for behavioural problems only because his consent is that of a prisoner deprived of freedom. The Commission is however aware that additional precautions are necessary to ensure that in practice, and not only in theory, certain minimal standards are indeed respected. One of them of course is making sure that they enjoy adequate legal representation for purposes of asserting their rights.

There already exist a number of rules and directives concerning the administration of medical treatment to inmates. These texts however are not complete and are not organized in a coherent and systematic manner. In view of the Charter, the various recommendations already made by the Commission on the subject, and the current situation in other countries, it appears that an effort should be undertaken in two directions: first, to delineate a precise policy regarding ethical principles applicable to prisoners in accordance with the main principles recognized by our legal system; second, to formulate in a single document a set of rules applying these principles.

It seems impossible that these could be incorporated into the *Criminal Code* because of their detailed nature and their administrative character. However, the Commission believes that a separate administrative document incorporating these rules would play a useful role.

The Commission therefore recommends to the appropriate authorities that they undertake to draft a code of ethics on the medical and psychological treatment of prisoners, which will faithfully reflect the main principles presently recognized by Canadian law. This code of ethics having the force of an administrative regulation, should address itself especially to the following problems: obtaining the consent of the prisoner to all forms of treatment; proper mechanisms to ensure the voluntary character of their participation; minimal standards for information on treatment and possible risks; accessibility to medical and psychiatric services; control of the participation in treatment programmes; the relation between this participation and parole.

Finally, the Commission recalls one of its recommendations made in 1976 which argued for the introduction of hospital orders into our law. Whatever the technical modalities, this reform would allow a court to order a prisoner to serve part of his sentence in a hospital so that he may receive needed psychiatric treatment.

Bibliography

American Psychiatric Association Commitee on Nomenclature and Statistics — *Diagnostic and Statistical Manual of Mental Disorders.* 3rd ed. Washington: American Psychiatric Association, 1980.

Anand, R. — "Involuntary Civil Commitment in Ontario: The Need to Curtail the Abuses of Psychiatry" (1979), 57 *Canadian Bar Review* 250.

Arbodela-Florez, J. — "The Development of a Forensic Psychiatric Service" (1975), 17 *Canadian Journal of Criminology and Corrections* 141.

Arkin, H. — "Forcible Administration of Antipsychotic Medication" (1983), 249 *Journal of the American Medical Association* 2784.

Ayllon, T. — "Behavior Modification in Institutional Settings" (1975), 17 *Arizona Law Review* 3.

Aynes, R. L. — "Behavior Modification: Winners in the Game of Life?" (1975), 24 *Cleveland State Law Review* 422.

Barrière, J. — "Droit à la santé et politique psychiatrique" (1970), 30 *Revue du Barreau* 282.

Bartholomew, A. A. and K. L. Milte — "Prisoners' Rights and Behaviour Therapy" (1979), 12 *Australian and New Zealand Journal of Criminology* 222.

Bazelon, D. L. — "Implementing the Right to Treatment" (1969), 36 *University of Chicago Law Review* 742.

"Institutionalization, Deinstitutionalization and the Adversary Process" (1975), 75 *Columbia Law Review* 897.

Bergeron, V. — *L'attribution d'une protection légale aux malades mentaux.* Montréal: Yvon Blais, 1981.

Bridges, P. K. and J. R. Bartlett — "Psychosurgery: Yesterday and Today" (1977), 131 *British Journal of Psychiatry* 249.

Brooks, A. — "The Constitutional Right to Refuse Antipsychotic Medications" (1980), 8 *Bulletin of the American Academy of Psychiatry and the Law* 179.

Burtch, B. E. and R. V. Ericson — "The Control of Treatment: Issues in the Use of Prison Clinical Services" (1979), 29 *University of Toronto Law Journal* 51.

Canadian Mental Health Association — *The Law and Mental Disorder Part Two: Civil Rights and Privileges.* A Report of the Committee on Legislation and Psychiatric Disorder; A Committee of the National Scientific Planning Council of the Canadian Mental Health Association. Toronto: The Canadian Mental Health Association, 1967.

Castel, J. G.	"Nature and Effects of Consent with Respect to the Right to Life and the Right to Physical and Mental Integrity in the Medical Field: Criminal and Private Law Aspects" (1978), 16 *Alberta Law Review* 293.
Center of Criminology	*Proceedings of the National Symposium on Medical Sciences and the Criminal Law*. Toronto: University of Toronto Press, 1973.
Centre international de criminologie comparée	*Dangerosité et agressivité chez l'humain*. Vth International Seminar in Comparative Clinical Criminology. Montréal: Université de Montréal, 1978.
Cocozza, J. and M. Melick	"The Right to Refuse Treatment: A Broad View" (1977), 5 *Bulletin of the American Academy of Psychiatry and the Law* 1.
Cook, J. W., K. Altman, and S. Haavik	"Consent for Aversive Treatment: A Model Form" (1978), 16 *Mental Retardation* 47.
Cragg, A. W.	"Psychiatry, the Inmate and the Law" (1976-77), 3 *Dalhousie Law Journal* 510.
Department of Justice of Canada	*The Mental Disorder Project: Criminal Law Review Draft Report*. Ottawa: Department of Justice, 1984. Unpublished.
Dworkin, G.	"Autonomy and Behavior Control" (1976), 6 *Hastings Center Report* 23.
Earp, J. D.	"Psychosurgery: The Position of the Canadian Psychiatric Association" (1979), 24 *Canadian Journal of Psychiatry* 353.
Ericson, R. V.	"Psychiatrists in Prison: On Admitting Professional Tinkers into a Tinker's Paradise" (1974), 22 *Chitty's Law Journal* 29.
	"Penal Psychiatry in Canada: The Method of Our Madness" (1976), 26 *University of Toronto Law Journal* 25.
Erwin, E.	*Behaviour Therapy: Scientific, Philosophical and Moral Foundations*. Cambridge: Cambridge University Press, 1978.
Freedman, B.	"A Moral Theory of Informed Consent" (1975), 5 *Hastings Center Report* 32.
Gaylin, W. and H. Blatte	"Behavior Modification in Prisons" (1975), 13 *American Criminology Law Review* 11.
Government of Canada	*The Criminal Law in Canadian Society*. Ottawa: Government of Canada, 1982.
Halleck, S. L.	"Legal and Ethical Aspects of Behavioral Control" (1974), 131 *American Journal of Psychiatry* 381.
Henebery, J.	"The Right of the Psychiatric Patient to Refuse Treatment", in Wecht, *Legal Medecine 1982*. Philadelphia: Saunders, 1982. p. 137.
Herr, S. S.	*Rights and Advocacy for Retarded People*. Lexington, MA.: Lexington Books, 1983.
Hill, B. P.	"Civil Rights of the Psychiatric Patient in Quebec" (1977), 12 *Revue Juridique Thémis* 503.
Hutchison, H. C.	"Behavior Theory, Behavior Science and Treatment" (1968), 10 *Canadian Journal of Corrections* 388.

"Learning Theory, Behaviour Science and Treatment" (1968), 10 *Canadian Journal of Corrections* 41.

Jacob, J. — "The Right of the Mental Patient to His Psychosis" (1976), 39 *Modern Law Review* 17.

Keyserlingk, E. W. — *Sanctity of Life or Quality of Life in the Context of Ethics, Medicine and Law.* A Study written for the Law Reform Commission of Canada. Ottawa: Minister of Supply and Services Canada, 1979.

"The Right of Psychiatric Patients to Refuse Treatment — The Principles, the Provincial Statutes and the Charter of Rights and Freedoms" (1985), 33 *Canada's Mental Health* 46.

Korenberg, M. and M. Korenberg — "Psychiatry: The Lost Horizon: The Erosion of Human Rights" (1981), 5 *Legal Medical Quarterly* 1.

Kouri, R. and M. Ouellette-Lauzon — "Corps humain et liberté individuelle" (1975-76), 6 *Revue de droit de l'Université de Sherbrooke* 85.

Law Reform Commission of Canada — *A Report to Parliament on Mental Disorder in the Criminal Process.* Ottawa: Information Canada, 1976.

Sterilization: Implications for Mentally Retarded and Mentally Ill Persons. Working Paper 24. Ottawa: Minister of Supply and Services Canada, 1980.

Medical Treatment and Criminal Law. Working Paper 26. Ottawa: Minister of Supply and Services Canada, 1980.

Euthanasia, Aiding Suicide and Cessation of Treatment. Working Paper 28. Ottawa: Minister of Supply and Services Canada, 1982.

Homicide. Working Paper 33. Ottawa: Minister of Supply and Services Canada, 1984.

Assault. Working Paper 38. Ottawa: Minister of Supply and Services Canada, 1984.

Manning, M. — *Rights, Freedoms and the Courts: A Practical Analysis of the* Constitutional Act, 1982. Toronto: Emond-Montgomery, 1983.

Marshall, T. D. — *The Physician and Canadian Law.* 2nd ed. Toronto: Carswell, 1979.

Martin, R. — *Legal Challenges to Behavior Modification: Trends in Schools, Corrections, and Mental Health.* Champaign, Ill.: Research Press, 1975.

Martindale, D. — *Psychiatry and the Law: The Crusade against Involuntary Hospitalization.* Minnesota: Windflower Publishing, 1973.

McCormick, W. O. — "'Informed Consent' in Psychiatric Practice" (1980), 1 *Health Law in Canada* 53.

McGrath, W. (ed.) — *Crime and Its Treatment in Canada.* 2nd ed. Toronto: MacMillan, 1976.

Mills, M. J. — "The Rights of Involuntary Patients to Refuse Pharmacotherapy: What Is Reasonable?" (1980), 8 *Bulletin of the American Academy of Psychiatry and the Law* 313.

Moya, B. and R. Achtenberg — "Behavior Modification: Legal Limitations on Methods and Goals" (1974), 50 *Notre Dame Lawyer* 230.

Nadin-Davis, R. P. — *Sentencing in Canada*. Toronto: Carswell, 1982.

Ontario Inter-ministerial Committee on Medical Consent — *The Health Care Services Consent Act*. Draft Act. Toronto, 1980.

Picard, E. I. — *Legal Liability of Doctors and Hospitals in Canada*. Toronto: Carswell, 1978.

Price, R. R. — "Psychiatry, Criminal-Law Reform and the 'Mythophilic' Impulse: On Canadian Proposals for the Control of the Dangerous Offender" (1970), 4 *Ottawa Law Review* 1.

Reiser, S. J. — "Refusing Treatment for Mental Illness" (1980), 137 *American Journal of Psychiatry* 329.

Ross, R. R. and H. B. McKay — "Behavioural Approaches to Treatment in Corrections: Requiem for a Panacea" (1978), 20 *Canadian Journal of Criminology* 279.

Rothman, D. J. — "Behavior Modification in Total Institutions" (1975), 5 *Hastings Center Report* 17.

Royal Commission on the Criminal Law Relating to Criminal Sexual Psychopaths (J. C. McRuer, Chairman) — *Report*. Ottawa: The Queen's Printer and Controller of Stationery, 1958.

Schiffer, M. E. — "The Sentencing of Mentally Disordered Offenders" (1976), 14 *Osgoode Hall Law Journal* 307.

"Psychiatric Treatment for Mentally Disordered Offenders: The Canadian Cuckoo's Nest" (1976-77), 41 *Saskatchewan Law Review* 269.

Mental Disorder and the Criminal Trial Process. Toronto: Butterworths, 1978.

Psychiatry Behind Bars: A Legal Perspective. Toronto: Butterworths, 1982.

Schwitzgebel, R. and D. Kolb — *Changing Human Behavior: Principles of Planned Intervention*. New York: McGraw-Hill, 1973.

Selva, L. H. — "Treatment As Punishment" (1980), 6 *New England Journal on Prison Law* 265, 325.

Shapiro, M. H. — "Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies" (1974), 47 *Southern California Law Review* 237.

Sharpe, G. and G. Sawyer — *Doctors and the Law*. Toronto: Butterworths, 1978.

Simpson, B. — "Psychiatric Facilities for the Mentally Ill Offender in British Columbia" (1967-68), 3 *University of British Columbia Law Review* 231.

Skinner, B. F. — *Science and Human Behavior*. New York: MacMillan, 1953.

Sommerville, M. A.	*Consent to Medical Care.* Protection of Life Series. A Study Paper Prepared for the Law Reform Commission of Canada. Ottawa: Minister of Supply and Services Canada, 1979.
	"Structuring the Issues in Informed Consent" (1980-81), 26 *McGill Law Journal* 740.
Spece, R. G.	"Conditioning and Other Technologies Used to 'Treat'? 'Rehabilitate'? 'Demolish'? Prisoners and Mental Patients?" (1972), 45 *Southern California Law Review* 616.
Stokes, R. E.	"Consent in Captive Circumstances" (1981), 2 *Health Law in Canada* 83.
Swadron, B. B.	*Detention of the Mentally Disordered.* Toronto: Butterworths, 1964.
Swadron, B. B. and D. R. Sullivan (eds.)	*The Law and Mental Disorder: Report of the Committee on Legislation and Psychiatric Disorder.* Toronto: Canadian Mental Health Association, 1973.
Szasz, T. S. (ed.)	*The Age of Madness.* Garden City, N.Y.: Anchor Books, 1973.
Szasz, T. S.	*The Myth of Mental Illness: Foundations of a Theory of Personal Conduct.* Rev. ed. New York: Harper and Row, 1974.
Tanay, E.	"The Right to Refuse Treatment and the Abolition of Involuntary Hospitalization of the Mentally Ill" (1980), 8 *Bulletin of the American Academy of Psychiatry and the Law* 1.
Trasler, G. and D. Farrington (eds.)	*Behaviour Modification with Offenders: A Criminological Symposium.* Cambridge: Cambridge Institute of Criminology, 1979.
Turner, R. E.	"The Delivery of Mental Health Services to the Criminal Justice System and the Metropolitan Toronto Forensic Service" (1981), 15 *Gazette of the Law Society of Upper Canada* 69.
U.S. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research	*Report and Recommendations: Psychosurgery.* Washington: Government Printing Office, 1977.
Vandervort, L.	"Legal Aspects of the Medical Treatment of Penitentiary Inmates" (1976-77), 3 *Queen's Law Journal* 368.
Webster, C. and B. Dickens	*Deciding Dangerousness: Policy Alternatives for Dangerous Offenders. A Report to the Department of Justice of Canada.* Ottawa: Department of Justice, 1983.
Weisstub, D. N.	*Law and Psychiatry: Proceedings of an International Symposium Held at the Clarke Institute of Psychiatry.* Toronto: Pergamon Press, 1978.
	Law and Psychiatry in the Canadian Context. Toronto: Pergamon Press, 1980.
Wexler, D.	"Token and Taboo: Behavior Modification, Token Economies, and the Law" (1973), 61 *California Law Review* 81.
Willis, R.	"The Incapacity of Mental Illness", [1965] *Meredith Memorial Lectures* 23.
Winick, B. J.	"Legal Limitations on Correctional Therapy and Research" (1981), 65 *Minnesota Law Review* 331.