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Résumé de l'article

Dans la province canadienne du Québec, les tribunaux jouent un rôle crucial dans les instances civiles, criminelles ou administratives concernant la santé mentale, puisqu'ils doivent assurer à la fois la sécurité du public et la protection des droits des défendeurs. Au cours des 30 dernières années, la théorie de la jurisprudence thérapeutique a eu une grande influence sur la pratique des tribunaux de santé mentale. Selon cette théorie, le système judiciaire doit tenir compte des effets thérapeutiques de la loi et du processus judiciaire pour inciter les défendeurs à suivre leur programme de traitement. L'analyse empirique des pratiques judiciaires suivies au Québec montre que le déclin des droits en matière de santé mentale est imputable d'abord et avant tout aux tribunaux. La justice thérapeutique est dominée par des attitudes de nature discriminatoire, contrôlante et réformiste. Ainsi, les inquiétudes entourant la judiciarisation des groupes qui vivent dans des conditions précaires sont banalisées, de même que celles qui concernent le recours à des arguments juridiques contradictoires et axés sur le mode de vie et les décisions judiciaires rendues en matière de traitement.

The Triumph of the "Therapeutic" in Quebec Courts: Mental Health, Behavioural Reform and the Decline of Rights

Emmanuelle Bernheim[*]

In the Canadian province of Quebec, the role of the courts is crucial in civil, criminal or administrative proceedings concerning mental health: the courts must ensure both public safety and the protection of the rights of defendants.
Therapeutic-jurisprudence theory has had a major influence on mental-health court practice over the past 30 years. According to that theory, the court system must take into account the therapeutic effects of the law and the judicial process to promote adherence to treatment by defendants.
The empirical analysis of judicial practices in Quebec shows that courts have been the main actors in the decline of rights in mental health. Therapeutic justice has been dominated by discriminatory, controlling and reformist tendencies. These include the trivialization of concerns about the judicialization of groups living in precarious conditions, inconsistent and lifestyle-oriented legal arguments, and treatment-related judicial decisions.

Dans la province canadienne du Québec, les tribunaux jouent un rôle crucial dans les instances civiles, criminelles ou administratives concernant la santé mentale, puisqu'ils doivent assurer à la fois la sécurité du public et la protection des droits des défendeurs. Au cours des 30 dernières années, la théorie de la jurisprudence thérapeutique a eu une grande influence sur la pratique des tribunaux de santé mentale. Selon cette théorie, le système judiciaire doit tenir compte des effets thérapeutiques de la loi et du processus judiciaire pour inciter les défendeurs à suivre leur programme de traitement.
L'analyse empirique des pratiques judiciaires suivies au Québec montre que le déclin des droits en matière de santé mentale est imputable d'abord et avant tout aux tribunaux. La justice thérapeutique est dominée par des attitudes de nature discriminatoire, contrôlante et réformiste. Ainsi, les inquiétudes entourant la judiciarisation des groupes qui vivent dans des conditions précaires sont banalisées, de même que celles qui concernent le recours à des arguments juridiques contradictoires et axés sur le mode de vie et les décisions judiciaires rendues en matière de traitement.

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I. INTRODUCTION AND HISTORICAL BACKGROUND: PRACTICES OF CONFINING AND DETAINING PEOPLE WITH MENTAL ILLNESS IN QUEBEC

"Insanity" as a form of legal defense has been practiced in common-law countries since the fourteenth century. At first, insanity was a legal concept that did not involve psychiatry, either for evaluation or for treatment. Instead, judges and juries determined the state of insanity of a defendant (who in most cases ended up in prison).[1] The detention of people labelled as insane aimed to prevent them from committing acts that threatened the safety of people or property. The first commitment laws, which appeared around the same time as asylums, were developed in the first half of the nineteenth century and allowed for the involuntary admission of people posing a danger as a result of their insanity.[2] Until then, except for cases of violations of the law, madness was considered a domestic problem that families had to deal with.

During the second half of the nineteenth century, practices evolved: as asylums continued to develop, psychiatrists worked actively to have their expertise on insanity recognized in criminal matters. Over time, psychiatrists became involved in the legal process both before and after criminal trials, in both prisons and in jails, both as treating physicians and as experts on insanity. This role allowed them to establish "their superior status as experts in insanity over other types of medical witnesses."[3] Psychiatrists then came to act as *amicus curiae*,[4] becoming essential in judicial decision-making and helping to shape the legal conception of insanity. With the first Canadian *Criminal Code*,[5] psychiatric expertise was recognized as a mandatory element of proof in criminal trials. By the end of the nineteenth century, the expert status of psychiatrists in the criminal justice system was well established. Psychiatrists came to play two central roles. The first was "to block access to the insanity defense to certain social types" not considered sufficiently deserving. The second was "to mitigate the sanctions that threate[n] deserving [defendants] through the use of parallel constructs differently applied."[6] In the early twentieth century, judicial authorities also began to develop their own forensic facilities where "insane" defendants were detained, and where court-ordered psychiatric assessments were subsequently conducted.[7]

At the same time, in connection with industrialization, urbanization and the decline in birthrate, asylums proliferated. Asylums had previously been reserved for the poorest members of society, with a significant proportion coming from prisons.[8] In a context of the development of the capitalist economy, families were less and less able to take care of their family members, especially those with low

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1 Allison Kirk-Montgomery, "'Loaded Revolvers': Ontario first forensic psychiatrists" in James Moran & David Wright, eds, *Mental Health in Canadian society: historical perspectives* (Montreal, McGill-Queen's University Press, 2006) 117.

2 Emmanuelle Bernheim, "Justice, power and intersectionality: Beyond psychiatry, the social issue in question" in Anna Kirkland and Marie-Andrée Jacob, eds, *Research Handbook for Socio-Legal Studies of Medicine and Health* (Cheltenham: Edward Elgar, 2020) 385 [Bernheim, "Beyond Psychiatry"].

3 Kirk-Montgomery, *supra* note 1 at p 118.

4 Friends of the court.

5 *The Criminal Code*, 1892, 55-56 Vict, c 29.

6 Kirk-Montgomery, *supra* note 1 at 132.

7 John PM Court, Alexander IF Simpson & Christopher D Webster, "Contesting Mad versus Bad: The Evolution of Forensic Mental Health Services and Law at Toronto" (2014) 21 Psychiatry Psychology & L 918.

8 André Cellard & Marie-Claude Thifault, "The Uses of Asylums: Resistance, Asylum Propaganda, and Institutionalization Strategies in Turn-of-the-Century Quebec" in Moran & Wright, *supra* note 1, 97.

productivity.[9] Increasingly, families themselves turned to asylums when relatives behaved in ways that, despite not being violent or threatening, were considered disturbing or inappropriate.[10] In this context, and without changing the legislative provisions,[11] the interpretation of the concept of danger expanded and made it possible to intervene in a wide variety of situations. This included when a person displayed signs of being irritable, refusing to work or, for women, not performing their traditional role in the family.[12] Those committed to institutions were considered legally incompetent, lost the right to manage their property and person, and had treatments imposed on them.

During the twentieth century, thanks to a transnational movement for rights, of which the first accomplishment was the adoption of the *Universal Declaration of Human Rights* by the United Nations General Assembly in 1948, calls to humanize psychiatric care became more and more insistent. Courts relied on constitutional texts to establish procedures concerning the arrest and deprivation of liberty of persons with mental disorders, focusing in particular on protection against cruel, inhumane and degrading treatment. Similarly, as U.S. jurisprudence developed the concept of the right to consent to treatment, the capacity for people with mental illness to manage their property and person was correspondingly legitimized and implemented.[13]

In the Canadian province of Quebec, practices with respect to mental illness have been slow to evolve. Up until the 1960s, Quebec had the highest number of psychiatric beds in proportion to its population, as well as the longest asylum stays in the Western word.[14] Voluntary hospitalization did not exist, with patients being systematically involuntary admitted.[15]

Deinstitutionalization began in the early 1960s, following the joint action of patients and psychiatrists to denounce the absence of medical treatment and the discrepancy between current practices and scientific knowledge. The process lasted four decades (1960-2001). Nevertheless, Quebec continued to exceed Canadian and international averages for the number of psychiatric beds until the early 2000s.[16] Hence, it seems that the practice of confining and detaining individuals with mental illness was particularly repressive in the Quebec context.

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9 Sarah F Rose, *No Right to Be Idle: The Invention of Disability, 1840-1930s* (Chapel Hill: University of North Carolina Press, 2017).

10 Cheryl Krasnick Warsh, "The First Mrs. Rochester: Wrongful Confinement, Social Redundancy, and Commitment to the Private Asylum, 1883-1923" (1988) 23 Historical Papers 145.

11 Bernheim, "Beyond Psychiatry", *supra* note 2.

12 Krasnick Warsh, *supra* note 10.

13 Lawrence O Gostin & Lance Gable, "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health" (2004) 63 Md L Rev 20; David Weisstub & Julio Arboleda-Florez, "Les droits en santé mentale au Canada: une perspective internationale" (2006) 31 Santé mentale au Québec 19.

14 Emmanuelle Bernheim, *Les décisions d'hospitalisation et de soins psychiatriques sans le consentement des patients dans des contextes clinique et judiciaire: une étude du pluralisme normatif appliqué* (PhD dissertation, University of Montreal and École Normale supérieure de Cachan, 2011) [unpublished] [Bernheim, *Hospitalisation*].

15 Louis-Marie Raymondis, *Quelques aperçus sur une réforme des services psychiatriques; étude des conditions juridiques et médicales de l'hospitalisation des malades mentaux au Canada* (Paris, LGDJ, 1966).

16 World Health Organization, *ATLAS country profiles of mental health resources 2001* (Geneva: WHO, 2001); Institut de la Statistique du Québec, *Le Québec chiffres en main*, 2009, online <https://bdso.gouv.qc.ca/docs-ken/multimedia/PB01600FR_qcem2009H00F00.pdf>.

Quebec was facing a multi-faceted problem: the province had enormous asylums, a large number of psychiatric beds, and abusive, involuntary institutionalization practices, often resulting in decades-long confinements. In addition, the province's legal mechanisms were often criticized as inadequate by both patients and psychiatrists.[17] The concept of danger, which prevailed in decisions over involuntary admission, was often vaguely defined, infused with morality and not clinically useful.[18] At the same time, as deinstitutionalization and a policy of psychiatric care was implemented, the development of psychiatric medications was giving rise to new abuses around consent to treatment. This abuse affected both institutionalized individuals and research participants;[19] the law remaining silent regarding the contexts in which treatments could be imposed. Even though consent to treatment has been formally legally required in Quebec since 1971, it seems that it was often not requested of institutionalized individuals. Without the constitutional authority to do so, courts took the liberty to give consent on behalf of confined patients who refused treatment.[20] Quebec was also the Canadian province with the highest number of defendants "acquitted on account of insanity" but "kep[t] in strict custody" under the mandate of the Lieutenant-Governor.[21] Whether in civil or criminal matters, no appeal processes existed for detained individuals, despite the fact that a multitude of commissions and studies have denounced inequity and abuses for decades.[22]

Two reforms were put in place simultaneously, with psychiatric patients' rights at the heart of the debate. The first, led by the Government of Quebec, resulted in substantial amendments to the *Civil Code of Quebec* in matters of involuntary admission[23] and forced treatment. The second, led by the federal government, [24] was the creation of Part XX.1—Mental Disorder in the *Criminal Code of Canada*.

In this paper, I will discuss how, under the guise of ensuring safety, civil and administrative courts play an active role, as reformative institutions, in the therapeutic movement in the province of Quebec.[25] In

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17 Hubert Wallot, *La danse autour du fou. Survol de l'histoire organisationnelle de la prise en charge de la folie au Québec depuis les origines jusqu'à nos jours, Tome 1. La chorégraphie globale*, Beauport, Publication MNH, 1988.

18 Katherine Brown and Erin Murphy, "Falling through the Cracks: The Quebec Mental Health System" (2000) 45 *McGill Law Review* 1037.

19 Bernheim, *Hospitalisation*, *supra* note 14.

20 Margaret A Somerville, "Refusal of medical treatment in 'captive' circumstances" (1985) 63:1 Can Bar Rev 59.

21 *Criminal Code 1953-1954*, 2-3 Elizabeth II, c 51, s 523 (2); Sheilagh Hodgins & Christopher D Webster, *The Canadian Database: Patients held on Lieutenant-Governors' Warrants* (Ottawa: Department of Justice, Research Report, 1992).

22 Viateur Bergeron, *L'attribution d'une protection légale aux malades mentaux* (Montréal: Yvon Blais, 1981); Comité de la santé mentale, *La Loi de protection du malade mental: Considérations du Comité de la santé mentale* (Montréal: 1978); Commission des droits de la personne du Québec, *Commentaires sur la Loi de protection du malade mental* (Montréal: 1978); Brian Hill, "Civil Rights for Psychiatric Patients in Quebec" (1977) 12:3 RJT 503; Canada, Royal Commission on the Law of Insanity as a Defence in Criminal Cases, *Report of the Royal Commission on the Law of Insanity as a Defence in Criminal Cases* (Ottawa: Office of the Privy Council, 1956); Law Reform Commission of Canada, *Mental Disorder in the Criminal Process* (Ottawa: Office of the Privy Council, 1976); Bruce Beanleands, *The development of the Lieutenant governor's warrant in Canada, 1841-1988: a history and a critique* (Master's Thesis, University of Ottawa, 1988) [unpublished]; Simon N Verdun-Jones, "The Doctrine of Fitness to Stand Trial in Canada: The Forked Tongue of Social Control" (1981) 4 Intl J L & Psychiatry 363; *Ibid*, Hodgins & Webster.

23 In Quebec, involuntary admission is formally referred to in English as "confinement in an institution". To promote clarity, and in accordance with the vocabulary used in the international literature, I have chosen to speak of "involuntary admission." Quotations or reference from French-language Quebec sources have been translated by the author.

24 Following the Supreme Court of Canada decision *R v Swain*, [1991] 1 SCR 933.

25 Although criminal law falls under federal jurisdiction, I will discuss its application in the province of Quebec only.

part II, I will examine the development of the therapeutic movement in justice since the 1960s, and, more specifically, the "therapeutic jurisprudence" doctrine.[26] In part III, I will show how the principles of the therapeutic movement have been integrated into Quebec's legal provisions and subsequent implementation. In part IV, I will analyze, based on empirical data, the nature of the attempts by civil and administrative courts to bring about behavioural reform in defendants, which involve the judicialization of poverty, lifestyle-oriented judicial practices and treatment-compliance measures.[27] I will conclude that, contrary to what the legislators promised, the therapeutic mission of justice is accomplished at the cost of the rights of defendants, including the right to consent to treatment.

II. THE THERAPEUTIC MOVEMENT IN JUSTICE: THEORY

For David Wexler, one of the founders of the therapeutic jurisprudence doctrine in the 1970s, the development of therapeutic justice is the result of the debate about the constitutional rights of defendants living with mental disorders or addictions.[28] In the early 1960s, the United States Supreme Court "held it violative of the cruel and unusual punishment clause of the Constitution to punish a person criminally for the illness of addiction, but in dictum the Court suggested it would be constitutionally proper to confine addicts involuntarily for the express purpose of treatment."[29] At the core of therapeutic justice is the principle that typical criminal justice, punitive or retributive, is not adequate in matters of mental health. Moreover, treatment, even if forced, is nevertheless considered desirable, adequate and does not constitute a punishment. The therapeutic movement in justice is therefore the result of the failure of the traditional

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[26] Since "normative agenda drives therapeutic jurisprudence research" (Bruce J Winick, "The jurisprudence of therapeutic jurisprudence" (1997) 3 Psychol Pub Pol'y & Law 184 at 188 [Winick, "Therapeutic Jurisprudence"]), speaking of doctrine is relevant.

[27] It should be noted that international research demonstrates the overrepresentation of racialized people among patients undergoing coercive practices in psychiatry: Phoebe Barnett et al., "Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data" (2019) 6 The Lancet 305. Although we do not have systematic data collection on the subject in Quebec, recent studies point in the same direction: Don Quan Tran, Andrew Ryder & Eric Jarvis, "Reported immigration and medical coercion among immigrants referred to a cultural consultation service" (2019) 56:5 Transcultural Psychiatry 807; Sommer Knight et al, "Ethnoracial Differences in Coercive Referral and Intervention Among Patients with First- Episode Psychosis" (2022) 73:1 Psychiatric Services 2. While I acknowledge the ethnocentric dimension of psychiatric practice, I cannot develop this kind of analysis in this paper due to the nature of my empirical data. On the subject, see: Franz Fanon, *Peau noire, masques blanc* (Paris, Seuil, 1952); China Mills, *Decolonizing Global Mental Health: The psychiatrization of the majority world* (London, Routledge, 2017); Rachel Gorman, "Mad nation? Thinking through race, Class, and Mad identity Politics" in Brenda LeFrançois, Robert Menzies & Geoffrey Reaume, eds, *Mad Matters : A Critical Reader in Canadian Mad Studies* (Toronto: Canadian Scholars' Press, 2013) 269.

[28] David Wexler, "Therapeutic Justice" (1972) 57 Minn L Rev 289 [Wexler, "Therapeutic Justice"]. See David Wexler, "Creating a therapeutic justice culture" (2021) SAL Prac 20, online: <https://journalsonline.academypublishing.org.sg/Journals/SAL-Practitioner/Family-and-Personal-Law/ctl/eFirstSALPDFJournalView/mid/594/ArticleId/1637/Citation/JournalsOnlinePDF> [Wexler, "Therapeutic justice culture"].

[29] *Ibid* at 291.

judicial system.[30] But for Wexler, this premise of therapeutic justice creates a slippery slope that works against the anti-paternalistic foundations of the law. In his article on therapeutic justice, he points out that t]he older view was that mentally ill persons were per se incompetent, enabling society to commit and treat them, even over objection, in order to further their best interests. Recently, however, it has been clearly demonstrated that mental illness does not automatically produce incompetence – "that many persons who are mentally ill are entirely competent to make rational and important decisions concerning their affairs, including the decision to accept or reject hospital treatment."[31]

Among the problems posed by therapeutic justice, Wexler identifies the indeterminacy of therapeutic concepts such as "danger" or "mental illness," which can have many possible meanings. This vagueness of concepts can directly compromise the rights of defendants: "The elasticity of the standards […] coupled with a pressure to intervene and treat whenever that appears possible, enables the therapeutic state to coerce conformity in many instances where coercion is not essential for social protection."[32] The fear that therapeutic justice will overstep legal boundaries and infringe on rights is therefore very real for Wexler, who contends that "[g]iven the uncertainty of these terms and of their scope, it is probably preferable, for [the] purpose of legal analysis, to look to traditional legal concepts for asserting state control over individuals, and to determine from them the acceptable boundaries for the exercise of therapeutic jurisdiction."[33]

Some twenty years after the publication of Wexler's article on therapeutic justice, the development of the doctrine of therapeutic jurisprudence was gaining momentum and appealed to both legal and mental-health professionals. Wexler identifies five main areas for the development of therapeutic jurisprudence: legal education, moving from theory to practice, interdisciplinary and international dimensions, and expansion across the legal spectrum – "the advance of therapeutic jurisprudence from its starting point in mental health law to its present involvement in the entire legal spectrum."[34] The creation of the International Society of Therapeutic Jurisprudence in 2017,[35] and the contributions in the special issue on therapeutic jurisprudence published in 2019 by the *International Journal of Law and Psychiatry,* confirm the actual development of the doctrine.

Therapeutic jurisprudence, originally developed as a reaction to therapeutic justice,[36] is a new way of envisioning the law and the courts. It puts dignity at the core of the judicial process.[37] Under this doctrine,

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30 Bruce J. Winick, "Problem Solving Courts: Therapeutic Jurisprudence in Practice" (2003) 30 Fordham L Rev 211 [Winick, "Problem Solving Courts"].

31 Wexler, "Therapeutic Justice", *supra* note 28 at 324 citing Ennis, "Civil Liberties and Mental Illness" (1971) 7 Crim L Bull 101.

32 *Ibid* at 294.

33 *Ibid* at 319.

34 David Wexler, "Two Decades of Therapeutic Jurisprudence" (2008) 24 Touro L Rev 17 at 17.

35 For David Wexler, Therapeutic justice culture, *supra* note 28 at para 20, "TJ [therapeutic jurisprudence] is an ongoing and dynamic field," and he invites "interested readers to become part of the TJ community and join the International Society of Therapeutic Jurisprudence."

36 David Wexler, "Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence" (1992) 16 L & Human Behavior 27; Michael L Perlin, "'Changing of the Guards': David Wexler, Therapeutic jurisprudence, and the transformation of legal scholarship" (2019) 63 Intl J L& Psychiatry 3 ["Changing of the Guards"].

37 Michael L Perlin, "Dignity and Therapeutic Jurisprudence: How We Can Best End Shame and Humiliation" in Chipamong Chowdury, Michael Britton & Linda Hartling, eds, *Human Dignity: Practices, Discourses, and Transformations* (Lake Oswego, Human Dignity Press, 2020).

the law and the courts should be used to promote mental health, in accordance with the idea that "[l]egal rules and the way they are applied are social forces."[38] This approach drives structural transformations in the judicial system through the development of alternative judicial adaptation mechanisms. For example, in penal "problem-solving courts," the law, legal procedures and legal professionals are seen as therapeutic agents.[39] Problem-solving courts are a response by the justice system to a growing demand for justice that, unlike conventional litigation, would metamorphose the judicial role to make it capable of dealing with social problems, such as homelessness and poverty.[40] Since "[l]egal decision making should consider not only economic factors, public safety, and the protection of patients' rights; it should also take into account the therapeutic implications of a rule and its alternatives."[41] To achieve their "therapeutic potential,"[42] legal professionals must develop interpersonal skills, including the ability to manage the emotions of all actors in legal proceedings and develop a holistic, motivational approach to chronic personal problems.[43] Therapeutic jurisprudence therefore aims to transform the legal system for the benefit of both individuals and society.[44]

The founders of therapeutic jurisprudence doctrine claim that they do not adhere to the paternalistic premises of therapeutic justice. Rather, they affirm that "the law's commitment to the principle of individual autonomy on the basis that self-determination is therapeutically advantageous."[45] In this context, the will of defendants is a key element, particularly when it comes to treatment.[46] Bruce Winick explains that "the thrust of much of the existing therapeutic jurisprudence work is that the individual's own views concerning his or her health and how best to achieve it should generally be honored."[47] The opportunity for defendants to express their views and feel validated produces greater acceptance of the judicial process, which increases compliance with judicial decisions.[48]

To accomplish the goal of "honoring" the views of the defendants, the doctrine of therapeutic jurisprudence "has left the concept of 'therapeutic' intentionally vague."[49] This is surprising, considering that proponents of therapeutic jurisprudence knew that the indeterminacy of concepts opens the door to coercion. According to this paradigm, social situations that are considered problematic –such as homelessness, drug addiction or mental disorders– may be solved through "behavioral contracts" that are designed "to increase motivation and psychological functioning."[50]

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38 Winick, "Problem Solving Courts", *supra* note 30 at 1062.

39 *Ibid*; David Wexler, *Therapeutic Jurisprudence: The Law as a Therapeutic Agent* (Durham, NC: Carolina Academic Press, 1990).

40 Winick, "Problem Solving Courts", *supra* note 30.

41 David Wexler & Bruce J Winick, "Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research" (1991) 45 U Miami L Rev 979 at 982.

42 Perlin, "Changing of the Guards, *supra* note 36 at 6.

43 Winick, "Problem Solving Courts", *supra* note 30; Michael S King, "Restorative Justice, Therapeutic Jurisprudence and the Rise of Emotionally Intelligent Justice" (2008) 32 Melbourne UL Rev 1096.

44 Michael L Perlin, "What is Therapeutic Jurisprudence?" (1993) 10 NYL Sch J Hum Rhts 623.

45 Winick, "Therapeutic Jurisprudence", *supra* note 26 at 191.

46 Bruce J Winick, "The right to refuse treatment: a therapeutic jurisprudence analysis" (1994) 17 Intl J Law & Psychiatry 99.

47 *Ibid* at 192.

48 Bruce J Winick, "Therapeutic Jurisprudence and the Civil Commitment Hearing" (1999) 10 J Contemp Leg Issues 37.

49 Winick, "Therapeutic Jurisprudence", *supra* note 26 at 192.

50 *Ibid* at 194.

Wexler observes that

> therapeutic jurisprudence would suggest that trial judges shaping conditional release orders might increase compliance with such orders if a patient/defendant were asked to embody the conditional release plan in a behavioral contract, and if the hearing were used as a forum for the patient/defendant to make a "public" commitment to comply – a commitment made in the presence of the judge and agreed-upon family members. Such a procedure would tap therapeutic potential without offending our notions of justice.[51]

The therapeutic jurisprudence doctrine calls into question neither the basic understanding of what constitutes a crime or deviance, nor the police or judicial practices in matters of investigation, accusation or sentencing. It does not take a stand against the criminalization of mental health,[52] does not recognize the coercive dimensions that the treatment may involve and does not question the validity of the consent obtained.

For many, therapeutic jurisprudence, like therapeutic justice, within the wider context of the "therapeutic State"[53] and "therapeutic culture,"[54] is in itself paradoxically punitive and constraining.[55] Several scholars since the 1970s have pointed out the disciplinary dimension of the therapeutic movement,[56] increasing behavioural control beyond the level formally allowed by the law, and asking individuals to "exchange rights for welfare"[57] "without offering any appreciable clinical benefit."[58] The same empirical observations, consistent with Michel Foucault's theoretical propositions about biopower and governmentality,[59] have since been made many times in different fields of research.[60]

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51 David Wexler, "Justice, Mental Health, and Therapeutic Jurisprudence" (1992) 40 Clev St L Rev 517 at 519.

52 Michael Rembis, "The New Asylums: Madness and Mass Incarceration in the Neoliberal Era" in Liat Ben-Moishe, Chris Chapman & Allison C Carey, eds, *Disability Incarcerated – Imprisonment and Disability in the United States and Canada* (New York: Palgrave Macmillan, 2014) 139; Linda Steele, *Disability, Criminal Justice and Law: Reconsidering Court Diversion* (London: Routledge, 2020).

53 James L Nolan, *The therapeutic state* (New York: New York University Press, 1998); Andrew J Polsky, *The rise of the therapeutic state* (Princeton: Princeton University Press, 1991); Thomas Szasz, *The therapeutic state: psychiatry in the mirror of current events* (Buffalo, Prometheus Book, 1984).

54 Philip Rieff, *The triumph of the therapeutic: uses of faith after Freud* (New York: Harper and Row, 1966).

55 Forrest Stuart, *Down, out & under Arrest: Policing and everyday life in Skid Row* (Chicago: Chicago University Press, 2015); Kelly Hannah-Moffat & Paula Maurutto, "Shifting and targeted forms of penal governance: Bail, punishment and specialized courts" (2012) 16 Theoretical Criminology 201; Teresa Gowan & Sarah Whetstone, "Making the criminal addict: Subjectivity and social control in a strong-arm rehab" (2012) 14 Punishment and Society 69.

56 Ronald Leifer, "The medical model as the ideology of the therapeutic state" (1990) 11 J Mind & Behavior 247.

57 David Garland, "The birth of the welfare sanction" (1981) 8 Brit J L & Society 29 at 43.

58 Nigel Eastman, "Anti-therapeutic community mental health law: Rules cannot substitute for resources" (1995) 310 Brit Med J 1081 at 1082.

59 Michel Foucault, *The birth of biopolitics: Lectures at the Collège de France, 1978-79*, translated by Graham Burchell (London: Picador 2010); Michel Foucault, *Security, territory, population: Lectures at the Collège de France, 1977-78*, translated by Graham Burchell (London: Picador, 2009); Michel Foucault, *Discipline and Punish: The Birth of the Prison*, translated by Alan Sheridan (London: Penguin, 1977) [Foucault, *Discipline and Punish*].

60 Rembis, *supra* note 52; Stuart, *supra* note 55; Marie-Ève Sylvestre, Nicolas Blomley & Céline Bellot, *Red Zone. Criminal Law and the territorial governance of marginalized people* Cambridge UK: Cambridge University Press, 2019).

Since criminal law is a powerful tool of social control,[61] penal courts are logically the place of the therapeutic. Problem-solving courts, such as mental-health courts, make it possible to protect private property and public safety and to support financial activities, while controlling and reforming people who do not meet the behavioural requirements dictated by the free market.[62] These courts have been developed in a number of areas, e.g. substance abuse, domestic violence, subsistence theft, homelessness. But over the past fifteen years, sociolegal research has documented changes in the way the court system operates that blur the usual boundaries between penal, civil and administrative law. On the one hand, the therapeutic has spread to new areas of law such as constitutional law.[63] On the other hand, civil and administrative courts, mandated to arbitrate or protect, are used to enforce safety, adopting the punitive methods of the penal courts.[64] All areas of life are affected: social security, immigration, housing, child protection, and, first and foremost, mental health.[65]

The "therapeutic" is most often studied in relation to particular areas of law, generally penal, and more specifically, mental-health courts. However, two elements militate in favour of transversal research practices. First, the theory of therapeutic jurisprudence claims to be applicable in all legal contexts, including outside problem-solving courts or penal proceedings. Second, mental-health law is inherently complex and cannot be reduced to mental-health courts, as it is at the crossroads of civil, administrative and criminal procedures.

III. THE THERAPEUTIC MOVEMENT IN JUSTICE: REFORMS AND IMPLEMENTATION IN QUEBEC

In the 1990's, Quebec and Canadian legislative reforms led to the creation of legal mechanisms in the areas of penal, civil and administrative law. They also created new judicial mandates entrusted to civil and administrative courts. In both cases, safety is invoked as a core concern to justify the implementation of exceptional mechanisms allowing for the application of coercive measures on defendants, such as involuntary admission and administrative control. In both cases, the judicial process must ensure the strict adherence to these exceptional proceedings to protect the fundamental rights of the defendant, in particular

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61 Howard Becker, *Outsiders, studies in the sociology of deviance* (New York: Free Press of Glencoe, 1963); Donald Black, "Crime as Social Control" (1983) 48 Am Sociological Rev 34; Foucault, *Discipline and Punish*, *supra* note 58.

62 Polsky, *supra* note 53; Sue-Ann MacDonald, Véronique Fortin & Stéphanie Houde, "Therapeutic justice or epistemic injustice? The case of mental health court in Quebec" in Kelly Fritsch, Jeffrey Monaghan & Emily Van der Meulen, eds, *Disability injustice: confronting criminalization in Canada* (Vancouver: UBC Press, 2022) 164.

63 Daniel F Piar, "A Welfare State of Civil Rights: The Triumph of the Therapeutic in American Constitutional Law" (2008) 16:3 Wm & Mary Bill Rts J 649.

64 Nolan, *supra* note 53; Katherine Beckett & Steve Herbert, "The Punitive City Revisited: the Transformation of Urban Social Control" in Mary L Frampton, Ian Haney Lopez & Jonathan Simon, eds, *After the War on Crime: Race, Democracy, and a New Reconstruction* (New York: New York University Press, 2008) 106.

65 Gijsbert Vonk, "Repressive Welfare States: The Spiral of Obligations and Sanctions in Social Security" (2014) 16 Eur J Soc Sec 188; Keramet Reiter & Susan Bibler Coutin, "Crossing Borders and Criminalizing Identity: The Disintegrated Subjects of Administrative Sanctions" (2017) 51 Law & Soc'y Rev 567; Matthew Desmond, *Evicted: poverty and profit in American city* (New York: Broadway Books, 2016); Emmanuelle Bernheim, "Sur la Réforme des Mères Déviantes. Les Représentations de la Maternité dans la Jurisprudence de la Chambre de la Jeunesse, entre Différentiation et Responsabilité" (2017) 47 *Revue Générale de Droit* 45; Bernheim, "Beyond Psychiatry", *supra* note 2.

the rights to liberty and to consent to treatment (A). The judicial practice that has subsequently developed demonstrates a steady increase in the judicialization of mental health (B)

A. The Orientations of the Last Reforms

In their parallel reform efforts, both the federal and provincial governments relied on similar strategies : judicialization, consistent criteria of "danger to themselves or to others" (in provincial law) or "significant threat" (in federal law), a rigid procedural framework and impossibility of forcing treatment through involuntary admission procedures or through Part XX.1 of the *Criminal Code of Canada*—Mental Disorder.[66] The radical separation of risk-management and forced treatment mechanisms was instituted in order to allow defendants to exercise their civil rights during their involuntary admission, detention, or conditional release.[67] The legislators therefore saw this separation as a way to protect the defendants' right to integrity, including their right to consent to their treatment.

The new legal mechanisms upheld the universality of fundamental, procedural and civil rights. The goal was to ensure that "there is equality of justice in the way in which we treat mentally disordered persons who come into conflict with the criminal law."[68] For both federal and provincial legislators, judicialization ensures the implementation of rights while harmonizing practices, thus eliminating the "arbitrary nature" of the process.[69] The courts act as the final "safeguard"[70], protecting the right to liberty and integrity.

New judiciary processes were put in place to deal with cases of involuntary admission, no criminal responsibility on account of mental disorder and unfitness to stand trial. In the case of involuntary admission, health institutions must file an application before a civil court and prove that the defendant is "a danger to himself or to others owing to his mental state."[71] To order involuntary admission, "[t]he court itself [must] have serious reasons to believe that the person is dangerous and that the person's confinement is necessary."[72] In the case of no criminal responsibility, a defendant found not criminally responsible on account of mental disorder [NCRMD] by a criminal court can be detained, conditionally discharged or discharged absolutely, depending on their level of "significant threat to the safety of the public."[73] The initial decision may be taken by the criminal court at the time of the verdict or by a specialized administrative tribunal, the Review Board, that is thereafter responsible for a review of the decision. This review must take place every 12 months. Three administrative judges sit on the Review Board: a lawyer, a psychiatrist and another mental-health specialist (a psychologist or a social worker). In the case of unfitness to stand trial [UST], a defendant declared unfit to stand trial must be detained or conditionally

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66 Treatment can be forced through a civil court process that, in Quebec, is not specific to people living with mental illness: see *Civil Code of Quebec*, CQLR c CCQ-1991, s 16.

67 This separation is also justified by the constitutional division of powers, where the federal government has no jurisdiction over health.

68 *House of Commons Debates*, 34-3, vol 4(21 November 1991) at 5132 (Hon Rob Nicholson).

69 *House of Commons Debates*, 34-3, vol 3 (4 October 1991) at 3297 (Hon Kim Campbell).

70 Quebec, National Assembly, Committee on Social Affairs, Clause-by-clause consideration of Bill 39, An Act respecting the protection of mentally ill persons and amending various legislative provisions (2), *Journal des débats de la Commission permanente des affaires sociales*, 35, No 100, 5 December 1997 at 6.

71 CCQ s 29.

72 CCQ s 30.

73 *Criminal Code*, LRC 1985, c C-46, s 672.5401.

discharged until such a time when they may become fit to stand trial. Like people found NCRMD, those found UST are placed under the administrative control of the Review Board, but without possibility of absolute discharge unless the charges are dropped or a judicial declaration of permanent unfitness to stand trial is reached.

The provisions added to the civil and criminal codes in the 1990s, which are still in effect today, are exceptions to the general legal principles according to which responsibility and absence of danger to oneself or to others are presumed. These provisions must therefore be interpreted strictly. Here as well, both federal and provincial governments retained similar safety-oriented criteria: danger in civil law and significant threat in criminal law. These criteria appear in the different versions of the legislation regarding psychiatric commitment and insanity since the nineteenth century. However, no association has been scientifically established between danger to self or others and psychiatric diagnosis, contrary to assumptions harboured by media, political and police discourses since the 1950s.[74] Among the different diagnoses, psychotic disorders, in particular schizophrenia, are more closely associated with unpredictability and violence than other disorders.[75]

With the exception of legal requirements to be quarantined for certain diseases or to undergo psychiatric evaluation against one's will, the above-mentioned legal mechanisms—involuntary admission, no criminal responsibility on account of mental disorder and unfitness to stand trial—are the only ways in which citizens not guilty of penal or criminal offences can be detained by civil or administrative authorities. In both cases, both mental disorder and the presence of danger or significant threat is what gives authority to the courts to restrict freedom.[76] However, legislators have not taken the time to define either the meaning or the level of danger or significant threat.

Table 1. Evolution of criteria for involuntary admission, no criminal responsibility on account of mental disorder and unfitness to stand trial[77]

	1851	1972	1998
Civil Law: involuntary admission	"[…] persons who, by lunacy or otherwise, are furiously mad, or so disordered in their	"[…] any person showing signs of mental disorders likely to endanger the health	"[…] persons whose mental state presents a

74 Angela M Parcesepe & Leopoldo J Cabassa, "Public Stigma of Mental Illness in the United States: A Systematic Literature Review" (2013) 40:5 Adm Policy Ment Health 384; Jade Boyd & Thomas Kerr, "Policing 'Vancouver's mental health crisis': a critical discourse analysis" (2015) 26:4 Critical Public Health 418.

75 Annik Mossière & Evelyn Maeder (2015) "Defendant mental illness and juror decision-making: A comparison of sample types" (2015) 42-43 Intl J L& Psychiatry 58; Parcesepe & Cabassa, *ibid*.

76 Many authors observe that mental health legislations violate section 14 of the *Convention on the Rights of Persons with Disabilities*, 13 December 2006, Res. A/RES/61/106 (entered into force 3 May 2008), which provides "that the existence of a disability shall in no case justify a deprivation of liberty." See Tina Moskowitz, "Why Mental Health Laws Contravene the CRPD – An Application of Article 14 with Implications for the Obligations of States Parties (16 September 2011), online: SSRN <https://ssrn.com/abstract=1928600>; Tess Sheldon & Karen R Spector, "Law as a Site of Mad Resistance: User and Refuser Perspectives in Legal Challenges to Psychiatric Detention" (2019) 10 J Ethics Mental Health 1.

77 *An Act to authorize the confinement of Lunatics in cases where there being at large may be dangerous to the public*, SPC 1851, 14–15 Vict, c 84, s 5; Mental Patients Protection Act, RSQ c P-41, s 2; *Act respecting the protection of persons whose mental state presents a danger to themselves or to others*, CQLR c P-38.001; The *Criminal Code* 1892, s 738; *Criminal Code* 1953–1954, s 526; s 672.54 CrC.

	senses as to endanger their own persons or property, or the persons or property of others, if permitted to go at large […]"	or security of that person or the health or security of others"	danger to themselves or to others"
	1892	1955	1992
Criminal Law: no criminal responsibility on account of mental disorder and unfitness to stand trial	"[…] a dangerous person […]"	"Where an accused is […] found to be insane, the Lieutenant-Governor of the province may make an order for the safe custody of the accused in the place and in the manner that he may direct."	Persons who are a "significant threat to the safety of the public"

If the presence of danger or significant threat justifies the restriction of freedom, both federal and provincial governments work to limit the infringement of rights to a minimum. In both cases, they exclude the issue of treatment, which is central to psychiatric practices and is covered by separate civil legal mechanisms, from the courts' jurisdiction. Individuals detained under these exceptional procedures retain their right to consent to their treatments and may not have treatments imposed upon them. The measures imposed, whether detention or otherwise, serve only to ensure safety.

The reaction of the psychiatric community to these reforms was swift. As judicial decisions informed by these reforms multiplied, the literature denouncing judicial interventionism, the role of "jailers" to which psychiatrists were now assigned and the cruel impacts on patients multiplied.[78] For psychiatrists, the radical separation between deprivation of liberty for safety reasons and treatment is a legal fiction that makes little clinical sense. At the same time, legal experts have applauded the recognition and protection of the rights of people living with mental illness, as well as the reduced role of psychiatrists in favour of the courts.[79]

B. Judicialization of Mental Health in Quebec Since 1990

In the early years of the reforms, the courts proceeded with caution. The judicial cases were few; the new provisions had to be interpreted, and the question of rights was discussed at length in case law. In several decisions regarding the interpretation of criteria (danger, threat), higher courts asserted that the restriction of rights and freedoms must be minimal and that exceptional procedures must aim only to protect the defendant and should under no circumstance be used for retribution or punishment.

Concerning involuntary admission, the Quebec Court of Appeal[80] reminded trial courts several times that they must take into account the intrinsic prejudice of deprivation of liberty.[81] Concerning no criminal responsibility on account of mental disorder and unfitness to stand trial, the Supreme Court of Canada asserts that the *Criminal Code* "does not create a presumption of dangerousness." On the contrary, "the

78 Bernheim, *Hospitalisation*, *supra* note 14.
79 *Ibid.*
80 No Quebec case of involuntary admission was heard by the Supreme Court of Canada.
81 *A c Centre hospitalier de St. Mary*, 2007 QCCA 358 at para 31.

threat posed must be more than speculative in nature; it must be supported by evidence," and no burden of proof can be placed on the defendant.[82] In all cases, decisions must be the least restrictive, and people found NCRMD who represent a significant threat to the safety of the public shall be absolutely discharged if they have all the support they need.

Despite this case law on rights and freedoms, court decisions soon generated ambiguity on what constitutes danger and significant threat, as well as on the role of treatment as a judicial tool to ensure safety.[83] It is settled case law that the danger or the significant threat in question does not have to be linked to self-harm or to aggressive behaviour toward others and that the situations involved must be assessed on a case-by-case basis. The concepts of danger and significant threat therefore remained largely undefined, but the issue of treatment appeared to be central.[84] Involuntary admission and administrative control are routinely ordered because they are deemed necessary in order to administer treatment. The Quebec Court of Appeal has repeatedly stated the importance of collaborating with psychiatrists, especially regarding treatment, at the time of involuntary admission and of keeping defendants confined in order to administer "the treatment required by their condition,"[85] even going so far as to order treatment.[86] The Supreme Court of Canada was even more explicit, affirming that the mental disorder provisions of the *Criminal Code* pursue "twin goals:"[87] "public safety and treatment."[88] At the same time, courts have paradoxically established that refusing treatment may not be considered as evidence of danger or significant threat.[89]

These ambiguous judicial interpretations of danger and significant threat potentially have the effect of increasing the number of situations where involuntary admission and administrative control seem required. First, professionals who have to assess danger and threat (such as trial and administrative judges, police officers and psychiatrists) enjoy a great deal of discretion that can be exercised in different ways,[90] especially since their goals and training diverge substantially. Second, with the issue of treatment being considered central, situations relating to collaboration with the treatment team, the quality of the

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82 *Winko v British Columbia* (*Forensic Psychiatric Institute*), [1999] 2 SCR 625 at paras 49 and 57.

83 Glen Luther & Mansfield Mela, "The Top Ten Issues in Law and Psychiatry" (2006) 69 Sask L R 401 at 412-416; Joaquin Zuckerberg, "Jurisdiction of Mental Health Tribunals to Provide Positive Remedies: Application, Challenges, and Prospects" (2011) 57:2 McGill LJ 267; Emmanuelle Bernheim, "Le refus de soins psychiatrique est-il possible au Québec? Instrumentalisation du droit et mission thérapeutique de la justice" (2019) 11:1 *Aporia* 28; Emmanuelle Bernheim et al, "Surveiller, contrôler et traiter: le consentement aux soins à la Commission québécoise d'examen" (2022) 47:1 *Santé mentale au Québec* 135.

84 Luther & Mela *ibid*; Zuckerberg *ibid* ; Bernheim *ibid* ; Bernheim et al *ibid* .

85 *SL c Centre hospitalier universitaire de Québec*, 2010 QCCA 959 at para 10.

86 *GJ c Directeur des services professionnels du Centre hospitalier Pierre-Le-Gardeur*, 2007 QCCA 1053.

87 *Penetanguishene Mental Health Centre v Ontario* (*Attorney General*), 2004 SCC 20 at para 19.

88 *Pinet v St. Thomas Psychiatric Hospital*, 2004 SCC 21 at para 19.

89 *J.M.* c. *Hôpital Jean-Talon du Centre intégré universitaire de santé et de services sociaux (CIUSSS) du Nord-de-l'île-de Montréal*, 2018 QCCA 378; *D.T.* c. *Centre intégré universitaire de santé et de services sociaux de Montérégie-Centre*, 2018 QCCA 1558; *I.F.* c. *Centre hospitalier de l'Université de Montréal*, 2017 QCCA 905; J.S. c. Centre universitaire de santé McGill (CUSM), 2016 QCCA 1085.

90 The proportion of risk assessment error for suicidal or heteroaggressive violence resulting from the use of rating scales is approximately 50%, most notably for racialized individuals: Thomas Douglas et al, "Risk assessment tools in criminal justice and forensic psychiatry: The need for better data" (2017) 42 European Psychiatry 134; Matthew Large et al, "Meta-Analysis of Longitudinal Cohort Studies of Suicide Risk Assessment among Psychiatric Patients: Heterogeneity in Results and Lack of Improvement over Time" (2016) 11:6 Plos ONE 1.

therapeutic relationship with the psychiatrist and treatment compliance become highly relevant. In Quebec, the number of court cases increased rapidly since the first years of the reforms. Of all Canadian provinces, Quebec has the highest number of NCRMD verdicts and therefore the most people under administrative control of the Review Board.[91] A comparative study of the practices of the Quebec, Ontario and British Columbia Review Boards found that the Quebec Board orders more conditional discharges than the other two.[92] The conditions most often ordered by the Quebec Review Board include following therapeutic recommendations, keeping the peace and living in a known location. This continued increase in mental health judicialization is consistent with a trend observed in most countries of the Global North.[93]

Table 2. Evolution of mental health judicialization in Quebec since 1990[94]

Involuntary admission*		Administrative control of people found NCRMD and UST **	
2015	5454	2001	898
2018	6618	2008	1572
2020	7030	2018	1998

*No consistent provincial statistics available until 2015 **Quebec Review Board case load.

In addition to this civil and administrative judicialization, various judicial initiatives in mental health have been multiplying from the mid-2000s in all judicial districts in Quebec. Mental-health programs and adaptability protocols (which constitute different types of problem-solving courts) allow charges to be dropped conditional upon successfully completing the required therapy. In the Montreal district, where the first program was set up, the number of court cases increased from 1579 in the first year (2008) to 3883 four years later.[95]

The Quebec Ministry of Justice is aware of this growing judicialization. In its Justice and Mental-Health Strategy,[96] the Ministry argues that significant progress has been made in recent years and encourages the development of collaboration between police and health services, as well as the recourse

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91 Anne G Crocker et al, "Dynamic and Static Factors Associated with Discharge Dispositions: The National Trajectory Project of Individuals Found Not Criminally Responsible on Account of Mental Disorder (NCRMD) in Canada" (2014) 32 Behav Sci L 577

92 Anne G Crocker et al, "The National Trajectory Project of Individuals Found Not Criminally Responsible on Account of Mental Disorder in Canada. Part 3: Trajectories and Outcomes Through the Forensic System" (2015) 60:3 Can J Psychiatry 117.

93 Gi Lee & David Cohen, "Incidences of Involuntary Psychiatric Detentions in 25 U.S. States" (2020), online: *Psychiatric Services* <https://doi.org/10.1176/appi.ps.201900477>; Michael Lebenbaum et al, "Prevalence and predictors of involuntary psychiatric hospital admissions in Ontario, Canada: a population-based linked administrative database study" (2018) 4 Brit J Psychiatry Open 31; Luke Sheridan Rains et al, "Variations in patterns of involuntary hospitalisation and in legal frameworks: an international comparative study" (2019) 6 The Lancet 403.

94 Administrative Tribunal of Quebec, *Rapport annuel de gestion 2018-2019 du Tribunal administratif du Québec* (Québec: 2019); Administrative Tribunal of Quebec, *Rapport annuel de gestion 2008-2009 du Tribunal administratif du Québec* (Quebec: 2009); Administrative Tribunal of Quebec, *Rapport annuel 2003-2004* (Quebec: 2004); Quebec, Ministry of Justice, *Demande d'accès aux documents R-94748* (Quebec: 2021).

95 Sue-Ann MacDonald et al, *Tribunaux de santé mentale : Procédures, résultats et incidence sur l'itinérance*, Research Report (Montreal: 2014).

96 Quebec, Ministry of Justice, *Stratégie nationale de concertation en justice et santé mentale* (Quebec: 2018).

to civil law and to problem-solving courts in penal and criminal matters. The Ministry's 2019-23 Strategic Plan provides support for the implementation of new judicial mental-health programs across the province.[97] However, the Ministry did not rely on any data to support its decisions or to demonstrate the effectiveness of these programs. A senior official working on ministerial policy development said in an interview that even though "it is difficult to demonstrate that [mental health programs] reduce crime," he still believes in the effectiveness of these programs. For him, by keeping an "official" record of events, these programs give the state authority to intervene on the therapeutic level and "improve behaviour."[98]

IV. THE RISE OF THE "THERAPEUTIC" MOVEMENT IN QUEBEC COURTS: POVERTY, LIFESTYLE AND MEDICATION

I carried out two ethnographic field studies in two courts, which involved observing hearings and analyzing randomly selected case law. The first was the Court of Quebec, the civil court charged with making decisions on applications for involuntary admission. The second was the Quebec Review Board, which is in charge of the administrative control of the people found NCRMD and UST.

The two observation pools are nine years apart: I attended Court-of-Quebec hearings in the summer of 2009; I then attended Review-Board hearings in 2017 and 2018. The two research fields were both in the judicial district of Montreal. Even though the first study may seem old, it was when completing the second study that I noticed the strong similarities between the two judicial processes and was able to establish structural links between the civil and administrative mechanisms that seem relevant to explore. To complete these observation pools, I randomly selected 100 decisions from the two courts from 2018. For the Review Board, I selected only decisions of no criminal responsibility on account of mental disorder to match the observation sample.[99] The analysis of the observation notes and case law was initially done inductively to identify relevant themes and build a coding grid. A thematic coding of the ethnographic notes and case law was then conducted on NVivo.

Table 3. Type of observations and sample

	Involuntary admission	Administrative control of people found NCRMD
Court	Court of Quebec	Quebec Review Board
Year of data collection	2009	2017–2018
Duration of collection	Every day for 6 weeks	Once per week for 18 weeks
Number of hearings observed	187	51
Hours spent in the courtroom	56	57

97 Quebec, Ministry of Justice, *Plan stratégique 2019-2023* (Quebec: 2021).

98 Guillaume Ouellet, Emmanuelle Bernheim & Daphné Morin, "Vu pour vulnérable : la police thérapeutique à l'assaut des problèmes sociaux" (2021) 22 *Champ pénal*, online : <https ://doi.org/10.4000/champpenal.12988> at para 64.

99 The number of hearings concerning UST is so low (3 out of 54) that no particular conclusion can be drawn. For more consistency in analysis, these hearings are excluded from the corpus.

Average duration of hearings	5 to 30 minutes	1 to 1.5 hours
Court decisions	100, selected randomly	100, selected randomly

The legal contexts of the two mechanisms studied are very different. When it comes to involuntary admission, defendants have not committed an offense. They are subject to a civil proceeding, in which a hospital asks the court to order an involuntary admission for a maximum number of days. Two psychiatric reports are submitted as evidence, but the psychiatrists are not present in court. In the corpus of decisions analyzed, this term varied between fifteen and sixty days, with the average being thirty days. Release orders accounted for twelve of the hundred decisions analyzed.

In the cases of no criminal responsibility on account of mental disorder, the defendants have, in contrast, committed an offense. Although the defendants are not guilty, it is this offense that authorizes the criminal court or the Review Board to rule initially on the level of threat they represent and on a possible detention, conditional discharge or absolute discharge. In the event that the tribunal orders detention or conditional discharge, a review hearing must be held every twelve months until the individual receives an absolute discharge. The attending psychiatrist produces a threat-level assessment and makes recommendations to the Review Board, in addition to testifying at the hearing. In the sample of decisions analyzed, thirty-eight defendants received an absolute discharge, including fourteen after one year; forty-six were discharged conditionally, and sixteen were detained in custody. The majority remained under the control of the Review Board for less than five years; however, some remained under the Board's control for more than ten years, including forty-two years for one defendant. No link can be established between the seriousness of the offense committed, the severity of the measure imposed and the time spent under the Board's jurisdiction. The majority of decisions concerned individuals who had committed assault, but included, for example, the absolute discharge after one year of individuals who had committed arson or breaches of conditions, while others were discharged with conditions for similar offenses. Similarly, after one year under the Review Board's jurisdiction, an individual who had loitered in a public place was put in custody, whereas another who had committed assault with a weapon and criminal harassment was granted an absolute discharge. In Quebec, as in other Canadian provinces and in the United States, the probability for people found NCRMD of being in custody is three times greater than for convicted defendants, regardless of the type of offense, and for longer periods.[100]

Despite the legal differences between the two mechanisms, the cross analysis of observations and judicial decisions highlights several identical findings. The results are consistent with those of research conducted since the 1970s in other jurisdictions and in a variety of courts, whether criminal, civil or administrative, and with judges sitting as a group or alone.[101] A review of the empirical literature on a

[100] Sandrine Martin, *Non responsabilité criminelle pour cause de troubles mentaux: Comparaison des pratiques de supervision des Commissions d'examen aux peines prononcées dans le système pénal*, (Master's Thesis, University of Montreal, 2019) [unpublished]; Michael L Perlin, "The Insanity Defense: Nine Myths that will not go Away" in Mark D White, ed, *The Insanity Defense – Multidisciplinary Views on it History, Trends and Controversy* (Santa Barbara: Praeger, 2017) 3.

[101] Agnieszka Doll, "Lawyering for the 'Mad': Social Organization and Legal Aid Representation in Involuntary Admissions Cases in Poland" in Bonnie Burstow, ed, *Psychiatry Interrogated* (New York: Palgrave Macmillan, 2016) 183; Katey Thom & Ivana Nakarada-Kordic, "Mental Health Review Tribunals in Action: A Systematic Review of the

variety of mental-health courts reports the same general observation as mine about the prevalence of "[t]he non-adherence to strict laws of evidence in the decision-making of the Tribunals, coupled with a tendency for opinion, intuition, 'rules of thumb' and subjective feelings about the right course of action to precede fact."[102]

Three main results are discussed here. The first result concerns the typical socioeconomic profile of the population affected by these two judicial processes. The second result is the inconsistency in what constitutes danger or significant threat. The situations observed are varied and processed in many ways; the safety issues are often not clearly defined, and the discussion regularly focuses on the lifestyle of the defendants. The third result is the assumption made by the courts about a likely link between not taking medication and danger or significant threat. This assumption is routinely made without definite scientific proof or sufficient attention to the nuances of each case. This means that refusing treatment is likely to directly impact court decisions, which would result in coercive measures such as involuntary admission, custody or conditional discharge.

Gender is the only major difference between defendants in a litigation over involuntary admission on the one hand and defendants under the administrative control of the Review Board on the other hand. The first group is composed of an equal number of men and women while the second is primarily male, corresponding to the over-representation of males in the criminal and penal courts. With some exceptions, these individuals are poorly educated, living off minimal social assistance or working for minimum wage, living precariously—in rooming houses, low-income housing, homeless on the street or in outpatient psychiatric facilities—and are single.[103] If mental disorders affect every social group, independently of their socio-economic status, gender, race or level of education, judicialization affects mainly people with few financial or social resources whose presence in the public space disturbs others.[104] Some studies have shown that, in mental health, people who face judicial measures are not only poorer and more isolated than the general population, but also more so than the general population of psychiatric hospitals.[105]

The most common psychiatric diagnoses are those of psychotic disorders (schizophrenia, schizo-affectivity, etc.), but also of mood disorders (bipolarity, depression, etc.) and, to a lesser degree,

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Empirical Literature" (2014) 21 Psychiatry, Psychology L 126; Jennifer A Chandler, "Legally-coerced consent to treatment in the criminal justice system" in Dave Holmes, Jean-Daniel Jacob & Amélie Perron, eds, *Power and the Psychiatric Apparatus: Repression, Transformation and Assistance* (Farnham UK: Ashgate Publishing, 2014) 199; William Brooks, "The Tail Still Wags the Dog: The Pervasive and Inappropriate Influence by the Psychiatric Profession on the Civil Commitment Process" (2010) 86 NDL Rev 260; John Q La Fond & Mary L Durham, "Cognitive Dissonance: Have Insanity Defense and Civil Commitment Reforms Made a Difference" (1994) 39 Vill L Rev 71; Virginia A Hiday, "Dangerousness of civil commitment candidates: A six-month follow-up" (1990) 14 L Human Behaviour 551; Virginia A Hiday, "Civil Commitment: a review of empirical research" (1988) 6 Behavioral Science & L 15[Hiday, "Civil Commitment"]; Virginia A Hiday, "Reformed commitment procedures: An empirical study in the courtroom" (1977) 11 Law & Soc'y Rev 651.

102 Thom & Nakarada-Kordic *ibid* at 116.

103 Since defendants are largely absent for their involuntary admission hearing, which is not the case when they appear before the Review Board, it is possible that these findings do not fully reflect their socio-economic reality. This limit of the field research cannot be compensated for by studying the judicial decisions which, being quite brief, generally do not discuss socio-economic situations.

104 This was confirmed by psychiatrists in interviews. See Bernheim, *Hospitalisation*, *supra* note 14.

105 La Fond & Durham, *supra* note 101; Hiday, "Civil Commitment", *supra* note 101.

personality disorders (borderline, antisocial, schizoid, etc.). This is not surprising given the prejudice and stigma discussed above concerning psychotic disorders.

During hearings, individuals reported being the subject of a variety of judicial measures, in particular regarding child protection, housing, medical treatment, various penal offences and, first and foremost, mental health. Defendants are alternately, but sometimes at the same time, involuntary admitted into psychiatric hospitals, under the control of the Review Board, followed by a problem-solving court, or ordered to take treatment. These observations allow for two conclusions to be drawn. First, the judicial mechanisms in mental health overlap, creating an over-judicialization of a relatively small group of people. Thus, the increase in judicialization observed over the past 30 years in civil and administrative matters seems to involve the same group of persons. This observation calls into question the objectives pursued by these various legal mechanisms, as well as their therapeutic efficacy. It seems, then, that judicialization in mental health does not mobilize legal mechanisms only in mental health, but also in a number of legal areas, invading and disrupting all spheres of life.

If danger and significant threat are not clearly defined in the law or in the scientific literature, case law states that they must be demonstrated by facts. The observations revealed that the evidence is variable. To begin with, while psychiatric reports are sometimes very detailed and clear about their methodologies, they are also often brief and incomplete. Nevertheless, courts accept them without questioning their reliability or methodology. It must be said that defense lawyers do not often question psychiatric assessments, nor do they argue the law in favour of their clients, an approach presented by some as "healing."[106] Advocacy is often seen as therapeutically counterproductive. According to this approach, defense counsels should work based on their own opinion of their clients' mental health rather than the mandate they have been given.

Violent or harmful incidents, or threats of violent or harmful incidents, have happened only in a minority of judicial cases. The examination of danger and significant threat seems to be concerned first with lifestyle, such as relationships with loved ones or neighbours, living space, existence of work or studies, and drug or alcohol consumption, as well as diet, debt or sexuality.

Of the 100 involuntary-admission decisions studied, four were based on behaviours that put the individuals or their loved ones in danger: two being suicidal behaviour such as "intentionally placing oneself in front of cars in the middle of the road"[107] and two being violent toward their mother such as a person having "hit his mother by doing karate moves, thinking he was Bruce Lee."[108] My observations at the court were similar: self-harming behaviour or aggressive behaviour toward others, or the threat of such behaviour, concerned a very small minority of cases.[109] A variety of facts is likely to be interpreted as proof of danger. These might include family disputes, engaging in evangelizing practices that led, according to one judge, to "bother people night or day," homelessness or living in an unsanitary apartment, neglected hygiene, leaving for a weekend trip without telling loved ones, not locking doors, fire risks,

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106 Susan Daicoff, "Law as a Healing Profession: The 'Comprehensive Law Movement'" (2005) 6 Pepp Dispute Resolution LJ 1.

107 *Centre intégré de santé et de services sociaux du Bas-Saint-Laurent c PL*, 2018 QCCQ 6613 at para 7.

108 *Centre intégré de santé et de services sociaux du Bas-Saint-Laurent c CC*, 2018 QCCQ 5626 at para 3.

109 Two out of 187 hearings observed.

"wandering the city in wintertime"[110] or "difficulties with meal preparation and everyday activities."[111] Doubting psychiatric diagnoses, not cooperating with the treatment team or not consenting to treatment are also regularly considered to be relevant facts with regard to the assessment of danger.

The examination of the 100 Review Board decisions concerning people found NCRMD reveals similar findings about the presence of significant threat. Only one of the decisions reports recent death threats. Several decisions note the seriousness of the offense that led to the verdict of not criminally responsible on account of mental disorder, most often assault, but without demonstrating that similar behaviour may be anticipated. Likewise, the observation of hearings reveals that recent violent or harmful incidents remained marginal and that a range of behaviours are discussed, such as the state of romantic and familial relationships, daily activities and personal projects. Therefore, contrary to hearings about involuntary admission, which concern individuals who have not acted out and for whom the assessment of danger aims to determine the potential for such actions, the hearings concerning people found NCRMD aimed to determine the existence of "protective factors" to prevent the commission of new offenses. These protective factors are related to the existence of a supportive family environment, residential stability, projects related to work, studies or other activities, and especially cooperation with the treatment team and treatment compliance.

The issue of drug or alcohol consumption is recurrent in both courts. Sixteen of the one hundred involuntary-admission decisions and twenty-four of the one hundred decisions involving people found NCRMD involve drug or alcohol consumption. Consumption of drugs and alcohol seems to be consistently associated with risk of violence, and the courts generally opt for the hard line: complete abstinence. During the hearings, the judges question consumption habits, such as the frequency and the quantity, as well as negative influences in the social environment, which could raise fears about an increase in consumption. Attending psychiatrists do not seem to necessarily adhere to this perspective, as several of them report having knowledge of the consumption habits of their patients and do not see the connection to particular behaviours, especially to those of a criminal or violent nature.

In cases of both involuntary admission and no criminal responsibility on account of mental disorder, elements of the clinical evaluation are considered by the court, even in the absence of factual evidence, in order to demonstrate safety concerns, in particular "altered judgment" and "lack of self-criticism." Based on a circular reasoning, the lack of self-criticism is directly associated with the psychiatric condition that poses a significant threat in itself. In this regard, the Quebec Review Board recently ruled, "the overall medical condition of the defendant prevents them from developing sufficient self-criticism to contain the significant threat to public safety."[112] Given the prejudices reported above, the courts clearly consider risk of violence as inherent to certain diagnoses.

The issue of treatment and, more specifically, refusal of treatment or non-compliance with treatment, is the most recurrent theme in judicial debates both on involuntary admission and on administrative control of people found NCRMD, despite the courts' lack of jurisdiction on the matter. Quite often, the psychiatric reports address danger, threat, treatment needs and attitudes towards treatment in a single argument, demonstrating that the law—both procedural and substantive—cannot be reconciled with psychiatric intervention.

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110 *Centre intégré de santé et de services sociaux du Bas-Saint-Laurent c CC*, 2018 QCCQ 9750 at para 7.

111 *Centre intégré de santé et de services sociaux de la Montérégie-Ouest c AL*, 2018 QCCQ 8496 at para 35.

112 *MA et Responsable du CIUSSS A*, 2019 QCTAQ 0141 at para 15.

Among the decisions studied, the issue of treatment is discussed by twenty-six concerning involuntary admission and seventy-two concerning administrative control of people found NCRMD. The observations established that consent to treatment is a subject of debate in half of the involuntary-admission hearings and in all of the hearings regarding administrative control of people found NCRMD. It seems that, for the courts, a causal link exists between taking medication and ensuring safety. The issue of treatment adherence is central because it ensures control not only of the current threat, but also of future ones. It is therefore not only a question of knowing if the individuals take their medication, but if they take it of their own will and if they accept that they must take it for the rest of their lives. The courts are therefore concerned with whether, without judicial pressure, the defendants will continue to take their medication, and the slightest doubt is enough to justify imposing exceptional measures. As a result, negotiations on the type of medication, the dosage or the method of administration (oral or injection) are interpreted as instability in commitment to treatment.

Refusal of treatment, despite being an exercise of the most fundamental of rights, is associated with unpredictability and lack of judgment. It justifies, sometimes in itself, involuntary admission or the maintenance of administrative control. For example, before ordering involuntary admission, the court stated that "R…G… [the defendant] refuses to be confined to an institution in order to receive the treatment that she needs."[113] In the case of a defendant found NCRMD who had been under the Review Board's control for five years, who was employed, and about whom no incident had been reported for three years, but who was refusing medication, the court imposed a conditional discharge. Upon delivering the decision, the judge stated: "Sir, of course you would like an absolute discharge and, as you said, this must stop someday, but the issue of medication concerns the Board." [114]

The risk of stopping a treatment in mid-course may also suffice to establish the presence of danger or significant threat, such as in the case where the tribunal used the "risk of stopping medication," among other reasons, to impose a conditional discharge on a defendant found NCRMD.[115] The existence of a court order for forced treatment, or the announced plan to apply for one, is generally an evidence for the courts that the individual would not willingly submit to treatment and therefore justifies maintaining exceptional restrictions.

On the contrary, adherence to treatment may be explicitly invoked by the courts to support a decision for release. For example, in a judgment rejecting an application for involuntary admission, the court stated that the defendant "expresses herself well and seems capable of understanding the benefits that would come from treatment."[116] Similarly, in a decision concerning a defendant found NCRMD, the Review Board considered that "the management factors for the risk that he represents are that he shall receive an intramuscular medication every 28 days as well as an oral medication."[117] The tribunal therefore granted him an absolute discharge, concluding that "even though he is still delusional, he takes his medication."[118] In the case law studied, submitting to treatment and cooperating with the medical team is directly correlated with the removal of coercive measures.

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113 *Centre intégré de santé et de services sociaux de la Gaspésie c RG*, 2018 QCCQ 5625 at para 5.
114 Observation notes.
115 *HY et Responsable de l'hôpital A*, 2018 QCTAQ 12767 at para 16.
116 *CIUSSS de l'Estrie-CHUS c LG*, 2018 QCCQ 8956 at para 15.
117 *MB et Responsable du CISSS A (Centre A)*, 2018 QCTAQ 12702 at para 25.
118 *Ibid* at para 26.

Table 4. Relationship between acceptance or refusal of treatment and confinement in an institution, detention or discharge in the corpus of judicial decisions

Involuntary admission	Admission		Discharge
Acceptance of treatment	0		2
Refusal of treatment	24		0
Administrative control of people found NCRMD	Custody	Conditional discharge	Absolute discharge
Acceptance of treatment	2	4	34
Refusal of treatment	10	10	0
Risk of stopping treatment	0	2	0
Ongoing court order for forced treatment	2	6	2

V. CONCLUSION: THE TRIUMPH OF THE "THERAPEUTIC" OR THE DECLINE OF RIGHTS IN MENTAL HEALTH

At the time of the reforms in the 1990s, the objective of Quebec and Canadian lawmakers was to create judicial mechanisms to ensure the protection of the rights of defendants involved in mental-health procedures. The judicial procedure appeared to be the means to frame medical decisions based on the best interests of patients and to make the involuntary admission and the administrative control of people found NCRMD or UST an essentially legal issue. The task of the courts in this context was to choose between the rights to security and to liberty, the right to integrity being protected by the division of jurisdiction between safety and treatment issues. The documentation of the evolution of judicial practice in the last 30 years shows the failure of these reforms in Quebec, while a growing number of people are experiencing coercion and detention.[119]

The most noteworthy observation when we examine the judicial practices concerning involuntary admission and administrative control of people found NCRMD is not only the increase in judicialization, but also the trivialization of this judicialization. On the one hand, certain groups are particularly targeted and must face long and complex procedures before a multitude of courts without having adequate legal resources, which compromises their ability to assert their procedural and civil rights. On the other hand, the judicialization of these groups does not seem to pose a problem for political actors, the legal community or those who uphold therapeutic jurisprudence, even though the courts have been overloaded for years. Although defendants regularly state in court that they do not understand the procedure in which they are involved, the judicial process and all that it entails, including stress and anxiety, is not seen as

[119] While these studies focus on the judicial process and role of the court in mental health, there is a need to question coercive practices, including detention, in light of the findings. However, such a study deserves in-depth analysis, which is beyond the scope of this paper. See: Laura Davidson, "From Pipe Dream to Reality : A Practical Legal Approach Towards the Global Abolition of Psychiatric Coercion" in Michael Ashley Stein et al,, eds, *Mental Health, Legal Capacity, and Human Rights*, Cambridge, UK: Cambridge University Press, 2021) 70; Steele, *supra* note 52; Kay Wilson, *Mental Health Law: Abolish or Reform?* (Oxford, Oxford University Press, 2021); Sheldon & Spector, *supra* note 76.

harmful in itself. While the basis of the therapeutic jurisprudence doctrine is the idea that the law is in itself a "therapeutic agent" intrinsically producing effects, whether therapeutic or antitherapeutic,[120] it is difficult to see how a multitude of stressful and obscure legal proceedings could produce positive impacts. The objective of therapeutic justice is laudable in theory. However, the structural state of judicial practices, when it comes to discrimination, control and overstepping of jurisdiction, does have very real effects that contribute to the marginalization of disadvantaged social groups.

A systematic review of the literature on mental-health courts concluded that "the empirical evidence suggested Tribunals are largely dominated by health perspectives, with studies suggesting hearings act as 'rubber stamps' for medical opinions."[121] In Quebec courts, the nature of the evidence, the way in which treatment is invoked in legal arguments and the impact of compliance to treatment on the outcome of proceedings confirm the same tendency. Observations from hearings confirm that defendants' views regarding treatment are not only not solicited but are most often ignored when expressed.[122] On the one hand, the side effects of psychiatric medication are not considered by courts, which claim that the expected benefits outweigh the adverse effects. On the other hand, the exploration of other kinds of therapy such as psychotherapy is discouraged by the courts either because they are not supported by the public insurance system, or because psychiatrists are considered more competent and qualified. Anything that does not come under conventional and Western therapies, such as acupuncture, herbalism and meditation, is most often denigrated.

In Quebec, treatments do not fall under the jurisdiction of mental-health law but under a general civil law provision. The therapeutic mission assumed by the courts I studied constitutes a clear overstepping of their jurisdictions within the context of their mandate to protect safety by preventing violent or harmful incidents. It appears that this therapeutic mission can be implemented because of the indeterminacy of the legal criteria – danger to self or others and significant threat – whose meaning is reinvented in each judicial case according to the personal histories of the defendants and the opinions of the professionals involved. This problem with therapeutic justice, which Wexler identified as early as 1972, is reinforced by the indeterminacy of the concept of "therapeutic," which leaves the scope of judicial action also indeterminate.[123] If, according to Winick, this indeterminacy must, in the spirit of therapeutic jurisprudence, allow for the expression and consideration of the defendants' views, it allows in practice for courts to violate the privacy of defendants and to take an interest in their living arrangements, personal and romantic relationships, eating habits, and other aspects of their lives.[124] All components of life, with its constraints and difficulties, are thus likely to constitute the object of judicial "therapy."

The therapeutic is a device by which, paradoxically, the courts are the main actors in the decline of rights in mental health. The combination of discriminatory practices, overstepping of jurisdictions in terms of treatment, intrusion into privacy, as well as the coercive and symbolic power of the law, makes courts powerful tools for behavioural reform. This practice results in a clear violation of the rights to integrity, consent to treatment and self-determination of people facing justice in the context of mental health. These

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120 Wexler & Winick, *supra* note 41; Winick, "Therapeutic Justice",7 *supra* note 26.

121 Thom & Nakarada-Kordic, *supra* note 101 at 122.

122 An observation that researchers have made in other judicial ethnographies. See MacDonald, Fortin & Houde, *supra* note 61.

123 Wexler, *Therapeutic Jurisprudence*, *supra* note 28.

124 Winick, "Therapeutic Justice", *supra* note 26.

rights, which are the foundation of Quebec civil and ethical law in health care, are the cornerstones of legal personality and therapeutic relationships. Given the importance and role of medication in psychiatry, the issue of consent to treatment is particularly important but is absent from legal and official publications concerning therapeutic justice, at least those of the Quebec Ministry of Justice.

It is worrying that, in mental health, ironically, rights that are the fruit of long legal and political struggles are daily and structurally violated by the institutions mandated to work for their protection. It seems that changes within the law do not easily translate into changes in actual practices. Therefore, the following question warrants further research, discussion and analysis: has the therapeutic movement within the justice system become in practice the "asylum" of the twenty-first century?