Canadian Journal of Law and Society / Revue Canadienne Droit et Société (2024),
39: 2, 289–311; doi:10.1017/cls.2024.25

RESEARCH ARTICLE/ARTICLE DE RECHERCHE

Regulating Restraint: Legal Oversight of Seclusion in Canadian Forensic Psychiatric Hospitals

Benjamin Perryman*

Faculty of Law, University of New Brunswick, PO Box 4400, 41 Dineen Drive, Fredericton, NB, E3B 5A3
Email: benjamin.perryman@unb.ca

Abstract

Prolonged solitary confinement is inconsistent with international minimum rules for the treatment of prisoners and may constitute cruel, inhuman, or degrading treatment. In a series of recent cases, appellate courts in Canada have curtailed the use of prolonged solitary confinement in prisons on the basis that such detention is "grossly disproportionate" and "cruel and unusual." But these judgments in the penal context have not resulted in comparable regulation of seclusion in forensic psychiatric hospitals. Seclusion in these contexts is often comparable to solitary confinement in prison and carries with it the same serious risks of lasting harm. This article comparatively reviews the legislative and policy framework that regulates the use of seclusion in different provinces in Canada. The article argues that case law on prolonged solitary confinement in the penal context has application to the forensic psychiatric context and that a failure to more closely regulate the use of seclusion may render this type of mental health legislation and treatment unconstitutional.

Keywords: solitary confinement; seclusion; forensic hospitals; Mandela Rules; cruel and unusual treatment

Résumé

L'isolement cellulaire prolongé est incompatible avec les règles minimales internationales relatives au traitement des prisonniers et peut constituer un traitement cruel, inhumain ou dégradant. Dans une série d'affaires récentes, les cours d'appel du Canada ont d'ailleurs

*The author thanks Sarah-jane Nussbaum, Hilary Young, Jill Marshall, Jennifer Metcalfe, and the anonymous peer reviewers for their helpful comments on drafts of this article. Mark Browne provided excellent research assistance and the information and privacy officers at several hospitals and government departments facilitated timely access to the data for this article.

limité le recours à l'isolement cellulaire prolongé dans les prisons au motif que cette forme de détention est « totalement disproportionnée » et « cruelle et inusitée ». Mais ces jugements dans le contexte pénal n'ont pas donné lieu à une réglementation comparable quant à l'isolement dans les hôpitaux psychiatriques médico-légaux. Pourtant, l'isolement dans ces contextes est souvent comparable à l'isolement cellulaire en prison et comporte les mêmes risques sérieux de dommages durables. Cet article examine ainsi, à travers une perspective comparative, le cadre législatif et politique qui régit l'utilisation de l'isolement dans différentes provinces du Canada. Il soutient que la jurisprudence sur l'isolement cellulaire prolongé dans le contexte pénal peut être appliquée dans le contexte psychiatrique médico-légal et que par conséquent le fait de ne pas réglementer plus étroitement l'utilisation de l'isolement peut rendre ce type de législation et de traitement en matière de santé mentale inconstitutionnel.

Mots clés: isolement cellulaire; isolement; hôpitaux médico-légaux; les Règles Nelson Mandela; traitement cruel et inusité

Introduction

Forensic hospitals in Canada use three forms of restraint when patients pose a risk of harm to self or others: (1) chemical, (2) physical, and (3) environmental. The environmental category, known in the medical community as "seclusion," involves placing patients in a secure room that is locked from the outside. These rooms are often like a jail cell: small in size, windowless (except for an observational portal in the door), empty (except for a mattress and possibly a toilet), containing no control over the lights or temperature, and isolating.[1] This article analyzes the legal regulation of seclusion in forensic hospitals in Canada, particularly in comparison to the practice of solitary confinement in prisons.

In the penal context, at least historically, the legal system failed to control the isolation of prisoners.[2] Over the past ten years, however, Canadian courts have grappled with the legality of prolonged solitary confinement in prisons.[3] Under the Mandela Rules, adopted by the United Nations General Assembly, solitary confinement is defined as "the confinement of prisoners for 22 hours or more a day without meaningful human contact."[4] Solitary confinement becomes "prolonged" when it is longer than fifteen consecutive days. Prolonged solitary confinement is prohibited for prisoners and solitary confinement of any length is prohibited for prisoners with mental disabilities if such confinement would

[1] Cornelia G. J. M. van der Venne et al., "Seclusion in an Enriched Environment Versus Seclusion as Usual: A Quasi-Experimental Study Using Mixed Methods," *PLoS One* 16, no. 11 (2021): e0259620; Salvatore B. Durante and John R. Reddon, "An Environment Enrichment Redesign of Seclusion Rooms," *Current Psychology* 42 (2023): 14584–97.

[2] Lisa Kerr, "The Chronic Failure to Control Prisoner Isolation in US and Canadian Law," *Queen's Law Journal* 40, no. 2 (2015): 487–93.

[3] Debra Parkes, "Solitary Confinement, Prisoner Litigation, and the Possibility of a Prison Abolitionist Lawyering Ethic," *Canadian Journal of Law and Society* 32, no. 02 (2017): 171–77.

[4] United Nations Standard Minimum Rules for the Treatment of Prisoners, GA Res 70/175, UN Doc A/RES/70/175 (17 December 2015), Rule 45.

exacerbate their disability.[5] Canadian courts now accept that the Mandela Rules represent "an international consensus of proper principles and practices in the management of prisons and the treatment of those confined."[6]

Based in part on this consensus, two appellate courts recently found federal legislation authorizing prolonged solitary confinement unconstitutional on the basis that such detention is "grossly disproportionate" and "cruel and unusual."[7] The Government of Canada initially responded by appealing the rulings that invalidated legislation authorizing prolonged solitary confinement, but abandoned those appeals in favour of passing new legislation to purportedly end solitary confinement and replace it with a constitutionally compliant "structured intervention unit" regime.[8] The new scheme is subject to an ongoing *Charter* challenge.[9] Notwithstanding these concerns, litigation to end prolonged solitary confinement in prisons was successful in establishing that such confinement is unconstitutional and achieving judicial recognition that prolonged isolation is harmful. These are not small victories.

The harmful effects of solitary confinement have now been "accepted by every Canadian judge who has seriously considered the issue."[10] Building on this recognition of harm, several class action lawsuits were instigated, pursuing damages for people with serious mental illnesses who were placed in solitary confinement for any length of time.[11] Focusing on people with serious mental illnesses as a class enabled courts to extend what is known about the harms of solitary confinement to this particularly vulnerable group. In 2020, the Ontario Court of Appeal held "that from the late 2000s it was widely recognized and accepted that placing inmates suffering from mental illness into solitary confinement caused them serious harm and therefore should be avoided."[12] In 2021, the same court went further, holding that placement of inmates with serious mental illnesses in solitary confinement for any period of time violates their constitutional rights to life, liberty, and security of the person, and to be free from cruel and unusual treatment or punishment.[13]

The story of this litigation is one of enhanced constitutional scrutiny of solitary confinement conditions in Canadian prisons, especially for prisoners with mental illnesses. These gains, however, have not translated into comparable scrutiny of seclusion and isolation in forensic hospitals. This article examines that

[5] Mandela Rules, Rule 45.

[6] *Corporation of the Canadian Civil Liberties Association v Her Majesty the Queen*, 2017 ONSC 7491, at para 61; *R v Capay*, 2019 ONSC 535, at para 157.

[7] *British Columbia Civil Liberties Association v Canada (Attorney General)*, 2019 BCCA 228, at para 172; *Canadian Civil Liberties Association v Canada*, 2019 ONCA 243, at para 119 (*CCLA*).

[8] Correctional Service Canada, *Commissioner's Directive 711: Structured Intervention Units*, November 30, 2019, https://www.canada.ca/en/correctional-service/corporate/acts-regulations-policy/commissioners-directives/711.html.

[9] *Fournier v Attorney General of Canada*, 2023 QCCS 2895.

[10] Lisa Kerr, "The End Stage of Solitary Confinement," 55 *Criminal Reports* (7th) 382, at 382 (2019).

[11] See *Brazeau v Canada (Attorney General)*, 2020 ONCA 184, at para 2; see also *Francis v Ontario*, 2021 ONCA 197, at para 32.

[12] *Brazeau*, at para 86.

[13] *Francis*, at para 48; see *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), c 11, at ss 7 and 12, respectively.

disjuncture. Part I discusses the objective and subjective harms associated with human isolation in the penal and hospital contexts, and shows that these harms are comparable in both contexts. Based on a series of access-to-information requests for hospital seclusion policies across Canada, Part II analyzes the existing regulatory framework for seclusion and explains why the scrutiny of solitary confinement that courts have provided has not transferred to seclusion in the hospital context. Part III proposes three legal avenues to achieve enhanced legal scrutiny of seclusion. The article argues that case law on prolonged solitary confinement in the penal context has application to the forensic psychiatric context and that a failure to more closely regulate the use of seclusion may render this type of mental health legislation and treatment unconstitutional.

I. The Harms of Human Isolation

1. Solitary Confinement in Prisons

Beyond positive outcomes, Canadian solitary confinement litigation is remarkable for its detailed recognition of both the subjective and objective psychological harm caused by solitary confinement and for the willingness of courts to place greater emphasis on the risk of such harms to prisoners ahead of governmental arguments about prison security.

In terms of objective harm—assessed by third-party professionals using accepted clinical standards—courts have found that prolonged solitary confinement "can and does cause physical and mental harm, particularly to inmates that have serious pre-existing psychiatric illness."[14] Examples of this type of harm include: "anxiety, withdrawal, hypersensitivity, cognitive dysfunction, significant impairment of ability to communicate, hallucinations, delusions, loss of control, severe obsessional rituals, irritability, aggression, depression, rage, paranoia, panic attacks, psychosis, hopelessness, a sense of impending emotional breakdown, self-mutilation and suicidal ideation and behaviour."[15] These harms can occur within forty-eight hours of being isolated and can be permanent.[16] On the basis of these objective harms, which have been characterized as "a consistent stream of medical opinion," courts have found it necessary to impose a firm cap on the use of solitary confinement for ordinary prisoners and an outright prohibition for prisoners with serious mental illnesses.[17]

In terms of subjective harm—assessed by self-reports from people with lived experience—courts have found that prisoners experience the isolation of solitary confinement "very negatively and stressfully."[18] Prisoners report experiencing "anger, hatred, bitterness, boredom, stress, loss of the sense of reality, suicidal thoughts, trouble sleeping, impaired concentration, confusion, depression and

[14] *Francis*, at para 16.
[15] Ibid.
[16] Ibid.
[17] *Brazeau*, at para 74; *Francis*, at para 48.
[18] *CCLA*, at para 76.

hallucinations."[19] Where isolation is prolonged, "prisoners who are denied normal social contact with others [...] experience heightened levels of anxiety, increased risk of panic attacks and a sense of impending emotional breakdown."[20] In *Francis v Ontario*, the trial court admitted several affidavits from prisoners who described their emotional experience upon being placed in solitary confinement.[21] While reliance on this subjective experience was perhaps unnecessary, it appears to have played a role in the intensity of judicial scrutiny of solitary confinement.

These types of objective and subjective factual findings are not remarkable when viewed against the extensive scientific literature documenting the psychological harms of solitary confinement.[22] However, when viewed against a long history of treating prisons as black boxes, shielded from theoretical and legal scrutiny, the judicial willingness to accept and engage with these facts is notable.[23] What is even more remarkable is that courts then gave these harms lexical priority over other competing interests (e.g. prison security) in their constitutional proportionality analysis.

Canadian constitutional law employs proportionality or balancing both at the rights violation stage (for some rights) and at the infringement justification stage. In the context of the deprivations of the right to life, liberty, or security of the person, claimants must show that interference with the right is also not in accordance with one or more principles of fundamental justice. One principle of fundamental justice is that against "gross disproportionality," which applies in extreme cases where the interference with the right is "totally out of sync" with the objective of the law in question.[24] In the context of cruel and unusual treatment, excessive punishment is one track or avenue through which a violation can be found.[25] Punishment will be excessive when it is incompatible with human dignity and shows "complete disregard for the specific circumstances of the sentenced individual and for the proportionality of the punishment inflicted on them."[26] In operationalizing what is excessive, the Supreme Court of Canada has adopted the language of "gross disproportionality" and called for a contextual and comparative analysis that examines the impact of the punishment in relation to the objective of the law.[27]

[19] Ibid.

[20] Ibid.

[21] *Francis v Ontario*, 2020 ONSC 1644, at paras 188–202.

[22] See e.g. Mimosa Luigi et al., "Shedding Light on 'The Hole': A Systematic Review and Meta-Analysis on Adverse Psychological Effects and Mortality Following Solitary Confinement in Correctional Settings," *Frontiers in Psychiatry* 11 (2020), https://doi.org/10.3389/fpsyt.2020.00840; Craig Haney, "Solitary Confinement, Loneliness, and Psychological Harm," in *Solitary Confinement: Effects, Practices, and Pathways Toward Reform*, ed. Jules Lobel and Peter Scharff Smith (Oxford: Oxford University Press, 2019), 129–52.

[23] I borrow the phrase "black box" from Lisa Kerr, "How the Prison is a Black Box in Punishment Theory," *The University of Toronto Law Journal* 69, no. 1 (2019): 85–116.

[24] *Canada (Attorney General) v Bedford*, 2013 SCC 72, at para 120.

[25] Lisa Kerr and Benjamin Berger, "Methods and Severity: The Two Tracks of Section 12," *Supreme Court Law Review (2d)* 94, (2020): 236.

[26] *R v Bissonnette*, 2022 SCC 23, at para 61.

[27] Ibid., at paras 62–63.

In comparing judicial approaches to these two rights, we see two important features: first, substantial analytical overlap between the notion of gross disproportionality compromising the principles of fundamental justice and operationalizing what constitutes excessive treatment or punishment; and second, reliance on "context" to determine what is outside acceptable constitutional boundaries. This second feature invites judicial discretion that makes case outcomes turn on how particular judges view the specific circumstances.

One explanation for the success of solitary confinement litigation in Canada is the incontrovertible evidence of its harm.[28] As one judge put it recently, solitary confinement is a "dungeon inside a prison."[29] But this harm only becomes disproportionate if judges are prepared to recognize the human dignity of prisoners as something that requires prioritization relative to state interests. The fact that courts were willing to recognize these dignity interests in carceral settings is what makes these cases truly remarkable, even if it has not ended solitary confinement in practice. Such recognition grants standing to people who are subjected to isolation even though they have themselves transgressed socially by violating criminal law. This empowers incarcerated people to demand responsive justifications or systemic change from the state.

2. *Seclusion in Forensic Hospitals*

Unlike in prisons, there is no hard cap on the length of seclusion in Canadian forensic hospitals or prohibition on the use of such treatment for people with serious mental illnesses. Before discussing the use and impact of seclusion as an intervention in forensic hospitals, it is important to distinguish between the ordinary or constitutional meaning of "treatment" and the medical meaning of "treatment."

Constitutionally, the Supreme Court of Canada has not definitively determined the meaning of "treatment" but has opined that it is a "process or manner of behaving towards or dealing with a person or thing."[30] Detention for non-punitive reasons, transfer to segregation, and detention conditions such as lockdowns, have all been found to constitute a "treatment" for the purposes of determining whether state action was cruel and unusual.[31]

Medically, the meaning of "treatment," if it is discussed at all, arises in conversations about consent. The common law recognizes a right to be free from non-consensual "medical treatment" but does not define that term.[32] The ordinary use of the word "treatment" means care provided to a patient in response to illness or injury. Some provincial health statutes do define "medical treatment." For example, the Ontario *Health Care Consent Act* defines "treatment" as "anything

[28] See *Francis v Ontario*, 2020 ONSC 1644, at para 269.
[29] Ibid., at para 1.
[30] *Canada (Minister of Employment and Immigration) v Chiarelli*, [1992] 1 SCR 711, at 735.
[31] *Charkaoui v Canada (Citizenship and Immigration)*, 2007 SCC 9, at para 98 (*Charkaoui*); *CCLA*, at para 85.
[32] See e.g. *Cuthbertson v Rasouli*, 2013 SCC 53, at para 18.

that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan."[33] What is common to all of these statutory articulations of "medical treatment" is the requirement that the treatment should assist the patient in some way, even if that assistance is merely cosmetic.

Historically, seclusion was considered to be a medical treatment that would assist the patient. Indeed, seclusion was often referred to as "therapeutic quiet," which implies that it was of some benefit to the patient.[34] In a survey of British physicians in 2001, 56 percent of respondents agreed or strongly agreed that seclusion was a treatment that could benefit patients, whereas 33 percent of respondents disagreed or strongly disagreed that seclusion was therapeutic.[35] Psychiatric literature from that period acknowledged there was no "inherent therapeutic property in the seclusion room itself" but contended there could be some theoretical benefit from the related isolation, containment, sensory deprivation, or punishment of the patient.[36] More recently, the therapeutic nomenclature has been removed in many jurisdictions and the isolation of patients is simply referred to as "seclusion." Even if seclusion is not considered therapeutic, the Canadian Psychiatric Association maintains that seclusion is a legitimate intervention that may be used in emergency situations in which there is a "risk of physical harm to patients, staff, and copatients."[37] Despite being part of accepted psychiatric practice in Canada, the harms of such seclusion and social isolation, particularly when viewed subjectively, are often comparable to those associated with solitary confinement.

In terms of objective harm, health professionals recognize that seclusion creates a significant risk of harm to people with mental illnesses, including "serious injury or death, retraumatization of people who have a history of trauma, and loss of dignity and other psychological harm."[38] Multiple studies have linked placement in seclusion with increased risk of post-traumatic stress disorder.[39] These findings are not new. One of the first comprehensive literature

[33] *Health Care Consent Act*, 1996, SO 1996, c 2, Sched. A, s 2.

[34] William Birnie and Kiyoko Matsuno, "The Psychiatric Acute Observation Unit in a General Hospital," *The Canadian Journal of Psychiatry* 33, no. 8 (1988): 709; Catherine Thibeault et al., "Understanding the Milieu Experiences of Patients on an Acute Inpatient Psychiatric Unit," *Archives of Psychiatric Nursing* 24, no. 4 (2010): 224.

[35] Tim Exworthy et al., "Seclusion: Punitive or Protective?," *Journal of Forensic Psychiatry* 12, no. 2 (2001): 425.

[36] Tom Mason, "Seclusion Theory Reviewed—a Benevolent or Malevolent Intervention?" Medicine, Science and the Law/Medicine, *Science and the Law* 33, no. 2 (1993): 95–102.

[37] Gary Chaimowitz, "Position Statement of the Canadian Psychiatric Association: The Use of Seclusion and Restraint in Psychiatry," accessed May 16, 2023, https://www.cpa-apc.org/wp-content/uploads/2023-CPA-Seclusion-and-Restraints-Position-Statement-ENG-Final-web-1.pdf.

[38] Kevin Ann Huckshorn, "Re-Designing State Mental Health Policy to Prevent the Use of Seclusion and Restraint," *Administration and Policy in Mental Health* 33, no. 4 (2005): 482.

[39] Marie Chieze et al., "Effects of Seclusion and Restraint in Adult Psychiatry: A Systematic Review," *Frontiers in Psychiatry* 10, (2019), https://doi.org/10.3389/fpsyt.2019.00491.

reviews of the subject, published in 1994, concluded that it is "well-established that these procedures can have serious deleterious physical and (more often) psychological effects on patients."[40] This parallels what Canadian courts have found was well established, by the late twentieth century, concerning the harms caused by solitary confinement in prisons.

Notwithstanding these harms, multiple studies have found that health professionals view seclusion as a coercive and unpleasant, but necessary, intervention to respond to violent patient behaviour towards self and others.[41] In this sense, seclusion is not a medical treatment even though it is ordered by medical professionals, but rather an administrative tool to control violent behaviour. Whether seclusion has any meaningful benefit from a clinical perspective is unclear. Mental Health America, a national nonprofit organization, takes the position that "[s]eclusion and restraints have no therapeutic value, cause human suffering, and frequently result in severe emotional and physical harm, and even death."[42] Recent research on the ethical challenges of ordering seclusion found "no studies that definitively support the therapeutic effect of seclusion."[43] As a result, there is a "major discrepancy between the widespread use of seclusion and its knowledge basis."[44] Designing randomized–controlled trials to determine whether seclusion is ever beneficial to patients is complicated by the ethical difficulty (perhaps impossibility) of knowingly subjecting patients to a treatment that has such deleterious effects.[45] What this reveals is that seclusion is almost entirely an administrative practice in hospitals, not unlike administrative segregation in jails, that responds to real and perceived institutional management needs.

Like administrative segregation, the subjective harms associated with seclusion, while not universal, are also substantially negative.[46] Qualitative studies of patient experience report emotions of fear, shame, neglect, anger, humiliation, worthlessness, powerlessness, loss of control, and loneliness.[47] Even when there

[40] William A. Fisher, "Restraint and Seclusion: A Review of the Literature," *American Journal of Psychiatry* 151, no. 11 (1994): 1587.

[41] See e.g. Carly Pohatu and Tai Kake, "The Attitudes of Nurses Towards Seclusion: A New Zealand In-Patient Mental Health Setting," *International Journal of Mental Health Nursing*, (2024): 1–11, https://doi.org/10.1111/inm.13341; Ataine Stíobhairt et al., "Are Principles of Recovery-Oriented Practice Evidence in Staff and Service User Perspectives on Seclusion?" *Mental Health Review Journal* 28, no. 2 (2023): 144–66; Eva Krieger et al., "Coercion in Psychiatry: A Cross-Sectional Study on Staff Views and Emotions," *Journal of Psychiatric and Mental Health Nursing* 28, no. 2 (2021): 149–62; Rolf Wynn, "Staff's Attitudes to the Use of Restraint and Seclusion in a Norwegian University Psychiatric Hospital," *Nordic Journal of Psychiatry* 57, no. 6 (2003): 453–59.

[42] Mental Health America, "Seclusion and Restraints," *Mental Health America*, n.d., https://mhanational.org/issues/position-statement-24-seclusion-and-restraints.

[43] Espen Woldsengen Haugom, Torleif Ruud, and Torfinn Hynnekleiv, "Ethical Challenges of Seclusion in Psychiatric Inpatient Wards: A Qualitative Study of the Experiences of Norwegian Mental Health Professionals," *BMC Health Services Research* 19, no. 1 (2019): 879.

[44] Ibid., 2.

[45] Chieze, "Effects of Seclusion."

[46] Ibid.

[47] Silvia Allikmets et al., "Seclusion: A Patient Perspective," *Issues in Mental Health Nursing* 41, no. 8 (2020): 726–28; Camilla Haw et al., "Coercive Treatments in Forensic Psychiatry: A Study of Patients'

are policies in place to offer alternatives to seclusion and post-seclusion debriefing, patients in a non-forensic psychiatric hospital reported not being offered any alternatives to seclusion or post-seclusion debriefing.[48] Several patients, in multiple studies, reported feelings of being caged and treated like an animal.[49] As one patient explained: "the thing is, when they put people in TQ [therapeutic quiet], they don't really treat them like people they treat them like an animal kind of thing."[50] The result is feelings of abandonment, pain, violation, humiliation, and being punished.[51] A recent review study found three consistent themes in the closed psychiatric ward patient experience: (1) unclear information and application of rules, including in the context of seclusion; (2) lack of time and contact with nurses; and (3) feelings of humiliation.[52]

For patients who have experienced social isolation in prison settings, the seclusion experience is often indistinguishable:

> the seclusion experience reminded me of the time I was in a jail cell [...] the seclusion forced me to revisit the bad experience I had in jail again [...] the seclusion room had no "peep holes" like they have in the jail [...] I thought how to get out of the room [...] uh [...] I mean [...] uh [...] if there was a ladder I would have climbed out of there.[53]

Despite the similarities between the subjective harms reported by patients in seclusion and those of prisoners in solitary confinement, Canadian courts have not yet applied comparable constitutional scrutiny to what may be an equally harmful isolative experience.

Experiences and Preferences," *Journal of Forensic Psychiatry & Psychology* 22, no. 4 (2011): 565; Päivi Soininen et al., "Secluded and Restrained Patients' Perceptions of Their Treatment," *International Journal of Mental Health Nursing* 22, no. 1 (2012): 47–55; Louise Askew, Paul Fisher, and Peter Beazley, "Being in a Seclusion Room: The Forensic Psychiatric Inpatients' Perspective," *Journal of Psychiatric and Mental Health Nursing* 27, no. 3 (December 23, 2019): 273; Alison Hansen et al., "What Do We Know About the Experience of Seclusion in a Forensic Setting? An Integrative Literature Review," *International Journal of Mental Health Nursing* 31, no. 5 (2022): 1109–24; Eva S. Trapman and Arjan W. Braam, "The Existential Dimension of the Experience of Seclusion: A Qualitative Study Among Former Psychiatric Inpatients," *BMC Psychiatry* 23, no. 1 (2023), https://doi.org/10.1186/s12888-023-05208-7; B. Christopher Frueh et al., "Special Section on Seclusion and Restraint: Patients' Reports of Traumatic or Harmful Experiences Within the Psychiatric Setting," *Psychiatric Services* 56, no. 9 (2005): 1123–33.

[48] Caroline Larue et al., "The Experience of Seclusion and Restraint in Psychiatric Settings: Perspectives of Patients," *Issues in Mental Health Nursing* 34, no. 5 (2013): 322.

[49] Allikmets et al., "Seclusion," 728.

[50] Thibeault et al., "Experiences of Patients," 224.

[51] Ibid.

[52] Willem Nugteren et al., "Experiences of Patients in Acute and Closed Psychiatric Wards: A Systematic Review," *Perspectives in Psychiatric Care* 52, no. 4 (2015): 298.

[53] Ifeoma E. Ezeobele et al., "Patients' Lived Seclusion Experience in Acute Psychiatric Hospital in the United States: A Qualitative Study," *Journal of Psychiatric and Mental Health Nursing* 21, no. 4 (2013): 307.

II. The Legal Regulation of Seclusion

There are at least two reasons why seclusion has not been subjected to the same legal scrutiny as solitary confinement. First, there is no consistent legal framework that regulates seclusion in Canada. Many provinces have no law that governs seclusion at all. This means that oversight, to the extent that there is any, must come from the common law and a patchwork of policies, often overseen by administrative tribunals with limited access to review by courts. Second, within this regulatory patchwork, physicians are afforded substantial deference and physician-ordered social isolation is viewed as qualitatively different from jail-ordered solitary confinement.

The regulation of seclusion in forensic hospitals starts off on a promising note. Subsection 672.55(1) of the *Criminal Code* expressly authorizes Criminal Code Review Boards to order the detention of not criminally responsible (NCR) patients in forensic hospitals, but it also prohibits such boards from ordering specific treatment for an NCR patient without their consent.[54]

In determining what level of detention order is required—for example, supervised day passes, unsupervised day passes, or overnight passes—the board may consider an NCR patient's compliance with recommended medical treatment insofar as non-compliance is linked to the risk that the patient poses in the community. But the board cannot compel a patient to consent to a particular treatment. Beyond restricting the imposition of treatment without consent, the *Criminal Code* says nothing further about what treatment is acceptable in forensic hospitals. This silence is not an oversight and results from the fact that health, the operation of hospitals, and the regulation of health professionals are all provincial matters in Canada's federal constitutional order.

The provincial jurisdiction over health means that seclusion, if it is to be regulated, must be regulated provincially. However, in the six provinces that were reviewed for this study (British Columbia, Alberta, Ontario, Quebec, Nova Scotia, and Newfoundland & Labrador), only one province (Ontario) provides statutory authorization for seclusion and that authorization is only implied under a broader definition of "restrain."[55] Other than stating that NCR patients may be restrained and including seclusion within the definition of restrain, the Ontario legislation is silent on when or how seclusion may be used.[56] The remaining provinces do not define or authorize seclusion by way of legislation or regulation (Table 1). Instead, these provinces rely on a patchwork of provincial or hospital-specific policies.

To understand how seclusion is regulated in practice, the author submitted freedom-of-information requests for every major forensic hospital in six Canadian provinces: British Columbia, Alberta, Ontario, Quebec, Nova Scotia, and Newfoundland & Labrador. Only British Columbia had a provincial policy on the use of seclusion. The other provinces all had hospital-specific policies that applied to one or more forensic institutions (Table 1).

[54] *Criminal Code*, RSC 1985, c C-46, s 672.55(1).
[55] *Mental Health Act*, RSO 1990, c M.7, s 1.
[56] Ibid., s 25.

Table 1. Provincial Regulation of Seclusion by Legislation, Provincial Policy, and Forensic Hospital-Specific Policies in Six Canadian Provinces

Province	Legislation	Provincial policy	Forensic hospital-specific policies
British Columbia	No*	Yes	No
Alberta	No	No	Yes
Ontario	Yes†	No	Yes
Quebec	No	No	Yes
Nova Scotia	No	No	Yes
Newfoundland & Labrador	No	No	Yes

*British Columbia defines "restraint" in its *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181, but this legislation does not apply to forensic hospitals.
†Ontario defines "restrain" in its *Mental Health Act*, RSO 1990, c M.7, which also states that any NCR patient who is detained in a forensic hospital can be restrained.

A comparison of the hospital-specific seclusion policies in five provinces (Table 2) as well as the seven hospital-specific seclusion policies from Ontario (Table 3) shows that there are both similarities and differences between the policies. Most policies permitted seclusion to be ordered by either a physician or a nurse and most required that seclusion should be used as a last resort. Roughly half explicitly precluded the use of seclusion as punishment.

All the policies permitted indeterminate seclusion. Like the prison administrative segregation schemes that were found to be unconstitutional, the policies do not expressly prohibit hospitals from isolating patients for more than twenty-two hours per day without meaningful human contact and for periods longer than fifteen days, contrary to the Mandela Rules.

Several policies implicitly envisioned that some placements in seclusion would last for longer than four weeks. This is evidenced by provisions of the policies that apply at the four-week mark. Internal review of the seclusion placement was required within anywhere between two hours and twenty-four hours. There were significant differences in when an external review was required. For the non-Ontario policies, only Nova Scotia had some form of external review after seclusion that lasted for longer than seventy-two hours and this was simply a report to the clinical director (Table 2). The Ontario policies, by contrast, employed a mixture of collegial review as well as review by physicians who were outside the treatment team; for prolonged placements in seclusion, in the range of seven to thirty days, most Ontario policies required some form of complex case assessment and notification of hospital management (Table 3).

Almost all the policies required some form of monitoring of the patient in seclusion with increased frequency at the beginning of the placement (Tables 2 and 3). Almost all the policies required that staff should provide basic hygiene and toileting opportunities to patients (Tables 2 and 3). Some specified that this should be outside the seclusion room, if possible, to protect the dignity of the

Table 2. Comparison of Seclusion Policy Characteristics in British Columbia, Alberta, Quebec, Nova Scotia, and Newfoundland & Labrador

Seclusion policy characteristics	British Columbia	Alberta	Quebec	Nova Scotia	Nfld. & Labrador
Who can order?	Not specified	Not specified, but physician order required within twenty-four hours	Physician or nurse	Physician or nurse, but physician assessment is required within one hour if initiated by a nurse	Physician or nurse, but physician assessment is required within one hour if initiated by a nurse
Only as "last resort"?	Yes	Not specified	Yes	Yes	Not specified
Punitive use prohibited?	Not specified	Not specified	Yes	Yes	Not specified
Maximum time limit?	Indeterminate	Indeterminate	Indeterminate	Indeterminate	Indeterminate
Internal review?	Psychiatrist or "Doctor of the Day" within two hours; psychiatrist reassessment every twenty-four hours	Physician reassessment every twenty-four hours	Not specified	Not specified	Physician or nurse every four hours; physician reassessment every twenty-four hours
External review?	No	No	No	Report to Clinical Director after seventy-two hours	No
Frequency of monitoring?	Q15 minutes ("Q" means "every" from the Latin word "quaque")	Q15 minutes to two hours	Q30 minutes	Q15 minutes	Not specified
Provision of personal or psychological needs?	Hygiene, clothes, blankets, meals, food, and toileting	Not specified	Evaluation of psychological and physiological needs and comfort	Nutrition, fluids, mouth care, and toileting	Toileting and care

patient; most permitted the use of bed pans, and one expressly prohibited the use of Styrofoam cups for toileting purposes. Only two of the twelve policies that were reviewed (17%) required staff to provide psychological counselling and support. None of the policies required patients in seclusion to be provided with meaningful human contact, but one of the twelve policies (8%) permitted family

Table 3. Comparison of Seclusion Policy Characteristics in Six Ontario Forensic Hospitals

Seclusion policy characteristics	Ontario Shores	The Royal	St Joseph's (Hamilton)	Waypoint	CAMH	St. Joseph's (London)	Providence care
Who can order?	Physician or nurse, but physician telephone order required within fifteen minutes	Physician or nurse (emergencies only) with notification to physician	Physician or nurse (emergencies only) with physician's order within one hour	Physician or clinical manager, but physician telephone order required	Physician or nurse	Physician or any member of the clinical team, but a physician order is always required	Nurse or development service worker or behaviour technologist (emergencies only), but physician notification and written or telephone order required
Only as "last resort"?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Punitive use prohibited?	Yes	Yes	Not specified	Not specified	Yes	Yes	Yes
Maximum time limit?	Indeterminate	Indeterminate	Indeterminate	Indeterminate	Indeterminate	Indeterminate	Indeterminate
Internal review?	Physician must see the patient within one hour and subsequent orders cannot exceed twelve hours	Physician must see the patient within two hours and reassess every twenty-six hours	Physician must see the patient within eight hours and reassess every twenty-four hours	Physician must see the patient in the first twenty-four hours, at day 3, day 7, and every twenty-eight days	Physician must see the patient within two hours and reassess every twelve hours	Physician must see the patient on a daily basis and twice daily for some patients	Physician must see the patient within two hours for telephone orders and reassess every twenty-four hours
External review?	More than seventy-two hours requires an in-person consultation with another physician; more than seven days requires an inter-professional consultation that includes the medical director	More than twenty-four hours requires notification of patient advocates office; more than four days requires the approval of two psychiatrists; more than seven days requires notification of the clinical director; more than thirty days requires notification of management	More than seventy-two hours requires consultation with another psychiatrist; more than seven days requires consultation with Head of Service; more than fourteen days requires weekly consultation with Psychiatrist-in-Chief	More than seventy-two hours, seven days, and every twenty-eight days requires consultation with physician colleague	More than seventy-two hours requires consultation with a physician external to the unit at every seventy-two-hour interval	More than seventy-two hours requires consultation (preferably) with a physician who is not a part of the team; more than seven days requires a complex case review; more than fifteen days is considered "long-term" and requires a complex case review no later than thirty days and monthly thereafter	More than seventy-two hours requires consultation with another psychiatrist and notification of the senior administration; more than five days requires a daily consultation with the Clinical Director or another Clinical Director if that person is the attending psychiatrist
Frequency of monitoring?	Not specified	Q15 ("Q" means "every" from the Latin	Not specified; vital signs every four hours	Continuous in first hour then Q15	Continuous in first hour then close observation	Q15	Q15 for the first hour unless constant observation is

(*Continued*)

Table 3. *Continued*

Seclusion policy characteristics	Ontario Shores	The Royal	St Joseph's (Hamilton)	Waypoint	CAMH	St. Joseph's (London)	Providence care
		word "quaque")					warranted, then Q30 if the client remains settled
Provision of personal or psychological needs?	Toileting at least every two hours while awake, oral fluids upon request	Therapeutic interaction and activities, counselling, reassurance, and support	Fluids, food, oral and skin care, and attention to elimination needs will be offered upon request and at minimum every two hours while awake	Meals offered while awake, fluids every two hours and PRN (acronym for the Latin phrase "pro re nata" which means "as needed") while awake, and elimination needs are assessed every two hours while awake	Not specified	Assistance with hygiene, toileting, fluids, and nutrition based on the nurse's clinical assessment; mattress and some form of clothing to ensure basic levels of comfort, privacy, and dignity	Family members, significant others, and some third parties (patient advocate, rights adviser, ombudsperson, and lawyer) may visit the person in seclusion; monitoring for signs of physical or emotional distress as well as monitoring for mental status and hydration/ nutritional and elimination needs; if possible bathed daily; lighting adjusted to provide quieting effect and balance day and night

members and close others to visit a patient in seclusion with the permission of the treatment team. None of the policies required that patients should have daily time outside of the seclusion room or daily access to the outdoors. One of the twelve policies (8%) required daily bathing outside of seclusion but only if sufficient staff were available. This suggests that seclusion may often meet the definition of solitary confinement in the Mandela Rules or, at the very least, that seclusion akin to solitary confinement is not expressly prohibited by the policies.

One of the limitations of this type of study is that a written policy does not necessarily provide evidence of how the policy operates in practice. On-the-ground implementation of the policy could be better or worse than what is required. The principle of "last resort" could be fastidiously followed, limiting the quantum of seclusion placements. The internal and external review processes may function to limit lengthy stays in seclusion. Frequent patient monitoring may also provide more meaningful human contact than what is evidenced on paper. All of this could make seclusion work in practice quite differently from solitary confinement. Case law and available statistics cast doubt on this hopeful perspective.

In *Re Edgar*, for example, a patient who had been found NCR for mischief and resisting arrest was "detained in seclusion for over three years with little progress."[57] During this time, the hospital obtained an internal and an external consultation from forensic psychiatrists pursuant to its policy on seclusion. The external psychiatrist recommended "relief from seclusion as frequently as possible in a safe manner."[58] Before the provincial review board that was responsible for overseeing deprivations of liberty in forensic hospitals, the patient's attending psychiatrist conceded that "there was not 'an easy end in sight' to his seclusion."[59] This was exacerbated by the patient's unwillingness to wear restraints when offered seclusion relief and the availability of non-oral antipsychotic medication.[60] Nonetheless, the review board found that there was no treatment impasse and no further supervisory responsibilities were needed. The Ontario Court of Appeal dismissed the patient's appeal, concluding that the board's determinations were reasonable even though the patient had "not made any progress" in the four years he had been detained at hospital.[61] As a result, no judicial constraints were placed on the prolonged use of seclusion in this case.

In *Re McFarlane*, the provincial review board found "any seclusion, with or without seclusion relief, is a significant restriction of the liberty of a person." However, the board also concluded that its jurisdiction to review deprivations of liberty required a significant change to a patient's liberty. The board reasoned that it was not compelled to review continuations of seclusion, prolonged or otherwise, that continued the same level of restricted liberty.[62] As a result, the board declined to review a two-and-a-half-month period of seclusion that started on the final day of a separate two-week seclusion period.[63]

As part of this study, one province (British Columbia) provided seclusion statistics that also raise serious concerns. What is notable and commendable about these statistics is that they are being gathered as part of province-wide efforts to reduce the frequency and duration of seclusion. These statistics track the number of seclusion placements and the duration of those placements. In the 2019/20 fiscal year in British Columbia, 9 percent of patients ($n = 67$) were placed in seclusion for up to six hours, 17 percent ($n = 131$) for seven to twelve hours, 18 percent ($n = 135$) for thirteen to twenty-three hours, and 41 percent ($n = 305$) for one to five days. Nine percent of patients ($n = 72$) were placed in seclusion for six to fifteen days and 9 percent ($n = 40$) for more than fifteen days. In the 2020/21 fiscal year in British Columbia, 9 percent of patients ($n = 9$) were placed in seclusion for up to six hours, 28 percent ($n = 27$) for seven to twelve hours, 18 percent ($n = 17$) for thirteen to twenty-three hours, and 29 percent ($n = 28$) for one to five days. Eight

[57] *Re Edgar*, 2023 ONCA 555, at para 3.
[58] Ibid., at para 14.
[59] Ibid., at para 16.
[60] Ibid., at para 12.
[61] Ibid., at para 30.
[62] *Re McFarlane*, ORB File No. 4980 (13 June 2022), unreported, at paras 63–65.
[63] Ibid., at para 78.

percent of patients (n = 8) were placed in seclusion for six to fifteen days and 7 percent (n = 7) for more than fifteen days.[64]

These statistics reveal that, in British Columbia, one or two out of every twenty patients (5–10%) are subjected to prolonged seclusion for a period in excess of fifteen days. Viewed in comparison with judicial findings about prolonged solitary confinement in prisons—specifically that such treatment is cruel and unusual—the prevalence of equivalent prolonged seclusion in hospitals is startling.

In discussing how solitary confinement was permitted to go unchecked for so long, Kerr highlights the role of administrative discretion and delegated authority to prison officials. Such delegated decision-making is part of the administrative state and so must conform to legal standards that, if not met, are actionable. But the existence of delegation and discretion often means that decision-makers are immunized in practice from effective judicial review. As a result, "[r]egimes that determine the character and quality of incarceration are often designed and implemented in a setting that can be characteristically unconstrained by the larger framework."[65] Part of the undoing of solitary confinement, according to Kerr, was external critique of the policies that prison officials developed pursuant to their delegated authority.[66]

There are good reasons to advance similar critiques of provincial and hospital seclusion policies. These policies permit indeterminate isolation of people with serious mental illnesses, often under conditions that are akin to solitary confinement, and with minimal oversight. But, unlike prison policies, hospital policies are implemented and overseen by physicians. Physicians hold a different place of trust in society and have substantially greater expertise than prison officials. Even though seclusion is associated with serious risks of objective and subjective harm, the fact that it is physicians who are overseeing the use of seclusion may immunize such policies from judicial scrutiny.

Not everyone is convinced that this immunity will last. Recently, Chaimowitz—the psychiatrist who authored the Canadian Psychiatric Association's position statement on seclusion—reviewed the legal developments in solitary confinement litigation. He then queried whether the lawyers involved in prison litigation will "turn their attention to seclusion in hospital."[67] As the following part shows, legal challenges to seclusion in hospitals have already started and, although these cases may prove to be more difficult than those in the prison context, there are several paths to legally contesting seclusion with the objective of better regulating its use.

[64] Seclusion QI Project Meeting Minutes, FOIP # F21-0956, on file with author (note that the absolute numbers cannot be compared between these fiscal years because only some of the 2020/21 data were available at the time the FOIP was released).

[65] Lisa Kerr, "The Origins of Unlawful Prison Policies," *Canadian Journal of Human Rights* 4, no. 1 (2015): 89.

[66] Ibid.

[67] Gary Chaimowitz, "Jail Segregation Today, Hospital Seclusion Tomorrow," *International Journal of Risk and Recovery* 2, no. 2 (2019): 2.

III. Constitutional and Administrative Challenges to Seclusion

There are three avenues to challenging the use of seclusion in hospitals: (1) test case litigation seeking to declare the practice unconstitutional, (2) class action litigation seeking damages for historic or ongoing misuse of seclusion, and (3) complaints to regulatory colleges for improper use of seclusion. Each avenue comes with benefits and difficulties. The latter two avenues, as this part shows, are already being employed by plaintiff counsel, with some degree of success.

1. Declaring Seclusion Unconstitutional

The most frontal way to restrict the use of seclusion in hospitals is to bring a constitutional challenge seeking to declare the practice unconstitutional in some or all circumstances in which it is presently used. This is also the most challenging avenue.

Most jurisdictions do not have legislation that authorizes, expressly or by implication, the use of seclusion in hospitals. This contrasts with federal and provincial legislation that does authorize the use of isolation in jails, albeit under a new structured intervention unit regime.[68] This means that there is no obvious law to challenge as being unconstitutional. Legislation in some jurisdictions does explicitly define "restraint" and authorize psychiatric hospitals to restrain NCR patients by using as minimal force as is reasonable to prevent serious bodily harm to the patient or others.[69] But, even in such circumstances, counsel are likely to be met with an argument that the impugned circumstances were maladministration of the legislation rather than an unconstitutional law. Characterizing systemic constitutional wrongs as isolated incidents of maladministration enables courts to avoid reviewing and remedying the legal and policy schemes that govern ongoing state practices.[70]

The reality is that the legal authorization for seclusion—to the extent that this practice is authorized by law—is found in the common law. The common law is unclear and underdeveloped in this area. The orthodox view is that physicians are authorized and even obligated under the common law to prevent patients from harming themselves or others. The genesis for this authority is a pre-*Charter* conception of "public necessity" that requires limitations on a patient's liberty for the benefit of themselves and others.[71] This reasoning has been extended to justify the legality of psychiatric restraint in the *Charter* era.[72]

Case law concerning psychiatric restraint, however, "does not set clear or precise limits on the common-law authority to restrain."[73] It was also developed

[68] *Correctional Services Act*, SNS 2005, c 37.

[69] *Mental Health Act*, RSO 1990, c M.7, ss 1, 25.

[70] Alison M. Latimer and Benjamin Berger, "A Plumber With Words: Seeking Constitutional Responsibility and an End to the Little Sisters Problem," *Supreme Court Law Review (2d)* 104, (2022): 153.

[71] Sheila Wildeman, "Consent to Psychiatric Treatment: From Insight (Into Illness) to Incite (a Riot)," in *Law and Mind: Mental Health Law and Policy in Canada*, Toronto: LexisNexis, ed. Colleen Marion Flood and Jennifer A Chandler (2016), 89.

[72] Ibid., 89–90.

[73] Ibid., 90.

before Canadian courts struck down solitary confinement in jails because of the disproportionate harm on offenders, particularly those with serious mental illnesses. As a result, the common law does not adequately take into consideration what we now know about the harms of human isolation, and it does not squarely confront the reality that the psychiatric use of this intervention lacks a robust knowledge basis.

Common-law powers are not immune from legal oversight and revision. In the context of common-law powers that are exercised by police, the Supreme Court of Canada recently remarked that strict limits must be placed on the powers of state actors when individual liberties are engaged.[74] The onus is always on the state to justify the existence of common-law powers that involve interference with liberty.[75]

The Supreme Court of Canada has also recently remarked that, in a free and democratic society, state actors may interfere with the exercise of individual freedoms only to the extent provided for by law.[76] State actors must also be aware of the scope of their powers. While they are not expected to be lawyers, they cannot rely on erroneous training and instructions as an excuse for unlawful conduct.[77]

These jurisprudential developments support Wildeman's claim that "an essential part of the defence of public necessity (and the related defence of protection of third parties) is that the one acting to protect must act reasonably, weigh the proportionality of the response against the risk, and otherwise contain the threatening behaviour in the least restrictive manner possible."[78] What once may have been justified can become unjustified when new information is produced on the benefits and harms of a practice. Psychiatrists are already starting to grapple with the ethical dilemma created by an intervention that has no "therapeutic effect" or benefit to the patient but may be needed or perceived to be needed to control their behaviour.[79] Others now view the use of seclusion as a "treatment failure."[80] This is a material change in the circumstances that warrants revisiting how the law governs seclusion.

To displace or refine the existing common-law rules that authorize seclusion, a claimant would have to show that seclusion, in some or all circumstances, is inconsistent with the constitution. The claim would rely on the same right to life, liberty, and security of the person, and the right to be free from cruel and unusual treatment that grounded the solitary confinement challenges. Claimants may also be able to advance discrimination arguments on the grounds that prisoners with mental illnesses receive greater protections against harmful isolation than

[74] *Fleming v Ontario*, 2019 SCC 45, at para 38.
[75] Ibid., at para 48.
[76] *Kosoian v Société de transport de Montréal*, 2019 SCC 59, at para 6.
[77] Ibid., at paras 55–59.
[78] Wildeman, "Consent to Psychiatric Treatment," 90.
[79] Haugom et al., "Ethical Challenges of Seclusion."
[80] Gregory M. Smith et al., "Special Section on Seclusion and Restraint: Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program," *Psychiatric Services* 56, no. 9 (2005): 1115–22.

patients with mental illnesses, but an analysis of such claims is beyond the scope of this article.

Establishing that liberty and protection from cruel and unusual treatment rights are engaged would not be difficult. Current case law recognizes that transfer to a more secure setting in a forensic hospital engages a patient's liberty interest.[82] Moreover, detention for non-punitive reasons is a treatment,[81] as is the transfer of an inmate to administrative or disciplinary segregation.[82]

Where the claim would face difficulty is in establishing that the risk of harm associated with seclusion is grossly disproportionate or totally out of sync with the objective of patient safety. It would not be enough to prove the harms associated with solitary confinement in prison. Canadian courts are likely to treat jailors and physicians differently, conferring greater deference on the latter because of their expertise. A claimant would have to prove that the solitary-confinement harms are also likely to occur in seclusion under the supervision of medical staff. This is not insurmountable given the existing literature on the objective and subjective harms of seclusion, the authorization of indeterminate isolation in seclusion policies, and the limited attention that those policies place on providing meaningful human contact. However, establishing an equivalence between solitary confinement and seclusion is not the end of what must be established.

The final step would be to convince a judge that these harms are grossly disproportionate or excessive. It is here that physicians may be afforded substantial deference in how they implement social isolation of patients. Courts will be alive to assertions of complexity, violence, and risk in the context of forensic hospitals. Those dynamics are objectively present in forensic hospitals. Additionally, risk assessment is shaped by social stigma: "People with a mental illness are not generally viewed as benign or in need of social support, but are more often considered a public risk."[83]

Even conceding this risk, at the justification or proportionality phase, the extensive literature on the objective and subjective harms associated with seclusion would have to be confronted. The state would have the onus of proving that the harms are not grossly disproportionate or excessive in the circumstances. This analysis would be informed by recent research showing that seclusion can be significantly reduced without increasing rates of violence in forensic hospitals and in some cases reducing patient-to-staff assaults.[84] Reductions in the use of seclusion have also been shown to improve patient outcomes, staffing costs (sick time, turnover, and workers' compensation), and economic

[81] *Charkaoui*, at paras 95–98.

[82] *CCLA*, at paras 83–86; *R v Marriott*, 2014 NSCA 28, at paras 34–46.

[83] Heather Stuart, Julio Arboleda-Florez, and Norman Sartorius, *Paradigms Lost: Fighting Stigma and the Lessons Learned* (Oxford: Oxford University Press, 2012): 108.

[84] Anu Putkonen et al., "Cluster-Randomized Controlled Trial of Reducing Seclusion and Restraint in Secured Care of Men With Schizophrenia," *Psychiatric Services* 64, no. 9 (2013): 850–55; Gregory M. Smith et al., "Correlation Between Reduction of Seclusion and Restraint and Assaults by Patients in Pennsylvania's State Hospitals," *Psychiatric Services* 66, no. 3 (2015): 303–9.

expenditures.[85] The focus would be on the viability of alternative interventions to seclusion that are not harmful or less harmful.[86]

The advantage of this approach is that it addresses the systemic constitutional wrongs associated with secluding patients with serious mental illnesses. It centres the harms, experiences, and human dignity of those people. It invites more widespread declaratory remedies that can reach beyond individual plaintiffs and compel responsive state action, including with the expenditure of funds to alter the forensic care environment. It also makes possible attenuated remedies that outlaw seclusion in some circumstances while permitting it in others.

The disadvantage of this approach is that it is by far the most complex. It faces the inherent difficulty of overcoming accepted practice that is reinforced by social stigma, in circumstances in which there is objective risk to other patients and staff. It is complex and expensive. Expert evidence would be needed. Because the conduct in question falls under provincial responsibility, the Court Challenges Program would not be available to finance the litigation, as it is restricted to federal areas of responsibility.

2. *Class or Individual Actions to Recover Damages*

A second way to challenge the use of seclusion is to bring a class action or individual actions seeking damages on behalf of forensic patients who have been historically and systemically mistreated in seclusion. Such a claim was recently certified in *Tidd v New Brunswick*, in which the plaintiffs, all former patients in residential psychiatric care, alleged that common operational failures at the hospital, including the improper use of solitary confinement and restraints, caused them and others harm.[87] In 2020, another class action claim was commenced against Waypoint Centre for Mental Health Care (a forensic hospital whose policies are included in this article) and the province of Ontario. The claim contends that seclusion is akin to solitary confinement, and that Waypoint has been "systemically negligent by routinely subjecting involuntary patients to solitary confinement [...] for weeks, months and sometimes years at a time."[88]

The goal of this type of litigation is both restitution for the individual patients and behavioural change on the part of the institution. One challenge with this type of litigation is that it is often historic and not forward-looking. For example, a seclusion policy may have changed since the time period of the litigation.

[85] Janice LeBel and Robert Goldstein, "The Economic Cost of Using Restraint and the Value Added by Restraint Reduction or Elimination," *Psychiatric Services* 56, no. 9 (2005): 1109–14.

[86] Laura Väkiparta et al., "Using Interventions to Reduce Seclusion and Mechanical Restraint Use in Adult Psychiatric Units: An Integrative Review," *Scandinavian Journal of Caring Sciences* 33, no. 4 (2019): 765–78.

[87] *Tidd v New Brunswick*, 2021 NBQB 208, at para 92.

[88] *Stolove v Waypoint Centre for Mental Health Care*, Court File No: CV-20-648579-00CP (ONSC); Rochon Genova LLP, "Waypoint Solitary Confinement Class Action | Rochon Genova LLP," n.d., https://www.rochongenova.com/current-class-action-cases/waypoint-solitary-confinement-class-action/; Sean Fine, "Waypoint Centre for Mental Health Care Faces Solitary Confinement Lawsuit," *The Globe and Mail*, October 19, 2020, https://www.theglobeandmail.com/canada/article-waypoint-centre-for-mental-health-care-faces-solitary-confinement/.

Accordingly, a finding of wrongdoing would not necessarily impact the ongoing practice of seclusion.

One feature, however, of class action and ordinary litigation is that it can be quite expensive to defend and can result in substantial damage awards in the millions of dollars.[89] Indeed, one of the lessons from the solitary confinement class actions is that, when the law shifts, institutions that have been systematically negligent can find themselves exposed to significant damage awards. Leaving aside human dignity arguments, the prospect of damage awards may convince some hospital administrators to take a more proactive and restrictive approach to the use of seclusion. The possibility of large damage awards also makes access-to-justice barriers less pronounced.

3. Complaints to Medical Professional Regulators

The final avenue for challenging seclusion is to bring a professional regulatory complaint against the healthcare professionals who are involved in ordering and implementing seclusion. In *Complainant v College of Physicians and Surgeons of British Columbia (No. 1)*, for example, an inmate in pretrial detention filed a complaint against the psychiatrist who was treating them while they were being held in solitary confinement.[90] The inquiry panel initially dismissed this complaint on the basis that the prohibition on the use of solitary confinement had not crystallized at the time of the complaint. In overturning this decision, the Health Professions Review Board found that the Mandela Rules informed the ethical obligations of a physician.[91] The Board then returned the matter to the inquiry panel for it to determine whether and to what extent the Mandela Rules and solitary confinement case law inform the ethical requirements of physicians.[92]

What is significant about this decision and the approach of filing complaints against healthcare professionals is that it will require regulatory bodies to explain why conduct that is profoundly offensive in the penal context should be acceptable in the healthcare context, particularly when medical professionals have been the source of proving the harms associated with isolation in the penal context. If there is evidence showing how the same treatment can be safely used in hospitals—a finding that is not readily apparent from the existing literature—then that evidence will have to be marshalled and presented to regulatory bodies. In other words, the existing professional practice may not be sufficient to protect against a finding of misconduct.

[89] See e.g. *Barker v Barker*, 2022 ONCA 567.

[90] *Complainant v College of Physicians and Surgeons of British Columbia (No. 1)*, 2022 BCHPRB 39.

[91] Ibid., at paras 144–145.

[92] The author wrote to the College of Physicians and Surgeons of British Columbia seeking a copy of the inquiry committee's redetermination. The college indicated that the inquiry committee's work is "protected by privacy laws and [is] not disclosed to the public" unless there is a "public reprimand or citation for discipline": correspondence dated November 1, 2023, on file with the author. In a subsequent telephone interview with Jennifer Metcalfe (counsel for the complainant), on November 14, 2023, she indicated that the complainant had filed a request for review by the Health Professions Review Board of the college's redetermination, which is ongoing, but could not comment further.

The threat of professional sanction, while again not centrally focused on the human dignity of patients, has the potential to act as a serious deterrent. Administrative complaints processes are easier to access than constitutional claims and class proceedings. Professionals do not like regulatory complaints.[93] The case reviewed above has been litigated over a four-year period, at significant expense. Even if the physician in that case is successful, the inquiry panel's dismissal of the complaint rests on the finding that the prohibition of solitary confinement had not been crystallized in or around 2015. This will not protect other healthcare professionals from complaints on a forward basis. At some point, healthcare professionals and their insurers will have to incorporate the human rights consensus on solitary confinement into their practice decisions. This is unlikely to end the use of seclusion, but it may further regulate when and how it is used.

Conclusion

The story of ending solitary confinement in Canada, even if incomplete and ongoing, is one of remarkable judicial recognition that human isolation is profoundly harmful, especially for people with serious mental illnesses. Although the practice of solitary confinement is similar, if not identical, to the practice of seclusion in forensic hospitals, the type of judicial scrutiny imposed on solitary confinement has not been imposed on seclusion.

The differential scrutiny of seclusion is not a product of its harmlessness—far from it. The literature clearly establishes: (1) that seclusion comes with serious risks of objective and subjective harm, and (2) that seclusion does not provide any therapeutic benefit to patients. This has been known since at least the beginning of the twenty-first century. Nonetheless, the practice of seclusion as an administrative tool continues in Canadian forensic hospitals.

One of the main reasons why this practice continues is that there is no legislative framework to regulate seclusion. Instead, a patchwork of provincial and hospital-specific policies govern when and how it is used. These policies are not consistent across the country, do not preclude indeterminate isolation, and do not require meaningful human contact on a daily basis. As a result, the policies do not preclude the possibility that seclusion may be akin to solitary confinement in practice. Indeed, data on the actual use of seclusion suggest that a sizeable percentage of the NCR patient population is exposed to prolonged social isolation every year.

There are three possible legal avenues for challenging this underregulated practice. A constitutional challenge could be brought to modify the common law and restrict when or how seclusion is authorized at common law. This has not occurred to date. What has occurred is the filing of class action lawsuits to

[93] Hanlé Kirkcaldy et al., "'Under the Sword of Damocles': Psychologists Relate their Experience of a Professional Misconduct Complaint," *Ethics & Behavior* 32, no. 5 (2022): 401–12.

address the misuse of seclusion. Patients have also started to file professional regulatory complaints against physicians, arguing that the Mandela Rules should inform medical ethics and professional practice. These latter two avenues have the potential to create litigation, monetary, and professional risk that may deter the ongoing underregulated approach to seclusion.

Cite this article: Perryman, Benjamin. 2024. Regulating Restraint: Legal Oversight of Seclusion in Canadian Forensic Psychiatric Hospitals. *Canadian Journal of Law and Society / Revue Canadienne Droit et Société* **39**, 289–311. https://doi.org/10.1017/cls.2024.25