SUBMISSIONS TO - The Honourable Dennis Timbrell

RE - Involuntary Civil Commitment

FROM - Canadian Civil Liberties Association

DELEGATION -

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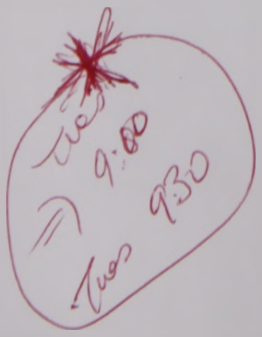

The Canadian Civil Liberties Association is a national organization with a cross-country membership of more than 3000 individuals, nine affiliated chapters, and some forty associated groups which, themselves, represent several thousand people. Our membership roster includes a wide variety of callings and interests - lawyers, writers, housewives, trade unionists, business executives, minority groups, media performers,etc.

The objectives of our organization are essentially two-fold:

1. To promote safeguards against the unreasonable invasion by public authority of the freedom and dignity of the individual.
2. To promote fair procedures for the determination of people's legal rights and obligations.

It is not difficult to appreciate the relationship between these objectives and the issue of involuntary civil commitment. On the basis of vague criteria and with few viable safeguards, the Mental Health Act of this Province permits a level of forced hospitalization which constitutes a substantial encroachment on personal freedom.

In 1974, between 18 and 19 thousand persons were confined involuntarily in the penal institutions of this country. In the same year, between 18 and 19 thousand persons were confined involuntarily in the mental hospitals of this country.

In the case of the penal detainees, a number of exacting procedures had to be observed. Such prisoners first had to be found guilty of some anti-social act which was specifically prohibited by the Criminal Code or some other discernible law. They had to have an opportunity in open court to call witnesses on their own behalf and to cross-examine those who testified against them. They had to have recourse to counsel and ultimately they had to be judged by an impartial judiciary or an independent jury of their peers.

In the case of many of the mental detainees, however, few such procedures were necessary. Under the statute with which we are primarily concerned here, the Ontario Mental Health Act, a person may be confined for up to one month if one physician believes him to suffer from a "mental disorder of such a nature or degree so as to require hospitalization in the interests of his own safety or the safety of others".[1] The Act fails to qualify this power by the kind of safeguards which are found elsewhere in our law - the right to counsel, the right to call and cross-examine witnesses, etc. Moreover, there is no elaboration of what is meant by "mental disorder" and no further indication of how great the threat to "safety" must be. Indeed, the confinement may be based essentially not on an assessment of past deeds but on a prediction of future ones.

The ensuing submissions are based upon the proposition that the exercise of prophesy represents a hazardous basis for encroachments on liberty. Despite the pivotal role of psychiatry in matters of mental illness, a number of comprehensive studies have raised serious questions about the ability of psychiatrists to predict future behaviour.[2] The conclusion shared by these studies is that psychiatrists are predisposed to overpredict dangerousness. So serious is this tendency that, according to the lead article in an American law review symposium, psychiatric opinions should be divested of their expert status in civil commitment proceedings.[3] If psychiatric testimony is not reliable for these purposes, where is there a category of experts whose predictions can be trusted?

The exercise of such predictions is rendered no less hazardous by the benevolence of its purpose. Indeed, some leading experts insist that, regardless of whatever good intentions may have been involved, institutionalization is frequently harmful to the individual concerned.[4] But, even without subscribing to this view, we can appreciate that, as far as the involuntary detainee is concerned, it matters little whether the encroachment on his liberty is accompanied by the smile of therapy or the growl of punishment.

These hazards are compounded further by the elusive concept of "mental disorder". How is such a concept to be defined? What distinguishes "mental disorder" from mere eccentricity or even non-conformity? When, for example, is a quest for promotion transformed from a healthy ambition into a paranoid obsession? How does an inspiring vision differ from a psychotic delusion?

In view of the susceptibility of mental diagnoses to subjective value judgments, the discipline of medicine is rendered an insufficient instrument. Unlike the diagnosis "pneumonia" the diagnosis "mental disorder" requires some evaluation of what is socially acceptable. Inherent, therefore, in the practice of involuntary civil commitment is the danger of incarcerating harmless non-conformists.

In response to this danger, the Ontario Mental Health Act imposes upon the committing physician the following procedures.

> S. 8 (2) It shall be stated and shown clearly that the physician signing the application personally examined the person who is the subject of the application and made due inquiry into all of the facts necessary for him to form a satisfactory opinion.
>
> S. 8 (3) The physician signing the application shall also in the application state the facts upon which he had formed his opinion of the mental disorder, distinguishing the facts observed by him from the facts communicated to him by others, and shall note the date upon which the examination was made.

Hunches, intuition, question-begging conclusions cannot justify the confinement of persons who live in a democratic society. In consequence, this Ontario statute requires the committing physician to articulate the facts, observations, and allegations upon which his judgments are based. This requirement is designed to reduce the risk of improper commitment. The need for documented demonstration tends to subvert the arbitrary inclination.

Unfortunately, however, there is reason to doubt the effectiveness of this safeguard. In a recent Master's thesis written for the Psychology Department of York University, Burton T Perrin analysed two hundred certificates on the basis of which persons in this Province actually suffered various periods of involuntary civil commitment between January 1972 and May 1973. After the completion of the thesis, the Canadian Civil Liberties Association examined the contents of these certificates (with names and identifying material deleted).[5] In order to ensure maximum objectivity, we requested two senior counsel not involved in the leadership of our organization to provide us with legal opinions as to the adequacy of the documents concerned.

After analysing the 200 certificates, the counsel, Kenneth Howie, Q.C., of Thompson, Rogers and John Sopinka, Q.C., of Fasken, Calvin, both agreed that at least 142 failed to satisfy the requirements of the Mental Health Act. Each of these lawyers, however, impugned even more. At first, Mr. Sopinka approved of only 44 certificates and Mr. Howie approved of only 28. When they discussed their respective analyses, they agreed that they might each have employed even stricter criteria. Indeed, it is not without significance that one of their original letters contained the following qualification.

> "We might add that, in reaching this conclusion, we may have erred on the high side and given the benefit of the doubt to some of the applications under consideration".

On the basis of all this, it seems fair to conclude that at least 70% of the certificates at issue violated the minimum safeguards of the Mental Health Act.

The certificates require the committing physician to provide the following written information.

1. Facts indicating mental disorder observed by myself: (e.g., appearance, conduct, conversation.)
2. Other facts, if any, indicating mental disorder communicated to me by others: (State from whom the information was received.)
3. State reason(s) why no measure short of hospitalization would be appropriate in the case of the above-mentioned person:
4. State reason(s) why the above-named is not suitable for admission as an informal patient:

In order to illustrate the inadequacy of the impugned certificates, we reproduce herewith the actual text in a few of these cases.

005

1. Crying on phone. Was admitted (to hospital) -discharged self. Was in emergency (another hospital) - discharged self.
2. Unable to stop drinking.
3. Leaves hospital.
4. Leaves hospital.

024

1. Shouting obscenities - very disturbed.
2. Discharged from (hospital).
3. Unpredictable - disturbed.
4. Unpredictable.

084

1. Patient very paranoid no insight. Will not cooperate.
2. Wife reports she doesn't want him back.
3. Dangerous to himself will not follow his diet.
4. Will not cooperate.

159

1. Extremely agitated and vociferous.
2. Speech incoherent and suspicious - almost paranoid.
3. Two previous admissions to Ontario Hospital.
4. Previous experience.

In addition to the absence of the required information, these certificates are virtually devoid of any suggestion that "safety" was a factor in the commitment decision. Without a lot more, allegations like "unmanageable", "uncooperative", "leaves hospital", and "unpredictable", hardly constitute a proper, let alone a legal, basis for encroachments on liberty.

Neither Mr. Howie nor Mr. Sopinka nor Mr. Perrin nor the Canadian Civil Liberties Association can deny the possibility that there may have been adequate grounds for the commitment of the persons discussed in these certificates. None of us interviewed the committed patients or the committing doctors. What we can say, however, is that, by failing to set out more adequately the basis for the commitments, at least 70% of these certificates contained serious legal defects.[6]

But even apart from strictly legal considerations, this issue involves more than inadequate form-filling. While it is possible that, despite an inadequate certificate, there may be grounds for a commitment, it is also possible that in such circumstances the grounds may not exist. Unless they are spelled out, how can one know and whom can one trust?

To argue by analogy, there may be grounds for the conviction and imprisonment of a criminal accused. But, unless such grounds are based upon proper evidence in court, the judge is required to dismiss the charge and acquit the accused. The incarceration of the criminal offender requires explicit evidence. There is no reason why the incarceration of the mentally disordered should require anything less. To whatever extent, therefore, the Mental Health Act permits the continuation of this perilous practice, it is necessary to devise more viable safeguards against the risk of improper commitment.

At the moment, the criteria for such commitments are expressed in regrettably vague language. The goal of Section 8 is the protection of safety - the safety of the prospective patient and the safety of other people. However, the Act nowhere indicates what level or nature of threat to safety will permit a forced hospitalization.

In view of the centrality of liberty in our society, only the most overwhelming threats to our most vital values could arguably justify the compulsory confinements contemplated by our mental health statutes. In our opinion, the anticipated injury should require, at the very least, a combination of three characteristics: severity, high probability, and immediacy.

The need for severity is designed to restrict these intrusions on freedom to the most serious of anticipated injuries. Such confinements should not be available in order simply to abate a nuisance or an annoyance. The need for high probability is designed to require substantial evidence that, unless some action is taken, the apprehended injury, in fact, will occur. Since commitment means the certainty of liberty being curtailed, there should be much more than a mere possibility of injury being sustained. The need for immediacy is designed to restrict these intrusions to those situations where nothing less than confinement is likely to prevent the apprehended injury. If there is enough time and chance for something less to work, confinement should be avoided.

In our view, therefore, no person should be subject to involuntary commitment unless, at a minimum, he suffers from a mental disorder of such a nature that there is a high probability he will imminently cause, himself or someone else, serious physical injury.

No less important than the articulation of workable criteria is the adoption of viable procedures. At the moment, a certificate of commitment signed by one physician like the 200 which we examined, is sufficient authority for a compulsory confinement of

up to one month. Should a patient wish to challenge his detention, the onus devolves upon him to seek a writ of habeas corpus from the courts or some special relief from the Board of Review.

In our opinion, the primacy of liberty requires a reversal of this onus. Those who seek to curtail a person's freedom should bear the burden of demonstrating the justification for their proposed course of action. In the light of our previous discussion of the present procedures, we would reduce substantially the duration of commitments which physicians unilaterally may impose.

To whatever extent the physicians' certificates are permitted at all, they should be confined to emergency situations and they should expire automatically after a short period of no more than 72 hours. Any desire to confine a person involuntarily beyond such a period should require recourse to independent review. Some official or tribunal, independent of the parties involved, the committing doctors, the psychiatric facility, and the Government, should be empowered to determine whether the facts of the case fall within the legally permissible criteria of commitment.

At this point, we are not necessarily wedded to any particular instrument for implementing such independent review. There are a number of possibilities. A special official or tribunal could be created by the Government to act in these matters. Conceivably, such a role could even be performed by the courts which are already conveniently located in many parts of the Province. It is sufficient, at this stage, to propose the adoption of the concept even without all of the details.

The procedure, we envision, might operate roughly as follows. Within the 72 hour period, those seeking to extend the commitment would be required to serve upon the patient, his counsel, and the independent tribunal an application to commit along with all of the relevant documentation. The tribunal would respond by notifying the parties that, if either of them wished to make additional representations, oral or written or both, they might do so within or at a specified time and place very shortly thereafter. In some cases, the tribunal, on its own motion, might require the parties to furnish such additional material. In those cases where nothing additional

was required or offered, the commitment application would be disposed of solely on the basis of the written documentation. If either or both parties provided additional evidence, the tribunal would decide the issue on the basis of all the material, both written and oral.

As a concomitant safeguard, we would recommend that a copy of the certificate of commitment be given to the patient or his representative as soon as practicable after the initial commitment is effected. The Act should also oblige the psychiatric facility involved to take all reasonable steps, as quickly as practicable, to ensure that the committed person has speedy access to legal counsel. While it is true that some psychiatric facilities voluntarily are observing such guidelines, we believe that these issues should be made a matter of legal requirement. For the purposes of independent review, we would recommend that the law confer upon the prospective patient the right, at his option, to a public hearing and the right to call favourable witnesses and to challenge adverse ones.

Since the onus throughout would remain with those who are seeking to extend the commitment, defective documentation, untimely notice, and/or inadequate evidence could precipitate the discharge of the involuntary patient. But even if the certificate were validated through this process, the commitment nevertheless should be of a short duration, say one month, and it should continue to be susceptible to the existing legal safeguards e.g. habeas corpus and, on renewal, the Board of Review. The key change here, is that, unlike the present system, every such involuntary commitment beyond 72 hours would be subject to some kind of independent assessment. This factor should reduce the risk of decision by arbitrary value judgment.

Since all such commitments would be accompanied by the possibility of a full-scale hearing and the certainty of at least a documentation review, there is reason also to expect an increased meticulousness on the part of the physicians and psychiatric facilities concerned. While we would not wish our recommendations to convey any particular misgivings about the integrity of the committing physicians in this Province, we are concerned about the stringency of many of their commitment practices. Anything less than scrupulous adherence to a strong set of statutory safeguards could easily lead to the improper deprivation of people's liberty. Herein lies the key rationale behind our proposed reforms.

The criteria and procedures advocated here cannot, of course, guarantee the right balance between safety and freedom. What we believe they can do, however, is reduce the disquieting imbalances which have been created under the existing system. Thus, while our recommendations are not likely to achieve, for this area, an ideal equilibrium, they are likely to produce discernible improvements. On that basis, we respectfully urge their early adoption.

Summary of Recommendations

To the extent that involuntary civil commitments are continued, the Canadian Civil Liberties Association recommends the adoption of the following minimum measures.

1. Such commitments shall require that the person involved suffer from a mental disorder of such a nature that there is a high probability he will imminently cause, himself or someone else, serious physical injury.

2. Physicians' certificates authorizing involuntary commitment shall be limited to emergency periods of no more than 72 hours.

3. Involuntary commitments beyond such 72 hour periods shall require review by an independent official or tribunal.

4. Certificates validated by such an independent review shall be of a short duration, say one month, and they shall continue to be susceptible to the existing legal safeguards including habeas corpus and, on renewal, the Board of Review.

5. The following procedural safeguards shall apply.

   a) The patient shall receive a copy of the certificate of commitment as soon as practicable after the initial commitment is effected.

   b) The psychiatric facility involved shall be required to take all reasonable steps, as quickly as practicable, to ensure that the committed person has speedy access to legal counsel.

   c) For the purposes of the independent review, the patient shall enjoy the right, at his option, to a public hearing and the right to call favourable witnesses and challenge adverse ones.

FOOTNOTES

1.. The Mental Health Act, R.S.O. 1970, c.269, s.8.

2. Bruce J. Ennis and Thomas R. Litwack "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom", California Law Review May 1974, Vol.62, No. 3, p. 693.

3. Ibid.

4. See H.J. Eysenck "The Effects of Psychotherapy", Handbook of Abnormal Psychology, 1960, Esyenck, The Effects of Psychotherapy, 1969, T.J. Schiff, Being Mentally Ill: A Sociological Theory, 1966.

5. Burton T. Perrin, Involuntary Commitment to Mental Hospitals: Why?, M.A. Thesis, York University, September 1973. The Canadian Civil Liberties Association wishes to thank Mr. Perrin for his contribution to this brief and for his permission to use his thesis materials.

6. Legal opinions contained in letters to the CCLA from Kenneth E. Howie, Q.C. and John Sopinka, Q.C.