Involuntary commitment in Ontario: some barriers to the provision of proper care

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The Ontario Mental Health Act, as amended in November 1978, provides strictly defined criteria for involuntary commitment for psychiatric assessment; the assessment can last up to 5 days. These criteria fail to cover a number of patients who are, in the author's opinion, in need of compulsory assessment or treatment. Four cases in which there was serious difficulty in giving proper care are described in this paper. The difficulties are discussed and improvements in the criteria for involuntary assessment recommended.

La Loi sur la Santé Mentale de l'Ontario, après les amendements de novembre 1978, énumère des critères bien définis pour décider de l'internement involontaire d'une personne aux fins d'évaluation psychiatrique; l'expertise peut durer jusqu'à 5 jours. Toutefois, ces critères ne tiennent pas compte d'un certain nombre de malades qui, de l'avis de l'auteur, nécessitent une évaluation obligatoire ou un traitement. On décrit quatre cas où de sérieuses difficultés ont été rencontrées lors de l'administration des soins requis. Ces difficultés sont commentées et des suggestions sont faites en vue d'améliorer les critères permettant une évaluation involontaire.

The Ontario Mental Health Act was amended, as an interim measure, in 1978; since Nov. 1 of that year the requirements for involuntary commitment to a psychiatric facility by a physician have changed in ways that have led to some serious difficulties. The act is under further review by a ministerial committee, and it received detailed comment in the Ontario Council of Health's 1979 report on mental health services in the province.[1] The experience of physicians in Ontario may prove of value to those advising on new legislation in other provinces, as well as to those planning the further amendment of the Ontario act.

The difficulties experienced in psychiatric facilities about commitment (or noncommitment) are primarily of concern to psychiatrists, but the difficulties experienced in the community in making decisions about whom to certify concern physicians in many fields — family doctors, emergency room doctors and others.

This paper discusses some serious problems that I have experienced working only 2 half-days a week in a community clinic. The four cases described represent the outstanding difficulties. They illustrate situations similar to those that must be presented by a large number of patients in the province. A review of new psychiatric assessments at the clinic in the 6-month period October 1979 through March 1980 (they average two per week) revealed four further worrying cases: two of self-neglect, one of gross overspending and marital distress, and one of grossly abnormal behaviour in a deluded patient that caused two relatives severe psychologic distress.

Criteria for commitment for assessment

The essentials of the requirements for involuntary commitment for assessment (for up to 5 days in a psychiatric facility) are embodied in form 1 (the application for psychiatric assessment) of the Ontario Mental Health Act.[2] A very helpful feature of the form is that the criteria are shown verbatim as notes 1 and 2 to the form, which are printed on a flip-up cover section. While completing the form the physician can read the notes:

1. *Subsection 1 of section 8 of the Act states in part:* "Where a physician examines a person and has reasonable cause to believe that the person,
   (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;
   (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or
   (c) has shown or is showing a lack of competence to care for himself."
2. *Subsection 1 of section 8 of the Act states in part:* "The physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,
   (d) serious bodily harm to the person;
   (e) serious bodily harm to another person; or
   (f) imminent and serious physical impairment of the person."

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The physician has to certify a *belief* in one or more of three risks for the person being assessed: danger to self, danger to others or lack of competence to care for himself. Further, the physician has to certify an *opinion* that the person suffers from a mental disorder and that the *degree* of risk meets the terms of note 2. In the case of risk of harm to self or others the degree of risk required is reasonable: "serious bodily harm". When the patient is unable to care for himself the only acceptable degree of risk is a belief that the illness "likely will result in . . . imminent and serious physical impairment of the person". This third category, lack of competence for self care, causes much concern.

When weighing the risks the physician lacks a legal definition of "likely" or "imminent". Common usage of the word "likely" suggests that the risk must be greater than 50%. "Imminent" suggests to most people a matter of hours or a few days. The likelihood of psychologic harm, as opposed to physical harm, is not a ground to be considered under the act as presently amended.

Case reports

I report here three cases in which the requirement to certify likely imminent serious physical impairment of the person led, I believe, to poor quality of care and considerable suffering. In the fourth case reported the lack of overt acts or threats of violence prevented the clinical judgement of a risk of future violence from being acted on. Some details of the cases have been altered to protect the identity of the patients.

Case 1

An elderly woman lived alone and suffered from unequivocal senile dementia. She was often incontinent of urine and occasionally incontinent of feces. She refused to consider a move to a hospital or a nursing home. A Victorian Order nurse visited regularly and did grocery shopping for the woman.

The staff who conducted a psychiatric assessment at the woman's home in early November 1978 fully recognized the diagnosis and ultimate prognosis. She refused any additional help. With the assumption of continued help from the nurse there was no imminent risk of serious physical impairment; therefore, the woman was not certified.

On the Friday preceding the New Year holiday weekend the visiting nurse came to our community clinic in distress. The old woman had a gross infection in a varicose ulcer; a bed was available in the general hospital, but the woman had locked herself in and was not opening the door even to the nurse.

We had to call the police to break in and now were able to certify that serious physical impairment had, indeed, become imminent.

Case 2

A woman in her 40s lived with a teenaged son and was in regular contact with her elderly mother. She had a well established history of bipolar mood disorder, with moderate violence in the manic phase.

When she stopped taking her medication, clear features of a moderate manic disorder developed: she was irritable, made lengthy irate phone calls, gave most of her welfare money to a casual acquaintance, wasn't dressing herself, keeping clean or getting enough sleep, and was sexually indiscreet in a manner most upsetting to her son.

A psychiatric assessment was made at the woman's home because she refused to see her therapist or me at the clinic. She displayed clear evidence of a manic disorder, her attitude quite out of keeping with her normal manner (which I had observed for over a year). There had been no acts or threats of violence. She refused treatment and I could not intervene.

Over the next 10 days the therapist and I received a series of phone calls from the woman's distressed and concerned son and mother. A complaint from her landlord that a neighbour was afraid of her led to a second home visit. The woman refused to let us in, and when her son tried to come to the door she struck him; later, in our presence, she pushed her mother with a force dangerous to an elderly person. Her state of undress and uninhibited interaction with a handsome plainclothes policeman reduced her son to tears. This time I certified her because of the violence.

Case 3

A middle-aged woman lived in a tiny apartment with her 18-year-old son. Our clinic was asked by a public health nurse to arrange a psychiatric assessment because the son had not left the apartment for many months. At age 14 he had been treated in hospital for depression with some suicidal ideas. An assessment at their home revealed a chaotically untidy apartment cluttered with boxes between which moved a dozen or more puppies, the offspring of three bitches also present in the apartment. The interview with the boy revealed that he was apathetic and depressed but adequately nourished and expressing no suicidal ideas. Talking to his mother we discovered that she had had some psychiatric admissions in the past, that she currently had active persecutory delusions and that she was only marginally able to care for herself. A large boil on her forearm was discharging pus onto a makeshift bandage. She refused to go to a doctor, asserting that she did not trust doctors and that the boil would heal; she permitted me to check that there was no lymphangitis or lymph gland enlargement. Neither mother nor son seemed, therefore, certifiable.

We decided to arrange regular visits by a psychiatric nurse–therapist in the hope of building up trust in the boy or his mother or both; they each refused to consider any form of therapy.

During the visits the nurse observed that the boil did heal, the boy continued to lie about at home and the dogs continued to breed. One day, 6 months after my first visit, the woman, who was postmenopausal, reported to the nurse some episodes of vaginal bleeding. She attributed this to "interference" by a man who used to sneak in at night if she did not fully barricade the apartment door with triple locks and several boxes

pushed against it. She refused to see a doctor about this potentially serious symptom, and on this occasion, with some reservations about the imminence of serious physical impairment, I certified her for assessment.

Case 4

In this case the problem was the lack of evidence of the patient's having behaved violently towards another person or having caused another person to fear bodily harm.

A young man who in the past had been admitted to hospital several times for paranoid schizophrenia with some violent behaviour was brought to the clinic for assessment by a relative who realized that he was having a relapse. The psychiatrist who assessed him found evidence of suspiciousness, paranoid ideas and half-admitted auditory hallucinations. His demeanour and suspiciousness led the psychiatrist to the clinical opinion that the patient was liable to be violent to someone but had not been violent, threatened violence or caused anyone to fear bodily harm. The patient refused informal admission and was allowed to go home, where he assaulted his landlord. Three hours after the first assessment the psychiatrist certified him with a sense of clinical failure, receiving a number of comments of the "I told you so" type from the relative.

Discussion

The first two patients and the mother in case 3 exhibited a significant lack of self care. Although medicine is not an exact science we could certainly predict in cases 1 and 2 that serious consequences were likely sooner or later. Suffering by the patient or close relatives or both was already obvious in all three cases. The need to certify likely imminent serious physical impairment or violence led to delay in care and prolongation of suffering.

The lack of any provision for protection of the patient's future mental health is unduly restrictive. Manic patients may commit "social suicide" in financial, sexual or interpersonal areas. When they recover or, worse, swing into depression, they look with horror at what they have done, and actual suicide may follow.

An important point made by the Ontario Council of Health's legal task force was that action in the community to have a patient brought to hospital for examination by specialist staff may have to be initiated by persons with relatively little expertise in psychiatry.[3] They advised against overly restrictive criteria for having a patient involuntarily brought for examination. They also recognized the problems with the present act, such as those encountered in dealing with the manic patient.[4]

The English and Welsh Mental Health Act of 1959 provides for compulsory admission of any person "in the interests of his own health or safety or with a view to the protection of other persons".[5] Health risk is not confined to risk of physical impairment, and protection is not explicitly confined to prevention of "bodily harm". Risks to health can be weighed regardless of whether they are imminent or merely reasonably foreseeable.

The present Ontario Mental Health Act, fortunately, leaves much room for reasonable clinical *opinion*; the physician does not have to "prove" the mental illness or the risks. It is a pity, however, that the risks are so narrowly restricted. In case 4 the clinical opinion was, correctly, that there were risks. The requirement for actual acts, threats or the causing of fear prevented clinically appropriate commitment of a clearly paranoid patient before the violence that ensued.

Few doctors want overly broad criteria for involuntary commitment, and it is accepted that many persons undoubtedly suffering from clear-cut mental illness should have the right to decline treatment.

With a 5-day limit to the initial assessment period and a review by an independent body available to patients, we should be allowed to use clinical judgement to anticipate serious harm before it occurs. Psychologic as well as physical harm should be considered, as recommended in the report of the Ontario Council of Health.[6] When harm is expected from lack of self-care, it should not have to be imminent.

Sincere clinicians faced with the Ontario Mental Health Act in its present form will sometimes take a rather broad view of the act to offer good and necessary care (see the paper by McCready and Merskey in this issue of the Journal, starting on page 719). If they follow the act in a narrow, literal way they will be forced into poor clinical actions.

Soon after the 1978 amendments to the act were passed, a physician who had considerable knowledge of health law is reported to have remarked: "Doctors will continue to certify those whom they really believe should be certified; they will merely learn a new language." Despite the considerable agitation about the rights of the individual to be protected from improper certification, there has been very little evidence that doctors have misused the powers given to them in Ontario, or other parts of Canada, in recent years. The cases cited in this paper are, perhaps, examples of the failure of the physician to "learn a new language" fast enough. They might, however, be described as the result of strict application of the Ontario law as it exists.

References

1. *Committee on Mental Health Services in Ontario: Legal Task Force*, Ontario Council of Health, Toronto, 1979
2. *The Mental Health Act. Revised Statutes of Ontario, 1970, Chapter 269 as Amended by 1978, Chapter 50*, Ontario Ministry of Health, Toronto, 1978
3. *Committee on Mental Health Services in Ontario: Legal Task Force*, Ontario Council of Health, Toronto, 1979: 25–26
4. Ibid: 29
5. *Mental Health Act*, sect 25, subsect (2), HMSO, London, Engl, 1959
6. *Committee on Mental Health Services in Ontario: Legal Task Force*, Ontario Council of Health, Toronto, 1979: 31