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Involuntary admission to hospital and treatment in Ontario: is pessimism among physicians warranted?

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In 1978 the Ontario Mental Health Act was revised to contain more specific and objective criteria for involuntary admission to hospital and treatment. The new requirements have elicited critical and pessimistic comments from psychiatrists and other physicians in Ontario. Two recent cases, described in this paper, indicate that the changes in the law have not obstructed good clinical care and treatment and may, in fact, be salutary to the management of patients who are involuntarily admitted to hospital.

En 1978 la Loi sur la Santé Mentale de l'Ontario fut revisée afin d'incorporer des critères plus spécifiques et plus objectifs régissant l'hospitalisation et le traitement d'un patient sans son consentement. Ces nouvelles exigences ont suscité des critiques et des commentaires pessimistes de la part de psychiatres et d'autres médecins de l'Ontario. Deux cas récents, décrits dans cette publication, indiquent que les modifications de la loi n'ont pas nuit à la bonne distribution des soins cliniques ou au traitement et peuvent même, en fait, avoir un effet salutaire sur le traitement des patients hospitalisés sans leur consentement.

Every province in Canada has commitment procedures whereby persons with mental disorders may be involuntarily taken to hospital and detained there for 1 to 30 days. Most provinces require one physician's certificate of committal, although British Columbia and Nova Scotia require two physicians' certificates. In eight provinces physicians may commit a person with a mental disorder to hospital for his or her own protection or welfare or for the protection of others, or if there is a risk to the patient's or others' safety. In Newfoundland "safety to property" is an additional criterion for commitment. Physicians in Ontario must specify that as a consequence of a person's mental disorder there is a likelihood of serious bodily harm to the patient or others, or a risk that he or she will become seriously physically impaired.

In most provinces mental health legislation permits, in some circumstances, treatment without the consent of a patient who has been involuntarily admitted to hospital. In Saskatchewan, for example, the medical officer in charge has the authority to provide appropriate care and treatment in hospital for up to 2 weeks before the certificate must be renewed, and in Alberta a patient may be cared for and treated for 24 hours initially and for up to a month after examination by a second physician. In Ontario a competent patient may be restrained (kept under control by minimal and reasonable use of force, mechanical means or chemicals) in hospital for up to 5 days. A physician may treat the patient without his or her consent only if another two psychiatrists, one of whom is not on staff at the hospital, support the decision to administer a specific treatment, and if that treatment is authorized by the regional review board. The board may interview the patient and the attending physician and must review the psychiatrists' opinions that the patient's mental condition is likely to be substantially improved by the treatment and is unlikely to improve without the treatment.

It is evident that Ontario law, compared with legisla-

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tion in other provinces, has moved towards more specific and objective criteria for involuntary admission to hospital and treatment. The stricter criteria of the 1978 revision of the Ontario Mental Health Act[1] were adopted partially in response to confusion among physicians over the intent and application of previous legislation. It is ironic, therefore, that many physicians in Ontario have been highly critical of the changes in the commitment procedures. O'Keefe[2] outlined three cases that were referred to the Ontario Medical Association during the first 6 months after enactment of the new legislation: one patient jumped from a highway overpass, suffering serious injury, after he was recognized as ill; the second, who was not considered certifiable, wounded another person; and the third, a paranoid schizophrenic, had to wait to become ill enough to be certified as dangerous. Presumably all three were certifiable under the previous legislation. Miller[3] cited four instances in which patients required commitment to hospital but could not be confined involuntarily under the 1978 act. He advocated a broadening of interpretation of the commitment criteria for physicians and more reliance on review boards by disgruntled patients. Similarly, McCormick[4] described four patients whose eventual involuntary admission to hospital was delayed at some medical risk and with considerable personal suffering and social cost. McCready and Merskey[5] concluded that the 1978 law must be revised to provide care for persons who are mentally ill but do not meet the existing criteria for commitment.

The cases cited in the literature illustrate the problems arising from the Ontario Mental Health Act as it is being interpreted and applied by physicians, who are guided by what they infer to be the intent of the law and how they expect it to be interpreted in the courts. These cases may have led physicians to be both critical and pessimistic about the act and to behave with undue caution with regard to involuntary admission to hospital.

We were recently involved in two cases that tested our authority and responsibility to commit and treat involuntary patients within the existing legislation. Rather than being overly restrictive or obstructive to the provision of good clinical care,[4] the current law supported our judgement that confinement in hospital and treatment should be imposed against our patients' wishes. Furthermore, the opportunity to test our medical judgement against legal standards did not seriously interfere with our patients' care and treatment, and the "day in court" may have been therapeutic for the patients and their families.

Case 1

A 50-year-old woman with a 3-month history of increasing hypomania was forcibly brought to the emergency department by her husband and daughter. After a 90-minute interview with the resident she agreed to be admitted to hospital "for a rest", although she denied that she needed psychiatric treatment. However, 20 minutes after she arrived on the ward she was unwilling to stay. The resident consulted by telephone with the psychiatrist on call, who advised that the patient's status be changed from informal to involuntary. A form 3 (Certificate of Involuntary Admission) was completed on the grounds that the patient (a) was suffering from a mental disorder, (b) was likely to cause serious bodily harm to another person (earlier that day she had struck her daughter) and (c) was likely to become seriously physically impaired (she had been unable to sleep for several nights and had been eating large amounts and odd concoctions of foods for several days). She was physically restrained from leaving the ward, and when she refused to take medication by mouth she was sedated with an intramuscular injection.

Eight days after the patient's admission to hospital her lawyer filed an application for a writ of habeas corpus, and in support of the application he filed an affidavit. In reply the hospital presented an affidavit of the attending psychiatrist, which gave his version of the facts. Because of the contradictions in the affidavits the judge ordered a hearing; as well, he ordered a ban on publication of the case.* The next day the patient, the admitting resident, the psychiatrist on call who had been consulted about the admission and the attending psychiatrist gave evidence in court. The patient was the only witness to support her case, which rested on the contentions that, although she was suffering from a mental disorder at the time of admission, she was not likely to harm anyone or to become physically impaired and that, had the necessary criteria for detainment been met, a form 1 (Application by Physician for Psychiatric Assessment) rather than a form 3 should have been filed, since she had not willingly been admitted to hospital before that time. The hospital's case was that the patient had already been admitted informally (i.e., voluntarily) when the form 3 was issued, and that the criteria for detainment specified on the form were met.

The judge found that the patient had been admitted voluntarily and that she had entered her room voluntarily. He therefore concluded that the resident had been correct to change her status to involuntary by completing a form 3 and that there had been adequate grounds for detaining her in hospital. Thus, the application for a writ of habeas corpus was dismissed without costs.

Discussion

The hearing supported the clinicians' judgement that the patient presented a risk of serious physical harm to others or herself, or both, unless she remained in hospital, and hence was suitable for involuntary admission to hospital, as specified by law. It is interesting that the judge relied on the expert opinions of the three psychiatrists, which were consistent, and heard no contrary psychiatric opinions. Furthermore, the judge considered the written statements of two other psychiatrists, who had been asked to see the patient after her admission; they expressed the same opinions as the hospital's psychiatrists. Many clinicians might hesitate to depend upon judicial support in a case such as this, assuming that the court would have taken a narrower view of physical risk than had applied to this patient.

*While this paper is published with the expressed consent of the patient, certain facts have been suppressed to ensure anonymity, consistent with the ban on publication and the informal advice of the main participants.

However, the outcome of this hearing indicates that Miller[3] was correct when he recommended a broader interpretation of physical harm.

An application for a writ of habeas corpus must be reviewed in court without delay; this case was heard 1 day after the application was made. Therefore, the time available for preparation was very limited. The three physicians involved had to suspend their activities for 2 days to prepare their material, be briefed by the hospital lawyer and appear in court. Furthermore, it was necessary to accompany the patient to court and remain with her. It seems likely, therefore, that the monetary cost of this hearing reached five figures.

Notwithstanding the considerable cost and the inconvenience to hospital staff, the process of testing the legality of the patient's confinement in hospital appeared to have encouraged her to accept the recommended treatment, and the hearing in itself may have had a therapeutic effect.

The morning after the patient's admission to hospital she had learned from her psychiatrist that she had a right to consult a lawyer and to appeal to a review board about her involuntary confinement. Later the same day she had agreed to take haloperidol orally, despite her denial of illness, saying that she was upset by the events of the previous day. Similarly, after meeting with her lawyer the following day she agreed to take lithium carbonate in addition to haloperidol. In this and other ways she indicated a growing sense of trust and respect for the hospital staff. When she learned, 2 days after her appearance in court, that the review board had supported the steps by which she had been committed to hospital, she immediately agreed to remain in hospital and to accept the treatment prescribed. Her status was therefore changed to informal. At the time of discharge, 1½ weeks later, her mood was normal and stable, and she had reconciled with her husband and daughter.

Throughout the patient's stay in hospital her husband and daughter were in close contact with her and the attending staff. They supported the hospital's efforts to detain the patient until she recovered by meeting with hospital staff and providing information about her potentially harmful behaviour. Their anger, which was generated by the tumult and frustration before the patient's admission, was directed not towards the patient, whom they recognized as ill, or the hospital staff but towards her lawyer, who they felt was misrepresenting the patient's real interests, and the legal system that permitted such misrepresentation.

Our patient had been in a concentration camp during World War II. Therefore, the opportunity to avail herself of the due process of law to the fullest extent doubtless constituted an important therapeutic factor, although she later regretted having undertaken an expensive and unfruitful legal proceeding. However, the experience demonstrated to her that she had indeed been protected from arbitrary and summary judgement.

Case 2

A 22-year-old man was brought to the emergency department by his father and a friend, who said the patient had been having bouts of mild elation, irritability, grandiosity and hyperactivity for 10 days. They also described a manic episode that had occurred 9 months earlier that had been accompanied by erratic behaviour, including extremely reckless highway driving, which had necessitated admission to another hospital. They were very concerned that his current condition might escalate to the same level of excitement and disorganization. The patient consented to an examination by a resident and later by the psychiatrist on call. Both clinicians diagnosed hypomania.

The patient refused to be admitted, but he agreed to take thioridazine daily and to return for reassessment. Three days later he was examined by another psychiatrist, who concurred with the diagnosis and, following consultation with a colleague who supported the diagnosis and the decision to admit the patient to hospital, completed a form 1 on the grounds that (a) the patient was apparently suffering from a mental disorder, (b) his condition would probably deteriorate, resulting in lack of competence to care for himself and (c) he was likely to seriously physically harm himself or others. The patient did not resist being admitted to the ward and was cooperative during physical examination. However, 1 hour later, when the admitting resident began discussing the need for medication, he became extremely angry and agitated and threatened to become violent if anyone approached him. Further discussion did not reassure him, so he was physically restrained and sedated with an intramuscular injection.

The next morning the attending psychiatrist reassessed the patient and completed a form 3, affirming that the patient had a mental disorder and restating the risks specified on form 1. He also informed the patient of his right to appeal the certification. The patient completed a form 16 (Application to Regional Review Board) requesting an inquiry into the grounds for his involuntary admission to hospital. In the psychiatrist's judgement the patient was competent to accept or refuse treatment; however, because the patient was unwilling to accept medication, the psychiatrist completed a form 18 (Application to Regional Review Board) requesting authorization to treat the patient with neuroleptics and lithium carbonate without his consent. The psychiatrist's recommendation was supported by the opinions of two consultants. One of the consultants, who came from a nearby hospital to examine the patient, agreed with the recommended treatment but questioned the grounds for certification.

The following day the patient was interviewed by the review board consisting of a lawyer, a psychiatrist and a layman; the clinical director of the hospital also attended. Later the admitting resident and the attending psychiatrist were also interviewed. The patient appeared to be relatively well, in part because he had received a neuroleptic 1½ days earlier and was still somewhat sedated. In addition, his intelligence and considerable charm gave a false impression of well-being. The board ruled that the patient should remain in hospital involuntarily, but that he should not receive treatment without his consent. The chairman of the board offered to reconvene the proceeding should the clinical picture worsen considerably.

Five days later the patient was re-examined, at the

attending psychiatrist's request, by the psychiatrist who had first seen him in the emergency department and the psychiatrist who had completed the form 1. Although both commented on the deterioration of the patient's condition since he was first seen, they shared the opinion that his clinical state did not fully meet the criteria for involuntary admission to hospital. They did, however, support the attending psychiatrist's recommendation to the review board that the patient be treated without his consent. The patient not only refused to consent to treatment but also lodged a second appeal against his involuntary status.

The review board met 2 days later, and the patient and the attending psychiatrist were again interviewed. Following a lengthy discussion the board adjourned after deciding to interview the patient's parents 2 days later. Although the parents had reservations about the psychiatric profession, apparently based on their experiences during their son's first illness, they provided vivid accounts of his dangerous behaviour. The board ruled that the patient should remain in hospital involuntarily and granted authorization to treat him without his consent.

While leaving the boardroom the patient eloped. He was apprehended by the police the next day and returned to the hospital, where he remained for 1 month. He made no further attempts to leave and received treatment with neuroleptic and mood stabilizing agents. At the time of discharge he was still somewhat irritable, but his condition was considerably improved.

Discussion

In this case the issue of consent to treatment was the central problem from the time of admission to hospital. Although the patient initially agreed to treatment with neuroleptics, once he was admitted to hospital he became adamantly opposed to the treatment; therefore, all therapeutic efforts were at an impasse until his opposition was resolved through the law. In comparison, the issue of his unwillingness to be committed to hospital and to remain in hospital was far less of a problem. Despite the patient's protests it was not difficult to confine him to hospital while he had access to legal channels for appealing his confinement. Nor, after he had tested the rule by eloping, did he show disregard for the law. Undoubtedly there would have been a far more difficult management problem had the patient had no mechanism for lawful appeal.

Although the members of the review board hesitated to authorize treatment before careful and lengthy deliberation, they did not hesitate in their decision concerning the patient's involuntary admission to hospital. In light of that, it is interesting that the patient was considered unsuitable for certification by the emergency department psychiatrist, the psychiatrist who initiated the involuntary admission to hospital when he reexamined the patient, and the consultant who commented twice on the patient's noncertifiability. One of the psychiatrists noted in the patient's chart: "It is said that the review board procedure exists to assist a young man in such a self-destructive course." This case, like case 1, illustrates that physicians may wrongly assume that the terms "bodily harm" and "physical impairment" will be narrowly interpreted by the law and, accordingly, may be unduly pessimistic about receiving support for their clinical judgements.

As in case 1, this patient's family had an active role in the decision-making process. The parents had ambivalent attitudes towards psychiatry and misgivings about involuntary admission to hospital and therapy. To some degree their preconceptions may have been acted out in their son's resistant behaviour. Through their involvement in their son's admission to and stay in hospital, and their meeting with the board, they had an opportunity to overcome their resistance to therapy and to form an alliance with the treating staff.

In its lengthy deliberation the review board was not greatly swayed by the attending psychiatrist's insistence that pharmacotherapy be initiated without delay to minimize disruptions in ward activities resulting from the patient's behaviour, or by his expostulations on the deleterious effect the patient was having on other patients in the hospital. The board was perhaps governed ultimately by the recognition that when a patient is confined involuntarily and left untreated, the hospital is cast into the role of detention centre rather than treatment facility, as Sharpe and Sawyer[6] pointed out recently.

Comments

We have presented two rather difficult cases of hypomania. Their management may have been regarded by many clinicians as problematic, at least from a legal point of view. Involuntary admission and treatment without consent are frequently avoided by clinicians who expect that their actions will not be upheld if challenged in a court of law. By making use of the Ontario Mental Health Act and other legal channels, we were able to manage these cases well, albeit with considerable time, cost and manpower.

After describing four patients who required involuntary admission to hospital and were not, because of the Ontario legislation, confined to hospital, Miller[3] wondered whether physicians are interpreting the law more narrowly than the drafters of the legislation intended. Our experiences indicate that this may be the case. We suggest that physicians will be supported in court if they make a broader interpretation of the law while exercising reasonable clinical judgement. Physicians in Ontario may need to "learn a new language"[4] to reconcile the wording of the 1978 Ontario Mental Health Act with the realities and requirements of good clinical practice.

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