LAW REFORM COMMISSION

MANITOBA

COMMISSION DE RÉFORME DU DROIT

REPORT

ON

EMERGENCY APPREHENSION, ADMISSIONS AND RIGHTS OF PATIENTS UNDER *"THE MENTAL HEALTH ACT"*

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INTRODUCTION

Under the law of Manitoba a person who is suffering from mental disorder whether or not it may endanger his or someone else's safety, may be forcibly detained in a hospital by a single physician, without appeal (*"The Mental Health Act"*, C.C.S.M., cap. M110, s. 9(1)). Commitment may be for a period as long as twenty-one days but can be renewed for an indefinite period once the attending physician has the approval of the Director of Psychiatric Services for the province or a judge of the Provincial Court. Despite the absence of stringent procedural safeguards and the almost unseemly ease with which an individual may be committed under *"The Mental Health Act"*, a recent government study has concluded that more effective means are required to detain a person for observation and treatment under the Act ("Mental Health and Retardation Services in Manitoba", prepared for the Department of Health and Social Services, Province of Manitoba, by Dr. J.C. Clarkson, 1973).

The conclusions of the Clarkson study may seem somewhat inappropriate coming at a time when challenges in principle to civil incarceration of the mentally ill are as great and demonstrative as they are today. Civil commitment is, after all, now being challenged by critics both within and without the medical field, where the trend is itself toward community-based treatment in preference to the long term committal of persons to institutions. Journalists, lawyers and civil libertarians have for years now been documenting the shortcomings and abuses of the mental health process, pressing for its modernization and more limited use. Today there is an ever-increasing and impressive array of medical specialists who support this approach.

In cases of extreme mental illness however, challenges

to the philosophical justification of confinement are more difficult. In these cases particularly, the principle of the protection of society as a whole overrides other considerations which must give way to stringent restrictions on personal liberty. Generally it is agreed, and there is widespread social approval of this principle, that emergency detention based on *"dangerous"* mental illness is a legitimate exception to the inalienable freedom of the individual and his otherwise unjustified detention for reasons of insanity. Good mental health legislation must permit these cases to be dealt with both in an expedient fashion with a minimum of difficulty and in a manner which will ensure that the rights of the individual are appropriately protected. In the words of the Clarkson report, which seems to keep the liberty of the individual clearly in view, "the Act should make it relatively easier to detain a person for observation and immediate treatment, and more difficult to hold him indefinitely".

POLICE POWER: EMERGENCY DETENTION

The real-life drama of a single event involving a former patient at the Selkirk Mental Health Center illustrates the point we are making about effective commitment procedures and the need for improvement of this law in Manitoba.

The patient in question was reportedly holed-up with a shot gun, two or three other firearms and $80.00 of ammunition in the bush in a remote area of Manitoba. Psychiatric assessments made while she was a patient indicated that she suffered from paranoid schizophrenia and there were suggestions that she could be dangerous, if only to herself. The medical director of the psychiatric facility requested the R.C.M.P. to "pick up" the patient and transport her to the centre for care and treatment. But the police responded that, even in an emergency, it would be improper for them, in effect, to

arrest the former patient for this purpose, without the appropriate judicial authorization. A subsequent review made by us of the police power in these circumstances confirmed the accuracy of that assessment. Among a number of reforms made to the *Criminal Code* at the time of the *Bail Reform Act* amendments was the removal of attempted suicide as an offence under the *Code*, and with it has gone the consequent authority of a peace officer "*to arrest without warrant . . . a person . . . who he believes is about to commit suicide*". Of course, in the case of present-day criminal offences, special considerations do apply and peace officers are empowered to arrest persons whom they find committing indictable offences or who on reasonable grounds they believe have committed criminal offences. However, an officer who arrests a person in this way is not authorized to take the person to a hospital, but is required to take him before a justice of the peace to be dealt with according to law (C.C.C., R.S.C. 1970, chap. C-34, s. 454). As for the common law, it offers only uncertain protection for officers who, using reasonable force, act outside of these provisions of the *Code* to prevent "*breaches of the peace, or danger to life and property*".

Today, the primary source of police authority to apprehend and dispose of mentally ill persons derives from provincial health legislation (R.G. Fox & P.G. Erickson, *Apparently Suffering From Mental Disorder*, Research Report of the Centre of Criminology, University of Toronto, (1972)). There is still a provision in "*The Mental Health Act*" which provides for the apprehension by police and compulsory examination of a person believed to be in need of examination and treatment in a hospital. Once again however, the section is of little use in the case of suicides and other emergencies.

Its peculiar wording requires that the individual first refuse to be medically examined and following this, that an application be brought before a magistrate (now called a judge) to determine whether or not a warrant should issue permitting the apprehension and examination (C.C.S.M. cap. M110, s. 15).

In other respects *"The Mental Health Act"* is generally no less deficient. Indeed none of its provisions would appear to provide an appropriate method for handling emergency situations. Earlier we referred to section 9(1) of the Act which allows any qualified medical practitioner to certify that a person needs confinement for up to twenty-one days. This is an otherwise very effective provision, except when one considers that subsection (2) of the section makes it a condition for judicial compulsion (that is obtaining a warrant requiring the hospitalization) that the person in respect of whom the medical certificate has been issued *". . . refuses to go to a hospital"*, voluntarily. This state of affairs has proved to be undesirable in instances where it has been difficult actually to prove that the person did, either in the instance of section 15 (allowing for compulsory examination) refuse to be examined, or as in the case of section 9 (allowing for compulsory confinement) refuse to have himself admitted to hospital. The situation could arise as it did in the events we just described, where it is difficult to ascertain whether a person refuses to be examined or to comply with a certificate, or for example, where the person apparently agrees to submit himself for examination, but in fact does not do so.

Finally, section 8 allows anybody to convey a person believed to be medically disordered to a hospital without using violence. This section, however, seems to require a

willingness on the part of an individual to seek hospital care, so that in a situation where speed is essential, there is no power in police to compel an unwilling or violent person to go to hospital without a warrant from the Director of Psychiatric Services, a justice of the peace, or judge obtained under sections 9 or 15.

Since their enactment in 1965, controversy has surrounded these provisions of "*The Mental Health Act*", for the most part because of their deficiency in the area of emergency measures. The Manitoba Psychiatric Association (sub-committee on the revision of "*The Mental Health Act*", 1965) is one of a number of community health organizations which has highlighted these problems in its many appeals to the Manitoba Government since 1967. As with the Clarkson report, the Association has called for the amendment of this legislation and the immediate inclusion of provisions for the more effective handling of emergency matters, including a procedure which in certain circumstances would permit the apprehension and involuntary committal of an individual to hospital without the necessity or intervention of any justice, magistrate or other judicial officer.

All but one of Canada's ten provinces have mental health legislation which includes this type of provision. Only Manitoba provides a procedure which in all cases necessitates the prior issue of a warrant. The others, although there are variations among them, also concurrently permit the police to act without a warrant in necessitous circumstances.

In Quebec the police may apprehend without a warrant but if committal beyond 48 hours following initial assessment by one psychiatrist is necessary, a hearing before a judge is required (*Mental Patients Protection Act*, S.O. 1972,

c. 166, s. 21 amended by Statutes of 1974, c. 43, 71, 39). In Alberta, Prince Edward Island, Newfoundland, New Brunswick and Saskatchewan a person apprehended may be taken directly to a hospital and subjected to an examination whereas in British Columbia the police must first take the person to a physician and then only on his advice, to a provincial health facility or unit ("*The Mental Health Act*", S.B.C. 1964, c, 29 s. 27(1)). In Nova Scotia, a peace officer who apprehends a person for medical examination must file an official report with the provincial Attorney-General within 24 hours of the apprehension ("*The Hospitals Act*" R.S.N.S. 1967, c. 249 as amended by S.N.S. 1977 c. 45 s. 30(2)). If, as a consequence of a medical examination, the person is not certified for committal in an institution, the legislation in Alberta provides that he be released within 24 hours of his arrival at the facility ("*The Mental Health Act*", S.A. 1972, c. 118, s. 26(2)). In British Columbia emergency detention is limited to 72 hours. The other provinces vary, although most offer quite specific provisions obligating the police to release a person not certified or admitted.

In 1973, following the lead of these other jurisdictions and as a result of the conclusions of the Clarkson study, amending legislation was proposed by the Department of Health and Social Development to section 15 of "*The Mental Health Act*", and at the request of Cabinet referred by the Attorney-General to the Manitoba Law Reform Commission for our consideration. The effect of the suggested section 15.1(1), as proposed, is that a person "*suspected or believed to be in need of emergency examination or treatment in a hospital*", can be apprehended upon application for a warrant to a magistrate or justice of the peace and brought to a hospital for confinement and treatment. There would accordingly be no need to prove that a person refused to be medically examined,

a condition which, as we explained earlier, has proved undesirable because of the cumbersome and almost unrealistic way it requires a crisis situation to be handled. In draft it reads as follows:

> *15.1(1) Where a person in Manitoba is or is suspected or believed to be in need of emergency examination and treatment in a hospital, any person may apply to a magistrate or a justice of the peace for a warrant directing that the person be apprehended and brought to a hospital for confinement and treatment thereat as a compulsory patient.*

The amendment also included a special subsection patterned on a similar provision in the Ontario *"Mental Health Act"* (R.S.O. 1970, cap. 269, s. 10), concerning the action of a peace officer, as defined by the *Criminal Code*. Under this subsection if a peace officer observes a person *"apparently suffering from mental disorder"* and acting in a manner which *"in a normal person would be disorderly"* he would have the power to take that person without warrant to an appropriate place for medical examination. This section was essentially designed to allow action in emergencies including suicide attempts where a physician may not be readily available, and to get a person into medical hands without undue delay.

Subsection (2) of section 15.1, as it was then proposed, reads as follows:

> *15.1(2) Notwithstanding subsection (1) where a peace officer as defined in the Criminal Code observes a person*
>
> *(a) apparently suffering from mental disorder; and*
> *(b) acting in a manner that in a normal person would be disorderly;*

> *that officer may, if he is satisfied that the person should be examined in the interest of his own safety or the safety of others take the person to an appropriate place for medical examination.*

Since undertaking its review of these amendments, the Commission has had to come to grips with the relative importance of the two competing needs to which we have earlier referred. The one is the emergency apprehension of a deranged person; the other the preservation of the liberty of the individual who may be unnecessarily apprehended and later detained in an institution as an involuntary patient. In fact, the emergency apprehension power has been invoked under statutes similar to the Manitoba amendment in the United States, when the officer's conclusions as to mental disorder and the safety either of the individual or others were later found to be unjustified, and the subsequent detention questionable. This suggests that similar problems could arise in Manitoba. Thus while in some situations the amendment may offer an alternative to the freedom of a potentially dangerous individual, the possibilities of unlawful detention and the subsequent commencement of unwarranted treatment and extended committal clearly exist.

For example, although a warrant in criminal cases issued prior to the determination of the facts usually causes the arrested person to be brought before a court where he or she may have counsel and can be heard in opposition to the charge or other proceeding, the warrant envisioned in draft section 15.1(1) leads directly into hospital confinement *"as a compulsory patient"* without observation or examination by any qualified person. There is no opportunity for objection and the constable executing such a warrant literally need not

be concerned whether the arrested person is about to catch a plane, address a meeting, or start a new job. Furthermore warrants are issued on *ex parte* application. The draft provisions seem to accord no opportunity for a summary judicial hearing.

In addition, considering draft section 15.1(2) if the adjective *"normal"* as applied to a person is not a precise psychiatric designation, it can hardly acquire more precision when made into a statutory one. Normal persons sometimes behave in a disorderly manner and should not necessarily be carted off directly for compulsory examination at the discretion of a peace officer. In our view, this combination of vague statutory language and a police officer's usually limited qualifications as a diagnostician may present serious problems in applying the Manitoba amendment. The language, which authorizes detention of those believed to be mentally disordered and manifesting abnormal behaviour, in essence endows the police officer with a broad discretionary power. It is simply unclear what behaviour will fall within the literal language of the statute.

In Ontario the legislation defining the similar police power under section 10 of *"The Mental Health Act"* requires not only that the person apprehended be apparently suffering from mental disorder and observed to be acting in a manner that is disorderly, but also, that the peace officer be satisfied that the delay in obtaining a warrant by judicial process *"would be dangerous"*. Although it is certainly more consistent with the concern to maximize civil liberties than is the Manitoba amendment, section 10 was nevertheless much criticized by the McRuer Commission Inquiry into Civil Rights in Ontario, which labelled it "insufficient to safeguard

the rights of the Individual" (*Royal Commission Inquiry Into Civil Rights*, Report No. 1, Vol. 3 at 1233 (1968)).

The substance of the McRuer Commission's argument was that the powers granted to police by section 10 were much wider than the power to arrest given police officers in other cases and, that the wording in the section *"if he is satisfied that the person should be examined in the interests of his own safety . . ."* (which is identical in the Manitoba draft) was excessively subjective and should be replaced with an objective condition such as *"if he has reasonable grounds to believe"* or *"if he believes on reasonable grounds"*. This suggestion has since been incorporated into the Ontario statute and the present provision is one in which we find considerable merit (*"The Mental Health Act"*, R.S.O. 1970, c. 269, s. 10 as amended by *"An Act to Amend the Mental Health Act"*, S.O. 1978, s. 5).

We note too that the Ontario statute provides that upon apprehension by police, medical examination of the individual shall be conducted forthwith. In Manitoba's draft provision there is no such requirement and presumably committal could be indefinite. Although it might be lawful and authorized under statute, such detention would be arbitrary and undesirable. Very often medical experts will themselves disagree on the need for certification and it seems illogical, if not reckless, to expect the police to exercise a similar judgment which is not immediately subject to confirmation and committal, or prompt release.

OTHER AREAS OPEN TO CRITICISM

The Clarkson Report on Mental Health in Manitoba has suggested that, while the law should make it easier to

take emergency action, it should in turn make it harder to detain people in custody under the Act. In contrast to the draft amendment it recommends that *"The Mental Health Act"* be rewritten and that it incorporate the more scrupulous concern for the patient's civil rights that is included in other recent legislation. That is a principle with which the Commission is in general agreement. In our view the present *"Mental Health Act"* fails to ensure that persons subject to the mental commitment procedure will receive even the most basic procedural protections which are presently available in other types of legal proceedings. The draft amendment, in addition to its own shortcomings, falls far short of remedying even this.

For example, in the present *"Mental Health Act"* the Director of Psychiatric Services and the Superintendent of a hospital have broad sweeping powers of detention. Section 4(1) of the Act enumerates the powers of the Director who may admit and detain for examination and treatment as patients in any hospital such persons as he may deem proper to be so admitted and detained. Similarly in section 4(2) the Superintendent or medical officer in charge of a hospital may admit and detain for examination and treatment as patients in the hospital of which he is in charge such persons as he may deem proper to be so admitted and detained. In each case the Director and/or the Superintendent may designate any suitably qualified person to act on his behalf to carry out any or all of the duties to be carried out by him.

These sections would appear to give the medical officers involved an excessive amount of authority without holding them liable for negligence in discharging their duties. It does not, for example, appear to be required that the

Director or his designee entertain even a reasonable belief that an individual is mentally disordered and as a result in need of examination or treatment before his admission.

Furthermore section 94(1) of the Act provides that no responsibility for the detention or custody of a person rests with the officers or staff of a hospital where the person in question is held in accordance with its provisions. It appears to us that under these sections the Director's immunity may extend to render him free from tort liability even in the face of an allegation of gross negligence against him.

Aside from the Director and Superintendent *"The Mental Health Act"* also gives the medical practitioner a considerable amount of power in his or her own right. In Manitoba certification of a mental disorder by one medical practitioner, or by one psychiatrist, is all that is needed to commit a person to a mental hospital. This certificate may be based on a single medical examination which, along with the practitioner's belief that *"the person should be confined as a patient at a hospital"*, is all that is necessary to effectively deprive an individual of his liberty, legal rights and individuality, at least for an initial period of twenty-one days. Furthermore there is no time limit placed on how long may elapse after this examination before the certificate is written so that in theory a physician could examine a patient and issue a certificate weeks or months later, at which time his condition may well have changed.

Besides the examination predating the certificate, the certificate itself may not be acted upon for some considerable period of time. The experience of a woman who was

committed to Bellevue under a similar provision of the New York statute on the authority of a six week old certificate illustrates the abuse which this type of provision may cause.*

The certificate described several minor reasons for commitment, chief among which was the allegation that the woman in question was "guarding the public bathroom" in her Brooklyn hotel. But after the certificate was written, and two weeks before she was apprehended and committed, the woman had moved to another hotel with a private bath, thereby removing the principal reason for complaint (B.J. Enns, "Civil Liberties and Mental Illness", 7 *Crim. L.B.* 101 at p. 114 (1971)). We can only conclude that if a limit were placed on how much time could elapse after which a certificate could not be acted upon, this important change in circumstances would have become known, and in all probability the woman would not have been committed. Similar situations in Manitoba could also be avoided in this way.

Another report before us indicates that it is quite common in this province for physicians' certificates to be inadequately filled out and for no corroborating evidence to be elicited from relatives or anyone else (Dr.W.G. Lamberd, "Observations on "*The Mental Health Act*" and Proposals for Changes", 1978 (unpublished)). Frequently the certificate issued is taken to a provincial judge who then issues a warrant for apprehension of the patient which is carried out by the police under section 9. Apparently it is rare indeed for a magistrate to do anything more than read the

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*Section 78 of *The New York Mental Hygiene Law* is the standard admission section. Among other things it authorizes detention based upon nothing more than the unwritten, unsworn allegation of a layman. In this case, however, the woman was committed on the authority of a written statement from the Welfare Department.

certificate and sign the warrant. Of course the application is *ex parte* but the magistrate is empowered, although not required by the Act, to hear evidence under oath with reference to the medical condition of the patient.

The initial twenty-one day period of detention for a compulsory patient may be extended if in the opinion of a psychiatrist on the staff of the hospital, the compulsory patient is *"in need of treatment that is likely to extend beyond twenty-one days"*. This extension must be issued by the Director, a justice of the peace or a judge for such further periods as may be necessary. However, section 11(2) of the Act states that before making such an order under subsection (1) the Director, a justice of the peace or a magistrate shall consider such evidence as may be adduced before him with reference to the mental condition of the person and if he is satisfied that the person is in need of treatment as alleged he shall grant the order.

A recent study by two lawyers of Legal Aid Manitoba (A Guide to *"The Mental Health Act"* by April Katz and Norman Larsen, 1975, unpublished) indicates that there is relatively little consideration of any evidence by the provincial judge in these situations. It says this:

> A recent change under section 11 of the Act illustrates the point we are making about the reliance everyone has on doctors, and the awe with which doctors and the subject of mental illness are held by the legal profession. Section 11 provides that if a person in a hospital is considered by a psychiatrist to be in need of treatment that would be more than 21 days, an application to extend the person's stay beyond 21 days can be made to the Director of Psychiatric Services for Manitoba or to a justice of the peace or to a magistrate. Until 1974, certain psychiatrists in Manitoba were appointed as magistrates

with power to extend a person's stay in a hospital beyond the 21 days. The situation then was that the *same psychiatrist who was applying for an extension could also grant it!* The practice was all the more unsatisfactory by the fact that the Act does not require that the patient or his relatives be given notice of the application, neither the patient or anyone else has to be present for the hearing, and sworn evidence is not required. Part of the reason for the lack of such procedures may well be to save the patient embarrassment and stress, but clearly there could be better provisions for the needs and rights of the patient and his family.

In an apparent attempt to make the application for extension a more just procedure, it recently became policy to have all applications for extension heard by a judge of the Manitoba provincial judges court. The procedure now used in at least one Manitoba centre (which has a mental hospital nearby) is for the application to be sent to the office of the designated judge. Along with the application, the doctor sends a letter indicating that in his opinion further treatment is required. Also included with every application is a typed order of extension, completed and ready for the judge's signature. The standard procedure is for the order to be signed and sent back to the hospital without any hearing, and with the judge considering only the evidence submitted by the hospital. There is no chance for anyone to suggest anything, because no one except the hospital authorities and the judge know what is happening.

We do not say that errors are being made or that orders of extension are being wrongfully made. We do suggest that the procedure may be too simple, with little or nothing in the way of checks and balances to see that the patient or his family, or both, are informed and protected. We also wonder whether the court's involvement shouldn't be for more than giving standard and ready approval to the actions and wishes of medical people. The psychiatrists may not now be granting extension orders, but it seems that they might as well be.

It should be noted from the above sections and the comments on them by the Legal Aid authors, that a person who is admitted as a compulsory patient, whether it be under section 8, 9 or section 15 of *"The Mental Health Act"*, may be detained for up to 21 days under the initial committal order. At the end of that period an application may be made for an order to extend the confinement, if the person is, in the opinion of the attending psychiatrist, *"in need of treatment likely to extend in excess of twenty-one days"*, and the Director or justice of the peace considering the matter is satisfied that the person is so in need. This order once granted is indefinite and, in fact, can last for the life of the person unless and until the order is discharged by the Director or by the Superintendent or medical officer in charge of the hospital. No requirement that the person be a danger to himself or others exists for this compulsory and indeterminate detention. What is more, no notice of these proceedings need be given to the patient or to his/her next-of-kin.

Doctors tell us that these powers are not abused and that the usual period of extension requested and granted is two to three months, a period of time which bears a relationship to the usual clinical course of mental illness and its meaningful treatment. In general the medical profession maintains that wherever possible an attempt to contact the next-of-kin is made. The legislation however prescribes no such limit, either on the length of a given period of extension or on the number of extensions of treatment that may be requested. Thus it would seem that the Act carries with it a dual potential for abuse. Persons committed under it can be held for the rest of their lives and in most of these cases, as demonstrated by the Legal Aid report, will

never receive a proper judicial hearing.

To borrow again from the Legal Aid Report, ""*The Mental Health Act*" is very much a doctor's law", with, it would seem, very little in the way of adequate legal safeguards. As we have seen, committal under the Act can potentially result in incarceration for a period extending up to a person's lifetime. In actuality it continues indefinitely until the person who is detained as a compulsory patient is "*in the opinion of the Director or Superintendent of the hospital where the person is confined, recovered from his mental disorder and competent to act for himself*" (section 24(1)).

This immense power which the legislation gives to the Director of Psychiatric Services and other medical professionals has not, unfortunately, been balanced by any spelled out appeal procedure by or on behalf of the patient, such as a review board, a tribunal or other mechanism. An appeal will lie as of right from the Director's, etc. decision to a judge of the County Court and is provided in section 26(1), with a further appeal to the Court of Appeal. But while section 26(1) gives the right of appeal from "*any order, decision or ruling*", medical certificates committing an individual to hospital for examination or treatment do not appear to be included in this section. In any event, the right of appeal to the Court of Appeal is exercisable only on a question of law to determine the legality of the detention. This right is rather insignificant, as the determination of a person's sanity is always a question of fact, not law. As far as we could determine there has never been such an appeal in Manitoba, a fact which would appear to leave the matter of

the propriety of confinement or discharge very much in the discretion of the medical profession.

Certainly another of the possible contributing factors to the lack of recourse and appeals carried to our courts under "*The Mental Health Act*" is that the onus of coming forward and initiating the legal process has always been on the patient. Unless he is very aggressive (and many mental patients are not) it is unlikely that a person committed under the Act will challenge the supervising psychiatrist and attempt to appeal his hospitalization. Furthermore no one is required by the statute to notify patients of their legal rights of appeal. Sometimes family members are aware of available legal remedies or have been told of them but the obvious problem with this is that the family interests and those of the patient may be in conflict. In contrast to the legislation in other jurisdictions and indeed to the *Criminal Code*, Manitoba's mental health legislation gives no heed to these conflicting interests and conditions.

Under federal law there must be a periodic review of all those persons held in institutions who have been found not guilty of criminal offences because of their mental condition. Only these cases are reviewed by the Mental Board of Review every six months at the instance of the State. While there is such a board to deal regularly with patients confined to mental institutions following criminal charges there is no similar machinery for other mental patients.

For several years now the Manitoba Division of the Canadian Mental Health Association has been requesting amendments to the provincial legislation to guarantee the mandatory

review at regular intervals of all patients compulsorily confined to hospitals. Without such a review process, says the Canadian Mental Health Association report, there is no guarantee that a patient will be examined regularly to see if his mental condition is such that he is improved or recovered adequately to the point where he could be released. If an order is granted which would confine a patient to hospital for a lengthy period or even permanently, the patient could conceivably be "forgotten". That very situation revealed itself in Alberta after the discovery, some years ago, by the Alberta Ombudsman of a man who had needlessly spent more than 20 years in a mental institution.

In Manitoba, the Ombudsman's function with respect to "*The Mental Health Act*" has been to check and investigate, on written complaint or his own initiative, all matters relating to its administration leading up to and subsequent to, detention. According to the Ombudsman this might include a review of certification by medical practitioners (section 9(1)), warrants to apprehend and convey (section 9(2)), orders of extension (section 11(1)), changes in status of patients from voluntary to compulsory or vice versa, as well as notifications of relatives and so on.

While the work of the office of the Ombudsman may go a long way to restore our and the public's confidence in the fairness of the mental health system and its concern for individual rights and due process, in actuality his jurisdiction and authority are severely limited. He is empowered to deal only with matters of administration as distinct from matters of professional opinion by medical or psychiatric doctors so that he has, for example, no statutory authority

to question or initiate a review of a medical opinion, either as to the committal or continuing detention of a patient. In practice, where patients or their families are dissatisfied with the diagnosis or decision of a medical practitioner or the medical staff at a hospital, they may submit to the Ombudsman the name of a psychiatrist of their choice and arrangements may be made by his office for an independent psychiatric assessment. This procedure is not, however, a matter of right and while the Directors of some of our mental health institutions have accepted the Ombudsman's recommendation for an independent examination on a number of occasions, the practice is truly an informal one which continues because of the cooperation and goodwill of these various hospital officials (Manitoba. Office of the Ombudsman, *Report of the Ombudsman*, Jan. 1, 1973 - Dec. 31, 1973, 9, 77-79, 87-89).

In addition, the Ombudsman is further restricted by section 18(d) of "*The Ombudsman Act*" (C.C.S.M. cap. O45) which actually bars him from investigating "*any decision, recommendation, act or omission in respect of which there is, under any Act, a right of appeal or objection or a right to apply for a review on the merits of the case to any court or tribunal . . . whether or not that right . . . has been exercised in the particular case . . .*" unless "*it would have been unreasonable to expect the complainant to resort to the tribunal or court . . .*".

Inadequate as these remedies are, the problem for the mental health patient is further aggravated by the fact that he will in all probability, be ignorant of them. If a person is charged with a criminal offence the court will see to it that he has legal representation, especially where he is unable to afford its cost. Such, unfortunately, has not

been the case where the question of an individual's liberty is before the quasi-judicial administrative officers and other officials who operate pursuant to "*The Mental Health Act*".

In our view, adequate safeguards have not, on the whole, been built into this Act, either to provide the mental health patient with appropriate medical review or, alternatively, recourse to the courts. There is a general consensus among the members of our Commission that changes in Manitoba's "*Mental Health Act*" are necessary. We are also in basic agreement as to what some of these changes should include: for example, more efficient emergency apprehension procedures should be enacted, the Act should permit a law officer to detain a person who seems to be dangerous as a result of mental illness and to convey that person to a psychiatric facility for assessment - without a warrant from a judge or magistrate. However, the criteria for committable mental disorders should be made more precise: there ought to be a strict time limit on initial confinement, after which a review should be mandatory; mental institutions should be legally required to give a patient a complete explanation of his rights; and friends and relatives should be notified promptly. The initial commitment of a patient should be reviewed by an independent tribunal, judge or psychiatrist - not by the same doctor or psychiatric facility which initiated committal.

In addition the present practice of discretionary hospital discharge is unsatisfactory. In its place should be some form of automatic, periodic review of each patient's present condition and his/her need for continuing hospitalization. The Review Board might, for example, determine that the

detention and treatment of a person be continued on a compulsory basis or, in the alternative, order that the person be released, or that he be permitted to remain in the facility as a voluntary patient. Patients and their friends and families who still feel aggrieved might also have some self-initiated period right of access, at little or no cost, to the review tribunal for appeal, as well as having available the existing procedures of *habeas corpus*, appeals to the County Court and the assistance of the provincial Ombudsman.

PUBLIC RESPONSE

Having considered these and other matters, the Commission prepared some tentative proposals which were circulated to certain interested persons and organizations in the province's mental health system, including the Department of Health and Social Development, the Canadian Mental Health Association, the Manitoba Psychiatric Association and others who had demonstrated some interest in and knowledge of the subject. These proposals were prepared as a legislative draft but were far from final in both content and form, even as tentative proposals. They were, however, intended as a working draft to stimulate discussion and response and to delineate certain notional ingredients which we wished, at the very least, to recommend as essential reforms.

In the main, these proposals incorporated the Commission's view at the time, that a person should be detained and treated only insofar as is necessary to restrain him and to relieve immediate danger to that person or to others. If he then fails to commit himself as a compulsory patient, the person should have the opportunity to contact his or her family, lawyer, physician or friend, etc., before he is

required to submit to any medical examination. The inquiry as to whether the person will be admitted as a compulsory patient and examined and treated or not should be either "in camera" or in open court at the option of the person.

The Commission was also unanimous at that stage, in asserting that there ought to be a regular and frequent review of all compulsory patients.

We now have copies of a large number of responses to these proposals. These responses, in the main, express a rather negative view of our proposed "due process" provisions. In general, the approach taken by many physicians has been that *"The Mental Health Act"* should provide for formal (involuntary or compulsory) emergency treatment as expeditiously as possible. The issue of effective emergency procedure raises a "chicken-or-egg" question which the Commission had earlier resolved in favour of adjudication first, to be followed by examination and treatment.

Many members within the medical profession are opposed to this view, however. Their representations indicate that in practice, where a person is behaving *"dangerously"* there will be no time for judicial review and no time to question a medical certificate or to consult a friend or counsel. In their view the expediency of these situations demands that the patient forgo his civil rights and that he be examined and treated before legal proceedings to question the detention are heard. Part and parcel of that requirement is that the Act itself should continue to allow the medical health officials the necessary leeway for informed and professional judgments.

By way of specific example, we cite the thoughtful response of staff members at the Brandon Mental Health Centre and the Selkirk Mental Health Centre, from many of whom we heard, either as groups or individually. In general their assessment was that:

(a) the procedures suggested were unwieldly;

(b) the procedures, if implemented would probably obstruct the obtaining of treatment for some patients;

(c) emergencies would not be well handled;

(d) the suggestions tended to encourage an excessively "legal" approach to an essentially medical problem; and

(e) the emphasis on civil rights was theoretically tenable, but rested on an absence of evidence that there has been any reason to be concerned that civil rights are not protected in fact, by the present system.

The Manitoba Psychiatric Association also reported considerable objection to our proposals by its members. After a study of them for a period of some eighteen months, the Association expressed its opinion to us by means of a number of resolutions adopted by its general membership, reiterating its long-standing view that emergency apprehension procedures were necessary to facilitate the care and treatment of persons who seem to be dangerous as a result of mental disorder, as follows:

> #13 . . . that a peace officer or constable may apprehend a person, whom they judge to be so emotionally disordered as to be a danger to themselves or others, by reason of his actions.
>
> The peace officer or constable may then bring the emotionally disordered person to a psychiatric treatment facility for a medical examination.

Notwithstanding this resolution the Association seemed to agree that, given the past record of civil commitment some legal modification in most other areas of the mental health process was essential to ensure that rights of the mental health patient will in future be protected while he is under the care of the psychiatrist or psychiatric facility in question.

Not all of our psychiatrist correspondents expressed negative opinions of the type of legislation we proposed. One opinion which not only seemed to lend support to our draft provisions but indeed to go much farther was outlined in part as follows:

> Some of the principles to be considered in new proposals for mental health acts are as follows:
>
> 1. Principle of the least restrictive setting. This is that no person should be admitted to a treatment facility unless a prior determination is made that the facility is the least restrictive setting necessary for that person.
>
> 2. Principle of informal admission. No person should be formally, that is compulsorily, admitted to hospital unless it has been previously determined that he is unwilling to enter informally.
>
> 3. Principle of the right to treatment. The use of compulsory powers on the grounds of mental disorder is only justifiable when there is a good prospect of benefit to the patient from the treatment proposed and a patient should only be formally admitted to hospital if he is capable of benefitting from treatment.

4. Rights of hospitals. Hospitals should not be compelled by law to admit compulsory patients. They should judge the need for admission on medical and social grounds only.

5. The principle of mandatory review and appeal. There should be a mandatory review of all patients compulsorily confined to hospitals at regular intervals. The burden of coming forward should be on the review and appeal system and not on the patient or his relative.

6. The principle of "best interests of the child". In the case of children parents' interests do not necessarily coincide with the interests of the child and in these cases issues should be decided by a review body in the best interests of the child only.

7. The principle of patient rights. Both formal and informal patients should have certain designated rights. These rights should be outlined in mental health legislation.

We have set out in some detail the tenor and in a few instances, the actual expression of the responses of those persons and organizations who are closely affected by and concerned with *"The Mental Health Act"* not only because it is useful in formulating our own recommendations but because in this case the details reveal two important conclusions: (1) that the strong opposition to our proposals stems largely from the medical profession's desire to see enacted effective emergency procedures; and (2) that otherwise the profession is committed, or at least responsive, to the need for reform in the area of civil safeguards for the mental health patient. We have been persuaded to re-examine this issue to re-evaluate our original proposals in light of these factors.

CIVIL COMMITMENT IN OTHER JURISDICTIONS: NEW LEGISLATION

As mentioned previously, most of the mental health legislation throughout Canada does make provision for the police to apprehend and detain allegedly mentally ill persons without a warrant. At the same time, however, the legislation in some of these provinces, in particular Alberta and Ontario, which are the forerunners in this field, and more recently Nova Scotia which enacted new legislation in 1977, so jealously safeguards and protects the rights of the mentally ill on admission to hospital that it is in this respect, amongst the most progressive in Canada.

"The Mental Health Act" (S.A. 1972, c. 118) was passed by the Alberta Legislature on November 22, 1972 and since its proclamation has been the subject of continual revision. According to reports the expressed purpose of this legislation is to provide advanced civil liberties protection, insofar as this is consistent with the effective treatment of mental disease.

For example, the Act prescribes very specific limitations under which a person can be involuntarily admitted to a treatment facility. A form issued pursuant to section 25 of the Act, which refers to an involuntary conveyance and examination certificate requires the signature of a registered therapist or a physician. This form certifies that the therapist or physician has examined the person named in the certificate and that in his opinion the person is suffering from a mental disorder and is in a condition presenting a danger to himself or others. This certificate is not valid unless it is completed within 72 hours of the personal examination of the person named in the certificate.

Once completed by the therapist or physician, the certificate is sufficient authority to convey the person named to a *"facility"* and for one or more therapists or physicians to prescribe for, to treat, to care for, detain and control the person while he is being so conveyed until the time he arrives at the facility for a period of 24 hours thereafter.

We also note that as soon as possible, but in any event not later than 24 hours after his arrival, a physician and a therapist or two physicians, after independent examinations, must confirm the order of conveyance and examination by certifying that the person is suffering from mental disorder, is in a condition presenting a danger to himself or others, and, is unsuitable for admission other than as a formal patient. Otherwise the person will be released.

The fact that the Alberta legislation authorizes accredited therapists to participate in the commitment of its patients is consistent with the fact that today many people actually receive counselling and treatment for their mental disorders in their homes, long before they reach the stage where they have to be admitted to hospital for more formal help. Physicians, in particular psychiatrists, are not after all readily available to see patients in a home setting. As a result, this task must be delegated to other suitably qualified individuals. In Manitoba, for example, it is not doctors but social workers and more usually, registered psychiatric nurses (R.P.N.), who now go out into the community treating people on an out-patient basis.

In fact however, what began as an attempt to implement this simple practical concept in Alberta has apparently

aroused a storm of debate in that province concerning the competence of types of therapists to diagnose and treat mental illness. As a result, Alberta therapists have never actually been registered or empowered to act pursuant to this legislation and there is now a proposal before the Alberta Legislature to remove these sections from *"The Mental Health Act"*. In their place, however, there is a further proposal under consideration by the Alberta Department of Social Services (Mental Health Services), to seek the creation of a special category of individuals each empowered simply to take a patient to a physician or facility for examination. It is envisaged that there will be a relatively large number of such individuals, many from the public health professions but others of whom might lack formal qualifications but who would nevertheless be community leaders.

Apart from the prescription of treatment, this Commission considers that the use of registered psychiatric nurses to assess the need for and to compel psychiatric examination is appropriate. While we appreciate that there is psychiatric expertise in many of the public health professions, including registered nursing (R.N.), social work and psychology, we nevertheless believe that next to physicians, registered psychiatric nurses are best qualified to deal with mental illness. In our view, these personnel, who take a training course of two years in length, and are strictly regulated under *"The Registered Psychiatric Nurses Association"* and *"The Psychiatric Nurses Training Act"* (C.C.S.M. cc. P170, P180) are competent to recognize potential cases of mental disease and, within prescribed limitations should be permitted to sign conveyance certificates so that a patient may be

taken to hospital for an examination at an early stage. Qualified psychiatrists would then be available to examine the patient to determine whether or not further care and commitment are necessary. We think that the use of the registered psychiatric nurses in this way would be an important element in crisis intervention and is in line with that approach which is more reliant on community resources.

In Alberta, a person may also be conveyed to a treatment facility when information on oath is brought before a provincial judge setting forth the grounds, as above, on which it is believed that such person is suffering from a mental disorder, and is in a condition presenting a danger to himself or others. The provincial judge is then required to make an inquiry and, if satisfied that an examination of the person is appropriate in the interest of safety and can be arranged in no other way, may issue a warrant to apprehend and convey the person for examination at a treatment facility.

As stated, if a peace officer observes a person *"apparently suffering from mental disorder"*, in a condition presenting a danger to himself or others and acting in a disorderly manner, and the circumstances are such that to proceed to obtain an order from a judge authorizing the apprehension and examination would be dangerous, the peace officer may take that person to a facility where he will be detained 24 hours until he is examined.

In each of these cases, if a certificate of conveyance and examination is confirmed within the 24 hours by two physicians or by a therapist and one physician, the patient may be observed, examined, cared for, treated, controlled and detained at the treatment facility for a period of one month from the date the second admission certificate is issued.

We also note that the Alberta legislation prohibits the detention of a patient in a mental institution for an indefinite time period. The longest period in respect of which a certificate of renewal may be issued is six months, and this certificate may only be issued after two other certificates of renewal for a period of no more than two months have already been issued.

Not only does the concept of issuing renewal certificates prohibit the admission of a patient for an indefinite period of time, but it also provides for a systematic review of the patient's condition. For example, the Act prohibits the issuance of renewal certificates, either by physicians or therapists, unless first of all, they have personally examined the patient and, secondly are of the opinion that the patient continues to suffer from a mental disorder to the extent that he is in a condition presenting a danger to himself or others. Also the period of detention will not be extended unless at least two renewal certificates are so provided. Further periods of extension are not permitted unless renewal certificates are issued prior to the expiry of the initial one month detention period from the date of admission. Subsequent certificates must be issued prior to the expiry of the term of the immediately preceding certificate, otherwise the patient becomes a voluntary patient not subject to detention and is to be properly advised of this fact.

CERTIFICATION AND REVIEW

The Alberta statute provides the additional procedural safeguard of an independent panel or review board. This panel is composed of legal and psychiatric experts who are independent of hospital administration and who are empowered to review and approve or cancel certificates of admission, renewal and incapacity. Mandatory hearings

before this panel are not automatic but the patient does have the right to a formal hearing at his request with some restriction on the number and timing of these applications.

The idea of the establishment of a provincial mental health review tribunal is not new; nor is it unique to Alberta. In fact a somewhat similar scheme was suggested for adoption in Manitoba in 1973 when, at the time Cabinet considered the amendment regarding police emergency apprehension procedures, it considered a further proposal to expand the present jurisdiction of "The Minister's Board" established under Part II of "*The Mental Health Act*" to review the cases of mentally retarded persons in this province, to include reviews of hospital patients who suffer from mental disorders within the meaning of the Act. The intent of this amendment was to provide both a yearly review of each patient's case, as well as a procedure whereby, on behalf of patients, their families and friends could apply on request, *at any time* within that year, for hospital discharge. The specific provision as it was then proposed, follows:

> *s. 26.1(1) The board established under Part II (s. 28) shall at least once a year review the case of every person who is confined at a hospital under this Act for a year or more and after the review may*
>
> *(a) determine that the detention and treatment of the person be continued; or*
>
> *(b) order that the person be released from the hospital.*
>
> *s. 26.1(2) Notwithstanding subsection (1), the parent or guardian of a person confined at a hospital under this Act, or any person mentioned in subsection 8(1) may, at any time, apply to the board to have the case of the person reviewed and the board may deal with the application in accordance with subsection (1).*

While we are of the opinion that it is commendable that a Minister's or other Board of Review should review the cases of patients detained in hospital, whether on a voluntary or compulsory basis, at least once a year, we are not of the opinion that this suggested amendment be passed into law. In our view more specific, detailed and studied provisions are required.

For example, section 28 of the Act, which deals with the composition of "The Minister's Board" provides for the appointment by the Lieutenant-Governor-in-Council to it, of no fewer than five and no more than ten persons, two of whom shall be duly qualified medical practitioners, one a member of the Law Society of Manitoba and at least two of whom shall be appointed from the citizens of the province at large, and of whom neither shall be a duly qualified medical practitioner nor a member of the Law Society. With the exception of these requirements, however, no other guidelines, regulations or prohibitions exist to determine qualification for membership on this board, a situation substantially different than in most other jurisdictions where review boards are already operating. Moreover, in other jurisdictions the number of members serving on review panels is generally not greater than five and frequently less.

In Alberta, where the Minister of Social Services and Community Health is obliged to establish one or more review panels for the province, four-member panels each comprised of a psychiatrist, a physician, a solicitor and a person representative of the general public, have been appointed for each hospital. Prior to the 1972 amendment of this Act however, the Alberta legislation provided for a three-member panel. This same approach has been adopted in

England, where the Lord Chancellor has established review tribunals for each Regional Hospital Board. Once again, their composition is governed by legislation which, very briefly, requires that each tribunal consist of representatives of the legal and medical professions as well as lay persons. As for the lay members, they must have *"such experience in administration, such knowledge of the social services or such other qualifications or experience as the Lord Chancellor considers suitable"* (Wood, "Mental Health Review Tribunals", 10 *Medical Science and Law* 86, 88 (1970)).

In the Commission's view the establishment of one or more three-member panels as in the English and earlier Alberta legislation would be preferable to the establishment of the large review board envisaged by draft amendment s. 26.1(1). Although a larger body might attract a wide range of representation to its membership it might also produce problems in scheduling meetings and hearing dates, resulting in a slow down in the process of review. In our view a small panel would operate more speedily and efficiently. In addition to the advantage of size however an odd-numbered panel of three members will also dispense with the need to employ a tie-breaking procedure in the person of the Chairman, as in Alberta.

In Ontario, the creation of review tribunals has been criticized by the McRuer Commission Inquiry Into Civil Rights because their establishment in that jurisdiction appears to be entirely within the discretion of the provincial Lieutenant-Governor-in-Council (Report No. 1, Vol. 3 at 1235). Section 27(1) of the Ontario Act merely states that the Lieutenant-Governor-in-Council *"may"* appoint a review board for any one or more psychiatric facilities. In Alberta the

establishment of these boards is mandatory, as it should be in Manitoba. In our view, the appointment of members to the review panels should be guaranteed by statute and each should be required to be composed of at least one psychiatrist and one solicitor. The selection of the third member is perhaps best left to the discretion of the Minister whose responsibility it should be to encourage citizen involvement as he sees fit.

Not all of our members favour this approach however. There are some of us who believe that greater medical representation on each panel is necessary, for one thing, because it will likely result in a panel more usefully equipped to determine the medical questions which will surely come before it. The majority of us do not agree. In our view it would be unwise and disruptive to the routine of the institutions to require any greater number of psychiatrists or medical practitioners than is absolutely essential to be available for the hearings of the various review boards. Besides this however, we suspect that over-representation of the medical viewpoint is prone to result in just that - too medical an approach to the question of discharge, for example. With due respect to all of the professions, there is a growing feeling on the part of those outside the professional circles that law is too important to be left to the lawyers, education too important to be turned over totally to teachers, and medicine too important to have only doctors make ethical and moral decisions. In our view a more balanced judgment is desirable and, while ever acknowledging the expertise of the medical profession on matters of health, we are inclined to adopt the opinion of Professor J.C. Wood that "*the coming together of legal,medical and social viewpoints, with each considered on an equal footing produces a balanced judgment that should, if communication is successfully established, [provide] the*

best chance of achieving good sense and sound judgment".

The Commission is divided on the question of which persons to exclude from sitting on boards of review because of bias. Earlier, we referred to the fact that the proposed amendment for the expanded operation of the "Minister's Board" contained inadequate provisions for the qualification of its members, particularly if it were to review the cases of mentally disordered patients. As with any court of law, the integrity of an administrative board or tribunal depends upon its actual and perceived objectivity. Without statutory prohibitions, impartiality is difficult to maintain, especially where members of the board have experienced professional involvement with patients.

In order to obviate this problem, in Alberta, no person who is related by blood or marriage to a person applying to the panel, no psychiatrist who is treating or who has treated an applicant and no solicitor who is acting or has acted for an applicant is eligible to sit as a member or an alternate member of a panel. Furthermore no person who is serving as a member of the staff at a facility is eligible to sit as a member or alternate member of the panel when it is considering an application from a patient of the facility with which he is connected.

While a number of our members have suggested that the solution adopted by the Alberta Legislature would be satisfactory for enactment in Manitoba at least two of us are concerned that the exclusion of staff members noted above, is too broad. According to these members, psychiatrists and other medical personnel who have admitting privileges at certain Manitoba hospitals are known as their consulting or

associate members of staff. In view of the large numbers of psychiatrists who would be disqualified as a result of the position adopted by such hospitals, it is proposed that the legislation exclude as panel members only active or full-time members of staff where the person appearing before the panel is from that facility. Only these personnel it is suggested, have a sufficiently strong connection or association with a facility to infer some partiality or interest in the outcome of a patient's review. In addition, these Commissioners suggest that the Alberta provision could be usefully strengthened by restricting members of a lawyer's and psychiatrist's family, as well as the lawyer and psychiatrist in question, from sitting on a panel where the psychiatrist or lawyer acts or has acted, treats or has treated the applicant.

Only one of our members has indicated strong objection both to the Alberta provision and to the proposal for its improvement. According to this member, no person should be eligible to sit as a member or alternate member of a panel when it is considering an application for review by a patient with whom he or she is acquainted.

For the most part, however, we are in agreement. On the whole we are much impressed by the Alberta legislation, its procedures for committal and in particular those of its sections which deal with the provision of information to patients regarding their rights of access to the review boards. These sections are specifically designed to provide special assistance for mental health patients, many of whom have difficulty both in articulating their concerns and in appreciating the significance

of their legal remedies. For example, in conjunction with this scheme the Alberta mental patient has the right (a) to be informed of the reason for his admission or continued detention *"in simple language"* and (b) to be given a written statement of the authority of his detention, the function of the review panel and his right to apply to it for judicial review. Interpreters are required to be used where necessary.

An applicant or his representative has the right to cross-examine during the presentation of evidence to the panel. If in the opinion of the panel there may be an adverse effect on the applicant's health by his presence, he may be excluded. In that event however, the review panel must see to it that a person is appointed to act in the patient's behalf if he does not already have representation.

In Ontario the review board has a similar jurisdiction. Patients involuntarily committed have a right to committal and renewal hearing and the state cannot continue to detain unless it can once again show that without hospitalization *"the patient is suffering from mental disorder of a nature or quality likely to result in serious bodily harm to the patient . . . another person; or imminent and serious physical impairment of the patient"*.

The review process is initiated by the patient but on the completion of the fourth certificate of renewal (after 9 months + 2 weeks) and on completion of every fourth certificate of renewal thereafter (every 12 months), the patient is deemed to have applied in prescribed form to the chairman of the review board for a hearing. As a further safeguard the Ontario statute requires a physician who certifies an involuntary admission or renewal, to give a notice

in writing of completion and filing of the certificate to the patient in question and *"to the area director for the area, in accordance with the Legal Aid Act, in which the psychiatric facility is located"*.

The provision in Ontario giving access to a *"patients' advocate"*, is in our view a very significant one. Even in jurisdictions where there are already established review boards, studies show that a vast number of mental health patients are totally unaware of their existence and purpose. Psychiatric staff often do not inform patients of their rights, either to appeal or to apply to Legal Aid for representation. In some jurisdictions, however, Alberta for example, the legislation contains provisions designed to ensure that the patient knows of his right to apply to the panel for cancellation of the certificate authorizing his detention. This information must be communicated by written statement which is supplemented by posters on conspicuous display in all psychiatric wards in the province, announcing the availability of legal aid to help qualifying patients to bring application for review (Margaret Ann Shone, "Confluence of the Mental Health and Legal Systems on the Process for Compulsory Civil Commitment in Alberta", unpublished LL.M. thesis, University of Alberta, 1976, p. 157).

In Nova Scotia, *"The Hospitals Act"*, 1967 (R.S.N.S. c. 249 amended by S.N.S. 1977, c. 45) also contains provisions to assist patients in exercising their rights under that legislation. These include directing the hospital facility to provide the patient with:

> *(a) advice in written form regarding rights to all patients or persons admitted for observation regarding . . .*

(iv) the right to counsel, [and]

(v) the right to have a file reviewed by a review board or a court, . . .

The facility is also directed to assist

(b) . . . any patient or person who is unable to read or understand and who wishes an oral explanation of any document or written communication with which the patient or person is concerned;

(c) . . . any patient or person admitted for observation who wishes to contact a barrister; and

(d) . . . any patient or person admitted for observation who wishes to apply for a review by the review board.

Without immediate access to objective legal assistance such provisions may nevertheless be inadequate and, as a result, the review board process actually inaccessible. Handing a piece of paper to someone who is in an extreme emotional or drugged state can hardly be considered appropriate notice of one's legal rights. Nor can the hospital staff always be counted upon to be objective advisers. In the case of family members, we can easily envisage instances where they will be unavailable to receive notice on behalf of a patient or alternatively where the family is itself instrumental in invoking the process by which the patient has come to be institutionalized. In each of these, the family will be unable or unwilling to render assistance, leaving the patient in an appalling predicament, with no one to intervene in his behalf. With the aid of a "*patient's advocate*" however, the patient will be assisted in retaining counsel or at the very least in assessing the desirability of bringing an application for review. Although we do not favour the use of the Legal Aid system in Manitoba for this purpose, we agree that there must be some form of

protection for the patient who is not in a position to understand or act pursuant to a notice of his rights. Specifically we suggest that a "Patients' Advocate" be made available in all psychiatric facilities to intercede in matters concerning the rights of patients. This office might best be established through the office of the Public Trustee.

GROUNDS FOR COMPULSORY ADMISSION

The recently amended Ontario statute also utilizes a narrower, more specific commitment standard, requiring that the grounds for involuntary admission be (i) serious bodily harm to the patient; (ii) serious bodily harm to another person; or (iii) imminent and serious physical impairment of the patient, unless the patient remains in the custody of a psychiatric facility as an involuntary patient. Under the former standard (ie. *"in need of hospitalization in the interests of his own safety. . ."*) it seems to have been extremely difficult to challenge the opinion of doctors that the allegedly mentally ill person required hospitalization. As a result the new definition could be the most significant reform in the new legislation because it will probably substantially narrow the scope of the commitment procedures in Ontario and provide much more objective criteria for determining who is properly subject to involuntary committal.

The question of the criterion for involuntary admission to a psychiatric facility has, of necessity, been a central part of our own discussions concerning changes in the Manitoba law. There is an immense variety of opinion which exists on this issue.

Recent statutory enactments indicate a trend toward restricting civil commitment to the *"dangerous"* mentally ill, and toward limiting the type and increasing the severity of harm necessary to support a finding of dangerousness. One study indicates that since 1959, the use of the concept of "dangerousness" or "likelihood of serious harm" *has markedly increased* in use as a criterion for committal in the United States where the various *state legislatures* have been actively involved in the recodification of their statutes (The Laboratory of Community Psychiatry, Harvard Medical School, The Centre for Studies of Crime and Delinquency, National Institute of Mental Health, *"Civil Commitment and Social Policy"*, final report, 1978). Sometimes more detailed and explicit requirements have been enacted, such as for example, those found in Arizona, where a prior act inflicting substantial bodily harm on another within the twelve months preceding the hearing is necessary for committal (Ariz. Rev. Stats. Ann. s.26-507(3) 1974). While few statutes are this specific, many now limit the type of harm or danger necessary for committal to *"physical injury"*. As mentioned previously, this is the criterion now in use in the province of Ontario; an approach which may have been dictated by that legislature's desire to limit the use of involuntary commitment in favour of increased de-institutionalization and community-based health services. The explicit reference to *bodily harm* in the Ontario legislation should result in more factual material and more stringent and explicit evidence of the likelihood of dangerousness before committal.

There are however some who believe that there is an undue emphasis in the Ontario law on the relationship between psychiatric illness and physical violence. In their

judgment the numbers of *"dangerous"* mentally ill are small and, by comparison, there are many more non-dangerous mentally ill persons requiring help who would not be brought into the hospital scheme as a result of criteria which are confined to physical abuse. In fact, if the criteria in Manitoba were similarly narrow, and restricted to physical harm - physical bodily harm, that is - a number of categories of mentally disordered patients would not be subject to the proposed law.

One category of patient is the patient who is causing severe emotional or mental stress, psychological harm not physical harm, to family or friends. Another is the usually "manic depressive" individual, who, by reason of his illness, has wasted and/or is continuing to waste his assets to the detriment of the family. Both of these examples are major problems to which such legislation is not addressed. Examples abound of family members, especially children, friends and business associates, who suffer emotionally as a result of the strain they must endure in day-to-day contact with the afflicted person. And, if we accept that an individual can inflict on another mental damage which is as great as physical damage, then the criteria for admission for psychiatric care should be broadened.

One possible suggestion for improved criteria might be those in place in the State of Iowa. The Iowa Code is unusual and includes within it as eligible for involuntary commitment *"a person who is likely to inflict serious emotional injury on the members of his or her family or others who lack reasonable opportunity to avoid contact with the afflicted person if the afflicted person is allowed to remain at liberty without treatment"*. By removing the

exclusive emphasis on the physical this alternative makes the criteria of harm substantially broader than those found in Ontario. At least one of our members advocates adoption of this proposal.

Another possible method of expanding the criteria beyond those found in Ontario would be to enact the following:

> *(1) Where a physician examines a person and has reason to believe that the person,*
>
> *(a) has caused or is causing harm to himself;*
>
> *(b) has behaved or is behaving violently toward another person or has caused or is causing another person to fear harm from him; or*
>
> *(c) has shown or is showing a lack of competence to care for himself,*
>
> *and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a quality or nature that will likely result in*
>
> *(d) serious harm to the person;*
>
> *(e) serious harm to another person;*
>
> *(f) serious physical or mental deterioration of the person; or*
>
> *(g) serious loss of family stability, finances or property*
>
> *the physician may make an application in the prescribed form for the admission of the patient.*

Still another approach would be to adopt a provision similar to that of the Alberta Act. Alberta uses broad criteria and relies heavily on the judgment of its medical profession, the members of which must certify not only that

a patient suffers from a mental disorder and is in a condition presenting a *"danger"* to himself and to others, but also that he is unsuitable for admission other than as a compulsory patient. Two members of the Commission favour this proposal.

The opinion of the three remaining members of the Commission is not to expand the Ontario criteria beyond those of physical danger. The chief reason for this view is a desire to ensure that non-conformists will not be subject to involuntary hospitalization. Virtually every alcoholic might, for example, be committable under the broad criterion of "harm" or "danger" to himself and families could plead that they were suffering excessively and seek committal of these relatives. Similarly parental distress over children joining cults or adopting offbeat lifestyles might be considered grounds for committal of youngsters. Accordingly it is suggested that the Manitoba legislation adopt the standard now in force in Ontario and abandon as far as possible the rather loose and subjective standard of the present law. While we are unable to present a majority recommendation on this issue the Commission is unanimously of the view that, whatever the criteria, no person should be admitted to hospital on a compulsory basis unless it has first been determined that the person is unsuitable for admission as a voluntary patient.

THE SCHEME FOR REFORM

In the preceding pages of this paper we have revealed some of the many shortcomings of the Manitoba law. We have referred to the limited role of the police in the administration of this legislation and, in general, the unsatisfactory

emergency apprehension procedures it now provides. We have touched on the rather extensive and far-reaching power of the Director of Psychiatric Services; the limited responsibility in tort of hospital personnel; the lack of attention to the civil rights of the individual; the possibility of indefinite committal which this legislation contains, and its general inattention to the principles of natural justice.

We have acknowledged and considered the views of the medical profession as they have thus far been expressed to us. Finally, we have compared Manitoba's *"Mental Health Act"* with the legislation in Ontario and Alberta, as well as with that in the other Canadian provinces and some American jurisdictions.

On the whole, the Commission is impressed by the Ontario and Alberta statutes and the solutions in them to the problem of reconciling the interests of society in preserving safety and health and safeguarding the liberty of the individual. We believe that with some modification such provisions would be appropriate for enactment in Manitoba. Already we have made some specific recommendations towards that end. Among these, we have said that the Act should provide some periodic or easily accessible review procedure, similar to that provided in Ontario. We have said that the criteria for committal should be made more precise; and that strict time limits should be set on the period of confinement. These and the remaining proposals are presented at the conclusion of this paper. On the whole they are intended to provide a comprehensive scheme for (1) the admission of persons to mental institutions, (2) the periodic review of these patients and (3) their release, the basis of which is a fair balance of the interests of the mentally ill with those of the public at large.

It is hoped that such provisions will reduce, if not entirely overcome, the possibility of unwarranted certification and furthermore result in the timely release of persons from our institutions.

FREE COMMUNICATION

In addition to this scheme of certification and review, we are disposed to recommend that there be enacted certain other provisions which will enhance the dignity and respect of the mentally ill by preserving for them, to the extent that is reasonable under the circumstances, certain basic rights of democracy, citizenship and privacy. Included amongst these would be provisions guaranteeing the liberty of the voluntary hospital patient and establishing for voluntary and compulsory patients alike their right to communicate by letter, to have counsel and to receive visitors.

On the question of the patient's right to send and receive unopened all personal correspondence addressed by and to him, the Commission is equally divided.

At present, the legislation in this province guarantees that patients will be furnished with necessary materials for communicating with any member of the Executive Council or Assembly, any hospital inspector, and with his attorney. In addition, pursuant to s. 22 of *"The Ombudsman Act"*, letters written by a patient in any mental hospital are to be forwarded immediately unopened to the Ombudsman where they are addressed to that official. With these exceptions only, all other communications, whether they are incoming or outgoing, are subject to be read and censored by the Director or Superintendent of the hospital before being delivered. No provision exists for the return to the sender or the retention of any mail or other communication

which is withheld, and not delivered to the patient or other party for whom it was intended. While one might assume that these restrictions arise only in the case of persons who are committed involuntarily, it appears that no such differentiation has been made between the rights of patients who are in hospital on a compulsory basis and those who remain freely and voluntarily as a result of less severe disorders. We do, however, acknowledge the practice in at least one Manitoba institution which permits all of its patients, irrespective of their status, to write to whosoever they wish; as a matter of policy, a patient's mail is neither to be read nor censored by any member of the hospital staff. Nevertheless we are of the view that the powers given by the legislation to the Superintendent of a hospital and to the Director of Psychiatric Services generally to censor or withhold mail are unnecessarily wide, and while there is no indication of dissatisfaction with the manner in which they are presently exercised in the various institutions, they are doubtless open to abuse and may permit unwarranted interference with the patient's basic individual rights.

In Ontario, *"The Mental Health Act"* requires a somewhat more objective and judicious consideration of this matter. Section 19(2) sets out the only conditions under which an officer in charge of a mental health facility may interfere with the private communications. This section provides as follows:

> *s. 19(1) Except as provided in this section, no communication written by a patient or sent to a patient shall be opened, examined or withheld, and the delivery shall not in any way be obstructed or delayed.*
>
> *(2) Where the officer in charge or a person acting under his authority has reasonable and probable cause to believe,*

(a) that the contents of a communication written by a patient would,

(i) be unreasonably offensive to the addressee, or

(ii) prejudice the best interests of the patient; or

(b) that the contents of a communication sent to a patient would,

(i) interfere with the treatment of the patient, or

(ii) cause the patient unnecessary distress,

the officer in charge or a person acting under his authority may open and examine the contents and, if any condition mentioned in clause a or b, as the case may be, exists, may withhold such communication from delivery.

(3) Subsection 2 does not apply to a communication written by a patient to, or appearing to be sent to a patient by,

(a) a barrister and solicitor;

(b) a member of the review board or advisory review board under the Act; or

(c) a member of the Assembly.

More recently, Alberta has amended its legislation and now guarantees its mental health patients an absolute and unrestricted right to communication by post. Similar reforms have been proposed in other jurisdictions. Some of these have even suggested that patients be permitted to make and receive unmonitored telephone calls, to have private interviews with legal counsel and to receive visitors without restriction at all reasonable times.

There are, of course, quite a number of valid reasons why it would be desirable to allow a committed patient to communicate freely. There is, for example, evidence to indicate that "loss of liberty harms the mental patient and is unnecessary to public safety". Indeed it has been amply demonstrated that freedom (especially to communicate) is a therapeutic tool and that it speeds recovery (Hearings Before the Subcommittee on Constitutional Rights of the Senate Committee on the Judiciary, 8th Cong., 1st Sess., pt. 1, at 45 (1961)).

Some of our members do not favour this proposal, however. In their view some reasonable form of censorship is desirable and should be designed to ensure that the innocent are protected and that valuable family relations will be unharmed. Several examples can be given to illustrate the unfortunate consequences which might follow were patients not restricted in their ability to send and receive mail. Unconvinced of the necessity for certification, a patient may blame his family for the confinement. In the process, he may strike out at its members in abusive and harmful ways, by breaching confidences and disclosing hurtful information. In other cases the family may actually be responsible for a patient's ill health, having played an etiological role in the development of his mental disorder. In these cases the patient should remove himself from the family circle and until he can himself recognize the need for isolation, he should be protected, and not subject to the hurtful influences of others. According to one doctor, even where relations with relatives and friends are agreeable, the letters which these persons send to a patient may awaken feelings of homesickness unconducive to recovery of patients with severe emotional disorders (S.E. Patterson, "The Committed Mentally Ill and Their Right to Communicate", 7 *W.F.L.R.* (1971) 297 at 298).

In order to protect all parties who are involved in correspondence with a patient, three members of our Commission suggest enactment of the Ontario provision with alterations in two major respects. The first would be to expand the patient's unrestricted right under *"The Mental Health Act"* to include communication, not only to or from his or her solicitor, members of Parliament, the Assembly, the Executive Council and hospital review boards, but also to and from the provincial Ombudsman. Very often, the most effective means of securing justice can be through the provincial Ombudsman. If communications are to be censored or withheld, clearly they ought not to be subject to interference where they involve resort to the Ombudsman. Replies from the Ombudsman to a patient should also be subject to this security. Finally it is suggested that in the case of withheld or censored mail, a copy of the original corresdence should be retained and delivered to the *"patients' advocate"* who may provide for its release or disclosure to the patient or alternatively to the addressee as he or she thinks appropriate.

THE RIGHT TO VOTE

Another question which provoked much discussion among members of the Commission is whether the mentally ill patient should be excluded from voting in provincial elections. Section 16(1) of *"The Election Act"* (C.C.S.M. c. E30) disqualifies from voting at an election *"persons who are patients in mental hospitals or institutions for mental retardates"*. This section appears to deprive of their rights unnecessarily persons who are admitted to mental hospitals on a non-compulsory basis.

We believe that the rights of a patient who is admitted to hospital of his or her own volition should be retained in all respects, save that he or she may be detained for a minimum number of hours, if necessary, to invoke emergency procedures. We are unanimous in our agreement with the Office of the Chief Electoral Officer (Manitoba) in its study of *"The Election Act"* which states that, "admission to a mental hospital is not considered to be evidence of incompetence and therefore there appears to be no justification for exclusion of all patients in mental hospitals". We therefore recommend that the appropriate amendment be made to *"The Election Act"*.

The minority of our Commission believes that the enfranchisement of all mental patients is justifiable. This proposal is not without precedent and is based on psychiatric literature which indicates that many forms of mental illness have a highly specific impact on their victims, leaving decision making capacity and reasoning ability otherwise largely unimpaired. *"The Model Draft Act Governing Hospitalization of The Mentally Ill"* (21, 26 Public Health Public No. 51 (Rev.1952) prepared by the Federal Security Agency) is based on this reasoning and at least nominally guarantees patients the right to vote although the exercise of the right is subject to regulation by the hospital supervisor which is based on legal competency, not committal or disorder.

The majority of our Commission, however, does not approve of the extension of voting rights to involuntary mental patients. Administrative difficulties aside, these members object to the proposal because they believe involuntary commitment to be clear and convincing evidence of a person's inability both to function normally within society, and consequently, to choose its elected representatives.

CONSENT TO TREATMENT

The issue of mental competency raises a number of other issues of concern to this Commission. Many current mental health statutes provide that a patient remains legally competent until he has been formally adjudicated incompetent and that neither hospitalization nor commitment is an automatic finding of incompetency. Patients who are committed but found not to be incompetent to do so may nevertheless manage their own financial affairs. A related issue concerns the right of a mental health patient to refuse or consent to treatment where he or she is competent to do so. While many compulsory patients will clearly lack the capacity to make a rational decision concerning their hospitalization and care, the commitment of *"dangerous"* individuals may often not involve a question of incapacity to make a treatment decision.

A few American statutes now require that an involuntary patient's consent be obtained before treatment can be administered. Although mechanisms are often available to override a patient's refusal to consent (by substituting consent of a relative, guardian or the court), these statutes seldom question the validity of a patient's own grant of consent. Although a patient may give nodding approval and thereby appear to consent to suggested treatment, he may not in fact fully appreciate what it is that his physician proposes. Apart from this, a patient's consent may be based on a delusion. Thus a patient's consent is not freely given if it is based upon fears of reprisals if, for example, he does not accede to the wishes of his doctor. The recently amended Ontario statute provides an interesting solution to this problem. An involuntary patient has the right not to have psycho-surgery of any kind performed on him under any circumstances. Moreover, although a patient's refusal to accept treatment other than psycho-surgery may be overruled,

the hospital must obtain an order after a hearing before the provincial review board at which the patient or his counsel may be present.

With the exception of Ontario and Nova Scotia which specifically prevent it, and a few other jurisdictions in which the legislation is silent, most provinces in Canada have enacted legislation to authorize treatment to be administered regardless of the voluntary or compulsory status of the patient and whether or not he consents to it. In Manitoba no such statutory authority exists and presumably the consent of a *competent* patient and, if the patient is *incompetent*, a substituted consent obtained from someone deemed to be standing in the shoes of the patient, is necessary before treatment can be administered. In this province, the Public Trustee is automatically constituted the committee of a mentally disordered person upon his compulsory admission to any one of the designated hospitals for mental treatment in Manitoba. Normally, the jurisdiction of the Public Trustee to administer the estate of such a person does not come into effect until twenty-one days after admission. Therefore, if no private committee has been appointed or applied for, the Public Trustee will commence administration of such patient's estate twenty-one days after his admission, unless the medical director of the hospital in question requests the Public Trustee to commence administration prior to this period.

In addition to the power to administer the estate of a mentally disordered person who is committed to hospital, the Public Trustee, when constituted a committee of the estate of a patient, is also the committee of his person. This means that he is also charged with the responsibility of protecting the civil rights of the patient. According to the Public Trustee this might include consent with respect to surgical operations and other matters.

However, it is possible that many physicians working in our provincial hospitals are of the view that they are able to do what they think best for their involuntary patients without considering the need to obtain the consent of their committees. Treatment of patients in this way is easily enough rationalized because the essence of this concept is to assist persons who are unable to seek help for themselves. The mentally ill patient, by definition, is precluded by illness from knowing what is in his own best interest (Rastacter, "The Rights of the Mentally Ill During Incarceration: The Developing Law" (1973) 25 *U. Fla. L.R.* 494 at 503). Indeed the patient's protestations with respect to his need for treatment may often be interpreted as lack of insight into his illness and thus new justification for his continued care and treatment. With benevolent intent assumed, provisions regarding the obtaining of official consents and other such procedural protections may seem unnecessary. Unfortunately, however, the reality of the treatment sometimes imposed on these individuals may be less than satisfactory.

The recent efforts of American author John Marks in exposing the startling experimental research conducted in Canada throughout the late 1950s and early 1960s supports us in this view. During the period reported by Marks, depressed and schizophrenic persons from around the world were drawn to McGill University's Allan Memorial Institute, then under the directorship of Dr. D. Ewen Cameron, where unsuspecting patients were reportedly subjected to bizarre and adverturesome experiments aimed at producing a quick cure for mental illness. The involvement of the American Central Intelligence Agency in attempts to develop techniques of mind control and brainwashing is evident in the particularly unorthodox methods employed by the Institute. These methods

included massive doses of mind-altering drugs, such as LSD and curare. Fifteen years later Dr. Cameron's "guinea pigs" report they are still suffering the aftereffects of the treatment in question.

Since both experimental and physical psychiatric therapies, such as psycho-surgery and heavy medication, are drastic and can have dangerous side effects, we think there is still cause for concern respecting this issue. In our view, patients should have some right to refuse treatment. On the other hand, we realize that because modern psychiatric hospitals are treatment facilities and not detention centres, an unlimited right to refuse treatment would frustrate the purposes of any mental health legislation. Nevertheless, there would appear to be no reason why, if surgical and especially experimental procedures are contemplated, a very formal and perhaps judicial process should not be brought into play to determine whether or not the procedure is appropriate. Three of our members favour a judicial review, while the remaining three members propose that the appropriate jurisdiction be vested in the provincial review board. We are however unanimous in our view that all controversial, experimental or surgical psychiatric procedures should be subject to independent review before they are permitted whether or not the patient is voluntary or compulsory and whether or not he appears to give his consent.

In addition to this scheme, it has been suggested to us that perhaps there could be a therapeutic committee of some sort to approve all other treatment programs for every involuntary patient. Again we wish to avoid the possibility that psychiatric institutions will simply become places for

custody and restraint; in our view that would be regressive and would almost obviate the need to have such institutions. Moreover, such a scheme would involve medical practitioners in what is likely to become an excessively administrative and adversarial procedure. In the result, doctors would be tied up before committees or review boards in an effort to obtain their consents and consequently would have less and less time to spend with their patients.

While we are not convinced that the patient should have the right to determine his care and treatment in all cases, we do believe that, in addition to the use of psycho-surgery and other controversial treatments which are not to be performed on him without independent review and approval, the patient should at least have the right to the independent opinion of a psychiatrist he selects when drastic treatment, such as electroshock therapy, is contemplated. Where the opinions of the psychiatrists vary, we recommend that the treatment not be permitted without the prior approval of the Mental Health Review Board. We have received a number of representations from various human rights organizations which support this approach. These representations, as a rule made on behalf of former mental hospital patients, allege that the drug and shock treatment which patients forcibly received while hospitalized were in part responsible for their long term detention. In a few instances it is claimed that such treatments gradually eroded some of these individuals even to the point of subawareness. On the other hand, we understand that many psychiatrists firmly believe that electro-convulsive shock therapy is among the most effective treatment available for certain mental disorders. If that is so, then we appreciate the concern of members of

the profession that, by prescribing limitations on the manner in which their patients should be treated, we may be contributing to the unfortunate result that what is an acceptable and effective treatment will not be used.

Notwithstanding the best intentions of the medical profession, we believe that the mental health review board should review consent issues in cases where the proposed treatment may be attended by significant discomfort or risk of side effects. In our view the use of such procedures and the appraisal of their desirability in the case of a given patient are not matters solely for medical determination. Where the patient and society in general have some apprehension about a course of treatment it should be subject to independent scrutiny by the Mental Health Review Board before it can be used.

A complete summary of our recommendations follows at the conclusion of this Report. In keeping with the earlier recommendations of the Clarkson study, they are intended to assist in the early treatment of persons apparently suffering from mental disorders. In addition we hope they will provide greater protection for persons apprehended and detained pursuant to *"The Mental Health Act"*, and correspondingly, more restraint on those persons having power to detain under it.

RECOMMENDATIONS

1. A person should be admitted to a psychiatric facility for compulsory observation and assessment, only upon:

   (a) the medical certificate (called a *"Medical Order for Psychiatric Assessment"*) of a single medical practitioner or psychiatric nurse duly qualified or registered to practise in the province;or

   (b) the order (called a *"Judicial Order for Psychiatric Assessment"*) of a provincial court judge; or

   (c) the emergency apprehension and conveyance to the hospital by a peace officer designated under the *Criminal Code* (called an *"Emergency Police Apprehension for Psychiatric Assessment"*).

The procedure for voluntary admission to a psychiatric facility for observation and assessment should be handled by the facility like any other voluntary admission (pages 21, 28-30).

2. (a) A *"Medical Order for Psychiatric Assessment"* should be signed and dated by the practitioner or psychiatric nurse who personally examined the person named in it, no later than within seven days of the examination and the medical order should cease to have any force and effect unless it is presented to the hospital in question within seven days of the time of the signature of the practitioner or psychiatric nurse (pages 12-13).

   (b) The practitioner or psychiatric nurse who signs a *"Medical Order for Psychiatric Assessment"* should be required to state his or her belief based on reasonable grounds that the person in respect of whom the order is made

      (i) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

      (ii) has behaved, or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

      (iii) has shown or is showing a lack of competence to care for himself

   and in addition, that the person is apparently suffering

from mental disorder of a nature or quality that is likely to result in

(iv) serious bodily harm to the person;

(v) serious bodily harm to another person; or

(vi) imminent and serious physical impairment of the person.

(For the discussion and minority position on this issue, see pages 41-45)

(c) The practitioner or psychiatric nurse who signs a *"Medical Order for Psychiatric Assessment"* should be required to state the facts upon which he/she bases his/her belief as above, that the person is apparently suffering from mental disorder. The practitioner or psychiatric nurse should also be required to distinguish as between those facts observed and those communicated to him/her.

3. (a) A valid and subsisting *"Medical Order for Psychiatric Assessment"* should be sufficient authority for anyone to take the person who is the subject of the order into custody and to convey the person to a psychiatric facility forthwith.

(b) Upon receipt by a peace officer of a valid and subsisting *"Medical Order for Psychiatric Assessment"*, the officer should be required to do all things necessary to take the person who is the subject of the order to a psychiatric facility forthwith.

4. (a) When information upon oath is brought before a provincial court judge or magistrate that a person

(i) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(ii) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(iii) has shown or is showing a lack of competence to care for himself,

and in addition, based upon information before him

the judge or magistrate has reasonable cause to believe that the person is apparently suffering from mental disorder of a nature or quality that likely will result in

(iv) serious bodily harm to the person;

(v) serious bodily harm to another person; or

(vi) imminent and serious physical impairment of the person,

the provincial court judge or magistrate should be empowered to issue a *"Judicial Order for Psychiatric Assessment"* of the person (pages 41-45).

5. Where a peace officer has reasonable cause to believe that a person

(i) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(ii) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(iii) has shown or is showing a lack of competence to care for himself,

and in addition the officer is of the opinion that the person is apparently suffering from mental disorder of a nature that likely will result in

(iv) serious bodily harm to the person;

(v) serious bodily harm to another person; or

(vi) imminent and serious physical impairment of the person,

and that it would be dangerous to proceed for a *"Judicial Order for Psychiatric Assessment"*, he should be enabled to make an *"Emergency Police Apprehension for Psychiatric Assessment"* of the person (pages 5-10, 24).

6. (a) A peace officer who takes a person into custody either pursuant to a medical order, judicial order, or emergency police apprehension for psychiatric assessment should be required to convey the person forthwith to a psychiatric facility for observation and examination.

(b) A patient who arrives at a psychiatric facility pursuant to a medical order, judicial order, or emergency police apprehension for psychiatric assessment should be accepted by the facility for psychiatric observation and assessment.

(c) A peace officer who takes a person in custody to a psychiatric facility should be required to remain at the facility and retain custody of the person until the facility accepts him for observation and assessment.

7. (a) A person who arrives at a psychiatric facility pursuant to a medical order, judicial order or emergency police apprehension for psychiatric assessment should be examined forthwith upon his arrival at the facility, but in any event not later than within 48 hours, by a psychiatrist duly qualified to practise in the province.

(b) Although medical officers on staff at psychiatric facilities should be empowered to detain, restrain and observe a person once he or she is admitted for assessment, no general power should be invested in the medical personnel to treat a person during the 48 hour period in which he/she is detained, except to the extent that it is necessary for the purpose of relieving immediate danger to the admitted person or to others, or to the extent that it is necessary to permit the required psychiatric assessment to be made (page 22).

(c) A person who, following psychiatric assessment, is not certified for admission to the facility either as a voluntary or as a compulsory patient is to be released forthwith, but in any event within 48 hours of his arrival.

8. (a) As soon as possible after his arrival at a facility for psychiatric assessment, a person is to be advised, in simple language, of his rights under the legislation, in particular the reasons and period of his detention, his right of release and his right to apply to the provincial Mental Health Review Board for a review. Efforts to contact next-of-kin should be required to be made at this time (page 21).

(b) An interpreter should be provided where there is language difficulty.

9. (a) A person may be admitted to a psychiatric facility as a voluntary patient where the psychiatrists conducting the examination for assessment are of the opinion that he suffers from a mental disorder of such a nature that he is in need of the treatment provided in the facility and that he is suitable for admission as a voluntary patient. The method by which the patient arrives at the psychiatric hospital should not determine his status (page 45).

(b) A voluntary patient should have the right to be discharged within a reasonable period of time following his request for discharge unless there are already in existence at that time two admission certificates duly completed for his compulsory committal. Eight hours would be a reasonable period of time in these circumstances (page 51).

(c) Every member of the staff of a psychiatric facility should have the responsibility to bring to the attention of the Superintendent of the facility or other medical officer in charge of the psychiatric facility in question every request for discharge which he or she receives from a voluntary patient.

10. A person should only be admitted to a psychiatric facility as a compulsory patient, or alternatively his admission should be extended only where, following separate psychiatric assessments by them, two psychiatrists duly qualified to practise in the province, independently issue their certificates of admission or renewal, as the case may be. Psychiatrists should be required to certify that in their opinion the person is suffering from mental disorder of a nature that likely will result in serious bodily harm to the person; serious bodily harm to another person; or imminent and serious physical impairment to the person unless that person remains in the custody of the hospital and that the person is not suitable for admission or continuation as a voluntary patient.

11. Every admission and renewal certificate should be dated and signed by the psychiatrist who issues it. In addition, each should show the date and time that the personal examination was made and the facts upon which the psychiatrist formed his opinion as to the nature of the disorder, distinguishing the facts observed by him from the facts communicated to him by others (page 31).

12. (a) Two certificates of admission should be sufficient authority to detain a person at a psychiatric facility for a period of no more than one month.

    (b) Certificates of renewal to extend the compulsory confinement beyond one month should be invalid unless they are issued within specified periods of time. These periods should be:

    (i) within one month from the date of the person's admission as a compulsory patient, that is, within one month from the issuance of the two certificates of admission;

    (ii) within two months from the date of the first renewal certificates;

    (iii) within three months from the date of the second renewal of the certificates and every renewal thereafter.

13. A compulsory patient whose authorized period of detention, either on admission or renewal, has expired, should thereupon become a voluntary patient. The patient and his/her nearest relatives should thereupon be advised of the changes in his/her status, and the patient's right to discharge upon eight hours' notice.

14. A compulsory patient whose authorized period of detention either on admission or renewal has not expired, should nevertheless be continued as a voluntary patient where, in the opinion of the attending psychiatrist, it would be appropriate. In this case, the certificates of admission and renewal should be deemed to be cancelled and the patient and his/her nearest relative should be so advised.

15. Upon his admission and later upon his continuation as a compulsory patient and upon every subsequent extension of his detention, a patient should have the right, on request, to have an independent assessment of himself by a psychiatrist of his own choice (page 20).

16. (a) Upon his admission or continuation as a voluntary or as a compulsory patient, both the patient and his nearest relative should be informed in simple language of the reason for his detention. He should also be given a written statement of the authority for his detention, the period thereof, of his right to communicate with counsel and the Ombudsman, and

other appropriate parties, and in the case of a compulsory patient his right to an independent psychiatric assessment by his own psychiatrist or by a psychiatrist he selects; in the case of a voluntary patient his right to request discharge. The existence of the office of the *"Patients' Advocate"* should also be made known to all patients at this time (pages 38-41).

(b) A statement made to a compulsory patient should also include information concerning the existence and function of the Review Board(s), the name and address of the Chairman of the appropriate board, and the patient's right to apply to the Board at specified intervals for cancellation of the admission or renewal certificates then in force.

(c) The information concerning the patient's rights which is contained in a written statement given to him should be supplemented by posters on display in all psychiatric facilities in the province. The posters should also advertise the existence and availability of Legal Aid, the Ombudsman and the office of the Patients' Advocate.

17. (a) A Patients' Advocate should be available in all psychiatric facilities to intercede in matters concerning the rights of mental health patients, such advocates could possibly be established through the office of the Public Trustee (pages 39-41).

(b) Where a person is admitted or continued as a voluntary patient or admitted or continued as a compulsory patient in a psychiatric facility the medical director or other officer in charge should be required to forward a notice in writing of that fact to the office of the Patients' Advocate (pages 40-41).

(c) Where there is a conflict of opinion as between the psychiatrist at a hospital and a psychiatrist selected by a patient to conduct an independent psychiatric assessment of him, the medical director or other officer in charge of the facility should forward a notice to that effect to the office of the Patients' Advocate.

(d) A notice to the office of the Patients' Advocate should contain information advising the advocate

of the presence of the patient at the facility, the date of his arrival, the date of his admission, his status in the facility, as well as other information needed to facilitate the bringing by the patient, or the advocate on his behalf, of an application for review, a notice for discharge and a request for independent psychiatric assessment.

18. (a) The province should establish a Mental Health Review Board for the purpose of hearing and considering applications from compulsory patients for the cancellation of admission or renewal certificates (pages 31-33).

(b) In addition the Mental Health Review Board should automatically, at least once a year, review the case of every compulsory and every voluntary patient who has been in a psychiatric facility for a year or more (page 33).

(c) The Mental Health Review Board should consist of one or more three member panels, the members of which should be appointed by the Minister of Health and Social Development for the province and should include at least one psychiatrist and at least one barrister or solicitor. (For discussion as well as the minority position on this issue, see pages 33-35.)

19. The Commission is unable to present a majority recommendation on the issue of membership on review panels. We therefore suggest one of the following be adopted:

19A. (a) No person who is serving as a member of the staff of a facility should be eligible to sit as a member or alternate member of the review panel when the panel is considering the case of a patient of that facility.

(b) No member of the Review Board should sit on a panel when the panel is considering the review of a patient or former patient, client or former client or relative of a member of the review panel in question.

<u>OR:</u>

19B. (a) No person who is actively serving as a member of the staff of a facility should be eligible to sit as a member or alternate member of a review panel when the

panel is considering the case of a patient of that facility.

(b) No member of the Review Board should sit on a panel when the panel is considering the review of a patient or former patient, client or former client or relative of a member of the review panel in question.

(c) Members of a barrister and solicitor or a psychiatrist's family should also be excluded from sitting on a panel when the panel is considering the review of a patient or former patient, client or former client of the barrister and solicitor or psychiatrist in question.

OR:

19C. (a) No person should be eligible to sit as a member or alternate member of a review panel when the panel is considering the review of a patient with whom he or she is acquainted (page 36-37).

20. (a) A compulsory patient or a person on his behalf should have the right to apply to the chairman of the Mental Health Review Board for cancellation of the admission or renewal certificates under which authority he is detained, but he should be permitted to make no more than one application with respect to the initial admission and to each subsequent renewal.

(b) Within 28 days of the receipt of an application by the chairman or such longer period as the Minister allows, the review panel appointed to hear the review should hear and consider the application.

(c) The panel which hears the review should be required to reach its decision within 14 days after completing the hearing.

(d) Within seven days of the date of its decision, copies of the decision of the review panel, including in the case of an adverse ruling, a notice regarding the right to appeal the decision, should be sent to the applicant, his nearest relative, and the office of the Patients' Advocate as well as to any other person interested in or present at the hearing.

(e) A decision of the Mental Health Review Board should be binding upon the board of the facility.

(f) An appeal *de novo* from the decision of the Mental Health Review Board should be to the County Court as of right. Notice of appeal should be given within 28 days of the decision and may be given by the patient or someone on his behalf or by the medical superintendent or director of the facility.

21. (a) The hearings of the Mental Health Review Board should be *in camera*.

(b) The patient and/or his counsel or someone on his behalf, his family, and a representative of the facility should however have the right to be personally present at the hearing.

(c) Any other person should be admitted to the hearing only with the prior consent of the panel.

22. (a) The patient or his representative should receive a summary of the contents of the medical records and of the reasons for his continued detention within a reasonable time in advance of the hearing of a review panel.

(b) In addition to the provision of a summary, a patient's legal counsel or other representative should have access within a reasonable time in advance of the hearing, to all of the patient's medical history and records at the facility.

(c) All of the patient's medical history and records relating to his admission and detention at the facility should be provided to the Mental Health Review Board within a reasonable time in advance of the hearing.

23. Notice of the date of a hearing should be given to the patient, his nearest relative, counsel and the Patients' Advocate within a reasonable time in advance of a hearing.

24. A patient should have reasonable opportunity to present evidence at the hearing.

25. The Commission is unable to present a majority recommendation on the issue of free communication. We therefore suggest one of the following alternatives be adopted:

25A. A patient in a psychiatric facility should have an unrestricted right to communicate in writing and no communication which is written by a patient or sent to a patient should be opened, examined, withheld or delayed.

OR:

25B. (a) Communications written by or to a patient in a psychiatric facility by or to:

(i) a barrister or solicitor;

(ii) a member of the Mental Health Review Board;

(iii) a member of the Legislative Assembly;

(iv) a member of the Parliament of Canada;

(v) the Ombudsman;

(vi) the Patients' Advocate;

(vii) the Public Trustee; or

(viii) a psychiatrist duly qualified to practise in Manitoba

should not be opened, examined, censored, withheld or delayed.

(b) Any other communication written by or to a patient should be subject to be opened, examined, censored, withheld or delayed only where the officer in charge of a psychiatric facility or other person acting on his instructions has reasonable grounds to believe that the contents would

(i) be unreasonably harmful or offensive to the addressee; or

(ii) would prejudice the best interests of the patient; or

(iii) would interfere with the treatment of the patient; or

(iv) would cause the patient unnecessary distress.

(c) Where the officer in charge of a psychiatric facility censors or withholds the delivery of a communication

either from the patient or to the addressee, a copy of the original communication should thereupon immediately be delivered to the office of the Patients' Advocate whose responsibility it should be to determine the question of delivery.

(d) Where a communication is not released to the patient or forwarded to the addressee as a result of the order of the Patients' Advocate, it should be returned to the sender. (pages 47-51)

26. (a) A patient who is in a psychiatric facility on a voluntary basis should be permitted to vote in provincial and municipal elections (page 51).

(b) A patient who is in a psychiatric facility on a compulsory basis should not be permitted to vote in provincial and municipal elections (for discussion as well as minority position on the issue, see pages 51-52).

27. All controversial, experimental or surgical psychiatric procedures should be subject to independent review before they are permitted whether or not the patient is voluntary or compulsory and whether or not he appears to give his consent (pages 52-56).

28. The Commission is unable to present a majority recommendation on what form independent review should take. We therefore suggest one of the following alternatives be adopted:

28A. Any treatment of a controversial, experimental or surgical nature should be subject to review by a court before it may be performed.

OR:

28B. Any treatment of a controversial, experimental or surgical nature should be subject to review by the Mental Health Review Board before it may be performed (pages 52-56).

29. (a) Where a compulsory patient objects to drastic treatment other than treatment of a controversial, experimental or surgical nature, the treatment in question should not be performed unless it is recommended following independent assessment by a psychiatrist selected or approved by the patient or his representative.

(b) Where the psychiatrist who conducts the independent assessment does not recommend the treatment, the attending psychiatrist who proposed the treatment should forward a notice of these facts to the Mental Health Review Board for a hearing (pages 56-57).

30. A person who is a voluntary patient in a psychiatric facility should have the absolute right to consent or refuse to consent to treatment of any kind.

The Commission acknowledges with appreciation the many individuals and organizations who corresponded with us concerning revision of *"The Mental Health Act"*. We attach a list of their names as Appendix A to this Report.

This is a Report pursuant to section 5(3) of *"The Law Reform Commission Act"*, signed this 12th day of February 1979.

R. Dale Gibson, Commissioner

C. Myrna Bowman, Commissioner

R.G. Smethurst, Commissioner

Val Werier, Commissioner

Sybil Shack, Commissioner

Kenneth R. Hanly, Commissioner

APPENDIX "A"

LIST OF PERSONS AND ORGANIZATIONS WHO CORRESPONDED WITH COMMISSION

G.W. Maltby, Ombudsman

Mental Health Manitoba, Canadian Mental Health Association (Manitoba Division)

April D. Katz, barrister

W.G. Lamberd, M.D.

R.H. Tavener, M.D., Chairman Psychiatric Nurses Education Advisory Committee

Province of Manitoba, Department of Health and Social Development (Chief Medical Consultant)

Norman Larsen, Executive Director, Legal Aid Manitoba

The Public Trustee

Manitoba Psychiatric Association

Canadian Association for the Mentally Retarded (Manitoba Division)

Ad Hoc Protection and Guardianship Committee, Age and Opportunity Centre, Inc.

F. Shane, M.D.

Michael Kovacs, M.D., Medical Director, Selkirk Mental Health Centre

Joseph O'Sullivan, Q.C. (as he then was)

Ian V. Dubienski, Provincial Judge

J. Matas, M.D.

J. Varsamis, M.D.

Anne Bolton, barrister

Harold ff. Gyles, Chief Provincial Judge

Citizens' Committee on Human Rights (Church of Scientology)

Leon Mitchell, Q.C.

A.H. Moyes, M.D., Medical Director, Brandon Mental Health Centre

D.L. O'Leary, M.D.

M.W. Bollenback, M.D.

R. Wehner, M.D.

W. Lebeden, M.D.

W.B. Wills, Rehabilitation Counsellor

M.R. Steinbart, M.D.

H.G. Andrew, M.D., Secretary, Medical Advisory Committee

Province of Alberta,Department of Social Services and Community Health (Division of Mental Health Services)

C.P. Hellon, Assistant Deputy Minister, Alberta Mental Health Services

E. Wahl, barrister, Alberta Social Services and Community Health (Legal Services)

Gilbert Sharpe, Legal Counsel, Associate Staff, Faculty of Health Science, McMaster University

Ontario Ministry of Health (Legal Branch)

Margaret A. Shone, counsel, Alberta Institute of Law Research and Reform