An examination of social workers' attitudes towards the issue of legal and civil rights of psychiatric patients.

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UNIVERSITY OF WINDSOR
SCHOOL OF SOCIAL WORK

AN EXAMINATION OF SOCIAL WORKERS' ATTITUDES
TOWARDS THE ISSUE OF LEGAL AND CIVIL
RIGHTS OF PSYCHIATRIC PATIENTS

by

Lawrence Duncan Barrie

A thesis submitted to
the School of Social Work of the University of Windsor
in partial fulfillment of the requirements
for the degree of Master of Social Work

Windsor, Ontario, Canada
1979
Research Committee

Dr. John Barnes, Chairperson

Professor Robert Chandler, Member

Dr. Stuart Selby, Member
ABSTRACT

AN EXAMINATION OF SOCIAL WORKERS' ATTITUDES
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RIGHTS OF PSYCHIATRIC PATIENTS

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The purpose of the study was to determine social
workers' knowledge and understanding of Ontario's present
Mental Health Act, as well as their attitudes towards
specific issues of psychiatric patients' legal and civil
rights.

A review of the literature was conducted in the
three general areas of: 1) historical trends; 2) psychiatric
admission procedures; 3) the mentally ill: loss of legal
and civil rights. This survey of the literature indicated
that the field of mental health and the legislative statutes
pertaining to mental health are in a state of ambiguity
and uncertainty regarding the meaning of mental illness
and the state's right to force psychiatric treatment on a
person through civil commitment procedures. The literature,
Furthermore, strongly points to the loss of "due process
of law," afforded to every Canadian citizen under the
Canadian Bill of Rights. However, the civil committed psychiatric patient is subjected to the unjust and indiscriminate loss of his legal and civil rights.

A sample of twenty Essex County social workers was investigated in this study. These social workers were required to meet a number of criteria before they were accepted into the sample. Two comparison samples were also obtained to provide a contrast of the statistical data secured from the questionnaire.

From the findings of the study, the researcher discovered that social workers did not possess a comprehensive understanding of Ontario's Mental Health Act. Though these social workers indicated an awareness of, and a concern for, the issues surrounding the psychiatric patient's civil liberties, very few of them were distressed enough to become actively involved as an advocate for the patient's rights. Speaking generally, these social workers were supportive of the psychiatric patient's legal and civil rights, though in reality their knowledge of the Mental Health Act and psychiatric patient's rights reflected ignorance of these issues. The attitudes of the Essex County social workers were similar to those attitudes possessed by mental health professionals in the Laves, Cohen study conducted in New Jersey in 1972.

The researcher recommends that further province-wide research be conducted in this area among the various mental
health professionals. Such a survey would be timely, since the Ministry of Health will be introducing a new Mental Health Act within the next year.

As a large portion of mental health professionals do not possess sufficient knowledge of the present Mental Health Act, or hold attitudes that favour the support of the psychiatric patient's legal and civil rights, the introduction of new mental health legislation does not necessarily mean the rectification of the deficiencies in the knowledge and attitudes of Ontario's mental health workers.
ACKNOWLEDGEMENTS

The researcher would like to express his appreciation to the members of the Research Committee, Dr. John Barnes and Professor Robert Chandler of the School of Social Work, and Dr. Stuart Selby of the Department of Communication Studies.

Special thanks are extended to: Dr. Barnes for his help in turning this project into a comprehensible study and to Professor Chandler for his guidance in the construction of the questionnaire and interview schedule.

The researcher is also grateful to the social workers who participated in the study and gave of their time to be interviewed, and to all of the other respondents who answered the research questionnaire.

The researcher expresses his love and thanks to his wife for her support, understanding and encouragement in their seven-year journey. They had a dream and through mutual support and love they made it come true.

This study is dedicated to the thousands of persons who yearly are confined to Ontario psychiatric facilities by civil commitment procedures without the benefit of "due process of law" or legal counsel, and through this process lose their legal and civil rights.
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CHAPTER I

INTRODUCTION

Civil Commitment

Involuntary psychiatric hospitalization for mental illness is beginning to develop into a potentially "hot issue", especially now that the Ontario government has introduced a new Mental Health Act. Arguments about civil commitment procedures take place against a background of controversy regarding the nature of mental illness, the role of mental health professionals and psychiatric facilities, and the issue of the loss of legal and civil liberties by psychiatric patients.

For a number of reasons, things seem to be coming to a head regarding the move for the recognition of the rights of the mentally ill. Even with what is considered liberalized mental health statutes, civil commitment to the province's psychiatric facilities has remained relatively high. Over 25 per cent of the admissions last year were due to formal commitment procedures. To this researcher, the high percentage of involuntary patients appears to reflect the continuance of old beliefs about mental illness by the lay community as well as by some.
members of the mental health disciplines. That is, "out of sight, out of mind." The apparent social philosophy is one of confinement, with the loss of legal and civil liberties as the appropriate approach to treatment and care of these people.

In the last twenty years empirical research has shown that mental health professionals cannot distinguish the mentally ill from the sane with any degree of reliability.\(^1\) Nor, can psychiatrists predict dangerousness to any great degree of certainty\(^2\) a necessary requirement of legislative statutes that provide legal authority for civil commitment certificates. In addition, further studies have shown that the majority of patients in psychiatric facilities really do not need to be there. Within the last thirty years there has been a pronounced change in the diagnostic composition of admitted psychiatric patients. Thus, the province's psychiatric facilities are admitting and treating people with disorders that formerly were not recognized as needing hospitalization. Those with psychotic disorders, thought before to require long-


term hospitalization, are now being treated within the community on an out-patient basis.

The Significance of Civil Commitment

The threat to personal freedom in the practice of involuntary civil commitment has become an important issue in the area of civil liberties. Dr. Patric Lynes, senior psychiatric advisor to the province's Ministry of Health, told a meeting of 100 health professionals at Windsor Western Hospital on December 1, 1977 that the province has a very pressing problem with former mental hospital patients living on skid row or in and out of jail. He indicated that between 1961 and 1975 the health ministry reduced the total number of psychiatric beds by about 10,000. The bed shortage, along with the acceptance of the "community psychiatric movement" by the psychiatric facilities, allowed for the discharge of too many psychiatric patients into the community without proper or adequate support services.

Lynes also reported that the demand in first admissions to psychiatric facilities is escalating yearly. In 1975 alone, 15,000 people were admitted to psychiatric hospitals, 28,000 to psychiatric units of general hospitals.

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and another 100,000 were treated in out-patient facilities. Until as recently as 1967, with the passage of the Mental Health Act, involuntary hospitalization was considered "ipso facto" evidence of the patient's incompetence. Aside from the person's loss of freedom, there is a loss of a number of legal and civil liberties. Today, depending upon certain events, circumstances, and adjudications, a mentally ill person may lose: 1) the management of his legal and financial affairs; 2) the right to vote; 3) the right to run for or hold public office; 4) the right to free communication; 5) the freedom to marry; 6) the freedom to divorce; 7) the right to pursue certain trade or professional occupations.

Civil commitment is also important because often it leads to a loss of human dignity and a fruitful life. Psychiatric incarceration is the first step toward dehumanization and the development of a lifetime career as a mental patient. Public identification and the label of being "mentally ill" can lead to a self-fulfilling prophecy that encourages the person's acceptance of inappropriate behaviours associated with those considered mentally ill.


The end process of psychiatric hospitalization for a great number of mentally ill people becomes merely custodial care with only a small segment of them receiving proper classification, treatment, and therapeutic recovery. Doubt has been cast on institutional milieu as an effective environment in which meaningful therapy may be given. In the long run, "patients . . . 'learn to be sick' and cooperate with the staff."\(^6\)

The Attack on Civil Commitment

There are signs that the pendulum is commencing to swing in favour of upholding the civilly committed psychiatric patient's legal and civil liberties. The attack on civil commitment has come from a widespread concern by many different groups of people. New literature on the social, legal, and ethical norms of formal commitment is coming from many different mental health disciplines. Increased understanding of civil commitment legislation is bringing into clearer focus other perspectives. It is clear that, that which is legal is not necessarily humane and just. Civil libertarians, mental health associations, concerned individuals, and patient rights groups have demonstrated that there is a need for societal checks on the proper application of existing mental health laws.

\(^6\) Nicholas N. Kittrie, *The Right to be Different*, p. 96.
with regard to a patient's loss of legal and civil rights. In the attack on involuntary hospitalization, concerned citizen groups have examined the laws associated with civil commitment in an attempt to have them revised for the betterment of the medical and judicial systems.

Rationale for the Study

Though the general lot of the institutionalized psychiatric patient has improved compared to the 40's and 50's, there is, nevertheless, a great deal of concern lately for the legal and civil rights of psychiatric patients. There appears to be an issue of doubt as to what extent the mentally ill person and staff within the facilities are sufficiently knowledgeable about patients' rights and legal status.

Even today, it remains astounding how poorly versed many professionals appear to be, as a whole, in issues concerning patients' rights and legal status, indeed in the very state or provincial legislation under whose authority these proceedings are sanctioned.7

During the researcher's own experience of working with psychiatric patients in his B.S.W. and M.S.W. field placements, he noticed violations of the patient's civil liberties. These infractions frequently occurred in the name of a "humanitarian" approach implemented by the professional staff, which included social workers. This loss

of personal rights seemed to develop when an individual's psychophysical and psychosocial condition was viewed from a medical perspective only, rather than from a general view based on medical, psychiatric, judicial, and legal grounds. This was especially true with regard to civil commitment and the forced hospitalization of a person against his wish.

Writers, such as Szasz and Torrey, view involuntary psychiatric hospitalization as a moral crime against a certain segment of the general public. Since the majority of these patients have committed no crime(s) or broken no law(s), there should be no forced psychiatric hospitalization through civil commitment procedures. Both these writers feel that this aspect is especially important, for the mentally ill person is not afforded any means of legal recourse during the process of civil commitment.8

Personal Concern

The researcher's concern about the mentally ill person's limited understanding of his legal and civil liberties as a hospital patient evolved from what the researcher perceived as a misunderstanding between the

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medical personnel and the patient himself. The hospitalized patient appeared to know or understand little about his official legal status, which, in turn, affected his legal and civil rights. Associated with this, it appeared as if members of the psychiatric staff were also unaware of the patient's legal status as it pertained to their rights and privileges.

The researcher believes that there are a number of primary concerns surrounding conflicting aspects of a psychiatric patient's commitment, which may affect his civil liberties. The researcher believes that members of the professional psychiatric staff, including social workers, have been reluctant to advise a patient about what commitment status curtails in regard to their rights and privileges under existing mental health legislation.

One concern is whether the mentally ill person understands the difference between formal and informal hospitalization and realizes which of these two admission procedures affects him. It is also a concern as to whether professional psychiatric staff, and especially social workers, know and understand the statutes as outlined in the Mental Health Act, Revised Statutes of Ontario, 1970, Chapter 269. If so, do they inform psychiatric patients or clients of their rights and obligations under this Act?

The researcher has the opinion that members of the social work profession are reluctant to advise the
psychiatric patient of their civil liberties for a number of reasons. This may stem from a personal lack of knowledge of the statutes themselves, a fear to confront the medical profession and advise the psychiatric patient of his rights, or the feeling that it is in the best interest of the patient not to discuss this subject, or that this issue should be handled by the medical profession personnel, namely the psychiatrist or head nurse.

It has also been the researcher's experience that civil and legal rights are a taboo area, a subject of concern which social workers do not discuss with a psychiatric patient or his family. It seems to be a topic that social workers trust the medical staff will have to deal with, thus letting the social workers off the hook and clearing their conscience of the subject.

The researcher believes, however, that this should be a major concern of all social workers—to inform the psychiatric patient of his hospital status, the hospital rights and restrictions, and any loss of legal and civil liberties. As this is not exclusively a medical matter, the types of problems associated with the psychiatric patient's hospitalized status may fall more within the realm of expertise of the social worker rather than that of the medical profession. The latter appears to have a vested interest in the hospitalization of the patient.

It is also the researcher's opinion that a social
worker who has a comprehensive knowledge and understanding of the Mental Health Act should be the member of the professional psychiatric team that informs the institutionalized patient of his commitment status and any civil rights which may be affected by the hospitalization.

Purpose of the Study

The purpose of this study is to examine the attitudes held by professional social workers who work primarily with psychiatric patients, towards the issue of legal and civil rights of psychiatric patients. It is the conjecture of this researcher that social workers, at times, unknowingly and unintentionally violate psychiatric patients' legal and civil liberties on humanitarian and other grounds. Violations of civil rights, based on a humanitarian approach, have arisen out of "Parens Patriae," the right of the State to treat the mentally ill person even against his own expressed wish not to be treated. Do social workers accept the mental health view, "the right to treat," over the mental health legislative view and the Canadian Bill of Rights?

The researcher openly acknowledges that mental health professionals have an extremely difficult task to perform. He realizes that, often, it is hard to walk the fine line between enforcing administrative policies and procedures and at the same time be properly aware of a
psychiatric patient's legal and civil liberties. The researcher also recognizes the difficulty of this task, since in determining what is best for the psychiatric patient, the mental health professional's point of view still apparently takes precedence over actual mental health legislation. The researcher, however, is also aware that many mental health personnel frequently pay no attention to patients' rights. Instead, they prefer to do what they believe to be in the best interest of the patient.

The nurses were motivated by what they felt were the best interests of the patient. I was obligated to stress that their action would restrict the patient illegally and that the law should be the paramount consideration. It was not uncommon to have the law and the professionals' view of what was best for the patient in conflict. [Italics are those of the researcher.]

Infringement of the psychiatric patient's rights has evolved because of a number of factors. Mental health workers, including social workers, may lack an understanding of the statutes outlined within the Mental Health Act, and therefore may over-step legal and civil boundaries due to their ignorance. Also, indifference, ineffectiveness, or a lack of concern for the psychiatric patient may lead a social worker to ignore the rights of his or her client. Even today, the views of many trained professionals of

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9 Grant Dobson and R. C. Hansen, "The Ombudsman in Mental Health: Lakeshore's Experience," Canada’s Mental Health 24 (September 1976): 11.
different mental health discipline appear to be clouded by popular but outdated misconceptions or myths regarding psychiatric patients and mental illness.

Scope of the Study

The researcher decided to examine five research hypotheses to obtain a better appreciation of the attitudes of social workers towards the issue of the psychiatric patient's legal and civil rights.

The researcher also wished to determine, through test questionnaires, social workers' comprehension and knowledge of the Mental Health Act, plus their knowledge of the psychiatric patient's legal and civil rights. This led the researcher to design the following five research hypotheses for investigation:

1. Social workers do not possess a knowledgeable understanding of Ontario's Mental Health Act.

2. Social workers who score low on the test questionnaire in their knowledge of Ontario's Mental Health Act will also score low on the test questionnaire in their knowledge of psychiatric patients' legal and civil liberties.

3. Social workers do not believe that the statutes as outlined in the Mental Health Act, Revised
Statutes of Ontario, 1970, safeguard and
protect the legal and civil liberties of
psychiatric patients.

4. Social workers do not inform psychiatric
patients about their hospital status (formal
commitment or voluntary admission) and how the
nature of the admission may, in turn, affect
their legal and civil liberties.

5. Social workers do not believe that it is a
right or a necessity for certified psychiatric
patients to receive "due process of law" or be
represented by legal counsel in civil commit-
ment proceedings.

Relevance of the Study for
Social Work

Coincidental with the development of forced civil
commitment, there has evolved a small but consistent public
out-cry against the inhumane treatment and the civil in-
justices suffered by the mentally ill patient in the name
of treatment. This public concern has been addressed by
Provincial Governmental Royal Commissions, Federal Gover-
ment Health Studies, Civil Libertarian groups, Consumer
groups, Psychiatric patient groups, and newspaper, tele-
vision, and professional journal articles. ¹⁰

¹⁰ For the reader to obtain a better perspective of
some of the groups that have led the way in the voice of
Within the last year and a half, Health Minister Dennis Timbrell has been asked on numerous occasions by the Canadian Civil Liberties Association to review the Province's ten-year-old Mental Health Act (see Appendix D). This association, as well as other lobby groups, have asked for a review on the grounds that the present Mental Health Act is a threat to personal freedom through the practice of involuntary civil commitment. The Canadian Civil Liberties Association brief of March 28, 1977 states that:

The Act fails to qualify this power by the kind of safeguards which are found elsewhere in our law - the right to counsel, the right to call and cross-examine witnesses, etc. Moreover, there is no elaboration of what is meant by "mental disorder" and no further indication of how great the threat to "safety" must be. Indeed, the confinement may

"public out-cry" against civil commitment procedures and some of the Governmental commissions, both Federal and Provincial, which have examined this issue, the researcher suggests the reader see the following. Committee on Legislation and Psychiatric Disorders, The Law and Mental Disorders, vol. 2: Civil Rights and Privileges (Toronto: Canadian Mental Health Association, 1967); James Chalmers McRuer, Royal Commission Inquiry into Civil Rights, Report No. 1, Vol. 13, 1956, better known as the "McRuer Report"; Mental Health Legislation in Canada, Health Care Series Memorandum No. 15 (Ottawa: Research and Statistic Division, March 1960); Royal Commission on Health Services, vol. 12: Trends in Psychiatric Care, vol. 13: Organized Community Health Services, vol. 14: Psychiatric Care in Canada: Extent and Results (Ottawa: Queen's Printer, 1966); Canadian Civil Liberties Association, briefs sent to The Honorable Dennis Timbrell, Ministry of Health, Ontario on February 18, 1977, March 28, 1977, September 30, 1977; Mental Health Windsor-Essex, Public Forum, Thursday, May 11, 1978 (see Appendix B); the reader may wish to look at the bibliography listing to see the works done by many professionals of different mental health disciplines.
be based essentially not on an assessment of past deeds but on a prediction of future ones. ¹¹

Since recent studies have indicated (these studies will be investigated in more depth later in the study) that the necessary requirement for documentation of a "Physician's Application for Involuntary Admission" is not being legally met, as outlined by the Mental Health Act, R.S.O. c.269, s.8, the majority of psychiatric patients who are committed under civil proceedings have certain legal and civil rights taken away from them. As social workers and social agencies are in the position to have direct contact with psychiatric patients, they are therefore likely to indirectly and unintentionally over-step the legal boundaries of patients' rights. Consequently, by their example they are also in a position to affect adversely the dominant beliefs held by other mental health workers, social agencies, and public opinion toward mental illness and the psychiatric patient. The opposite is also true.

Social Work: A Helping Profession

Social work is not only a helping profession; it is also a responsive profession concerned about the stress of everyday life events that face individuals. Social work

¹¹Brief submitted to The Honourable Dennis Timbrell, Ministry of Health, Ontario by the Canadian Civil Liberties Association on March 28, 1977.
has evolved from an emphasis on coordinating the charity efforts of voluntary groups in the late 1800's into involvement in many areas of governmental and private efforts to improve life conditions. Its recent direction has been to work with groups which are not part of the influential and decision-making elements of society. This shift of attention has evolved due to social work's concern for expansion into new fields of endeavour in its bid to meet the needs of its clientele, especially through advocacy. In spite of such efforts, the trend in today's society of social dehumanization and non-interpersonal relationships has, in many ways, directly affected the focus of attention in social work. Social work roles and functions also tend to reflect the way in which social workers carry out their functions and may take on the appearance of apathy.

Social Work: Code of Ethics

A consensus on professional conduct, a professional code of ethics, has evolved with the historical development of social work. The code of ethics of the Canadian Association of Social Workers states that:

Social work is a profession which endeavours to foster human welfare through professional service and activities aimed at enhancing, maintaining or restoring the social functioning of persons. Its members believe in the dignity and worth of each human being regardless of individual differences. It employs a body of knowledge, skill in human relationships, . . . and social action to change conditions and practices infringing upon individual
rights and human well-being.

It is committed to creating and maintaining social institutions sensitive to human needs and supportive of human fulfilment and to changing or abolishing institutions and systems which do not serve the public good. ¹² [Italics are those of the researcher.]

Both the Canadian Association of Social Workers and the Ontario Association of Professional Social Workers have adopted twelve professional obligations based upon the fundamental values and principles of the profession of social work. These should determine the professional behaviour of its members.

One of the more important professional obligations for a social worker is:

To work for social change required to promote the well-being of all citizens and to participate with colleagues and others in social action and social intervention designed to effect change consistent with the values, goals and objectives of the profession. ¹³

Thus, social workers, under the professional code of ethics and obligations, have an individual as well as a professional responsibility to speak out against social injustices. They have been given a directive by their professional association to work for social change and the betterment of any client or client group in need.


¹³ Information for Prospective Members, Ontario Association of Professional Social Workers, information pamphlet.
The Social Worker as Advocate

Since social workers have been given a directive by their professional association to work for and promote social change to protect individual rights, "advocacy" on behalf of the civilly committed psychiatric patient is an avenue that is wide open for social workers to explore. In an attempt to bring about meaningful reform in the treatment of mentally ill people, the advocacy role that social workers might assume could be vitally important. Operating outside of the mental health system, the social worker, in the role of advocate, is more likely to be objective than physicians or lawyers in evaluating both the correctness and quality of the medical and legal care to the psychiatric patient. The social worker's function of intervening effectively between the mental health establishment and the powerless, individual psychiatric patient, would add to the stature of the profession.

Moving into such a role, the social worker advocate, within the mental health field, would be strategically placed in a position to evaluate the specific consequences of both medical and legal decisions regarding the psychiatric patient. Such a role would allow the advocate to challenge or to make recommendations on practices, regulations, and statutes which affect the legal and civil liberties of the patient. Through the advocate role, the social worker would
have a prime opportunity to transmit to the policy-makers and legislatures the deficiencies he perceives in the legislation and in its administration.

The most important personal quality for the role of advocate would be the social worker's aggressiveness in ferreting out injustices associated with involuntary civil commitment of mentally ill people. In this attempt to rectify these social injustices, the advocate may have to influence the public's attitude through social education and build up public reaction against inhumane conditions and loss of personal freedoms.

Importance of the Study

The most critical variable for implementing a sensitivity to patient rights, independent of written codes, formal statements of law, and administrative degrees, lie in the values and attitudes of all mental health workers.\(^{14}\) [Italics are those of the researcher.]

A major responsibility of a social worker and any mental health professional is to create an environment beneficial to the psychiatric patient. One step toward the attainment of this condition is to treat all mentally ill people as individuals with respect and dignity and to respect the rights and privileges of every patient guaranteed to them by law. In order not to infringe upon the legal rights of mentally ill patients, social workers must make

themselves aware of the laws which pertain to the care of the mentally ill as established by the Province's Mental Health Act.

Social workers who work in direct conjunction with psychiatric patients need to be familiar with the laws governing admission to a psychiatric facility. It is important for social workers to know what hospital rights and obligations are associated with the different hospital admission statutes. It is also of the utmost significance for a social worker to discern what legal and civil liberties may be restricted or denied a hospitalized psychiatric patient upon admission. These restrictions should be conveyed to the patient and family members upon his admission to the psychiatric facility.

It is felt by the researcher that some social workers have been reluctant to deal with the issue of legal and civil rights of the psychiatric patient. Therefore, an examination of social workers' attitudes on this issue will bring to the forefront their concern for and awareness of the needs and rights of the patients. Awareness of the mentally ill person's legal and civil rights on the part of social workers will, in turn, lead to better worker/client relationships and better treatment conditions. A concern for human rights will, in turn, help to break down the dehumanization and stigmatization process of psychiatric hospitalization.
It is felt by this researcher that the study will direct itself to this issue and begin a long campaign for the legal, civil, and human rights of patients in psychiatric facilities.
CHAPTER II

REVIEW OF THE LITERATURE

Evolution of Man's Views on Psychopathology

The Ancients and Demonology

Mental illness has been with man throughout his entire evolution. From the earliest knowledge of primitive man to the developing civilizations of China and Egypt, the ancient laws that governed the mentally defective person were based on forms of taboos and tribal customs. Throughout this historical period, possession by demons was the prevailing explanation for mental disabilities. It was felt that such maladies were the result of supernatural forces: the only cures depended entirely upon magic, brutal surgical procedures, or physical tortures.

Early Chinese and Egyptian references to mental disorders generally attributed mental illness to demons which had taken possession of the individual's mind or body. As these civilizations already attributed many apprehensive events of their daily life (thunder, lightning, storms, sickness) to "good" or "evil" spirits, it was only natural that they would extend this theory to the in-
comprehensible behaviours of their fellow man.\textsuperscript{15}

Possession by either good or evil spirits was usually determined by the individual's behaviour. Spiritual or mystical overtones in speech or actions appeared to suggest that the person was possessed by a good spirit or god. On the other hand, excited overactive conduct or behaviour, contrary to social norms, indicated possession by a bad or evil spirit. Possession was, therefore, wrapped within a mystical cloak which represented the wrath and punishment of a demon. Exorcism was the primary type of treatment available for demonical possession.\textsuperscript{16}

Flowing from man's maturation and more highly developed civilizations, treatment once in the hand of shamans was taken over by priests. A curious mixture of priest, physician, and magician, these divine individuals practiced a doctrine dominated mainly by beliefs in demonology and established exorcistic practices. The care of the mentally ill began to be carried out in temples by these priest-physicians. Their ministration of ritual ceremony consisted of prayers, incantations and purgatives, which had medical connotations. These priest-physicians, it

\textsuperscript{15} James C. Coleman and William E. Broen, Jr., \textit{Abnormal Psychology and Modern Life} (Glenview: Scott, Foresman and Company, 1972), ch. 2.

\textsuperscript{16} Frank T. Lindman and Donald M. McIntyre, Jr., \textit{The Mentally Disabled and the Law} (Chicago: The University of Chicago Press, 1961), pp. 5-12.
appears, were the first to supplement demonology with scientific treatment for the mentally ill.

Early Greek and Roman Concepts

During the Golden Ages of Greece and Rome, great strides were made to dispel the previous theory that mental disabilities were supernaturally induced. Greek physicians and philosophers began to view mental illness as a natural phenomenon. Great philosophers such as Hippocrates, Plato, and Aristotle slowly began to drift away from the notion that the body was befouled by an evil spirit who caused the mental disturbance. These philosophers emphasized the opinion that mental illness was associated with brain pathology and that man was motivated by his physiological needs as well.¹⁷

Hippocrates, through his clinical observations and daily recordings of patients' behaviours, commenced to classify and categorize what he believed to be various forms of mental illness. It is interesting to note that such charting and recording of behaviours is routinely done today by numerous mental health professionals on psychiatric patients.

Plato investigated disturbed individuals who committed criminal acts and endeavoured to have these

¹⁷Ibid., p. 6.
individuals exempt from serious punishment. In review, this is purported to be the common law origin of our insanity defense in criminal justice. Furthermore, Plato advocated more humanitarian treatment of the mentally ill through supervision in the community by relatives. However, Aristotle retained the general belief of his time that mental disorders were partly caused by organic, moral and divine elements.¹⁸

Roman physicians continued in the tradition of their Greek counterparts. The medical advances made during the Roman era gradually caused mental illness to be viewed as a medical problem rather than a supernatural one.¹⁹ Although this was an age of historical advancement in the pursuit of medical treatment of abnormal behaviours, the significance of these medical ideas and theories was far outweighed by Roman law which offered the earliest legal references to the mentally ill. Early Roman law stated that, "If a person is a fool, let this person and his goods be under the protection of his family or his paternal relatives, if he is not under the care of anyone."²⁰


²⁰ Ibid., p. 8.
As Roman law evolved, a magistrate had judicial authority to designate a guardian to exercise control and supervision over a mentally defective person. Guardianship was suspended during the person's lucid moments, but became operative again as soon as the illness returned. Roman law also extended itself into the field of contracts and tort law on behalf of the mentally ill person. Furthermore, Roman law prevented the afflicted person from entering into valid contracts, for it was assumed that the person did not possess the needed judgment. Surveying the present Mental Health Act and certain other legal statutes, the researcher found laws in mental health legislation comparable with those mentioned above. Certain of these statutes will be touched upon in more depth later on in this report.

A Revival of Demonology:
The Middle Ages

With the downfall of the Greek and Roman civilizations, the advances in medicine and other scientific pursuits completely collapsed. To fill the tremendous void that existed during this historical period, there was a revival of ancient superstitions and demonology. Ancient rites that had been deeply embedded in traditional cultures, but shunned due to the advent of Christianity, slowly began to emerge and flourish again. The treatment of the mentally ill, once again, rested with the clergy.
As religious beliefs concerning abnormal behaviour developed and were endorsed by the secular world, the clergy exhibited a great intolerance for deviation. With the ecclesiastics' adoption of demonical possession once again, exorcistic techniques became much more sadistic. In the Middle Ages, ecclesiastical tribunals were established by the Roman Catholic Church for the trial and punishment of "heretics". This is known as the Inquisition. As Medieval European society was dominated by the Church, social transformation came about through widespread and terrible human suffering. In such an atmosphere of change and uncertainty, the rulers of Europe, in a desperate effort to solve their problems, sought out scapegoats. Thus, from approximately the thirteenth century on, all manners of misfortune were blamed on witches or Jews. In order for society to rid itself of its misfortunes, the massacre of these "evil" persons became an accepted practice.

Undoubtedly, the Inquisition made the plight of the mentally ill intolerable. They were thought to be possessed by the devil or at least in league with him. Those who would have been considered obviously mentally abnormal by present standards, were victimized by the myths and beliefs

21 Nicholas N. Kittrie, The Right to be Different, pp. 50-63.
of the time. Like the Jews, the mentally ill were held responsible for all of society's ills. They became the scapegoats to be exterminated in order to cure the evils of society.22

Establishment of Asylums and Early Humanitarian Reform

As the Inquisition's idea of mental illness being a punishment by God or an alliance with the devil began to wane, there arose in its place a commencement of scientific activity. Whereas the Middle Ages persecuted the insane, the milder rulers of the Renaissance confined them within institutions. The mentally ill now became the charges of the State and responsibility for them was shifted from local to national authorities. Utilizing abandoned cloisters and monasteries, these state institutions provided the space and facilities to house and confine the mentally unfit. The new institutional mode nonetheless was compulsory and, like imprisonment, stood for complete social exclusion. These early asylums were modeled after penal institutions. The inmates were treated like criminals.

Szasz describes this era as the decline of the Church with the inquisitor-witch relationship disappearing; rising

22To read a dramatic account of the Inquisition, see: Thomas S. Szasz, The Myth of Mental Illness and The Manufacture of Madness.
in its place was an alienist-madman relationship. Even within this secular and scientific climate, conformity was still required. The non-conformist, the mentally ill who denied or refused to affirm society's dominant values, were still considered enemies of the state.

The proper order of society was no longer conceived in terms of "Divine Grace", but was instead viewed in terms of public health. The State's internal enemy was now seen as madness, and institutional psychiatry evolved in these early asylums as protection for society from this dangerous threat.

Although scientific skepticism had almost completely undermined the belief that mental illness was a form of demonology, these early mental facilities were no better than concentration camps. Long-term incarceration in these asylums was the only major public program for dealing with the insane. Early commitment procedures were very informal and viewed strictly as an administrative procedure. It was because of these inhumane social conditions that individuals such as Pinel, Tuke, Rush and Dix became involved in crusading for more humanitarian treatment of the mentally ill.

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24 Nicholas N. Kittrie, The Right to be Different, pp. 56-57.
The success of Pinel's and Tuke's experiments in more humanitarian treatment methods revolutionized the care of mental patients. Rush's extensive writings and Dix's zealous campaigns aroused the general American public and governmental officials to an awareness of the need for more humane care and housing for the mentally ill. Out of the work of these individuals and others like them, there emerged the beginning of the mental health movement.

Organic Viewpoint and the Medical Model

The emergence of modern experimental science brought forth tremendous knowledge within the fields of natural and social sciences. These advances further supported the concept of mental illness as a disease, with natural causes, scientifically understandable and treatable. Once accepted and admitted to the domain of medicine, physicians and psychiatrists have continuously searched for an organic base and a medical treatment for mental illness.

This tradition of medical psychiatry is best exemplified by Emil Kraepelin (1856-1926). Kraepelin attempted to discover the precipitating patterns of mental illness. He believed that through a proper nosological scheme, medical research would discover the organic cause of mental disease. Through this approach he began a classification system based on defining mental patients
according to their symptoms, thus identifying and classifying mental disorders. Synthesizing numerous observations of behaviours associated with specific disease entities, Kraepelin labelled the two most common forms of severe mental illness, *dementia praecox* and manic-depressive psychosis. Kraepelin postulated a biological defect within a person as the cause of mental illness.\(^{25}\)

These advancements led to the acceptance of a belief that organic pathology was the major cause of many psychiatric ailments. Physicians and psychiatrists began to apply these findings to mental disorders and viewed mental illness as a definite sickness, similar to that of a physical sickness. The organic viewpoint assumed further significance when Swiss psychiatrist, Eugène Bleuler (1856–1935) coined the term *schizophrenia* to characterize *dementia praecox*.\(^{26}\) He noted the important disharmony between the individual's intellectual and emotional life in the *dementia praecox* state.

In North America, the new founded medical model theory had a major consequence:

In the North American continent the asylums became medical institutions and their superintendents were actually both the experts in the area of mental


\(^{26}\) Ibid., p. 63.
health and also united to form the core body which in time became the American Psychiatric Association.  

For a time, this theory dominated the field of psychopathology. The "organic viewpoint" of mental illness which is based on brain pathology is well entrenched in psychiatry, even today. Such an avenue finally placed mental illness on an almost equal footing with physical illness. The medical model, as Thomas Szasz views it, holds that, "The contemporary physician must distinguish persons afflicted with bodily diseases from those afflicted with mental diseases."  

Psychological Approach to Mental Illness

Within the medical model there emerged a psychogenic orientation towards mental illness. Psychopathology, in the early 1900's, was now being conceived not only as diseases of physiological functioning but also as disorders caused by psychological factors. Out of the investigation of hysteria, evidence emerged that particular behaviours could be produced without voluntary participation or knowledge on a patient's part. The discovery of the psychodynamics of mental illness was made by Sigmund Freud. He


developed a psychological theory of human motivation and psychopathology and, in turn, designed a psychotherapy based on rooting out the individual's internal conflicts.

Freud's discovery has spawned numerous schools of thought on the nature of mental illness and these disagree with the issue of mental illness as a physical disease. The behaviouralists, humanists, existentists, and socially orientated clinicians argue that:

Continuing to think of psychologically disturbed behaviours in disease terms limits attention to essential ethical and social questions and keeps intervention within the institution of medicine. . . . The use of medical metaphors block proper understanding and treatment of psychosocial problems and should be abandoned.29

In review, it appears that there has been two major trends in explaining mental illness. One defines mental illness as a biochemical state and the other a psychological and social nature and treatment of pathological behaviour. In actuality, the current field on mental health is organized around three contrasting and conflicting orientations. The first is the traditional bio-medical approach associated with the Kraepelin theory. Second, there is the psychological approach following the Freudian concept; there are now included within this circle many divergent theories. Finally, there is the emerging psychosocial orientation which directs its attention to the

impact of social systems on mental health.

In summary, mental illness has less stigma since becoming associated with the organic viewpoint and the medical model. It is now thought that a person ill with a mental dysfunction can be treated, cured, rehabilitated, and returned to a normal state of mental health. However, if one receives treatment, he is regarded as being different from the rest of the members of society. The physician-psychiatrist's use of the medical model is based on organic treatment and custodial care which allows treatment based on psychiatric diagnosis.

This approach, however, has the tendency to keep the individual in a state of complete dependency, believing that he will be made well only by a doctor's or institution's treatment. For the first time, though, adoption of the medical model allowed mental patients to receive more humane treatment and care based upon scientific findings. Organic pathology and the medical treatment of mental disturbances remains, even today, the dominant practice within our medical society, though actively challenged by other orientations.

This overview has been presented in order to illustrate some of the historical antecedents of modern treatment of the mentally ill. The researcher feels that it has provided the reader with a flavour of what went on before and led to the adoption of present views and
attitudes regarding mental illness. As the next segment of the report will indicate, attitudes have changed dramatically over time, yet myths associated with mental illness still linger. One may question just how much the views have really changed from that of demonology.

Mental Illness

Defining Mental Illness

The efforts to define and classify mental illness have had a somewhat confusing history. The elusive process of defining mental illness reflects the fact that it is very difficult to determine and draw a line between the concepts or behaviours associated with mental illness and those of mental health. Owing to this uncertainty, there evolved an imprecise and mystifying comprehension of the exact nature, nomenclature, and uniform classification of mental illnesses. Behaviours which were acceptable at one time in an individual in his culture are not acceptable at another. What one society approves or condones as mental illness or mental health another society will censure and punish depending upon the time span of its history. As this statement indicates, an enormous amount of effort throughout history has been directed at defining mental illness. Even today, the continuum remains one of confusion, disagreement, and disorder, although psychiatry and
psychiatrists have wrested a monopolistic position in the field of mental health as diagnosers and explainers of mental illness.

Within the growth and development of the field of psychology there has emerged a number of psychosocial models of man. Each of these divergent models emphasizes contrasting views about the theory of man's personality and behaviour, the concepts of psychopathology, and the model's basic principles which pertain to its theory and practice techniques. Today, one finds many psychiatrists, psychologists, and social workers practicing various theoretical models. To many of the mental health professionals and especially the public at large, these divergent theories confuse the definition of mental illness and mental health.

Opposite Ends of the Spectrum

At one end of this broad spectrum of definitions of mental illness is the psychoanalytic concept and explanation advanced by such men as Sigmund Freud, Carl Jung, Alfred Adler and Carl Menninger.\textsuperscript{30} Though differing in

\textsuperscript{30} Though Freud counseled mainly individuals with neurotic tendencies, he began the first systematic attempt to discover and answer the growing recognition that many mental disorders may have a psychological base. Both Jung and Adler were prominent students of Freud. However, they were dissenters who felt that the Freudian system placed too much emphasis on sex as the major determinant of behaviour. Thus, both these men found their own schools of psychology, the Analytic and the Individual Schools respectively. Menninger has stayed more or less within the general theoretical framework of the Freudian concepts.
parts, each views man's relationship between his intrapsychic subsystems of id, ego, and super ego as crucially significant in determining man's behaviours. Mental illness occurs, therefore, when the individual is unable to resolve the conflict of his intrapsychic subsystems which arise as the person passes through a series of dynamically different sexual stages of development.

At the other end of the mental illness spectrum, there are the theories and concepts advanced by such men as Thomas Szasz, E. Fuller Torrey, and Nicholas Kittrie. These men argue that mental illness is an inappropriate term for most abnormal behaviours. They view mental illness as the result of social and psychological problems originating in a person's attempt to cope with everyday life events, rather than from organic, chemical, or neurological imbalances in the body.

In general, these various theories determine not only the way a psychological disorder is conceived, but

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Thomas Szasz has been predominantly associated with the attack on the medical model and the lessening of its influence in psychopathology. In his books The Myth of Mental Illness (1961), Law, Liberty and Psychiatry (1963), The Manufacture of Madness (1970), Schizophrenia: The Sacred Symbol of Psychiatry (1976), and Psychiatric Slavery (1976), Szasz argues that mental illness is an inappropriate term to use. He maintains that mental illness is a metaphorical disease and psychiatry is not a medical, but a moral and political enterprise; E. Fuller Torrey, The Mind Game (1972) and The Death of Psychiatry (1974); Nicholas N. Kittrie, The Right to be Different (1971).
furthermore how it is defined. The different orientations not only determine how mental illness will be studied and treated, but also the professional roles clinicians and institutional settings will play. Since there is no one acceptable explanation of mental illness suitable to the various theories, interpreting mental illness has become a vague and elusive process.

Since mental health professionals often disagree among themselves as to the definition, classification, and cause of mental illness, the legislative body in whom the power rests to write mental health legislation has been placed in a situation where its interpretation of mental illness has to be broad enough to encompass the whole spectrum of psychopathology. Due to this situation, the definition of mental illness remains vague and loose in order to act as a general catchment statute. In fact, the present-day legislative definition for mental disorder is "'mental disorder' means any disease or disability of the mind."32

Diagnostic and Statistical Manual of Mental Disorders I, II, III

In an attempt to define mental illness, the American Psychiatric Association devised specific standards for the

diagnosis of psychiatric disorders. The Diagnostic and Statistical Manual of Mental Disorders represents a somewhat loose, incomplete, and inadequate description of categories characterizing problems associated with society or the sufferers. The categories outlined in the three manuals, nevertheless, make all the difference in how an assumed mentally ill person's problem is regarded by the therapists of different orientations, institutional and hospital settings, and health care and insurance company programs.

Often, the terms used in these manuals have administrative or legal consequences for the individual classified as being mentally ill, rather than simply serving as a guide, description, or treatment classification manual. The label the mental health professional chooses for description may carry with it the authority to

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In 1952 the American Psychiatric Association introduced the first Diagnostic and Statistical Manual of Mental Disorders. This manual was revised in 1968 with the introduction of the second edition of D.S.M. II as an attempt to bring American usage more in line with international practice and to coincide with the World Health Organization's publication of its own manual, the International Classification of Diseases. Since 1973, the American Psychiatric Association has been preparing a new revision of its manual. The new manual is being field tested at this time in 80 institutions in the United States to determine its workability of diagnostic categories. The D.S.M. III manual will become official if it is accepted at the American Psychiatric Association 1979 annual meeting.

It is important to note here that both these manuals, D.S.M. III and I.C.D., are used in Canada for the diagnosing and classification of mental disorders.
formally commit or release a person to or from a 
psychiatric facility. The label may determine the legal 
and civil liberties afforded to the patient as well as if 
he will be held for criminal proceedings.

In the past with the **Diagnostic and Statistical 
Manual I** and **Diagnostic and Statistical Manual II**, "Much of 
the controversy over D.S.M. III comes from its definition 
of the term 'mental disorders'. To qualify as a disorder, 
a patient's problem must, in its extreme form, cause him 
distress or disability." Goldman indicates that, like 
its predecessors, D.S.M. III is "bloat" with a number of 
ew categories in keeping with the so-called major advances 
in diagnosis and treatment techniques.

As with the earlier introductions of the American 
Psychiatric Association's manuals, a large segment of 
various mental health professionals feel threatened by 
the new D.S.M. III and are vigorously lobbying against it.

Clinical psychologists and psychiatric social workers 
are amongst those who charge that the manual tends to 
look at every problem as organic, thus representing 
a power play by psychiatrists to preempt their 
territory.34

Psychiatrists, who are viewed as the primary members 
of the mental health profession, once again appear to be

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33 Daniel Goldman, "Who's Mentally Ill?", *Psychology 

34 Ibid., p. 34.
attempting to interpret, on behalf of all members of mental health organizations, mental illness in such a way as to provide an all-embracing phrase that will service the medical model and opinion. Nevertheless, what remains, even today, are various mental health professionals practicing from different orientations of mental illness. Thus, numerous professionals and the vast majority of the lay community are still left to decipher the vagueness and differences of unresolved positions on the nature of mental illness. At this time, however, psychiatry, psychiatrists, and the medical model concept from which these physicians practice hold the dominant position in society when it comes to explaining who is mentally ill and the type of disorder from which one is suffering.

Mental Illness is Present when Someone Says It Is

People are concerned about being designated as different from their relatives or friends. Owing to this fear, many people who require professional help do not seek it and those who are hospitalized are extremely distressed about being labeled mentally ill. Thus, mental illness is established not by physical realities, but by social ones, even though mental health professionals still attempt to impose a medical diagnosis and rehabilitative treatment program.
Rarely does an individual consider, let alone declare himself mentally ill. In reality, people generally consider a person mentally ill on the basis of some of the following information:

1. He is under psychiatric care.
2. Respectable, influential members of the community (teachers, judges, parents, spouses, priests) agree that his behavior represents a given degree of maladjustment.
3. A psychiatrist or clinical psychologist makes a diagnosis of mental disturbance.
4. His test scores on psychological self-report inventories deviate by a specified extent from standards of a group designated as normal.
5. He declares himself to be "mentally sick" either explicitly or through his expressed feelings of unhappiness, anxiety, and inadequacy.
6. He behaves publicly in such a way as to call attention to his behavior as deviating from standards accepted by the majority of others in society.\(^\text{35}\)

The researcher wishes to point out at this time that these same behavioural factors influence the civil commitment process of forcing the detention of an individual in a psychiatric facility. In conjunction with the professional's interpretation of mental illness, "Canadian commitment laws do not adequately or precisely define 'mental disorder' or 'mental illness', although these are statutes generally alleged to be involved in someone's commitment."\(^\text{36}\)


As with the definition of mental illness, the physician is entrusted by society to interpret and cope with the vagueness of the mental health statutes in accordance with his personal and professional responsibility, judgment, and integrity when he diagnoses mental illness or commits a person for psychiatric treatment. The researcher will further examine these behavioural factors which help establish the criteria for defining mental illness later on in this report under the section dealing with civil commitment procedures. The researcher believes that it is evident that the material which is used to define a person as being mentally ill is also used to commit a person to a psychiatric facility either through formal or voluntary means.

The Premise Underlying the Definition of Mental Illness

It is perfectly clear, therefore, that in Ontario's jurisdiction, the interpretation of mental illness and the committal of those individuals so identified as being mentally ill serves more than a simple medical objective. It appears that the assumed predominant objective is for the protection of the public from the mentally ill person. The second objective is to protect the individual from himself. In order to accommodate the process of commitment, the medical and judicial professions have not required or
challenged one another for a precise definition of mental illness. This practice has consequently allowed for vague, all-encompassing statutes to determine who defines the circumstances, under public authority (usually psychiatrists or physicians) to interfere with an individual's personal freedom. The purpose of a definition of mental illness in a commitment proceeding is to identify the mental condition of the individual whose status is to be changed, since his personal liberty is to be infringed upon by apprehension, detention and forced treatment. Although a somewhat precise concept of mental illness is required for civil commitment, both the medical and judicial interpretations associated with mental illness and civil commitment are conspicuously nebulous.

The whole premise underlying the concept of involuntary hospitalization is currently based on one of (or a combination of) the following postulates: that the individual in question is mentally ill and dangerous or that the patient is mentally ill and in need of treatment for his own welfare, a state which he does not recognize because of the severity of his mental illness.37

Owing to differences of opinion between individual members of the mental health profession and because of the vagueness of the statutes contained within the Mental Health Act itself, it is no wonder that it is nearly impossible for many mental health professionals to agree

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37 Michael Alfred Preszke, Involuntary Treatment of the Mentally Ill, p. 49.
upon a single definition of mental illness. The point is:
a person might be committed by one physician but not by
another. Therefore, the mental health legislation is not
applied on a consistent basis, and consequently is unjust.

Popular Misconceptions

Entangled among the mythology of value judgments
about mental illness are misconceptions held by a large
proportion of the lay community and some professional
mental health personnel. The major beliefs held by the
majority of the population are extreme ones. Most people's
beliefs centre around the suppositions of irrational and
dangerous behaviours possessed by the mentally ill person
for which there is no reasonable explanation.

One of the three leading misconceptions appears to
be the belief that the mentally ill person's behaviours
are always abnormal and bizarre. On the contrary, however,
the behaviours of most mentally ill individuals in and out
of psychiatric hospitals, are without a question for the
most part indistinguishable from that of "normal" people.
There is really no justification for such a sharp dividing
line between "normal" and "abnormal" behaviours. By looking
at behaviours in terms of a continuum, any behaviour then
has a socially acceptable range of occurrence and either
end of the continuum can be viewed as unnatural. 38

38 See: Sheldon J. Korchin, Modern Clinical Psychology,
pp. 530-538; David P. Bailey and Sharon O. Dreyer, Therapeu-
tic Approaches to the Care of the Mentally Ill, pp. 27-
30.
dividing line does not exist as sharply as people believe it does.

A second distorted view associated with mental illness is the concept that mental disorders are hereditary illnesses which run in families. According to present mental health knowledge, most abnormalities are not related to genetic factors and the fear surrounding this assumption is largely unfounded. Bailey and Dreyer suggest that, "Many authorities believe that while a person cannot inherit a specific mental illness, one may inherit a predisposition to certain types of mental problems." 39

Where it is assumed that a genetic factor may play a role in the development of a mental disorder, the precise nature or the importance of its role is not fully known or understood. Other than in those incidents where chromosomal or biochemical irregularities have been medically determined as the contributing component, the majority of mental disorders have functional characteristics. That is, the mental abnormality appears to be primarily the consequence of pathogenic family patterns and faulty learning, primarily associated with "social" rather than "genetic" origin. 40

The third and probably most common misconception that continues to persist with the general public, is the

39 Ibid., p. 5.

40 Ibid., pp. 3-7.
view that mental illness is incurable and the behaviours of a person so afflicted are dangerous. Berger states that the basic beliefs which many people possess about the mentally ill person is that, "Mental patients are all prone to act violently."41 As a result of these beliefs, mentally ill people are discriminated against in all areas of life, even though, "70 per cent to 80 per cent of all hospitalized mental patients recover, and most make a satisfactory adjustment in society."42 In fact, the vast majority of mentally ill people do not engage in violent or dangerous acts of behaviour before or after their hospitalization. The assumption of these beliefs on the part of society has caused untold misery for the mentally ill.

As already attested to, these misconceptions and the myths which surround mental illness cause various problems for the mentally ill segment of our population.

Myths are neither "true or false." They are "true" or "false" in their consequences when we believe them to be true or false, because we tend to act on our beliefs. Myths not only serve to interpret reality; they also create it.43

The possession of these various notions produces a sharp dividing line between behaviour patterns among people.

42 Ibid., p. 6.
The fear element of suspecting oneself of having a mental disorder makes many people afraid to admit to it, for if they should seek professional help, they are exposed to ridicule, misunderstanding, and discrimination, as well as the acceptance of the fact that they are abnormal. Most people do not hesitate to consult certain professional people for assistance. Yet, the majority of people are reluctant to go to professionals with their emotional problems because there is still the tendency to reject the mentally ill in our own society. Furthermore, there is the additional fear of one's own susceptibility to mental illness. The mentally ill person does not feel that other people could possibly feel or have anxiety, despair, or irrational impulses such as their own.

Stigma of Mental Illness

The brand that traditionally has been attached to mental illness from an earlier era still remains with our society. The label of mental illness so marks those designated people as being different from the rest of the so-called normal population. This value judgment implies that those individuals' behaviours be changed to be more in keeping with what is regarded as appropriate by society. Arising out of this belief has been a statutory program implemented to protect the individual and the community
from dangerous behaviours, real or imagined, supposedly possessed by the mentally ill. 44

The consequence of labeling has many implications for those so classified. First of all, labeling is permanent. Once the diagnosis has been made the person cannot escape the label. If labeled, one is either a mental patient or a former mental patient and this social stigma is carried for life. At the present time, mentally ill people are often committed to psychiatric facilities for their own good so that society can rehabilitate them. "The state has not only the right, but also the duty to make therapeutic intervention in the lives of individuals considered too disordered to act on their own behalf." 45

The individual who is diagnosed as mentally ill tends to lose his civil rights and privileges. On admission to a psychiatric facility he is customarily deprived of his personal possessions, legal and civil liberties, social status, privacy, and individuality. Throughout his period of institutionalization, his behaviour is closely regulated and fixed to the facility's routine. At the same time, the individual loses his civil liberties,


he finds himself having to abide by very stringent rules and regulations of hospital procedures.

The problem faced by the mentally ill person is the dehumanization process that he goes through once admitted to a psychiatric facility. Dehumanization occurs as the mentally ill person becomes aware that his existence is nothing more than a burden on his family, friends, and the staff. A sense of helplessness evolves as the person becomes aware that the social controls placed upon him are designed to make it easier for other people to manage him. Once he stops perceiving himself as having the same thoughts, feelings, and purpose in life that others do, he often psychologically eliminates any of his own human qualities and becomes a dehumanized object.46

Socially imposed values, myths, or misconceptions may cause dehumanization. Dehumanization is imposed in self-defense or rationalized as being for the public's good. Such conditions already fit the previously mentioned problems of mental illness: social values, misconceptions of beliefs and labels. All carry social stigmatization.

Dehumanization evolved in order to process large numbers of hospitalized people efficiently. Psychiatric facilities became more concerned with managing the flow of

patients, time schedules, and minimizing disruptions of hospital routines. Moving psychiatric patients in and out of the dining hall may take precedence over therapeutic concerns. "Despite updated clinical rhetoric, they are usually stigmatizing and demeaning institutions whose primary purpose is to control and manage, not to provide therapy."47 As society advances the values it perceives as desirable for the general welfare of its members, those who are viewed as being unfit or a threat to the majority are dehumanized for the public good. The public "rationalizes" that it is for the "best" that the mentally ill are institutionalized and in the process are subjected to dehumanization.

Social Exclusion of the Mentally Ill

As has already been discussed, every social era throughout history has devised ways and means to deal with the mentally disordered. Even at present, society still excludes the mentally ill populace from entering into and participating in social and community life. Basically, people perceive the mentally ill person as being, at some level, responsible for having become mentally ill. The public's unconscious reasoning appears to be that if there is no physical basis for mental illness, then the person

must have become dysfunctional through his own accord.

Ruch and Zimbardo offer a graphic representation of specific social behaviours that are generally considered unacceptable by society and which are responded to with punishment. These authors depict, along a continuum curve, levels of certain socially unacceptable behaviours and, associated with them, the punishment regarded as appropriate to fit the degree of intolerance. These writers show that neurotic behaviours receive social ostracism as their punishment, while psychotic actions gain isolated punishment and commitment to a mental institution. 48 This social ostracism or commitment of the mentally ill resembles the punishment that society reserves for criminals and other antisocial deviants.

Simply living in a community does not necessarily lead to social inclusion. The community in which the mentally ill person lives exercises "formal" and "informal" mechanisms designed to alienate him from community life.

By formal mechanisms we refer to the use of alternative legal and administrative procedures that seem to accomplish the exclusion and to the use of rules and regulations that serve the same function. Informal mechanisms are referred to here as the various group pressures reflected in neighbors' attitudes and various kinds of bureaucratic manoeuvrings that serve the functioning of exclusion. 49

48 Floyd L. Ruch and Philip G. Zimbardo, Psychology and Life, p. 558.

49 Uri Aviram and Steven P. Segal, "Exclusion of the Mentally Ill," Archives of General Psychiatry 29 (July 1973).
Physical exclusion of the mentally ill individual from a geographic location by a formal mechanism transpires when a person is committed to a psychiatric facility through the statutes of the Mental Health Act or the Criminal Code. Exclusion by informal mechanisms comes about through the process of ghettoization of the mentally ill. Their seclusion into a certain defined area appears to be due to community pressures. Citizens resist encroachment by the mentally ill person into their neighbourhood by enacting zoning laws, city ordinances, and regulations and applying neighbourhood pressure and bureaucratic manoeuvres. Many citizens base their resistance on outdated facts and myths associated with mental illness which continues to shroud, stigmatize, and dehumanize the mentally ill.

Public Attitude Towards the Mentally Ill

To date, the mental health movement's crusade to persuade the general public to adopt and accept the proposition that mental illness is just like any other illness has failed. Current survey reports indicate a public trend to possess negative (rejecting) valuations on persons diagnosed as mentally ill.

A review of the studies of the public's attitudes toward mental illness and mental health demonstrates
that the moral enterprise of promoting the "mental illness" metaphor has failed.  

From the mid-50's to the present time various studies have revealed that the public attitude toward the mentally ill person is a negative one. The general public lacks concern for, and is unwilling to assume some responsibility for conditions of mental illness in others. The Cummings' and Nunnally studies found that the vast majority of citizens have a marked tendency to reject people who are described as being mentally ill. The public usually assigns evaluations to the mentally ill as worthless, dangerous, and unpredictable compared to normal people.

The Phillips's and Crumpton studies also indicate a desire to avoid social contact by the lay public with those

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52 J. Nunnally, Popular Conceptions of Mental Health.

53 Ibid., p. 46.
persons said to be mentally ill. Generally speaking, when
the public is asked for ratings of the concept "mental
patient" they are likely to assign adjectives such as
"dangerous," "sick," and "unpredictable" to these people.
The lay population's general attitude about psychiatric
hospitalization favours incarceration, a penal-type of
hospitalization, or external management.

Sarbin and Mancuso, in summarizing their findings,
suggest that foremost the public is not sympathetic towards
people labeled mentally ill. They also conclude that
society possesses a negative and disrespectful attitude
towards the mentally ill populace. Sarbin, in 1969, had
already argued that, "a mentally ill person is relegated to
a degraded status, to the social identity of a nonperson."54
Nevertheless, the public states that mentally ill people
should have help available. However, they personally feel
that it is a good idea to have them segregated and out of
the community. Sarbin and Mancuso terminate their findings
with this statement:

The public has a low opinion of the efficacy of
psychiatric treatment, and expresses little confidence
in the state of knowledge on psychiatric matters.55

54 T. R. Sarbin, "The Scientific Status of the Mental
Changing Perspectives of Mental Illness (New York: Holt,

55 Theodore R. Sarbin and James C. Mancuso, "Failure
In their final analysis they conclude that the work done by the mental health professionals has failed. The metaphor of mental illness has been transformed by the lay community into a myth. As the above studies have indicated, the label "mental illness" has become a degrading one.

Professional Attitudes Toward the Mentally Ill

Investigators who have studied the attitudes of professional and non-professional hospital personnel regarding mental illness and the mentally ill person have ascertained a difference in the attitudes between hospital workers and the general public.\(^\text{56}\) Hospital employees differ from the lay public on estimating a shorter length of stay for hospitalized psychiatric patients. There is a greater difference between hospital and community people regarding whether more men or women require psychiatric hospitalization. In ranking thirteen hypothetical causes of mental illness, hospital personnel and lay community people picked the same

cause in the top five positions, (way the parents treated the child, deformity or injury of the brain, alcohol, unfortunate life experiences, and heredity) although they did not rank them in the same order.\footnote{Fred H. Wright and Robert A. Klein, "Attitudes of Hospital Personnel and the Community Regarding Mental Illness," \textit{Journal of Counseling Psychology} 13 (1966): 107.}

Wright and Klein compared hospital personnel to lay community people to determine if there were any differences in beliefs about mental illness between these two groups. At the same time, they also compared personnel categories within the hospital setting itself. The results obtained from this study indicated that, "the mean acceptance score for the hospital personnel was more favorable than the community at large."\footnote{Ibid., p. 106.} Of the professional treatment personnel, social workers received the highest mean composite acceptance score on the Wright Mental Illness Questionnaire, Form I.

These investigators advance the position that social workers and registered nurses have more acceptable attitudes towards the mentally ill and mental illness in general due to their formal education and training within their chosen professional field. These researchers also suggest the theme that persons who engage in mental health services possess an attitude which is favourable to
psychiatric patients and view mental illness as less of a threat to society compared to other hospital personnel and individuals within the community.

Recently, some researchers have investigated the staff attitudes towards patients in psychiatric care. Some of these researchers related treatment milieu to treatment-disposition behaviours in four hospital units with comparable staff and patients. A significant point found by these investigators was that there is a strong belief among hospital staff that patients should be informed of their psychiatric condition. Therefore, staff who endorse attitudes of informing psychiatric patients about their condition also endorsed an openness and frankness in interaction and interpersonal relationships with patients.

The DeWolfe, Barrell, Spanner study investigated staff attitudes towards patient care and treatment-disposition behaviour in a large psychiatric hospital.


Their major finding indicated a positive relationship between three of the seven patient care attitude areas measured: a) interpreted rules in an authoritarian manner; b) thought patient should be told of his condition; f) viewed patient unfavourably. Even those who endorsed a more authoritarian stance and held less favourable attitudes towards the mentally ill patient believed that the patient should be informed of his psychiatric condition. These researchers expressed an opinion that when psychiatric hospital staff endorsed attitudes of informing patients about their condition, they were, in reality, endorsing openness and frankness in relationships with patients. They further suggested that the common thread among the three attitudinal areas which correlated, was a generalized open and frank approach in working with hospitalized psychiatric patients.61

These researchers further related these three patient care attitude areas to a measurement of trust as reflected in the condition under which a patient was released from psychiatric hospitalization. They obtained a significant positive relationship between all three attitude areas and the trust measure. These findings further supported the openness, frankness, and trust interpretation of the relationship between staff and patient at this particular

facility.

In summary, the DeWolfe et al. study indicates that hospital staff personnel apparently work from an orientation that involves acceptance of a more authoritarian and less laissez-faire approach to patient care. Staff are less accepting of psychiatric patients as they are, but place greater trust in the ability of the patient to handle stress. The researchers conclude, "Thus, it is possible that the proposed openness, frankness, and trust orientation might also include an orientation towards helping patients change." 62

A number of experiments have been designed to trace the route taken by a psychiatric patient to hospitalization and the influence, if any, it may or may not have had on the staff members' predictions of the patient's behaviour. 63 All these studies supported the assumption that the events preceding entry into hospitalization, as well as the attitude and behaviour of the patient, occupied a place of importance to hospital staff members.

62 Ibid., p. 93.

The circumstances surrounding the decision of the patient to enter treatment and the legalistic definition with which he enters provides the staff with clues to the patient's future performance as an inmate.\textsuperscript{64}

Mental health personnel gave higher ratings to patients entering under a voluntary legal status. They gave higher mean self-presentation and conformity ratings to voluntary patients than involuntary patients.

It was found that staff members anticipated that patients who entered psychiatric hospitalization voluntarily would be more interactive and conforming than those who did not enter voluntarily. Staff members also tended to believe that patients who entered the hospital due to a family decision would be better patients. The hospital staff members again rated those individuals who entered because of a primary group referral higher on the mean self-presentation and conformity scales, compared to those individuals referred by an outside agency. Such findings lead the researchers to conclude that patient role behaviour is, in part, determined by the attitudes held by staff members and the roles in which they function.

A large amount of research has also been done regarding patient/staff variables in the decision-making...  

\textsuperscript{64}Norman K. Denzin and Stephen P. Spitzer, "Paths to the Mental Hospital and Staff Prediction of Patient Role Behavior," p. 266.
process which results in psychiatric hospitalization. One of the major findings of the Bartolucci, Goodman and Streiner study of the characteristics of the decision-maker was that social workers admit mental patients less frequently than do psychiatrists. This differential was attributed to the difference in training between these two mental health professional groups. The psychiatrists evidently reflected their medical approach and relied on hospitalization.

The reluctance to hospitalize on the part of social workers is further supported by Fontana, Gessner and Lou. In their study, these researchers documented that social workers report patients' complaints and symptoms as accurately as psychiatrists. In fact, social workers are much more accurate at reporting complaints of cognitive confusion.

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In summary, these authors indicate that social workers and psychiatrists report patients' complaints quite well. Generally though, social workers' recommendations are highly related to their patient's expectations. The most pronounced difference between the judgment of social workers and psychiatrists regarding treatment approaches used, however, was in the greater emphasis placed upon inferences by psychiatrists and upon patients' stated expectations by social workers.

Though much has been written in regard to mental health professionals' positive frame of reference to mental illness and the mentally ill, other authors write in reference to this subject:

Public authorities and the community have such guilt about their attitudes toward the mentally ill and the inadequate treatment services provided that they are like the ostrich which hides its head in the sand.68

Those authors who write in this vein appear to be saying that for many years hospital staff personnel and administrators have only given lip service to the medical model that the mentally ill are sick people and should be treated as such. Basically, these writers are saying that many psychiatric facilities seem insensitive to change.

68 C. A. Roberts, "Let's ... Do Away with Mental Hospitals!," Canada's Mental Health 5 (May 1961):11.
originating from within. They state that it is not an uncommon observation to view a large portion of mental health staff for which significant change does not seem to be a salient issue. Since the avenues of power, authority, and lines of communication run vertically, based upon professional training hierarchy, there is a tendency to resist or defeat activities likely to produce change.

Page also argues that public psychiatric facilities are relatively insulated and closed social systems. The daily functioning of the staff and therapeutic treatment is characterized by bureaucracy, inefficient communication and professional staff differentiations. Owing to this milieu, it would appear to be an unlikely arena in which moral and philosophical issues are raised and brought to the forefront. Furthermore, Page states that:

In institutional society, the moral worth of the institutional's practices is seen largely as a "given," authorized by legal statute and by the assumed consensus among professionals that the institution does exist for the purpose of housing society's misfits and incarcerating the socially

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gauche, even against their will. In fact, it is difficult to conceive how the institution could function, devoid of significant day-to-day disruption, without endorsing these very assumptions.

Nature of the Problem Today

In 1976, a total of 128 psychiatric facilities provided statistical information to Ontario's Ministry of Health. The facilities reporting comprised of 13 provincial psychiatric hospitals, 53 psychiatric units in general hospitals, 5 community psychiatric hospitals, 54 out-patient clinics sponsored by community agencies, and 3 private institutions.72

Table 1 offers a comparison of certain highlights of the recorded statistical mental health information among provincial psychiatric hospitals, psychiatric units of general hospitals and community psychiatric hospitals. It provides data in eight specific areas of interest. Referring to Table 1, the daily average patient population rate in the provincial psychiatric hospitals was 4,581, a decrease from 1975. The patient population rate was up from the previous year in both psychiatric units, 1,454, and community psychiatric hospitals, 447. The average


72For a more comprehensive view of statistical data concerning these facilities see: Hospital Statistics 1976, Public and Private Mental Health Services (Toronto: Data Development and Evaluation Branch, Ministry of Health, 1977) Table 26, p. 152; Table 25, p. 153; Table 33, p. 160; Table 32, p. 159.
Table 1
Highlights of Mental Health Services in Ontario, 1976

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<tr>
<th>Psychiatric Units of Public and Community Psychiatric Hospitals</th>
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<td>Provincial Psychiatric Hospitals</td>
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<td>Number of facilities reporting</td>
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<td>Bed capacity</td>
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<td>Daily average population in hospital</td>
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<td>Admission by diagnosis</td>
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Table 1 - Continued

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<tr>
<th>Provincial Psychiatric Hospitals</th>
<th>Psychiatric Units of Public and Community Psychiatric Hospitals</th>
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<tbody>
<tr>
<td>Alcoholism without psychosis for 2,360 (17.0 per cent)</td>
<td>Alcoholism without psychosis for 2,500 (7.8 per cent)</td>
</tr>
<tr>
<td>Mental retardation for 442 (3.2 per cent) of the admissions</td>
<td>Personality disorders for 2,013 (6.3 per cent) of the admissions</td>
</tr>
</tbody>
</table>

*Of the 14,112 admissions in 1976, 13,910 were analyzed and 45.6 per cent of those admissions analyzed were diagnosed as psychotic.

+Of the 33,044 total admissions in 1976, 32,031 were analyzed to provide statistical information.

Note: The writer designed this table to show a graphic comparison of 8 specific characteristics between the 3 types of psychiatric facilities.

length of stay was 21 days for psychiatric units and 39 days for community psychiatric hospitals. These figures represent a significant increase in average length of stay over the previous year's statistics. In all three settings, the number of patients on the books has decreased from the following year as well as the total number of patients under care for the year. Furthermore, males outnumber females in admission to all settings and schizophrenia is ranked either number one or two as the major diagnosis of admission to all three settings.

Data collected by the Ministry of Health from outpatient clinics did not provide for an analysis between provincial and local agency sponsored clinics. The Ministry only provided data collected from the 54 community out-patient mental health services. Total admission for these facilities was 50,332 in 1976, an increase over 1975. In contrast, there was a decrease in the number of terminations of 43,115 compared to 38,563 in the previous year. Data also suggested that 88.8 per cent of the cases were without psychosis. These out-patient clinics experienced an 11.6 per cent increase in the total number of patients served from 101,909 in 1975 to 113,776 in 1976. At year's end, there were 70,661 active cases.73

Three private psychiatric institutions reported to the Health Ministry in 1976. Their information indicated that they experienced very little change from the previous year. The total bed capacity of the private institutions remained at 342. There was an increase in the number of patients by four to bring their 1976 total to 323. The only other change in statistical data was an increase related to the number of days of care provided in the year from 118,976 in 1975 to 119,651 in 1976.\textsuperscript{74}

Under provisions of Regulation 576 of the province's Mental Health Act, the following hospital settings in Windsor are designated as psychiatric facilities:

- Psychiatric Units of Public Hospitals: Windsor
  - Hotel Dieu of St. Joseph's
  - Metropolitan General Hospital
  - Windsor Western Hospital Centre, Inc.
  - Community Psychiatric Hospital
  - I.O.D.E. Regional Children's Centre

- Community Sponsored
  - Windsor Western Hospital Centre (I.O.D.E.).\textsuperscript{75}

Under the Health Ministry guidelines, a mental hospital is considered an institution that provides treatment for all types of psychiatric conditions and includes

\textsuperscript{74} Ibid., p. xxii.

\textsuperscript{75} Mental Health Act, R.S.O., 1970, c.269, Regulation 576.
those facilities that are designed for long-term care. A psychiatric hospital is an institution providing short-term intensive psychiatric treatment, whereas a psychiatric unit of a public hospital is a unit within a general hospital organized for the treatment of patients with psychiatric disorders. Community sponsored facilities are those out-patient facilities sponsored by local agencies within a community providing for on-going psychiatric treatment to members of the community.\textsuperscript{76}

The 1972 Statistical Report (the latest data available regarding individual and metropolitan psychiatric facility information) indicated that Windsor's three general psychiatric units had a total referral population of 1,426 for the year ending December 31, 1972. Of that number, 1,382, or 97 percent, of those patients' source of referral was listed as "other medical." This appears to suggest that many family doctors (general practitioners) and psychiatrists within Windsor and Essex County accounted for the most significant means of hospitalization.\textsuperscript{77} One out of every three psychiatric admissions to Windsor's


community psychiatric hospitals was through "other medical" as the source of referral.

Since there is no other accompanying information, the table offers a puzzling array of data concerning voluntary and formal admission into these psychiatric facilities. As there is a referral column for "self or relative" one must assume that this represents an involuntary admission inasmuch as "relative" can connotate a coercive measure on the part of the relative(s). If such is the case, the admission cannot be assumed a voluntary one.

In regard to "other medical" as a source of referral, one is left to wonder if this represents voluntary admission on the part of these individuals due to advice and guidance from the family, physician or psychiatrist, or whether it, in fact, represents a medical commitment through a Form 1, "Physician's Application for Involuntary Admission." If this is the case, Windsor's psychiatric facilities and medical practitioners have an extreme bias toward medical commitment and forced psychiatric hospitalization.

The average length of stay in a general psychiatric unit in Windsor in 1972 was 26 days. The three Windsor units had mean stays of 28, 29 and 21 days respectively. These figures compare fairly accurately to the average
length of stay (21 days) as documented by Turnbull in 1976. 78

In view of disposition on discharge, approximately three out of four patients of Hotel Dieu's psychiatric patient population in 1972 were discharged on the basis of self-integration back into community life. The remaining patients were placed with family or relatives who assumed the responsibility for the guidance of these individuals back into community life. Of the 653 discharged patients at Windsor Western Hospital Centre, 519, or 81 per cent, of the dispositions of discharge were transferred over to family or relatives. There were 76 psychiatric patients, or less than 11 per cent, who assumed their own responsibility for integration back into the social mainstream. At Metropolitan General, 302, or 95 per cent, of the psychiatric patients discharged were also released to family or relative guidance. 79

78 Teresa Turnbull, Ombudsman Evaluation Committee Report One (Windsor, Ont.: Mental Health/Windsor-Essex April 6, 1976); Ombudsman Evaluation Committee Year-End Report, July 1975–July 1976 (Windsor, Ont.: Mental Health/ Windsor-Essex, 1976). These two separate evaluation reports are based on the Ombudsman Project undertaken at Windsor Western Hospital Centre, sponsored by Mental Health/Windsor-Essex in conjunction with the Hospital Administration. The reports present the evaluation committee's findings and recommendations.

The Right to Treat the Mentally Ill: The Therapeutic State

Parres Patriae

Every society has its rules and it is expected that the majority of the citizens will conform to these rules. Nevertheless, every society has a fairly substantive group whose symptoms mark them for attention. These are individuals who are seen as non-conformists, described as being mentally ill or defective and who are often at variance with the socially acceptable standards and mores of their society. Though heterogeneous in composition, they do have one thing in common. Their behaviour is proscribed or controlled by law. "They also have the distinction of being increasingly sought out for 'treatment' instead of 'punishment'."\(^{80}\)

Criminal law has traditionally been the state's major tool for enforcing conformity on those who refuse or are unable to abide by its statutes. In its quest for social order, criminal law metes out penalties to fit the severity of the offense and the degree of guilt. These laws in their origins failed to differentiate the various classes of deviants. Consequently, to be mentally defective was as much an offense as to commit a violent crime.

\(^{80}\)Nicholas N. Kittrie, The Right to be Different, p. 3.
The departure from criminal sanctions began to increase during the late 1700's and early 1800's due to the evolvement of the humanitarian treatment concept. There evolved a concomitant utilization of the new medical model and treatment concept for social control. Western civilizations adopted a system of social controls described as "civil," "therapeutic," or "parens patriae," as derived from the English concept of the king's role as father of his country.  

The therapeutic state now places little or no emphasis upon individual guilt. Instead, much weight is placed upon the individual's physical, mental, or social shortcomings. Society now acts out of a parental role (parens patriae) when dealing with its deviants, including the mentally ill.

Additionally, the states are vested with the historic parens patriae power. . . . The classic example of this role is when a State undertakes to act as "the general guardian of all infants, idiots and lunatics."  

Society did not seek to punish, but to change or socialize the non-conformist through confinement, treatment . . . .

81 A more precise historical review towards the state's control over the mentally ill may be found in the following readings: Nicholas N. Kittrie, The Right to be Different (1973); Kent S. Miller, Managing Madness: The Case Against Civil Commitment (New York: The Free Press, 1976); Thomas S. Szasz, Law, Liberty and Psychiatry (1963); The Myth of Mental Illness (1961), The Manufacture of Madness (1970); Frank T. Lindman and Donald M. McIntyre, Jr., The Mentally Disabled and the Law (1961).

and therapy. The therapeutic state proclaimed more humane attitudes and promised greater skills for the control of antisocial conduct. It was also assumed that the individual would not require protection against the state who was supposedly acting in his behalf as "parens patriae" or guardian.

The authority of the state to exercise power over any individual can be traced to three distinct sources. The first conflict between the state and the mentally ill was the early confinement of deranged individuals in order to stop them from committing acts of violence. The second source was the guardianship of a person and control of their property as designed in medieval England. Originally, the role of feudal lord, the function was assumed by the king in the 13th century.

The King . . . as the political father and guardian of his kingdom, has the protection of all his subjects, and of their lands and goods; and he is bound, in a more peculiar manner, to take care of those who, by reason of their imbecility and want of understanding, are incapable of taking care of themselves.\(^{83}\)

Thus, the second source of state authority was found in the recognition of the state's position as "parens patriae."

\(^{83}\) Nicholas N. Kittrie, *The Right to be Different*, p. 59. It is interesting to note that Western civilization from Rome until today has shown a greater concern for the protection of the property of the mentally ill than for his person. Under our present Mental Health Act, upon admission of a patient to a psychiatric facility, that person has to be immediately examined by a physician to determine if that individual is competent to manage his estate and personal affairs. R.S.O., 1970, c.269, s.32.
Finally, the third source of state authority derived from the king's power over the indigent mentally ill as members of the pauper community. The mentally ill were at first charges of their local municipalities, towns or cities, until the Elizabethan Poor Law of 1601 shifted this responsibility to national authorities. Although the Poor Law had national sanctions, it was still enforced by local officials. The national control over the local action was very loose, leading to highly localized practices.

As these concepts began to evolve, society also began to recognize the special characteristics of the mentally ill. Recognition of the mentally ill's special characteristics surfaced once the insanity plea as a defense came into existence. A violent criminal offender could now be exempted from the criminal process. Thus, as more and better psychiatric institutions grew in number, the insanity defense helped to divest the criminal authority over the mentally ill. The citizens of society now began to house their social and criminal non-conformists or misfits in mental asylums.

84 Notable the years 1563, 1572 and 1576 were significant due to the laws that were enacted relating to the poor - taxes and enforced contribution of putting people to work. These acts were codified in the Acts of 39 Elizabeth, 1597 and 43 Elizabeth, 1601. For further information on England's effort to deal with the welfare of its people over six centuries see Karl de Schweinitz, England's Road to Social Security (Philadelphia: University of Pennsylvania Press, 1943).
But the new institutional model was also compulsory and, like imprisonment, stood for total social exclusion... confinement in the name of parens patriae was almost certainly more a preventive detention measure for the benefit of society than an individually oriented program of treatment.  

With the advent of the therapeutic state, society built on a foundation of science rather than faith. It abhorred the concept of "mens rea," or free will, and looked to descriptive and scientific indices such as mentally ill, alcoholic, psychosis. The therapeutic state believed in the curative power of science and it attempted to use science for the prevention and cure of socially unacceptable persons. The therapeutic state relied on its "parens patriae" powers and its state's responsibility for public welfare. Such powers allowed the state the right and duty to exercise civic control over its citizens and to force and compel individuals to undergo treatment. Thus, the therapeutic state sought to impose its beneficial services in an authoritarian manner upon any deviant individual.

The state's parens patriae authority stems from its obligation to provide protection, and treatment for those who cannot provide for their basic personal needs as a result of a mental disorder. In contrast, the state's police power is used to protect the public rather than further the interest of the individual.  

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85 Nicholas N. Kittrie, The Right to be Different, p. 61.
86 Kent S. Miller, Managing Madness, pp. 16-17.
The new institutional model stood for total social exclusion and, like imprisonment, was compulsory. Confinement under the early efforts of "parens patriae" was almost certainly a detentional measure for the benefit of society, rather than an individually oriented program of treatment. Under the common laws of the time (1700's - 1800's) an insane offender was exempted from criminal punishment. The person was usually turned over to the care of the local magistrate who confined him in jail as a means of protecting the community. Society's utilization of repression, correction, and therapy was the dominant means of controlling the insane and other deviants. It was not until the middle of the nineteenth century that any special programs for the mentally ill were possible. It was at that time that the provinces of Canada began to adopt civil commitment laws.

Long-term commitment to insane asylums became the major method of dealing with the mentally ill. Commitment at that time was strictly viewed as an administrative procedure. An order from a public official, medical doctor, or the police was sufficient authority to admit any individual to a mental institution. The cornerstone of the full-fledged, modern therapeutic state was laid in Ontario in the early 1830's. Commitment laws were enacted which specified the removal of a person judged to be mentally ill from his usual surroundings to an institution.
authorized to detain and treat him.

Under this doctrine, the state has not only the right, but also the duty to make therapeutic interventions in the lives of individuals considered too disordered to act on their own behalf. 87

This was the direction taken by Ontario in the early design of its mental health legislation. Ontario's earliest mental health statutes, therefore, authorize commitment by court order of individuals considered to be too dangerous to self or others to be at large within their community.

Evolution of Legal Statutes in Ontario 1830-1970

The earliest provision in Ontario for mental health legislation was an act passed in March, 1830, entitled An Act to Authorize the Quarter Sessions of the Home District to Provide for the Relief of Insane Destitute Persons in that District. Under this act, the clerk of the peace had to present the grand jury of the sessions with an account of the money expected for the maintenance of insane people within each district of the province. Based upon these expected yearly expenditures, the grand jury made yearly contributions for the support of the insane population in Ontario. The treasurer of the district allocated these sums of money to support the insane in either the common gaol or some other place. Throughout

this period, no institutions were set aside for the care of these people.

In May, 1839, Ontario passed another act entitled An Act to Authorize the Erection of an Asylum within this Province for the Reception of Insane Persons. The institution established under this act is now known as the Queen Street Mental Health Centre at 999 Queen Street West, Toronto. There were now facilities designed for the incarceration of mentally ill people, but commitment procedures for dangerous individuals still consisted of immediate confinement in jail. This detention was accomplished by an order obtained by a justice of the peace. The alleged mentally ill person could be detained indefinitely pending disposition of his case by the court.

Ontario legislation in 1877 provided that such an apprehended person might be discharged from jail only when a judge of the county court or two justices of the peace, along with two medical practitioners certified that he was not insane, and therefore not a proper person to be committed to an asylum. If sent to an asylum he was required to remain there until his discharge was directed by the Lieutenant Governor.88

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88 Mental Health Legislation in Canada, Health Care Series Memorandum No. 15 (Ottawa: Research and Statistic Division, Department of National Health and Welfare, March 1960). This memorandum is derived from the Martel Committee on Mental Health, which had a Federal Government mandate to define and make recommendations to the Department of National Health and Welfare on the Federal Government's role in mental health.
Court procedures have continued down to our present-day legislation and are found in a number of acts that relate directly to a person who is or is thought to be mentally ill.\footnote{See: R.S.O., 1970, c.269, s.9 and R.S.O., 1970, c.269, s.10 of Ontario's Mental Health Act, 1970 as well as the Mental Hospitals Act of Ontario. The Mental Hospitals Act required a judicial hearing to begin within 24 hours after a court warrant had been granted for the apprehension of an alleged mentally ill person. It also further stated that within another 24 hours a mental examination must be completed upon the person so named in the warrant.}

In general, the power of commitment has increasingly been a medical one rather than one of judicial authority. The system of medical certification has not really changed essentially from the earlier provisions established by the 1877 statute.\footnote{An Act Respecting Lunatic Asylums and the Custody of Insane Persons, S.O., 1877, c.220 (Toronto: King's Printer, 1877).} Under this act, three certified physicians were responsible for examining a patient and formulating their own medical opinion, independent of one another, regarding commitment.

Along with admission procedure changes, Ontario introduced modern terminology into its mental health legislation. "In designating conditions of mental disorders, such words as 'insane,' 'lunatic,' 'feeble-minded' and 'idiot' have disappeared from the statutes."\footnote{Mental Health Legislation in Canada, p. 2.} Ontario formally replaced "lunatic asylum" with "hospital for the
"insane" in its 1907 mental health legislation. This law provided precise regulations in effect to the admission of patients. At this time, admission into a hospital for the insane was limited to voluntary patients, or to those individuals who had been certified by two physicians.

Incorporated in this new legislation, specific guidelines were advanced for the medical requirement of commitment. Physicians were required to personally examine the patient and write the specific facts upon which the physician based his opinion. The commitment certificate was required by law to be signed by the physician in the presence of two witnesses. The commitment certificate, along with a statement of the patient's finances, had to be presented to the administrator of the institution within three months of the person's entrance to validate the admission procedure.

The superintendent of a mental institution also had the authority to admit and detain any person who was considered in need of care and treatment who applied in writing for voluntary admittance. Judges could also order the arrest and conveyance by a police officer of any person deemed to be dangerously insane. In addition to this, any police officer was vested with the authority to detain for mental examination any person who appeared to be insane or

92 The Hospital for the Insane Act, S.O., 1907 (Toronto: King's Printer).
acted in an insane manner.

By 1907, Ontario was in possession of structures to control the management of the property of an insane person incarcerated in a mental institution. The superintendent of the facility forwarded a financial statement of the patient's property to an inspector. The inspector acted as a court-appointed "Public Curator" and became the provisional administrator of the patient's estate. The power of the inspector continued even after the patient's release from hospital depending on the person's mental condition and ability to administer his own estate. 93

In 1927, Ontario passed the Public Trustee Act. 94 This Act allowed a curator or a trustee to oversee the property of the mental patient. The trustee fulfilled the same role as the previous inspector did in the 1907 statute. Appointed by the Supreme Court, the trustee's position consisted mainly of administration and protection of the property of mental patients.

The next change in the mechanisms for admission did not take place until 1935. 95 In 1935, Ontario extended its

93. The Hospital Trustee Act, S.O., 1907, c.39 (Toronto: King's Printer, 1907).

94. The Public Trustee Act, S.O., 1927 (Toronto: King's Printer, 1927).

95. The Mental Hospital Act, R.S.O., 1935, c.39 (Toronto: King's Printer, 1935).
voluntary admission of patients for observation or short-
term treatment. "Under this new act, any person who was
mentally ill could be admitted to an institution as either
a voluntary or a certified patient." However, certain
categories of people, such as those suffering from senility,
infirmities of old age or incurable diseases, or persons
who were retarded, could not be accepted as voluntary
patients. Medical certification was based upon two
physicians' signatures, plus a statement of the patient's
property being supplied to the superintendent of the
institution.

After 1935, the Public Trustee was able, due to an
order of the Supreme Court, to replace any other individual
or committee and administer the institutionalized patient's
property. The Public Trustee also had the power to deal
with the property of a voluntary patient if such a patient
remained in an institution for more than three months. A
voluntary mental patient was also given the option of re-
questing, through writing, that the public trustee control
his property while he was hospitalized.

In 1967, Ontario up-graded its mental health legisla-
tion. It took into account the new liberalized theories on
mental disorders, treatments, and the social needs of

96 Lyne Langlois, "The Evolution of Legal Status of
Mental Patients in Quebec and Ontario - A Comparison."
Canada's Mental Health 24 (September 1976):3.
patients, their families and society. The Mental Health Act, R.S.O., 1967 introduced numerous statutes which made it easier to commit an individual under civil commitment procedures. However, for the first time, admission to a psychiatric facility could be refused based on certain conditions.

Under a Form 1, "Physician's Application for Involuntary Admission," medical certification became a much easier practice.

8.- (1) Any person who,
(a) suffers from mental disorders of a nature or degree so as to require hospitalization in the interest of his own safety or the safety of others; and
(b) is not suitable for admission as an informal patient,
May be admitted as an involuntary patient to a psychiatric facility upon application therefor in the prescribed form signed by a physician. 97

This application gave sufficient authority to any citizen to detain and convey the person so described in Form 1 to psychiatric facility. The facility is legally able to confine the individual for a period of not more than thirty days.

Forms 6, 7, and 8 98 of the Mental Health Act provide

97 The Mental Health Act, R.S.O., 1967, c.269, s.8

98 The Mental Health Act, R.S.O., 1967, c.269, Form 6 provides an order for attendance for an examination to determine whether a person is suffering from a mental disorder. Form 7 is an order for attendance for treatment at a psychiatric facility. Form 8 is an order by a judge for admission to a psychiatric facility for a period of not more than two months, for a person who appears before him whom he believes to be suffering from a mental disorder.
wide areas of latitude for justices of the peace and judges to bring civil commitment procedures against those individuals whom other citizens claim to be mentally ill. Should a justice of the peace believe that information presented to him indicates examination or treatment for mental illness, he has the power to sign the forms which, in turn, convey authority to any police officer to detain the named individual in an appropriate place for a mental examination or treatment, depending upon which form is used.

Police officers are also provided with broad powers under the 1967 Mental Health Act. Section 10 allows police officers to make personal value judgments regarding an individual's mental condition. If the officer believes that the person's manner indicates that the individual should be examined, the officer has the authority to detain the person and take him immediately to an appropriate place for a mental examination.

It should be noted, however, that admission of patients in Ontario does not have as restrictive a clause regarding the time limit for an examination of the patient. It is also important to note the broad powers of police officers to arrest any individual whom they identify as suffering from mental disorders.99

Since 1967, the Mental Health Act has required that:

99 Lyne Langlois, "The Evolution of Legal Status of Mental Patients in Quebec and Ontario - A Comparison," p. 3
Forthwith upon the admission of a patient to a psychiatric facility, he shall be examined by a physician to determine whether he is competent to manage his estate.\textsuperscript{100}

If found incompetent a Certificate of Incompetence is issued to the Public Trustee from the hospital administration. The Public Trustee may remain in power of a patient's property even after release of the person, if that person is still deemed incapable of managing his estate. Should an incompetent patient be re-examined and found to be competent, the hospital is required to issue a Certificate of Competence to the Public Trustee. The Trustee then ceases to act as curator upon receipt of this notice of cancellation, unless the patient requests, in writing, that the Public Trustee continue to administer his property for him.

The 1967 Mental Health Act was reviewed and revised in 1970. In comparing the 1967 and 1970 Acts, very few changes are found. Essentially, the system of medical and judicial certification has not changed drastically from the provisions of the 1877 Ontario statutes. If anything, the present Act makes it much easier for medical commitment because admission is now based on only one physician's signature.

However, due to important lobbying concerns, Health

\textsuperscript{100} The Mental Health Act, R.S.O., 1967, c.51, s.32, ss.(l).
Minister Dennis Timbrell inaugurated into Ontario legislation on December 13, 1977, *Bill 19* which amends the 1970 Mental Health Act, R.S.O. On Tuesday, April 11, 1978, Mr. Timbrell moved for a second reading of *Bill 19, An Act to Amend the Mental Health Act*. At the time of this writing, *Bill 19* was before the Standing Committee on Social Development which will take into consideration the pros and cons of the bill as viewed from many quarters before introduction of third reading.

Law and Psychiatry: Opposite Viewpoints

For the professionals of law and psychiatry, mental illness and the implications of civil commitment have been and still remain a double-edge sword.

Ambiguous terms of reference and the absence of a model of freedom acceptable to psychiatry and the law, seem to contribute much to the misunderstandings between the two professions in the field of mental illness and human freedom.  

When the judiciary enters the arena of mental health, the professions of law and psychiatry are found in confrontation. What is viewed as basically a legal problem has superimposed upon it, by the mental health professionals, a psychiatric


qualification of insanity or incompetence. On the other hand, in psychiatric facilities, what is viewed as a psychiatric problem also has superimposed upon it the legal qualification of constitutional liberties. Underlying this conflict is the power struggle between the two professions in their efforts to determine who has the major influence in controlling involuntary psychiatric hospitalization.

The debate between the lawyers and the doctors centres around what the method should be for involuntary commitment and detention of the mentally ill. Broader commitment standards are generally recommended by physicians as a means of reaching the mentally ill as soon as possible. "The medical profession basically believes that the law must remain as informal as possible, arguing that excessive legal formality is harmful to the individual."103 The lawyers oppose broader commitment policies in cases where neither public safety nor public welfare is in immediate danger. In such non-dangerous situations they feel there are not sufficient reasons or evidence to support deprivation of legal and civil rights.

The legal profession, on the other hand, states that the fundamental principles of justice (presence at the hearing, the right to legal counsel and trial

by jury, etc.) are guaranteed to all and must not be withheld from mental patients. 104

Alan Borovoy, General Counsel for the Canadian Civil Liberties Association, stated at the 1977 annual meeting of Mental Health Windsor/Essex that:

This is not exclusively a medical problem and doctors should not be solely responsible for the decision. They have the right to make a diagnosis and to tell us what they, as professionals, feel the patient may do if not confined. This is a medical judgment on a medical issue. But we, the community, should then make the ethical decision of whether or not that person's rights and freedoms should be taken away. 105

Throughout the history of their debates, psychiatry and the legal profession have competed in their claims of expertise and decision-making authority regarding psychiatric commitment. Each professional group believes that it should have the ultimate authority in this area and only be accountable to their own professional peers. Thus, the psychiatrists and lawyers find themselves deadlocked in their endeavours to define each other's role and consequently view each other with suspicion and distrust.

Specifically, there are several areas of disagreement between the two professions. As stated earlier, the medical profession favours "easy" commitment procedures.

104 Ibid., p. 66. In fairness to members of both these professions it should be pointed out that many lawyers and physicians sit on the opposite side of the fence in contrast to the dominant position of their professional group.

Doctors believe that the patient's needs are best met by easy and rapid placement into a psychiatric facility, without legal qualifications.

Psychiatrists have argued that the requirements of due process have stigmatized the patient, have made treatment less accessible to those needing it, and have retarded the abatement of mental illness. They assert that commitment procedures resembling criminal proceedings adversely traumatize the patient, and the resultant taint of criminality is partially responsible for the adverse public attitude towards mental illness.106

The second issue raised by physicians is that the question of commitment is a medical decision. They view the issue simply as a question of whether the person is or is not mentally ill. If the person is mentally ill he must be committed and given treatment as soon as possible. The medical profession sees commitment primarily as a medical question based upon diagnosis and treatment.

Since diagnosis is part of the expert body of knowledge that lies within the domain of the medical profession, psychiatrists should have the ultimate authority in decisions on commitments.107

The legal profession counters by pointing out the opposite concepts of these issues. They are in favour of "strict" commitment policies. Lawyers believe that the individual's civil liberties are protected under the constitutional process of "due process of law." In answering

106 Nicholas N. Kittrie, The Right to be Different, p. 82.

the psychiatrists' charge that due process has a traumatic effect on a person who is mentally ill, lawyers reply that, "the traumatic effect could not possible be any worse than the trauma of finding oneself detained in a mental institution without prior warning."108

Lawyers do not see the situation of commitment as a simple problem of diagnosis and treatment as professed by the physicians. They state that the problem is basically a legal one, due to the loss of certain legal and civil rights which result from commitment. The legal profession views psychiatric facilities as corrective institutions whose main functions are to incarcerate, treat, and rehabilitate.

Many members within the mental health field believe that psychiatry and law are on a collision course. The appalling lack of understanding and cooperation between these two professional groups is beginning to hamper the progress in the field of mental health legislation. Psychiatrists resent lawyers meddling in their professional establishment and monitoring medical ethics and rules. The medical profession is also beginning to feel the public backlash with regard to the ease with which fellow citizens are forcibly institutionalized by civil commitment.

On the basis of my experiences, I have seen certain things which make me want to extend to the involuntary committed individual in this respect all the civil

108 Ibid., p. 85.
liberties that is in my power within this Legislature to offer that individual.109

Finally, the issue of the psychiatric patient's civil liberties versus public safety, as viewed by the medical profession, is being challenged. In the name of "mental health" the public can enforce conformity. The medical profession, especially psychiatrists, have become society's priests of the status quo. In the area of human rights, the medical profession has taken a back seat.

With some shame we state that most of the changes in establishing patient's rights were not brought about primarily by psychiatrists but by civil libertarians led by lawyers.110

Psychiatric Admission Procedures

In this section, the researcher examined the present mental health statutes which are contained in the provincial Mental Health Act and are associated with admission procedures into Ontario's psychiatric facilities. A review is provided on all three means by which a person may enter a psychiatric facility: 1) voluntary admission; 2) civil commitment; 3) criminal commitment. The major emphasis of this study is on the civil commitment process.

109See: Legislation of Ontario Debates, Official Report (Hansard), Second Session, 31st Parliament, Tuesday, April 11, 1978, Evening Sitting, p. 1451; this statement was issued by Mr. S. Conway (Renfrew North, Liberal M.P.P.) in reference to the second reading of Bill 19, An Act to Amend the Mental Health Act.

Voluntary Admission

As has already been documented in the section on the Evolution of Legal Status in Ontario, since 1907 this province has provided legal measures for voluntary admission into the province's psychiatric facilities. The statutes governing voluntary admission have changed to reflect the growing belief that voluntary admission is desirable from the viewpoint of effective medical treatment. The 1967 Mental Health Act was criticized for being too liberal in its humanitarian spirit to abandon civil commitments. The Act's design was to adopt the less restrictive ideology of "the open door" concept based on voluntary admission.

Up until 1965, a person who had voluntary admitted himself had to agree to give five days written notice of his intent to leave and had to be judged competent to make these agreements. Then in 1965 the competency element was dropped.\textsuperscript{111}

Since the 1967 Mental Health Act, the voluntary patient may legally leave whenever he wishes. His release papers may indicate that he left against medical advice, though this is not legally binding.

The rationale for providing procedures for admission to psychiatric facilities at the patient's instigation is the belief by mental health professionals that voluntary

\textsuperscript{111} "Ontario's New Mental Health Act," Canada's Mental Health 16 (May-August 1967): 27.
admission circumvents the problems of publicity, coercion, and ill feelings associated with compulsory admission. Voluntary admission, hopefully, encourages early entrance into hospitalization. Early diagnosis and treatment can thereby increase the likelihood of an earlier cure. Provisions for such procedures have paralleled the trend in medical thought which is now beginning to emphasize the curative rather than the custodial aspect of treating mentally ill people.

It is questionable whether involuntary commitment is an appropriate tool for bringing treatment to those for whom therapy is available. Aside from philosophical and constitutional objectives, placing the therapist in the role of a guard has corrupted the rehabilitative role of the mental hospital and has adversely affected both patient and therapist.112

Individual Action to Seek Psychiatric Hospitalization

Voluntary admission refers to admission to a psychiatric facility which commences by the affirmative action of an individual himself. Under our present mental health statutes:

Any person who is believed to be in need of the observation, care and treatment provided in a psychiatric facility may be admitted as an informal patient upon the recommendation of a physician.113

112 Nicholas N. Kittrie, The Right to be Different, p. 97.

113 The Mental Health Act, R.S.O., 1970, c.269, s.7.
Any individual could thus present himself at a psychiatric facility and ask for permission to be admitted as a voluntary patient. If the examining physician believes the individual presenting himself for admission is in immediate need of psychiatric treatment, the physician may admit that person. Nevertheless, cloaked within this voluntary admission procedure is an admission process known as the "non-protested" admission. This procedure is a process usually initiated by a spouse, relative, friend, or the family doctor. The individual merely acquiesces or consents to the admission.

Non-Protest Admission

It should be emphasized here that the researcher does not personally view "non-protested" admission as a true form of voluntary admission. Barry Swadron writes, "For those patients who do not require detention, admission to a mental hospital should be on the same basis as admission to a general hospital."\(^{114}\) Under such a proceeding it would appear that the psychiatric facility and the physicians themselves are violating "strict laws and moral principles which hold that a person may not be coerced into medical treatment he doesn't want."\(^{115}\) Under hospital rules all voluntarily admitted patients, including non-protesting

\(^{114}\) Barry B. Swadron, "Recent Mental Health Legislation," Canada's Mental Health 14 (September-December 1966):11.

\(^{115}\) Stewart Page, Mental Patients and the Law, p. 50.
ones, are held to imply their consent to normal, innocuous or routine procedures since they have agreed to enter the psychiatric facility willingly.

Difficulties may arise here in that there are a substantial number of persons who enter an institution on some sort of voluntary basis but who simply do not know at the outset what the institution is all about and what it offers in the way of treatment and are, therefore, in the position of appearing to have consented to an array of treatment they may know little about.\[116\]

Thus, these non-protesting individuals are not granted the same privilege as general hospital patients. They have not really been given the right to consent to treatment.

Voluntary Admission Statistics

Hidden within the non-protested admission process is the medical profession's ability to mishandle statistical information regarding the numbers of voluntary and formal admissions per year and the categories for referral. Thus, Ontario's Mental Health statistics are often misleading. The general trend of Ministry reports seem to indicate a rise in voluntary admission over each preceding year. In reality, the method of admission (voluntary) and source of referral (self or relative) are being used somewhat dishonestly.

Mental Health Ontario cites 7,000 to 8,000 involuntary

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\[116\] Ibid., p. 57.
admissions to Ontario psychiatric hospitals in 1968.\(^{117}\) Dr. Patrick Lynes indicated at a November 30, 1977 meeting in Windsor of one hundred Mental Health Professionals that, "In 1975, 15,000 people were admitted to psychiatric hospitals, 28,000 to psychiatric units in general hospitals, and 100,000 were treated in outpatient clinics."\(^{118}\)

Health Minister Dennis Timbrell stated in the legislature on Tuesday, April 11, 1978 that, "More than 25 per cent of admission to Ontario mental hospitals last year were involuntary."\(^{119}\) Using Dr. Lynes figures of 15,000 and 28,000 admissions and Mr. Timbrell's account of 25 per cent of hospitalized patients being involuntary, Ontario had over 10,700 people committed to psychiatric facilities in 1975. This is a rise of some 3,000 from 1968. Yet, mental health figures document an increase in voluntary admission and a decrease in formal commitments. The decrease in formal commitments as reported by mental health figures is questioned by this researcher.

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Is A Voluntary Patient Really A Voluntary Patient?

The researcher feels that it is most important to note that, "the 'voluntary' patient is not really voluntary" in the ordinary sense of that word. He may be free to enter the hospital, but he is not always free to leave."¹²⁰ There is no guarantee that a voluntary patient will not be prevented from leaving the psychiatric facility, for the person is open to being committed under a medical certificate (Form 2, Change to Involuntary Status) by the attending physician, even though their original admission was voluntary. The voluntary patient who attempts to avoid treatment, openly refuses it, or who frustrates and challenges the staff may be punished by commitment to the facility, thus bringing the patient under the direct power of the medical staff. Ontario's Mental Health Act stipulates:

An informal patient may, upon completion of the prescribed form, be continued as an involuntary patient,¹²¹ and in such cases section 8 applies mutatis mutandis.

Therefore, under present Ontario statutes, there would appear to be some doubt as to exactly what is meant by being a "voluntary" patient. The haziness centres around whether the voluntary patient is a person who is not deemed

¹²⁰ Bruce Ennis and Loren Siegel, The Rights of Mental Patients, p. 37.

¹²¹ The Mental Health Act, R.S.O., 1970, c.269, s.12.
dangerous to himself or others, or if he is a person who just willingly agrees to enter a psychiatric facility.

To be a voluntary patient need not mean that one has volunteered. There is always the threat of involuntary hospitalization procedures, and if the intended patient is aware and apprehensive of these procedures, he may reluctantly become a patient on a voluntary basis.\footnote{122}

As has been documented, psychiatric facilities in Ontario are granted wide discretionary powers over who they may or may not admit as voluntary patients. It also appears that they have great latitude in deciding whether to detain or release a voluntary patient from care and treatment.

The Reason Behind the Low Voluntary Admission Rate

The overall percentage of voluntary admission may not be statistically high when compared to the total psychiatric admission rates. The reasons for this are manifold due to the defects in the voluntary admission procedures.\footnote{123} Farmer, Lindman and McIntyre, and Swadron suggest approximately four major areas of concern. First, voluntary patients face the loss of liberty and certain rights. The mental health

\footnote{122}{Barry B. Swadron, Detention of the Mentally Disordered: Including the Applicable Criminal Law (Toronto: Butterworth and Co. (Canada) Ltd., 1964), p. 11.}

\footnote{123}{See: Robert A. Farmer, The Rights of the Mentally Ill, pp. 31-33; Frank T. Lindman and Donald M. McIntyre, eds., The Mentally Disabled and the Law (Chicago: The University of Chicago Press, 1961), pp. 107-115; Barry B. Swadron, Detention of the Mentally Disordered, pp. 5-7.}
statutes do not clearly specify rights, obligations, and procedures on the part of the voluntary patient or the facility. Each psychiatric facility may interpret the admission statutes differently. Due to varying practices and hospital policies, voluntary admission procedures may restrict or benefit the patient. Owing to this, voluntary patients usually find themselves under the same restrictions advanced to formal patients, which affects the free exercise of their legal and civil rights.

Secondly, hospital authorities may detain a voluntary patient against his will for a length of time, although the patient has the legal authority to leave the psychiatric facility at his own choosing.

Legislation in many jurisdictions provides for a period in which the voluntary patient may be detained after a request for release. During this period there are steps which may be taken to have the status of the patient converted into a non-voluntary one.124

Next, these writers stress the fact that the relationship between voluntary admission to a psychiatric facility and competency to manage one's own affairs is not well defined. The statutes do not distinguish between voluntary and formal hospitalization and competency. Part III, section 32 of Ontario's Mental Health Act125 explains that, upon admission to a psychiatric facility, a patient has to

124 Barry B. Swadron, Detention of the Mentally Disordered, p. 7.

125 The Mental Health Act, R.S.O., 1970, c.269, s.32.
be examined by a physician to determine if he qualifies as
competent to manage his personal affairs. This statute
makes no reference to the status of the patient, be he
voluntary or formal. Thus, a voluntary patient, upon ad-
mission into a psychiatric hospital, could find himself
declared incompetent to manage his own personal affairs
and find his property in the hands of the Public Trustee.

The final point these authors make is the stigma
attached to mental illness and mental hospitalization.
These writers suggest that to ask an individual to submit
himself to being a second-class citizen is a very tall
order. In general, the public still views a person who
has been in a mental hospital as having a tarnished record.

Criminal Commitment

The laws dealing with mental health and criminal
procedures are complex and ill-defined in Ontario legisla-
tion. There are three major areas in which mental health
considerations enter into the criminal procedure. The
first procedure is the judicial decision of determining
whether a person standing before a justice is or is not
mentally fit to stand trial. It is this issue, "fitness
to stand trial," that is the only procedure dealt with by
the present Mental Health Act. The second procedure and
probably the most controversial topic in the area of
criminal law, is that of the insanity defense. The third
procedure associated with criminal commitment and mental health deals with sexual offenders and those criminal offenders who are already incarcerated in prisons and who are mentally ill or thought to be mentally ill. These last two procedures are found in the Criminal Code of Canada and any action carried out is dealt through a Lieutenant Governor's Warrant.

Although there are three separate procedures which deal conjointly with the criminal commitment process, this researcher will only examine the "fitness to stand trial" process; it is the only procedure that is directly affected by legislative statutes under the Mental Health Act.

Fitness to Stand Trial

Specific sections of the Criminal Code of Canada and the Ontario Mental Health Act provide judges with the power to order an accused person to undergo a psychiatric examination or be admitted to a psychiatric facility for observation for a determined period of time.

A judge has thus the power to circumvent or to stop altogether or temporarily the judicial process by submitting the accused to psychiatric examination or hospitalization.126

Under criminal proceedings, it is generally held that

no person should be made to undergo the strain of a trial or the criminal court system if his mental status clearly suggests the need for psychiatric observation, care, and treatment. The issue of fitness to stand trial is related to the mental condition of the accused at the time of his trial.

"Is the accused fit to stand trial?" This is the question asked when a person awaiting or standing trial shows signs of mental disorder. If the court answers the question negatively there is no trial and the accused is exempted from the proceedings until he regains sufficient mental ability to participate. This exemption is the fitness rule and the process of initiating and implementing it is the fitness procedure.127

A judge or magistrate who believes there is sufficient reason to doubt the mental condition of a defendant may send that person to a psychiatric facility to receive a mental examination or for observation. Sections 14 to 16 of the Mental Health Act allow judges to order psychiatric examinations or to remand the person in custody to a psychiatric facility for not more than two months.128 It is only when a judge or magistrate constitute the court that he tries the question of "fitness to stand trial" and renders the verdict. When the accused is tried before a


128 The Mental Health Act, R.S.O., 1970, c.269, s.14-15.
judge and jury, it is the jury who tries and renders the verdict regarding fitness to stand trial.

Difference to Medical Certification

The criteria used to determine fitness to stand trial is not the same as that which is used to determine whether a person should be medically certified and committed to a psychiatric facility.

Certification, on the one hand, is a finding that a person should be detained in a mental hospital. Unfitness to stand trial, on the other hand, is a finding that it would be unfair to try the accused at that time.129

It should be reiterated that certification is a matter to be ascertained by a physician, whereas, the fitness issue is a matter for the court to decide. The purpose of the fitness rule is to promote fairness to the accused by protecting his right to defend himself as well as to assure society and the judiciary institution that the person is an appropriate subject for a criminal proceeding. It is always open to the court to either implement or not implement the fitness procedure and fitness rule. The court may or may not find the accused fit to stand trial despite the evidence presented on behalf or against the accused. Furthermore, the court may find the accused unfit to stand trial even

129 Barry B. Swadron, Detention of the Mentally Disordered, p. 277.
though a physician cannot medically certify the person to psychiatric hospitalization through civil commitment. The Law Reform Commission of Canada recommended in their Working Paper 14, a three-part test to establish unfitness. They believe a person should be considered unfit if:

1. he does not understand the nature or object of the proceedings against him, or
2. he does not understand the personal import of the proceedings, or
3. he is unable to communicate with counsel.  

Remands for Court Examination

Since the early 1970's a number of investigators have examined the issue of court appointed psychiatric examinations. The Greenland, Rosenblatt and the Arboleda-Florez et al. studies came to similar conclusions regarding court appointed examinations.

Greenland and Rosenblatt reviewed the hospital records of 80 women and 707 men who were remanded by court order for psychiatric examination between June 1969 and May 1970. These 787 cases were all of the remands for

130 Law Reform Commission of Canada, The Criminal Process and Mental Disorder, p. 36.

psychiatric examination in Ontario during that one-year period.

Florez et al. investigated 518 psychiatric examinations ordered by the Ottawa Court House during a two-year period from 1972-1973.

The Greenland and Rosenblatt study provides documentation of the types of remands issued and what courts authorized the examinations. They discovered that 41 persons, or 5.2 per cent out of the total 787 remands, were issued under the Criminal Code of Canada. The remaining 746 remands (94.8 per cent) were remanded under statutes provided for by the Mental Health Act of Ontario. Of these 746 cases, 390, or 52.2 per cent, were remanded for a thirty-day examination period in a psychiatric facility. In about 3 per cent of these cases, the period of examination was renewed for a longer period of time. These investigators also stated that in 90 per cent of all the remands, the issue for psychiatric assessment was authorized prior to the accused's trial.

Greenland and Rosenblatt provided information regarding what percentage of warrants were issued by what courts. They discovered that Ontario's Provincial Criminal Courts accounted for 653, or 82.9 per cent, of all the remands. Family and Juvenile Courts issued 98 remands, the Supreme Court of Ontario ordered 11, and County Court judges issued 21 remands for medical examination. Four
cases were not accounted for.

In comparison, the Florez et al. study drew its sample from one source, that being a Provincial Criminal Court, the Ottawa Court House.

In their findings, Greenland and Rosenblatt did not relate the medical recommendation back to the issue of "fitness to stand trial." Instead, they divided the psychiatric recommendation to court disposition into three categories: 1) in-patient treatment; 2) out-patient treatment; 3) no specific psychiatric reference.

Florez and his colleagues placed their subjects into two categories relating to the fitness question—those fit to stand trial and those who were referred to psychiatric hospitalization and deemed unfit.

Unfitness

Attempting to decipher the unfitness question, Greenland indicated that of the 787 remands investigated, 175 cases, or 25 per cent, were recommended for in-patient psychiatric treatment. In 84 per cent of these 175 cases, the court accepted the medical recommendation.

This researcher believes that the above category is the same as Florez's unfit group. Within that particular group, 172, or 33.2 per cent of the 518 investigated remands, were viewed as unfit to stand trial and were referred to psychiatric hospitalization under several different orders.
Greenland and Rosenblatt found that 25 per cent of their cases fell into a group who were unfit to stand trial. The Florez et al. study shows that 33.2 per cent of the sample was deemed unfit to stand trial.

Fitness

In the issue of "fitness," Greenland and Rosenblatt divided the cases which fell within this group into two categories. The first category of this group recommended 245 remands, or 35 per cent of the cases, to out-patient treatment. This advice was accepted by the courts in approximately one-third of the cases. It would be justifiable to say that this category certainly relates to a finding of fitness to stand trial, for in 139 of these 245 cases the accused were either sentenced to prison, given a suspended sentence or placed on probation. In another 39 cases, charges against the accused were withdrawn or dismissed.

In the second category of this group, no specific medical recommendation was given in 287, or 40 per cent, of the cases. The disposition of these cases was handled in a variety of ways by the particular courts involved. Sentences were imposed in 174 cases by the courts, 44 cases had the charge dropped and in 64 cases, the court's disposition was not known. Again, because of the court's sentencing procedure, this category certainly reflects
cases that were deemed fit to stand trial.

As for the Florez et al. study, the researchers found that of the 518 examinations investigated, 338, or 65.25 per cent of the cases, were sent back to the court deemed fit. Of this group, 209 cases were viewed as fit and no further recommendations were offered. The remaining 129 cases were also sent back for court disposition due to fitness but out-patient treatment through community mental health service was advised in every one of the cases. 132 Therefore, Florez and his research team discovered that 65 per cent of the remands for examination in their investigation were deemed fit.

The Greenland and Rosenblatt investigation discovered that 75 per cent of their sample population were deemed fit to stand trial.

Remand Stops the Legal Process

In conclusion, these studies agree in one specific area, "The examination had a direct effect in stopping the legal case temporarily or completely in at least one-third of the examinations." 133 Where a person is found unfit to stand trial, the charges remain outstanding against him

132 See: J. Arboleda-Florez et al., "A Two-Year Review of Court Examinations," Figure 2, p. 471.

133 Ibid., p. 473.
until such time as the person becomes fit to re-stand trial. Until such time as the accused is fit to stand trial, he is held in custody under a Lieutenant Governor's Warrant.

"The Lieutenant-Governor invariably directs that the accused be kept in custody in a mental hospital."[^134] It should be mentioned that there is no appeal procedure provided for an accused once a finding of unfitness to stand trial has been rendered.

Remands and Civil Liberties

The Greenland, Rosenblatt and the Florez et al. studies differ significantly in one important area, the issue of the accused individual's civil liberties. Florez and his colleagues write, "Psychiatric Court Examinations do not seem to alter the legal process in ways damaging to the rights of those examined."[^135] [Italics are those of the researcher.]

Greenland and Rosenblatt's conclusion seems to refute Florez and his colleagues' statement, because they state that:

The issue of the individual's civil liberties must also be raised in considering these remands. At least


80 persons had charges against them dropped and they were released after spending time in hospital. Several other persons were found not guilty and were also released.\textsuperscript{136} [Italics are those of the researcher.]

They further state that of 70 cases remanded for 30 or 60 days, none were found to be in need of or suitable for psychiatric treatment. In another 100 cases, the courts apparently failed to act on the recommendations provided by the psychiatrists. In 29 cases, at one hospital alone, the courts employed minor offenses, such as vagrancy, malicious mischief, or wilful damage as the reason for the remand. Greenland and Rosenblatt conclude by stating that:

\begin{quote}
On the contrary, it must be concluded that the Courts are not making the most effective use of psychiatric services. . . . The lack of understanding between some of the Courts and some of the psychiatric hospitals results in injustice to patients and misuse of scarce psychiatric resources.\textsuperscript{137} [Italics are those of the researcher.]
\end{quote}

The stance of the Law Reform Commission of Canada, Working Paper 14 regarding the disposition of the accused unfit would appear to be supportive of the conclusion of Greenland and Rosenblatt compared to that of Florez et al. on the issue of the accused individual's civil liberties. The Commission writes:

\textsuperscript{136} Cyril Greenland and Ellen Rosenblatt, "Remands for Psychiatric Examinations in Ontario," p. 400.

\textsuperscript{137} Ibid., pp. 400-401.
Most of us would rather be found guilty than unfit because the consequences of unfitness are less predictable and potentially more restrictive. . . . If unfit, we would be certain of very little beyond the inevitability of detention in a mental hospital. . . . We would be involuntarily held in a mental hospital where, by law, we would be treated differently from the other patients with fewer rights and fewer therapeutic options.138 [Italics are those of the researcher.]

Civil Commitment

Involuntary hospitalization (civil commitment) is the procedure of removing a person who is judged to be mentally ill from the community to a psychiatric facility authorized to detain such an individual. Ontario's Mental Health Act, R.S.O., 1970, provides three measures for formal hospitalization. The determination of whether a person's mental condition qualifies him for statutory criteria for civil commitment is based upon a medical certificate, court order, or police power. Thus, "civil commitment" is the process of legally placing any individual, with the use of force if necessary, into a psychiatric facility.

Civil commitment applies to persons who have, almost without exception, broken no laws and, in a few cases, to minor law-breakers who are committed rather than tried in a court of law.139 [Italics are those of the researcher.]

Under our present-day statutes, the three procedures

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139 Stewart Page, Mental Patients and the Law, p. 7.
for civil commitment are designed to channel the patient into compulsory hospitalization. The word commitment is used to signify the forceful and coercive nature of the hospitalization. In reality, the idea of hospitalizing oneself in a psychiatric facility did not originate with the person being committed.\textsuperscript{140} Obviously, a person committed to a psychiatric facility loses certain legal and civil rights, and his freedom during his hospitalization. According to the medical authorities (psychiatrists), the loss of these rights is certainly justifiable, for the person is being offered the opportunity for treatment, rehabilitation, and the return to society. The mental health establishment does not view the loss of freedom as punishment in any way. Their only desire is to diagnose, treat, and rehabilitate the person.

Civil commitment, however, is usually initiated at the request of a person's relatives or other supposedly responsible individuals (i.e., physician, judge or police officer). Ontario statutes, sections 8-16 and Forms 1, 6, 7 and 8 of the Mental Health Act provide means for the examination and detention of the citizen who is thought to be mentally ill. The above mentioned forms provide the necessary means by which a responsible citizen can exercise measures to commit a person to psychiatric hospitalization.

\textsuperscript{140} Ibid., p. 7.
If these liable individuals can answer in the affirmative at least one of two key decisions commitment is granted. They must determine: 1) whether the person is likely to endanger his own life or safety or endanger the safety of others; 2) the person will not accept psychiatric hospitalization on his own accord and, therefore, is not considered a suitable candidate for voluntary admission. 141

Medical Certification

Ontario provides legislation under the Mental Health Act, R.S.O., 1970, authorizing admission to a psychiatric facility by means of a medical certificate. The provisions of section 8, sub-sections 1 to 4 of the Act, allow any qualified medical practitioner, through due application and the physician's signature on a Form 1, "Physician's Application for Involuntary Admission," to commit a person to a psychiatric facility for at least one month. In Ontario, the certificate, completed in full and duly signed by a physician, is sufficient authority for admission in itself. The facility's administration is required to admit such a person and detain him for a period not longer than one month, unless events arise which would provide authorization for a longer period of time. 142

141 The Mental Health Act, R.S.O., 1970, c.269, s.8-(1).
142 Ibid., s.8, ss.5.
Therefore, a doctor who certifies mental illness under the Ontario statute is at the same time certifying the individual requires care, supervision, and control. This confinement is viewed medically as for the individual's own protection or welfare, and as well as for the protection and welfare of the public. It would appear, however, that these broad medical power's sole purpose is to designate a class of persons who may be confined to psychiatric facilities. It is interesting to note that a physician is not required to provide a psychiatric diagnosis on the face sheet of the admission certificate. Under the guise of civil commitment, which is a necessary prerequisite for medical certificate, the certificate is the cause of the person's detention.

The Process of Certification

Involuntary hospitalization by means of a medical certificate is the procedure by which any individual may be hospitalized for a determined period of time without that person's consent, even over his objections, on the basis of a physician's examination. Present mental health legislation outlines specific procedural steps and regulations by which physicians must abide in order to establish authenticity to the medical commitment and grant it legal statutory power. A Form 1, signed by a physician, must clearly demonstrate that the physician has personally
examined the person.

The physician must then show that he also made due enquiry into all facts necessary for him to form an opinion regarding the individual's mental status. It is imperative for the physician to state in writing on the Form 1 the facts upon which his opinions are based. Once these regulations have been met and the application signed (Form 1 requires the signature of one physician. A physician even without a background in psychiatry may sign), the application is legal authority for that person to be conveyed and detained at a psychiatric facility for a period of one month.

Although the certificate calls for the detention of the person for a specific time period, the psychiatric facility is really under no obligation to follow this time reference. Due to certain events or circumstances, the detention period may be shortened or lengthened at the discretion of the attending physician. Actually, the 30 days might be extended to several months or a year. The first medical certificate can be renewed by a physician at his own discretion by his signing a Form 4, Certificate of Renewal. The renewal of certification is statutory authority for the facility to detain the individual for an additional two months. The process of certificate of renewal extends the period of detention with each renewal. The researcher feels that the use of the term "determined
period of time" is a very misleading statement applied to the medical certificate since the period of time can be extended and re-extended.

Validation of the Certificate

The Mental Health Act also provides explicit guidelines for the time period in which the certificate must be completed as well as a period of validation. Ontario statute states, "Every such application shall be completed no later than seven days after the examination referred to therein."143 This seven day period exceeds what may be thought of as a reasonable time period to perform the relatively easy task of filling out a required form. However, the medical profession defends this lengthy time period. Physicians indicate that since they can take into account facts communicated to them about the individual from others, the delayed completion of the certificate allows them to further investigate and substantiate the claims. Furthermore, physicians suggest that one's mental status or condition may alter significantly within a short period of time after the examination. Again, the hiatus between the examination and the filling out of the certificate allows the doctor to take into account the person's changed condition and to act accordingly.

143 The Mental Health Act, R.S.O., 1970, c.269, s.8-4.
Ontario also provides a provision in the Mental Health Act which invalidates a certificate within a certain time frame. "No person shall be admitted to a psychiatric facility upon an application except within fourteen days of the date on which the application was completed." This provision sets a time limit for admission on the strength of the certificate, for the certificate must not be stale.

It is usually the case that the authority of a certificate expires after a certain period of time, which period is tied to the date of the examination referred to therein. Therefore, the certificate must have, of course, been completed by that period in order to be effective.\(^{145}\)

If all these regulatory provisions are met and the Form 1 accurately completed and filled out and signed by the examining physician, the certificate is a valid one and authorizes admission into a psychiatric facility.

**The Necessity of a Complete Certificate**

When a medical practitioner has decided that the circumstances involving an individual warrants certification and he is of the opinion that his reasons to certify are correct, he may sign a Form 1. It is necessary for the physician to document the commitment form accurately and completely, for the commitment certificate indicates that,

\(^{144}\)The Mental Health Act, R.S.O., 1970, c.269, s.8.

\(^{145}\)Barry B. Swadron, Detention of the Mentally Disordered, p. 66.
"the committed person represented a demonstrable danger to the 'safety of other' or to himself, documentation of which is required under existing mental health legislation."\textsuperscript{146}

This documentation is required because a person who is detained by civil commitment has no legal right to question his confinement. Therefore, the following reasons point out the necessity for a complete, accurate, and valid Form 1.

1. The certificate may either cause compulsory hospitalization on its own strength or be the \textit{sine quo non} of the hospitalization.
2. The hospital authorities should have some written indication of the reasons for the certification of the person whom they are admitting.
3. The doctor is, in a sense, making a judgment which is indicative of his reputation, and his sincerity should be well-substantiated to show that he has not lightly considered the question.
4. If it ever be the case that the certificate is reviewed in a court of law, upon the issue of the justification for the certificate in the first instance, there should be sufficient data on the face of the certificate, thus avoiding the embarrassment of greatly detailed explanation.\textsuperscript{147}

The significant criteria in Ontario's civil commitment statutes requires that the person being committed be deemed of some "danger" to himself or other citizens within

\textsuperscript{146}Stewart Page, "Towards Evaluating the Meaningfulness of Legal Counsel," p. 8. For a further reference regarding the aspect of danger to self or others, see: \textit{Mental Health Act}, R.S.O., 1970, c.269, s.8.

\textsuperscript{147}Barry B. Swadron, \textit{Detention of the Mentally Disordered}, pp. 42-43.
the community. Yet, when one reads sections 2 to 32 of our present *Mental Health Act*, one realizes that the statutes do not clearly define just what the parameters of danger to self or others is or might be. Nowhere in the *Act* are there any specific guidelines with regard to what behaviours or types of situations may be considered serious enough to warrant civil commitment due to medical certification.

*Vagueness in statutory criteria therefore invites arbitrary and inconsistent commitment practices that depend heavily on the perception, skill and sophistication of the committing physician or of the police officer.*¹⁴⁸ [Italics are those of the researcher.]

The problem of the vagueness of the statutes enters when physicians, drawing from different professional backgrounds and views, attempt to draw the line in defining "commitable" acts. This gap is further widened when one considers that a physician signing a *Form 1* does not even have to possess a comprehensive background in or substantial knowledge of psychiatry. It has been recognized that vagueness on the physician's part in unduly completing and filling in all sections of the *Form 1* may lead to unlawful and wrongful commitments. Therefore, since 1967, the documentation of "dangerousness" has become the prerequisite for civil commitment.

Commitment Certificates do not document the danger mandate.

During the last year a number of critical newspaper articles have appeared condemning psychiatric legislation, care, and conditions in Ontario. In concert with this condemnation of psychiatric care and provision in the province, numerous groups and associations have presented briefs to several of the Health Ministers asking for a major review of the present provincial Mental Health Act. The major concern voiced by these groups focuses around the threat to personal freedom in the practice of involuntary civil commitment.

A number of these associations are basing their request for a review on the findings of recent studies.


150 Some of the groups and professional associations which have presented briefs to the Health Ministry regarding a review and up-date of our present Mental Health Act have been the Canadian Civil Liberties Association, Ontario Medical Association's section on psychiatry, Ontario Psychological Association, Citizen Commission on Human Rights as well as Canadian Mental Health Association on behalf of its Ontario divisions.
which indicate that the "danger mandate" is not documented sufficiently on commitment certificates to justify the large percentage of individuals committed to psychiatric facilities each year in Ontario.\footnote{151} Toronto lawyers, John Sopinka and Kenneth Howie, independent of one another, examined 200 commitment certificates which were part of a master's thesis conducted by Burton Perrin, a York University psychology student. When asked by the Canadian Civil Liberties Association for a legal assessment of these certificates, the two lawyers agreed that 142, or 70 per cent of the forms, were invalid. That is, these commitment certificates did not comply with the legal requirements under our present Mental Health Act.\footnote{152}

J. Firth found the same conditions to be true when he examined 120 involuntary certificates at a large Toronto hospital.


\footnote{152}{See: "Civil Rights Lawyer asks Mental Health Review," \textit{The Windsor Star}, 21 February 1977, p. 32; Brief presented to Health Minister Dennis Timbrell, regarding "Involuntary Civil Commitment" from the Canadian Civil Liberties Association, March 28, 1977, p. 3.}
psychiatric hospital. By designing a specialized classification and rating procedure, he found that 60 certificates (50 per cent) contained no evidence of danger to self or others. In examining the documentation used to demonstrate "alleged danger to self or others," Firth indicates that 27 commitments (23 per cent) appeared to meet the acceptable legal standards; 41 (34 per cent) were not acceptable while another 50 (42 per cent) were considered dubious and of questionable legal validity.\footnote{153}

Page and Yates analyzed the medical certificates of 89 persons committed in Ontario under the 1967 Mental Health Act and 109 individuals committed under the older 1960 Mental Hospital Act. Most pre-1967 certificates were not concerned specifically with demonstration of the danger mandate. Under the 1967 Mental Health Act, however, more careful and explicit documentation of danger to self or others became mandatory for a legal civil commitment. These writers state that, "Overall, more than 75 per cent of all tallies occurred in categories other than those concerning possible or actual danger to self or others."\footnote{154}

\footnote{153} J. Firth, "Criteria for Involuntary Civil Commitment in Ontario," unpublished study, Lakeshore Psychiatric Hospital, 1975.

\footnote{154} Stewart Page and Elizabeth Yates, "Civil Commitment and the Danger Mandate," p. 270.
Physicians Cannot Predict Dangerousness

The sorting and analysis of data by these writers indicate that few cases of involuntary civil commitment under either of the Acts contained sufficient evidence which documented the committed person as being a dangerous individual.

A large sample of commitment certificates indicated that few contained evidence of involuntary hospitalized patients as being dangerous, nor did the present sample of certificates indicate clearly that operating commitment criteria have been altered with the new and liberalized legislative formulations of such criteria. 155

Therefore, it would appear that few physicians enter or record into the certificate specific events or behaviours of the individual to justify their opinions, judgments, or allegations in predicting the person's dangerousness. Thus, it is fair to suggest that such inaccurate certification would appear to be legally insufficient under the present standards required today.

An accumulating body of material is beginning to suggest that the standards for determining commitment are imprecise and vague. 156 There is no empirical evidence

155 Ibid., p. 271.

to support the belief that psychiatrists can predict dangerous behaviour in an individual with any great certainty.

A review of the research on psychiatric assessments of dangerousness indicates psychiatrists are rather poor evaluators. Checks on the ability of psychiatrists to predict 'dangerous' behavior have shown them to be no better than estimates based upon chance alone.157 [Italics are those of the researcher.]

In fact, psychiatrists cannot tell whether a person is dangerous or will be dangerous in the future. In reality, psychiatrists really cannot predict dangerousness in a person to the extent that they believe they can.

The Test for Certification

The evidence presented in this section of the study certainly indicates that the medical profession has difficulty legally documenting and supporting their claim for civil commitment via medical certificate. Yet, physicians daily certify approximately twenty-two individuals to Ontario psychiatric facilities. For the physician,


"It is an 'all or not at all' process. 'Almost certifiable' must mean 'not certifiable'."¹⁵⁸ Physicians who examine, diagnose, and then issue a commitment certificate against an individual must do so with a definite end in mind. The sole purpose of the certificate is to force confinement of the person to psychiatric hospitalization through legal channels, if needed. Inasmuch as there is an analogy between medical certification and the criminal process, "'almost guilty' must mean 'not guilty'."¹⁵⁹ In a court of law, evidence must be established beyond a reasonable doubt. This stringent burden of proof is designed to avoid wrongful deprivation of liberty and property. Since a person who is certified mentally ill is also in the same position losing his liberty and the management of his property,

Could we, therefore, borrow this test from the criminal process and say that the doctor must be satisfied 'beyond a reasonable doubt' that the person requires mental hospitalization.¹⁶⁰

It appears that physicians have fallen far short in providing this criteria and have a way to go in meeting the present-day legislative standards associated with

¹⁵⁸ Barry B. Swadron, Detention of the Mentally Disordered, p. 47.

¹⁵⁹ Ibid., p. 48.

¹⁶⁰ Ibid., p. 49.
civil commitment procedures. A certified psychiatric patient in Ontario has no right of appeal from confinement until after his 30-day period of incarceration. By virtue of the statutory authority of the civil commitment certificate, it would seem logical to have just as stringent a test for physicians to execute as the courts.

Judicial Warrant

For the person who appears to be mentally ill but will not submit to a medical examination or, due to circumstances, an examination cannot be carried out, Ontario statutes provide means and assistance through the machinery of law for a psychiatric examination. An application for a psychiatric examination of an alleged mentally ill person may be laid in a judicial proceeding. In this procedure, sworn testimony is presented to a "justice of the peace," who, in Ontario statute, is authorized to hear such information and to initiate the necessary action required, depending upon his further investigation into the claim. In the application of judicial examination, an individual swears under oath that he personally believes another individual is, or is suspected, or is believed by the informant to be mentally ill.

161 The Mental Health Act, R.S.O., 1970, c.269, s.9, ss.1-4.
Judicial Inquiry

After the justice of the peace has made due inquiry (he has examined the application, investigated the merit of the application and believes reasonable grounds exist for filing) he has the authority to issue a Form 2, "Order for Examination." Form 2, when authorized by a justice of the peace, entitles any peace officer in the county to convey the said person, named on the form, to an appropriate place for a medical examination. The place of examination, however, does not necessarily have to be a psychiatric or other health facility. It was not until the passage of the Mental Hospitals Act in 1960 that Ontario legislation amendments made it clear that, for the purpose of a judicial examination, a mental hospital was considered a safe and comfortable place. "Before that amendment, the place of the interim custody was often a gaol, and indeed may still be a gaol."162

Mental Health Act, Form 2

Form 2, when duly completed and signed, provides legislative authority for a police officer to apprehend, forcibly if necessary, the person named on the form and to detain them until the medical examination is completed.

162 Barry B. Swadron, Detention of the Mentally Disordered, p. 219.
An order under this section shall direct, and is sufficient authority for, any constable or other peace officer to whom it is addressed to take the person named or described therein to an appropriate place where he may be detained for medical examination.\footnote{The \textit{Mental Health Act}, R.S.O., 1970, c.269, s.9(4).}

It must be emphasized at this point that a judicial warrant is only authority to detain an individual thought to be mentally ill and then only for a medical examination. In fact, at the bottom of the Form 2 there is a memorandum stating, "This form does not constitute an order for admission to a psychiatric facility."\footnote{Ibid., R.S.O., 1970, Reg. 576, Form 2.}

Admission of the person named on the Form 2 may come about in two ways. Although the request for examination and hospitalization did not originally start with the individual, he may, once detained, not actively oppose the attempt to hospitalize him and may enter as a voluntary patient. The second avenue open is a formal civil commitment by means of a physician's certificate. If the physician is of the belief that the individual, after medical examination, is in need of observation, care, and treatment and cannot be admitted as a voluntary patient, he has the legal authority to sign a Form 1, "Physician's Application for Involuntary Admission." The signing of this form then allows the forcible detention of the
individual for 30 days in a psychiatric facility in Ontario.

Thus, a judicial warrant procedure is a process by which a justice of the peace determines whether a person who is deemed to be mentally ill requires medical examination. If the person is considered by the justice to be of the mental condition that needs psychiatric examination, he has the vested power to authorize the medical examination of the person. Under this procedure, the justice of the peace has wide discretionary power and it is apparently open to him as to whether he is willing to authorize a Form 2 or not. 165

Emergency Detention: Police Apprehension Without a Warrant

In Ontario, the primary function of the police force is to preserve the peace for the general citizenry. The usual powers and duties of the police are contained under the Ontario Police Act, enforced at that time. The 1970

165 To further emphasize the wide discretionary power of the justice of the peace concerning judicial warrants under the Mental Health Act, it was conveyed to this writer by a social worker that he interviewed regarding this research that one of the justices of the peace in Windsor would not accept her sworn testimony regarding a client's apparent mental status because she was not a member of that individual's family. This procedure on the part of the justice of the peace was an arbitrary decision on his part. For nowhere in the Mental Health Act is there a criterion presented regulating who can or who cannot bring forth, under oath, information about another person's mental status.
Ontario Police Act cites the general obligations of the police as escorting and conveying convicts, prisoners and mentally incompetent persons to and from courts, place of confinement, hospitals or other places. The three types of situations which generally bring police into contact with mentally disordered people are suicide attempts, incidents within the community involving bizarre or psychotic behaviours by an individual, and family disturbances. Owing to these, the police derive from Ontario mental health legislation their primary source of authority to apprehend, detain, and dispose of individuals who are mentally ill or thought to be mentally ill.

Judicial Warrant

The first approach the police may employ in removing from the community a person suspected of being mentally ill is the apprehension of the person on the authority of a warrant issued by a justice of the peace. The police may apply in the same manner as any citizen to a justice of the peace for a judicial warrant permitting them to arrest and detain the person named on the warrant for a psychiatric examination. The warrant only signifies the authority to apprehend and convey the person for a medical examination. It is not, however, a binding judiciary certificate for admission and the examining facility is not
under the duty to arbitrarily admit the person just because he is under warrant.

Police Apprehension Without a Warrant

Ontario mental health legislation also permits the police to act without a warrant. This second line of approach allows the police, under certain circumstances, to apprehend a person without a warrant, who apparently appears or acts as if he is mentally ill. "Most provinces empower police to take persons 'apparently suffering from mental disorders' into custody without charging them and to take them to a hospital." The grounds for police detention without warrant require the police to exercise their own judgment of the allegedly mentally ill person, based solely on their own personal opinions and value judgments. If the police believe that the person: 1) appears to be mentally disordered; and 2) conducts himself in a manner that, in a normal person, would be considered disorderly, the police may detain the person for a medical examination.

Even under this emergency action, detention has only a limited, short-range goal. Police apprehension without warrant, "is concerned with the suppression and prevention

of conduct likely to create a 'clear and present danger' to persons or property. As with police apprehension, with warrant, police apprehension without warrant is only authority for the police to convey an individual suspected of being mentally disordered to an appropriate facility for a medical examination. It is then up to the examining physician to determine whether the person is released, coerced into becoming a voluntary patient, or committed by medical certificate. Thus, police detention is an emergency measure which is used primarily as a control over a suspected immediate threat. Owing to this emergency measure, detention is only permitted until a medical examination can be completed.

The Legislation of Police Authority

Arising out of common law, constabulary power dates from approximately the seventeenth century. However, today, common law is less important than the statutory sources of police power. The *Custody of Insane Person Act*, 1906-1907 was the earliest form of mental health legislation in Ontario granting special powers to the police to apprehend and detain without warrant individuals deemed mentally ill.168


168 *Custody of Insane Person Act*, S.O., 1907.
Up until this time, the police were compelled to obtain a warrant from a justice of the peace. Even with this new legislation, the police were still required to bring the apprehended individual before a justice of the peace for judicial directing of the case.

In 1913, the Hospital for the Insane Act\textsuperscript{169} stipulated that the police could not hold an allegedly insane person in a jail before bringing him before a justice. Under this Act a jail was no longer considered to be a safe and comfortable place for a person apparently suffering from a mental disorder. The semantics behind this legislation were designed to limit the justice's power of disposition so that apprehension and detention would not be seen as criminal in nature. Legislation was further amended by the Mental Hospitals Act,\textsuperscript{170} 1935, which restricted the use of jails, prisons, or reformatories for the detention of persons suspected of being mentally ill. The next major amendment to the statutes outlining police detention without a warrant is found in the Mental Hospital Act, 1961-62. Section 28 of this Act, outlining the action which police may take, was altered to allow the police to seize any individual and convey him immediately to a hospital.

\textsuperscript{169}\textit{Hospital for the Insane Act}, S.O., 1913, 3-4, Geo. 5, c.83.

\textsuperscript{170}\textit{Mental Hospital Act}, S.O., 1935, c.39.
for a medical examination. Police, for the first time, had the legislative authority to bypass the application of a judicial warrant. The superintendent of the hospital was obligated to admit any person brought by the police as a patient. Finally, section 28, subsection 4, limited to 48 hours the time period that a person could be held for observation and examination before he had to be discharged or detained under other legislative provisions. 171

In the following years the provisions governing apprehension without a warrant and disposition of said individuals were repealed and re-enacted in the 1962-63 Mental Hospital Act. 172 The statutes made it clear that taking an allegedly mentally ill person to a hospital was considered an "alternative" to the judicial process for determining a person's mental condition. Again in 1967, the legislation was revamped by section 10 of the Mental Health Act of that year. 173 This statute was re-enacted in identical terms in the 1970 revision of the Ontario statute, which constitutes the present-day Mental Health Act. Unlike the earlier Ontario legislation, section 10 of the present mental health statutes does not compel the ad-

171 Mental Hospital Act, R.S.O., 1961-62, c.79, s.28.
172 Mental Hospital Act, S.O., 1962-1963, c.81, s.5.
173 Mental Health Act, R.S.O., 1967, c.51, s.10.
mission of a person only upon the police's criteria. 174

Admission to Psychiatric Facilities
Due to Police Referrals

In Ontario and within Canada there has been little empirical research done on the subject of the police role in making referrals to mental hospitals. 175 It is also safe to say that police referrals vary from community to community and from facility to facility. A recent article examining psychiatric emergencies admitted to an Ottawa general hospital out-patient department indicates that 18 per cent of these psychiatric admissions arrived with a police escort. 176 Fox and Erickson's analysis of official statistics on sources of referral of all admissions to psychiatric facilities in Ontario in 1969 indicates that:

The year ending December 1969 disclosed that 3.3% of all admissions were the result of police referrals. However, the proportion of police re-

174 The Mental Health Act, R.S.O., 1970, c.269, s.10.

175 This researcher during his review of literature came across only two books and one journal article which dealt with the subject of police referrals to mental hospitals. See: B. J. S. MacDonald, "The Police and the Mentally Ill," Criminal Law Quarterly, vol. 1 (1959); Barry B. Swadron, Detention of the Mentally Disordered, pp. 236-241; Richard G. Fox and Patricia G. Erickson, Apparently Suffering from Mental Disorder, Research Report of the Centre of Criminology (Toronto: University of Toronto, 1972).

ferrals varies, according to the type of facility, from a high of 6.2% at Psychiatric Hospitals, to a low of 0.2% at Facilities for the Retarded.177

It is interesting to note that as police authority to detain a person without a warrant became easier under present-day legislation, the number of people admitted to psychiatric facilities, due to police referral, increased. In 1973, the number of police referrals to psychiatric units of general hospitals and community psychiatric hospitals were well above the 1969 figures.178 Examining the latest available Mental Health Statistical figures (1972) relating to police referrals, there were only three police referrals for admission to the three Windsor general hospitals psychiatric units.179 Two of these police referrals were at Windsor Western Hospital Centre and the remaining one was admitted to Windsor Metropolitan. These figures appear to be well below the Ontario average for a community of this size. The researcher wonders if the Windsor police have a high tolerance rate for unusual behaviour, or they do not recognize the presence of psychiatric problems among community members, or they use other means to cope with this problem.

177 Richard G. Fox and Patricia G. Erickson, Apparently Suffering from Mental Disorders, p. 23.

178 Ibid., Table 1:1, p. 24.

179 Hospital Statistics 1972, Table IV, p. 32.
The researcher, at this point, would like to state that he is not advocating more police detention without warrant, nor more admissions into Windsor's psychiatric units through police referrals. The findings of the Fox, Erickson study state that:

It appeared, from the observation study, that the police only reported approximately a third of the cases dealt with, and from matching of police and hospital records, that the hospital recorded less than half the admitted police cases as police referrals. Though the police and hospital records indicate an overall police referral rate of between 5-7% and 6-9% of all hospital admissions, the estimate of actual admissions arrived at in this study indicates that the true overall proportion of police to total admission is between 14% and 19% and that, in some hospitals, police referrals may constitute up to a third of all admissions.\footnote{Richard G. Fox and Patricia G. Erickson, Apparently Suffering from Mental Disorders, p. 164.}

The above findings may account for a feeling of doubt or controversy in the picture of the questionable authenticity of the Windsor figures and the data provided by the Statistical Branch of the Ministry of Information System Division regarding mental health figures for Ontario in general.

Fox and Erickson further report that the police noted that in 61 per cent of the cases associated with police apprehension without a warrant, no charges could have been laid against those individuals seized by the police. In fact, in only 12.7 per cent of the cases did
police even consider the possibility of charging the person apprehended. It appears, therefore, that given the vagueness of the mental health statutes, the police may rely upon a definition of dangerousness which may have more to do with what they perceive to be threats to "self or others" compared to the actual mental condition of the person apprehended. Accordingly, such a preconceived notion could account for the large number of people seized and detained by police without the issue of a judicial warrant.

These researchers also disclose that the majority of police officers interviewed personally did not like the idea of having the authority to arrest, detain, and refer an individual for admission to a psychiatric facility. Such a pervasive attitude on the part of the police may explain a new trend in which the police and courts use jail more frequently to cope with those individuals apparently apprehended under mental health legislation. F. A. Allodi et al., in their study, indicate that about half of the people in psychiatric units of Ontario jails are former mental patients who were released from psychiatric facilities within the six months. It was also found that approximately

181 Ibid., p. 170.

65 per cent of the jailed offenders had prior convictions and a history of psychiatric treatment. These findings are further supported by a report prepared by Mental Health Metro, commissioned by the Ontario Health Ministry, to review psychiatric services within the province. The report reveals that 60 per cent of former mental patients return to psychiatric hospitals because the province does not provide adequate follow-up services.\textsuperscript{183}

The large reduction of psychiatric beds in Ontario has been accompanied by an increase of 300 per cent in admissions to psychiatric units in general hospitals between 1965 and 1975. There has also been an increase in the number of psychiatric patients placed in jail.

On the other hand, the increase of psychiatric cases in jail, both in absolute and in proportional terms, reveals a trend to use the jail to cope with a number of people, who are both psychiatrically disturbed and former patients of mental institutions, as an alternative to mental hospitals.\textsuperscript{184}

\textbf{The Mentally Ill: Loss of Legal and Civil Rights}

Warning. There is an enormous difference between the rights mental patients have in theory and the rights they have in practice.\textsuperscript{185}


\textsuperscript{184} F. A. Allodi et al., "Insane But Guilty," p. 6.

\textsuperscript{185} Bruce Ennis and Loren Siegel, \textit{The Rights of Mental Patients}, p. 11.
Under Ontario legislation, the condition of being or having been mentally ill can be the cause of being deprived of various legal and civil rights. The deprivation of some or all of these rights can occur without notice and without the chance to refute and defend oneself. The various mental health legislations in Ontario generally do not provide a clear consensus as to what should be the specific behaviours, circumstances, or factors which disqualify a person from retaining his civil rights. The loss of certain rights is not approached from an equal or consistent basis from case to case or at times, handled appropriately whether through judicial or medical channels. The interpretation of mental health statutes by judicial and medical administrative officials often vary even within the same institution. Frequently, these officials arbitrarily (usually based upon their own ethical and moral opinions associated with their knowledge of mental illness) and unintentionally pay no attention to the individual's "rights." Instead, they prefer to do what they believe is in the "best interest" of that particular individual. Examination of this aspect has indicated that some judges and physicians (they control the loss of legal and civil rights) are themselves not familiar with all of the existing legislation or the legal aspects of mental illness.

"There is an enormous difference between the rights
mental patients do have and the rights they should have." Under present Ontario legislation, a person identified as being mentally ill, thought to be mentally ill; a mental patient, or a previous mental patient may be restricted in various areas of legal and civil rights. In Ontario, this "loss of rights" may affect some of the following capacities:

- Being married.
- Acting in a judiciary capacity (e.g., trustee, executor).
- Being responsible for unlawful acts.
- Driving a car.
- Voting in Provincial and Federal elections.
- Holding, or running for public office.
- Being a juror.
- Being a fit parent.
- Being sued or suing.
- Making a contract, deed or sale.
- Adopting a child.
- Receiving or holding property.
- Giving a binding release or waiver.
- Being a professional person (e.g., doctor, lawyer).
- Making a will.
- Entering or leaving the province or country.

In his investigation of the laws that restrict an individual's liberties and privileges, due to the classification of mental illness, Swadron found these laws fall into three categories.

a. Those limitations and restrictions the purpose of which are to protect the ill person himself from the consequences of behaviors arising from the nature of the illness, ... e.g., wasting his money.

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b. Those liberties and rights which are vested in a person in regard to other persons in a special relationship and which are restricted for the benefit of the special parties, e.g., rights as parents or guardians, rights as a testator, right to marry.

c. Those rights or privileges that may be limited in the case of mental disorder for the protection of others generally from actions and deeds arising from the nature of the illness, e.g., voting, acting as a judge, juror, physician, lawyer . . . etc.\textsuperscript{188}

One needs only to do a small examination of the current movement regarding mental patients' legal and civil rights to discover that the judicial and medical fields are beginning to be scrutinized and challenged in reference to the large number of people these institutions place in psychiatric facilities against their will. There has evolved, in recent years, an awareness by specific groups (patient right groups, civil libertarians, mental health associations, concerned individuals) of the enormous power and authority the medical profession has in restricting the legal and civil liberties of psychiatric patients. This grass roots movement is challenging the medical model which labels disturbing behaviours as psychiatrically abnormal. These groups view mental illness as essentially a moral or political judgment and feel that the medical institutions and especially the psychiatrists themselves have accepted the role of modern-day moral

\textsuperscript{188} Committee on Legislation and Psychiatric Disorders, \textit{The Law and Mental Disorders}. 
entrepreneurs. However, this civil libertarian movement is fighting the "pares patriae" role possessed by the legal and medical professions over psychiatric patients. The civil libertarian movement believes that mental illness and psychiatric hospitalization should not extinguish the rights and privileges of the mentally ill. The civil libertarian movement bases its stance upon the following principle from the Committee on Legislation and Psychiatric Disorders, The Canadian Mental Health Association:

Principle XXVIII Similarly, a certificate by a physician or an order of a magistrate or judge for the removal or detention of a patient suffering a mental disorder who is unwilling or unable to seek hospital care voluntarily should not, ipso facto, be the basis for a declaration of incompetency or incapacity to exercise any right or privilege beyond that of his freedom of movement.189 [Italics are those of the researcher.]

More specific signs of the degree of ferment surrounding mental patients' legal and civil rights can be found in the discussion presented in recent professional journals, newspaper articles, and books. Nationally televised programs dealing exclusively with involuntary hospitalization, and the large number of mental patients' rights groups indicate a widespread concern. The loudest voice raised in this issue comes from the Canadian Civil Liberties Association. In the last two years, it has presented numerous

189 Ibid., p. 3.
briefs to Health Minister Dennis Timbrell regarding the abuse of civil liberties in civil commitment cases.

Due Process of Law

"Due process" is a safeguard against arbitrary governmental decisions. The requirement of due process protects the individual in his efforts to protect and defend himself from government intervention. The legal process requires that a citizen's life, liberty, and property not be decided upon in closed sessions. Due process, thus, emphasizes the right of the citizen to have an open hearing regarding charges which are brought against him. The open hearing allows the individual to challenge the specific charges. Due process also entitles the citizen to obtain the necessary assistance of legal counsel to act on his behalf, as well as be permitted to introduce his own witnesses.

There has been a recent movement to challenge forced psychiatric hospitalization without the benefit of due process and the consequent loss of the committed person's legal and civil rights. These critics\(^\text{190}\) maintain that

\(^{190}\) The major critics of forced psychiatric hospitalization without the benefit of "due process of law" are found in the writings of Thomas Szasz, Irvine Goffman, Nicholas N. Kittrie, E. Fuller Torrey, Robert A. Farmer, Bruce Ennis, Ronald Laing, Thomas Scheff, Ronald Leifer and other writers who have written books or journal articles regarding the "Civil Liberties of the Mentally Ill." Most of these authors have been mentioned in this study.
formal psychiatric hospitalization is a moral crime against humanity. They feel that since the vast majority of involuntarily committed patients have usually not broken any laws, they should not be forced into a psychiatric facility through civil commitment procedures. Those who challenge this avenue do so on the grounds that most commitment laws do not extend “due process of law” to the committed individual. To these critics, this aspect is viewed as a social injustice against a specific population. They believe that the committed person is not provided with means of legal recourse at the onset of his forced psychiatric hospitalization in an attempt to maintain his rights. This recourse is provided to every other citizen, regardless of the charge.

Thomas Szasz writes that though psychiatric incarceration within a public psychiatric facility is usually administered through a public procedure, the process is nevertheless seen as a private imprisonment sanctioned by the state. He believes this arrangement is an area that has long been overlooked with unseeing governmental eyes.191

Canadian Bill of Rights

Most people in Ontario do not realize that a person who is certified to a psychiatric facility due to a civil

commitment procedure is deprived of certain liberties without the protection of "due process of law." The patient is deprived of his liberty on the basis of what he supposedly might do. Other people, those not labelled mentally ill, cannot be jailed for this reason. The legislative reasoning behind this is that the individual may be dangerous to self or others. These criteria, however, have been shown by studies already cited in this paper not to meet the required legal mandate.

Canadian law allows commitments based on second-hand information given to the doctor by X's family about X's behavior. The law presently does not allow X to effectively contest such evidence, which is of course "hearsay" and not permitted in a criminal court of law.192

The Canadian Bill of Rights proclaims the right of a citizen to lose his liberty only via "due process of law." Excerpts from The Canadian Bill of Rights read:

1. (a) the right of the individual to life, liberty, security of the person and enjoyment of property, and the right not to be deprived thereof except by due process of law;

2. (a) authorize or effect the arbitrary detention, imprisonment or exile of any person;

(b) impose or authorize the imposition of cruel and unusual treatment or punishment;

(c) deprive a person who has been arrested or detained
   (i) of the right to be informed promptly of the reason for his arrest or detention,
   (ii) of the right to retain and instruct counsel without delay, or

192 Stewart Page, Mental Patients and the Law, p. 38.
(iii) of the remedy by way of habeas corpus for the determination of the validity of his detention and for his release if the detention is not lawful; ...

(e) deprive a person of the right to a fair hearing in accordance with the principles of fundamental justice for the determination of his rights and obligations. [Italics are those of the researcher.]

Therefore, it appears to this researcher that the Bill itself remains largely a philosophical and theoretical statement with no apparent protection for those individuals who are forcibly coerced into psychiatric treatment. The researcher suggests that under The Canadian Bill of Rights, "due process of law" should require: 1) that an individual be notified in advance that someone has begun proceedings which, if successful, will result in the loss of the person's liberty (Section 2(c)(i)); and 2) the citizen is provided with the opportunity in court to oppose the proceeding before he loses his liberty (Section 2(e)). Both these statutory requirements are not provided to all citizens of Ontario. In fact, the province's Mental Health Act substantially restricts and removes rights and privileges accorded to most citizens through civil commitment proceedings. The researcher trusts that the right to a judicial hearing will be documented in the preceding pages.

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193 The Canadian Bill of Rights, 8-9 Elizabeth II, c.44, (Toronto: The Queen's Printer, 1960).
Freedom from Seizure

Under statutes of The Criminal Code of Canada and the Ontario Mental Health Act, medical practitioners, judges, and magistrates, as well as police officers, are provided with legislative power to apprehend, arrest, and hold certain individuals who are deemed mentally ill without the right to a trial or the benefit of counsel. At the same time, Section 2(a) of The Canadian Bill of Rights states that no person shall be arbitrarily detained, imprisoned or exiled. The Act advances that:

Every law of Canada shall, unless it is expressly declared by an Act of the Parliament of Canada that it shall operate notwithstanding the Canadian Bill of Rights, be so constructed and applied as not to abrogate, abridge or infringe or to authorize the abrogation, abridgment or infringement of any of the rights or freedoms herein recognized and declared, and in particular, no law of Canada shall be constructed or applied so. 194

Therefore, that Ontario's Mental Health Act refutes provisions of The Canadian Bill of Rights and infringes upon the freedom offered to all citizens—freedom from seizure and coerced imprisonment. Farmer (1967) and Ennis (1973) have pointed out that the casual taking into custody of an individual thought to be mentally ill, upon the direction of a relative, physician, or police officer, can certainly be viewed as an unreasonable seizure. They also

194 The Canadian Bill of Rights, 8-9 Elizabeth II, c.44, s.2.
suggest that if the arrest is not authorized under mental health statutes, grounds are then open to bring suit against the seizing person. Ennis and Siegel write:

Don't be put off by the response that you are not being "arrested" but only transported to a hospital. Any substantial interference with your right to go or remain where you like is an arrest, whether the person arresting you calls it that or not.\textsuperscript{195}

The Right to a Trial

One of the major questions regarding the issue of the loss of legal and civil rights of a certified individual is the loss of judicial trial to determine the person's mental status and the need for forced psychiatric hospitalization. Though our legal system operates on the hypothesis that a public trial is essential in the course of justice, this right is not afforded to a person suspected of being mentally ill. In fact, judicial checks are turned over to supposedly concerned members, such as, relatives, physicians, judges, and police officers. At times, it is questionable as to whether these persons are or are not looking after the best interests of the individual.

Miller (1976) indicates that in hearings applying for judicial warrants:

The patient is usually not present and has not been observed by the judge, and there is very little in

\textsuperscript{195}Bruce Ennis and Loren Siegel, \textit{The Rights of Mental Patients}, p. 19.
the way of a serious attempt to elicit information or determine facts as in other types of legal hearings.\textsuperscript{196}

Denial of trial is based upon the rationale that the accused mentally ill person would not be able to understand the trial proceedings. Psychiatrists argue that "due process" by means of physical appearance at proceedings stigmatize an accused individual, make treatment less accessible to those who need it, and may traumatize the person adversely.

Farmer's writing supports Miller's findings. He indicates that a large percentage of these court proceedings are not bound by rules of evidence. Usually no transcript is taken and rarely is an appeal lodged. Farmer suggests the hearing is ceremonial rather than functional and decisions are made at some other point in the process.\textsuperscript{197}

Ontario mental health legislation only provides hearings in regard to the process of obtaining a judicial warrant for the apprehension of a person deemed mentally ill. There is no legislation in this province which requires mandatory trial by jury in commitment proceedings. One may speculate that the courts do not hold that such a right is constitutionally required, which in itself is in contradiction to section 2(e) of The Canadian Bill of Rights.

\textsuperscript{196}Kent S. Miller, \textit{Managing Madness}, p. 101.

Those who support due process of law and the right to a jury trial suggest that the courts may take its role as fact-finder more seriously and apply due process requirements more stringently if it was compulsory in every commitment proceeding. It is also felt that there would be a desire to avoid jury trial. Lawyers would be able to negotiate the least restrictive measure for their client or release. The fact of facing a jury trial in itself would force the careful analysis and scrutiny of each commitment case before commitment was sought. This proceeding would reduce the number of persons committed to psychiatric facilities. Of greater importance, however, would be the introduction of the public's values into the decision-making process.

The Right to Counsel

The right to counsel is recognized as a basic procedural safeguard in trial proceedings. Ontario provides this right to all citizens except those in civil commitment proceedings. It was only recently, 1973, that Ontario introduced a legal aid system designed to provide legal counsel to psychiatric patients. In the vast majority of civil commitment cases, attorneys are rarely present and this program is merely a provision for compensation for the loss of the right to counsel. Counsel, through the Ontario Legal Aid program, is designed to alleviate problems arising
as a consequence of psychiatric hospitalization, or to challenge a certificate of renewal, or to represent a psychiatric patient at a Review Board hearing. All of these events take place after the fact of civil commitment.

Attorneys are reluctant to get involved in commitment proceedings and, furthermore, the situation is so legislated that their participation is discouraged. There is a trend among mental health professionals to discourage legal questions in warrant hearings on the assumption that this would place undue stress upon the patient. Cohen argues that, because of this set up, the attorney is:

Frequently silent and essentially roleless . . . this is so because the proceedings are defined as non-adversary, and the adversary role is the only one in which the lawyer is trained. 198

Should a lawyer be present, his role is one usually of formality, rarely one of opposition.

Due to this unique situation, the accused mentally ill person finds himself in a peculiar position when it comes to being represented by counsel in a commitment proceeding. The patient must protect his own interest by asking for an attorney and if he does not do so it is automatically assumed that he has waived his right to counsel. Ennis and Siegel point out the strangeness of this rule of

law. They suggest that such an arrangement places upon the accused the burden of protecting his own interest by demanding counsel. In comparison, these writers argue that people charged with a criminal offense do not have to demand a lawyer, for if they are without funds they are automatically assigned one, whereas, for the prospective psychiatric patient the rule is just the opposite. 199

Page presents the findings of a study conducted with 30 psychiatric patients who had used the legal aid program in a Toronto psychiatric hospital. These patients were asked to evaluate legal aid, especially in regard to the issue of civil commitment. The major finding indicates that 68 per cent felt that legal counsel would have been most valuable to them prior to psychiatric hospitalization for the purpose of challenging their involuntary admission. 200

Legal Counsel: The Ultimate Authority

Recent research has demonstrated that when an accused mentally ill person is represented by legal counsel, he is less likely to be committed against his will. 201 These

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199 Bruce Ennis and Loren Siegel, The Rights of Mental Patients, p. 41.


201 See: F. Cohen, "The Function of the Attorney and the Commitment of the Mentally Ill," pp. 424-467; S. B. Fein and K. S. Miller, "Legal Processes and Adjudication in Mental
studies show that representation by lawyers appear to lessen the likelihood of the client being admitted to psychiatric hospital under civil commitment procedures. The Wenger and Fletcher study (1969) revealed a high correlation (.942) between the presence of an attorney and the judicial decision not to admit the accused mentally ill person to a psychiatric hospital.

Ennis and Siegel report that, "Psychiatrists do not like to appear in court - it is time-consuming and it doesn't pay - and they certainly do not like to be cross-examined by lawyers." This aspect is furnished as the most common reason why psychiatrists will hospitalize the accused mentally ill person right up to the day of the judicial hearing and then release him. Lawyers who possess knowledge of the state mental health statutes influence the physician's decision not to admit the accused for psychiatric hospitalization.

In summary of the issue of "due process of law," it appears that the notion of providing legal counsel for


202 Bruce Ennis and Loren Siegel, The Rights of Mental Patients, p. 12.
individuals facing civil commitment proceedings is not an attractive aspect for a number of mental health professionals in Ontario, despite its existence in many states in America. The introduction of legal aid was met with numerous conflicts in Ontario's psychiatric facilities. Legal aid was immediately viewed skeptically by many mental health professionals as a personal affront of monitoring their professional judgment and authority to commit people through civil commitment procedures.

Rights of Hospitalized Psychiatric Patients

In general medicine and surgery in Ontario today, no competent adult patient can be treated without his informed consent. A person has the supreme legal right to be free from being touched against his will. Therefore, it is the responsibility of the hospital administration and its doctors to obtain consent from the patient in order to provide necessary medical treatment. In many cases in psychiatric hospitals, this right is apparently denied the patient. Loss of this right means the person cannot make decisions about medical and surgical procedures. They may be forced to submit to what many citizens would consider cruel and unusual treatments, such as, electric shock treatment, insulin coma treatment, prolonged major pharmacological therapy, conditioning treatments to modify
behaviour and, in some cases, sterilization. Physicians, through "pares patris" are able to restrict the rights of patients on the simple premise that, because commitment to a psychiatric facility in itself indicates that the person does not know what is best for himself. Tied to this premise is the additional assumption, on the part of many mental health professionals, that mental illness is synonymous with incompetency; therefore, the person must undergo the treatment package deemed necessary for him.

Notice of Rights

In many psychiatric facilities, patients face the additional burden of discovering for themselves their rights while hospitalized. Few are advised of their hospital status and advised of the effect it may have upon their rights and privileges while hospitalized. Reitsma's investigation of fourteen psychiatric hospitals discovered that the majority of the hospitals examined tended to adopt a somewhat shiftless approach to the whole issue of patient's rights. She states that:

Few hospitals delegated total responsibility for advising patients of their rights to one staff member. One may well wonder whether the patient is every adequately informed. Moreover, detailed information about rights was generally given only on specific request.203

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203 Marge Reitsma, "Civil Liberties and the Mentally Ill," p. 11.
Even in hospitals where patient's rights are usually explained, this information is often withheld. The hospital may run out of forms and neglect to order new ones. Doctors and attendants may decide to withhold notice because they believe it might agitate or disturb the patient. This researcher knows of one psychiatric facility in Windsor that provides a pamphlet entitled "You Have a Share" to its psychiatric patients. Accompanying a copy of this pamphlet, which the researcher received, was a note from a nurse indicating that it was "O.K." for this pamphlet to be given out to patients due to its positive nature, for it was written, produced, and edited by the hospital administration.

Obviously, patient's rights is a meaningless concept if the patient does not know he has these rights.

Right to Refuse Treatment

The existing legislation is unclear and vague regarding the issue of the right to refuse treatment. Those writers who write from a civil liberties approach contend that mental illness and commitment are not sufficient conditions to take away the patient's right to refuse treatment. These writers believe that if a person is not declared incompetent and he personally does not want to be subjected to any treatment, then this right should be honored. 204

Page suggests that just because a person is admitted to a psychiatric facility does not remove that person's legal right to refuse treatment. The involuntary nature of the admission does not automatically prove a person's incompetency to decide the issue of his treatment. Page believes that, "Test cases in courts are needed in which the right to refuse treatment is debated and such a right is defended." 205

In researching this subject matter, the researcher examined the Ombudsman Program sponsored by Mental Health/Windsor-Essex in the department of adult psychiatry at Windsor Western Hospital Centre. The goal of the Ombudsman is to inform all persons who are receiving psychiatric treatment of their rights while in hospital. The Ombudsman is there to help increase the patient's understanding of hospital procedures and policies. When the researcher obtained a copy of the Ombudsman Service pamphlet outlining the rights of psychiatric patients, he could not help but notice one statement.

Note: Involuntary patients who are certified because they are judged to be a danger to themselves


205 Stewart Page, Mental Patients and the Law, p. 61.
or others are not in a position to refuse treatment or leave the institution freely. [Italics are those of the researcher.]

Such a policy statement seems to be in direct opposition to a civil libertarian frame of reference and not what one would expect an Ombudsman service to supply, especially if the Ombudsman program was attempting to protect the psychiatric patient's rights. In investigating this aspect further, the researcher learned from a discussion with a member of the executive board of Mental Health/Windsor-Essex that the reference was one of those aspects Mental Health had to concede to the hospital administration in order to set up and implement the Ombudsman program.

Confidentiality

When a patient consults with a physician, a contractual term is applied indicating that any information disclosed by the patient is private and confidential. There appears to be no law, however, which guarantees and safeguards the privacy and confidentiality of patient records. In fact, "Unlike the attorney-client privilege, the doctor-patient privilege is not recognized as common law." In a court proceeding, a physician may be called upon to divulge information given to him by a patient under the guise of

206 Ombudsman Service, a pamphlet produced by Mental Health/Windsor-Essex and given out to psychiatric patients in the Department of Psychiatry, Windsor Western Hospital Centre.

privileged communication.

Annas, Kelly and Weston, and Ferster all mention the loss of control of information by patients. Psychiatric records, which are generally more sensitive in nature than general medical records, are available to all hospital personnel. They may be kept in a central computer available to anyone who has access to the computer. They also believe that the average citizen is subject to approximately ten to twenty governmental and private dossiers, all of which are held in computer files.

Within the last year in Ontario, the grave and serious misuse and abuse of the confidentiality of medical records has come to light. The newspapers have carried accounts of the Ontario Health Ministry sending Statistics Canada forms on psychiatric patients that contain their social insurance numbers. Articles have covered the limiting of who may obtain medical records, the establishment of a Royal Commission to inquire into the confidentiality of health records (see Appendix F), and some of the findings

of the Commission's investigation. Kelley and Weston reiterate in their article that:

Once control is lost, information leakage becomes comparable to a virus in the blood stream. There is no telling what its course will be, where it will end, and what damage it will do.

Even without the patient's loss of confidentiality in the form of their medical records, a statute contained in the Mental Health Act allows the information compiled by a psychiatric facility on a patient to be released to any person when it is judged by the senior physician to be in the best interest of the patient. According to the testimony heard in the Royal Commission hearing, "in the best interest of the patient" has not always held true.

Communication and Visitation

The right of communication is exercised by a psychiatric patient in two ways: 1) visitation; and 2) correspondence. Hospitals are in the position, however, to interfere or deprive a psychiatric patient of these rights by denying the patient mail or visitors. There is

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210Verne R. Kelley and Hanna Weston, "Civil Liberties in Mental Health Facilities," p. 50.

211The Mental Health Act, R.S.O., 1970, c.269, s.17.
no legislation which authorizes or permits a psychiatric patient to be held incommunicado, or explicitly prohibits any interference with the correspondence of a psychiatric patient. There is a statute in the Mental Health Act that authorizes such interference if the officer in charge or those acting under him have cause to believe that the correspondence is not in the best interest of the patient. 212 A question develops regarding how the staff determines and justifies the restriction of mail without first actually tampering with it. Providing psychiatric facilities staff the power and opportunity to interfere with a patient's mail certainly appears to be a clear violation of that person's civil rights.

The rules and regulations designed by hospital administrators may furthermore restrict and regulate the visitors and visitation of psychiatric patients. Psychiatric patients may find it very difficult to communicate by telephone at some psychiatric facilities. Many facilities require psychiatric patients to use pay telephones that are only equipped to handle out-going calls. Personal calls may only be made during specific periods of time! Any other hospital patient would balk at accepting these restrictions and consider it an infringement on their civil rights.

212 The Mental Health Act, R.S.O., 1970, c.269, s.19.
In reviewing Windsor Western Hospital Centre's pamphlet You Have a Share, a curious fact comes to light. The majority of the points discussed in this pamphlet pertain to the restrictions the hospital believes it has the right to place upon psychiatric patients. For instance, the psychiatric patient's ground privileges, bed time, visitation, and ability to phone, and personal belongings are all regulated by hospital procedures. To provide the reader with a flavour of the restrictiveness of this pamphlet, two items from the brochure are presented.

Telephone: A pay telephone is available for patients on each unit. We request you limit your calls to fifteen minutes, to allow all of the patients access to the phone. As the Unit phones are very busy business phones, no patient calls can be made at the nursing desk.

Visiting Hours:
6:00 p.m. to 8:00 p.m. each week-day
10:00 a.m. to 8:00 p.m. weekends and holidays

Visitors are screened according to the doctor's orders and the patient's wishes.

These are restrictions which are not placed on the general hospital patient, nor would they be accepted by the general hospital patient.

213 You Have a Share is a pamphlet distributed by the ward clerk to all psychiatric patients in the Department of Adult Psychiatry, Windsor Western Hospital Centre and outlines to patients certain hospital policies and regulations in a positive nature.

214 Ibid., p. 7.
Political and Constitutional Matters

In the very roots of a free and democratic society is the inherent right of an individual to exercise his franchise, run for or hold public office, and be part of the judiciary system as a member of a jury. Accordingly, Ontario legislative machinery withdraws these basic rights from a select group of citizens—those who are incarcerated in the province's institutions. Ontario's laws appear to seriously discriminate against the mentally ill for they represent a particularly large segment of the population who have these specific rights revoked. As with most myths which surround mental illness and the mentally ill, the denial of these particular rights are based on the assumption that mental illness is synonymous with lack of mental ability.

Disenfranchisement

In examining Table 2 it must be brought to the reader's attention that the exclusion from the right to vote is for the most part dealt with on the same footing as with prisoners under sentence. The strongest objection to this restriction, as with most others, is that the laws are too vague and imprecise in governing such an important
Table 2

The Right to Vote - Exclusion in Canadian Legislation

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Statutory Reference</th>
<th>Provision</th>
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<tr>
<td>Ontario</td>
<td>Election Act, Revised, Statutes of Ontario, 1970, c.142, s.11</td>
<td>Persons who are prisoners in penal or reform institutions or who are patients in mental hospitals, or who have been transferred from mental hospitals to homes for special care as mentally incompetent are disqualified from voting.</td>
</tr>
</tbody>
</table>

Note: The writer has revised the original table to document the revised statutes of 1970 and has only shown the Ontario provision.

constitutional matter. Disenfranchisement becomes a greater infringement on an individual's right if the provincial enactment is operatively different from that of the federal legislation. The situation in Ontario appears to be somewhat simpler than in other Canadian provinces: "A certified patient in an Ontario Hospital appears to be disqualified from voting in either a provincial or federal election."  

Certain issues arise due to the ambiguities of the statutes contained in the Ontario Election Act. In regard to mental hospitals, it is not clear what type of facility is considered here. There is also a question about the status of patients still on the books but discharged into the community (Mental Health Act, c.269, s.26, ss.2) or in approved homes. The major stumbling block is associated with the issue of what status of patient (formal or voluntary) in a psychiatric facility is disqualified from voting.

Moreover, it is not always clear whether the prohibition extends to a patient who is on an informal or voluntary status, or whether it is of application only to a person who is hospitalized under compulsory procedures.


216 The Law and Mental Disorder, Two: Civil Rights and Privileges, p. 57.

217 Ibid., p. 53.
Is it really necessary to have a special voting law? A revealing study carried out in New York during the 1966 and 1968 state elections discovered that mental patients were as competent as anyone else in exercising their right to vote. It was found in these primaries that a psychiatric patient, regardless of his degree of disability, was given a sample ballot to fill out. There was no significant difference in voting patterns between the two groups. When the ballots were counted, the researchers found that the patient voters and the citizens of the community voted very similarly. In fact, the two major candidates received the most votes from the hospital voters and the community.218

The ramification of this study appears to indicate that psychiatric facilities traditionally have not helped patients in their right to exercise their franchise. Enumeration lists are not checked by hospital authorities, nor are they available within the facility, as well as balloting stations themselves. Candidates, on the whole, have not paid much attention to this particular group of potential voters. No doubt, many mental health professionals believe erroneously that all mentally ill people do not have

218E. Fuller Torrey, The Death of Psychiatry (New York: Penguin Books Inc., 1974). Bruce Ennis and Loren Siegel, The Rights of Mental Patients also cites this study as their introduction on "civil rights" of hospitalized psychiatric patients.
the right to vote. Such a concept is a particularly disturbing situation when one considers the large percentage of citizens who could legally vote and choose not to do so.

Holding Public Office

The statutes in Ontario that determine qualifications for holding public office are quite similar to those required for voting. The statutes state that one of the requirements necessary for holding public office is that the person be a qualified voter. Such a provision usually disqualifies the mentally ill person from running for or holding public position because their hospitalization generally removes their name from the provincial and federal election lists.

Jury Duty

The problems of jury service are essentially the same as those surrounding the ability to vote. The requirement is usually that a juror be a qualified voter. Jury lists are drawn from the province's enumeration lists, presumably containing only those names of qualified voters. The initial selection of prospective jurors or the voir dire examination in a jury trial would surely exclude those persons who are or are deemed to be mentally ill.
Personal and Property Rights

In Ontario, mental health legislation deprives a institutionalized person deemed by his physician to be "mentally incompetent," the right to exercise control over his personal affairs. The right to execute a document or initiate litigation is transferred over to the Public Trustee as determined by sections 32 to 56 of the Mental Health Act. The Trustee or committee then handles the person's affairs as long as the certificate of incompetency is kept in force.

Executing a Legal Document:
Contracts

Early common law voided any contractual obligations which occurred during the period of a person's mental illness. Today, however, no arbitrary stance is adopted in respect to the right of avoiding obligations incurred while mentally ill. Most courts now distinguish between the contracts and conveyances of an incompetent made prior to an adjudication of his condition and those executed after the certificate of incompetency. Present laws seem to hold that contracts made prior to adjudication of incompetency are void.

In Ontario, for example, any financial deal transacted (e.g., a purchase or sale of property) by a
"person who is or becomes a patient could be deemed 'fraudulent' and void." 219

In most cases, a legal transaction made by a person certified as incompetent is usually automatically considered "null and void." This applies particularly to those cases in which a guardian or Public Trustee has already been appointed. The basis of this rule 220 is that it may become very difficult for the guardian to preserve the estate of a ward if every transaction the patient entered into was allowed to stand. It would override the guardian's purpose of guardianship.

Upon the Public Trustee becoming committee of the estate of a person under this Act or by an order made under this Act, every power of attorney of such person is void. 221

Wills

A person's ability to make a will is known as his testamentary capacity. Today's statutes describe this capacity in terminology "of sound mind and memory." Courts in Canada have assigned a fairly even interpretation to the phrase "of sound mind" for the purpose of making a will. For the objective of validity, the testator must be able to:

219 Stewart Page, Mental Patients and the Law, pp. 71-72.

220 Frank T. Lindman and Donald M. McIntyre, eds., The Mentally Disabled and the Law, p. 264.

221 The Mental Health Act, R.S.O., 1970, c.269, s.44.
1. Know without prompting the nature and extent of the property involved.
2. Know the meaning of making a will.
3. Know who are the named beneficiaries.
4. Understand his relationship to the beneficiaries.
5. Be able to remember the will and the decisions involved in making it.222

Since Ontario statutes restrict a person deemed incompetent and, therefore, "of unsound mind" to execute a conveyance or a contract, a mentally ill person is prohibited by administrative regulations from making out a will. "The law does not allow him to make a will, since such a document would be recognized as null and void if contested after his death."223 The only way possible for an incompetent person in Ontario to make out a will is after certification of incompetency. Under the power of the Public Trustee, the incompetent person may so designate the disposition of his property according to his wishes after his death. In effect, the Public Trustee makes out the will.

Right to Sue and be Sued

Though laws have changed over time regarding the aspect of instituting suits, today the mentally ill may not sue and be sued, unless they have been divested of the

222See: Robert A. Farmer, The Rights of the Mentally Ill, pp. 76-79; Frank T. Lindman and Donald M. McIntyre, eds., The Mentally Disabled and the Law, pp. 264-265.

power to act on their own behalf due to an adjudication of incompetency.

The right to sue is an essential one and in this area the mental patient does have some difficulty. The Court must, therefore, upon proof of mental incompetency, require the appointment of a third party to defend the rights of the patients.224

Therefore, the mentally ill person who is certified incompetent may sue or be sued by a suit being initiated by or brought against the guardian. This requirement, that a guardian sue or be sued on behalf of the incompetent person, is for the protection of the incompetent and his estate, rather than a limitation on the capacity to institute a suit.

An interesting point of tort law must be brought to the reader's attention here. Although a mental patient has the right to bring suit against another citizen, he does not have the legal right to take action against the psychiatric facility or any of its employees. This right is divested from the mentally ill person under mental health legislation. "No action lies against any psychiatric facility or any officer, employee or servant thereof for a tort of any patient."225

Furthermore, there is a statute in the Mental Health Act which prohibits any actions, prosecutions, or other

224 Ibid., p. 4.

225 The Mental Health Act, R.S.O., 1970, c. 269, s. 59.
proceedings from being initiated against a psychiatric facility or any person for not following the regulations of this Act after a six-month period after the occurred complaint. Judge McRuer writes that this legislation is very unique in that it imposes a limitation period in which action for breach of trust must be brought. Furthermore, the time period is a very short one and the time limitation usually works against the psychiatric patient who is confined to a psychiatric facility.

Domestic Relationships

Society believes a tragic consequence of mental illness is the disruption of the normal family entity. Mental illness is seen as preventing the afflicted person from functioning adequately in normal domestic relationships. When one of the marriage partners suffers from mental illness, it is assumed a very heavy burden is placed on all other family members. In fact, the immediate members of the family are not the only ones involved in the event. Laws, therefore, have been passed to lessen the consequences of domestic disruption. In Ontario, legislation prohibits certain people from marrying, or allows certain family...

226 Ibid., s.58.

relationships to be terminated through divorce or adoption.

Marriage

As Table 3 clearly denotes, Ontario legislation prohibits a mentally ill person from marrying. Prohibition has evolved out of common law on two specific grounds. The first point is designed to prevent a marital contract when one of the partners is unable to understand the nature, duties and obligations of the relationship. The second policy attempts to prevent reproduction by persons whose offspring may become public charges. In Ontario legislation, "the ability to comprehend the nature and the commitments of the contract being entered into seems to be the deciding issue." 228

The Committee on Legislation and Psychiatry revealed that in their examination of marriage statistics, they were unable to determine to what extent, if any, the number of occasions that a marriage license has been refused or revoked on the grounds of mental illness. The committee also questioned the ability of officials' capacity to recognize and distinguish mental illness or mental defectiveness in one of the marriage partners. There is also the issue of the effectiveness of such a statute's attempt to limit

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<tr>
<th>Province</th>
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<tbody>
<tr>
<td>Ontario</td>
<td>Marriage Act, R.S.O., 1970, c.261, s.6</td>
<td>No person shall issue a licence or special permit to or solemnize the marriage of any person who is mentally ill or mentally defective, or who is under the influence of intoxicating liquor or narcotic drugs.</td>
</tr>
</tbody>
</table>

Note: The writer has revised the original table to document the revised statute of 1970 and has only shown the Ontario provision.

marriage and what legal effect or penalty would be brought against a mentally ill person who does marry.\footnote{229}

Divorce

Divorce is designed to dissolve marriage based upon postnuptial causes. An annulment is granted for causes that existed before or at the time of marriage. In Ontario, postnuptial mental illness is a consideration for the granting of a divorce. Should a married spouse develop mental illness during the marriage, the same conditions which prohibit the marriage of a mentally ill person comes into play in granting a divorce. However, in the latter situation, the court is much more diligent in its investigation.

Since divorce on the grounds of mental illness is characterized as divorce without fault, establishing the existence of mental illness is made more difficult. Requirements for postnuptial divorce is that the mental illness of a spouse must have been present for at least five years, and the illness must be severe enough to be considered probably incurable by medical prognosis.\footnote{230}

\footnote{229}Ibid., pp. 43-47.

\footnote{230}Robert A. Farmer, The Rights of the Mentally Ill, pp. 58-62; Frank T. Lindman and Donald M. McIntyre, eds., The Mentally Disabled and the Law, pp. 200-204.
The legal rights of the mentally ill person in many divorce proceedings may be overstepped or completely ignored. Depending upon the person's condition, mental health statutes do not require personal service of process. Instead, the application is served on the psychiatric facility's administrator. Thus, the mentally ill defendant may be totally unaware of the pending divorce proceeding initiated against him.

The right of the mentally ill to sue for divorce is quite a different issue. A guardian will usually not pursue a suit for divorce of his ward. Legislation which provides the guardian to sue on behalf of his dependant does not apply in divorce proceedings. The reasoning behind this course of action is twofold. First, the petition in a divorce proceeding must be personally verified and it is assumed that a mentally ill person is incapable of doing this. Secondly, divorce is considered too personal for one other than a spouse to request dissolution. This, however, leaves a question unanswered. Does legislation allow a mentally ill person to obtain a divorce when there is proven fault on the part of the sane partner?

\[231\] Ibid., p. 59, p. 204.
Adoption

Provincial adoption legislation requires the consent of the natural parent(s) or surviving parent. In situations when it has been determined that the parent(s) or guardian(s) is mentally incompetent, or has neglected or abandoned the child, or the parent or guardian cannot be found, the court may dispense with the consent of these individuals. Rights of the mentally ill parent or guardian may be infringed upon due to the fact that the applicable statutes do not address the critical question regarding the degree and type of mental illness one has. Another factor overlooked at times is that the interest of the mentally ill parent or guardian may not be represented by legal counsel.

The rights of the mentally ill may also be affected in adopting procedures. The judge of the appropriate court, through the Director of Child Welfare, investigates the physical, mental, and moral fitness of the adopting parents. The fact that one of the prospective adopting parents has been or is considered to be mentally ill or mentally defective may be used as evidence against the couple to preclude the adoption.232

Occupational and Professional Practice

Professional Licensing

Ontario has about fifty statutes governing the practice of professions and trades which specify the loss or suspension of practice in the event of mental illness. Table 4 shows only a few of the statutory references which restrict individuals employed in those professions from working due to mental illness. The purpose behind the statutes of suspension or revocation of a professional license of the mentally ill person is presumably to protect the general public from unqualified persons practicing their profession. This provision supposedly protects the individual and the public from liability. An important additional consideration is the protection of the "good name" or "reputation" of the trade or profession as a whole. In many instances, these statutes have been accepted and passed within Ontario legislation at the request of the particular trade or profession. 233

The power possessed by these licensing boards can be questioned regarding the protection of the rights of a

233 Committee on Legislation and Psychiatry, The Law and Mental Disorders, Vol. 2, pp. 64-75; Frank T. Lindman and Donald M. McIntyre, eds., The Mentally Disabled and the Law, p. 267; Stewart Page, Mental Patients and the Law, pp. 66-67.
<table>
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<tr>
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<th>Statutory Reference</th>
<th>Specific Reference to Mental Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>Accountant</td>
<td>The Public Accountancy Act, R.S.O., 1970, c.373</td>
<td>18-(1) If a person licensed under this Act (b) becomes of unsound mind; the Council may subject to the provision of this section, revoke his license</td>
</tr>
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<td></td>
<td>Denture Therapists</td>
<td>The Denture Therapists Act, S.O., 1974, c.34</td>
<td>11-(5) Where the Discipline Committee finds a licensee guilty of professional misconduct or incompetence it may by order (a) revoke the license of the licensee</td>
</tr>
<tr>
<td></td>
<td>Engineer (Operating)</td>
<td>The Operating Engineers Act, R.S.O., 1970, c.333</td>
<td>24-(1) Subject to section 24a, the Board may cancel or suspend a certificate of qualification if the operating engineer or operator, (c) is declared to be mentally incompetent or becomes physically incapable of safely performing his duties</td>
</tr>
<tr>
<td></td>
<td>Dentist</td>
<td>The Health Disciplines Act, S.O., 1974, c.47, Part III, Dentistry</td>
<td>38(1)(b) &quot;incapacitated member&quot; means a member suffering from a physical or mental condition or disorder</td>
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Table 4 - Continued

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<th>Specific Reference to Mental Disorder</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Medical Doctor</td>
<td>The Health Disciplines Act, S.O., 1974, c.47, Part III, Medicine</td>
<td>62-(1)(b) same as above</td>
</tr>
<tr>
<td></td>
<td>Nurse</td>
<td>Part IV, Nursing</td>
<td>85-(1)(b) same as above</td>
</tr>
<tr>
<td></td>
<td>Optometrist</td>
<td>Part V, Optometry</td>
<td>same as above</td>
</tr>
<tr>
<td></td>
<td>Pharmacy</td>
<td>The Health Disciplines Act, S.O., 1974, c.47, Part VI, Pharmacy</td>
<td>same as above</td>
</tr>
</tbody>
</table>

Note: The writer has revised the original table to document revised statutes and the new Health Disciplines Act.

Source: Committee on Legislation and Psychiatry, The Law and Mental Disorders, Vol. 2 (Toronto: Canadian Mental Health Association, 1967).
member who is assumed to be mentally ill.

Power to revoke a license may be widely delegated, often to the board that originally granted the license. Representation of the mentally ill person's interest is usually not possible, proceedings are summary and adequate review procedures are not available. The cured mental patient returning to society may find it exceedingly difficult to get his professional license restored. 234

As with the vast majority of statutes designed to control the mentally ill, these trade and professional statutes are no different. The regulations contain wide variations, vagueness, lack of precision in use of terminology, plus an absence of any specific designation of who is responsible for declaring a person mentally ill.

Appointment of an Agent

A mentally ill person deemed incompetent is limited in his capacity to appoint an agent to represent him. Should such a person appoint an agent, the act of appointment may be set aside by court order. Not only is an incompetent person prohibited from designating an agent, but an agent agreement set up when the person was considered competent is terminated when a person is determined incompetent. In no event can a mentally ill person become an agent. 235


235 Ibid., p. 75.
Operating a Motor Vehicle

Driver's License

The province is concerned with people's ability to operate motor vehicles in a safe and proper way so as to reduce the danger to the public and the increasing incidents of traffic accidents. Due to these facts, the general trend in Ontario is that:

The right to drive is forbidden to those who are unable, due to mental or physical disability, to pass the examination to obtain a driver's license. 236

The right to not issue or to revoke a driver's license is granted under the Highway Traffic Act. Statutes contained in this Act allow the Lieutenant-Governor of the province to regulate the issuing of licenses based on mental and physical examinations.

6. The Lieutenant-Governor in Council may make regulations relating to this section; (e) respecting practical and written driving examinations, and mental and physical, including ophthalmic and auditory, examinations for applicants for holders of drivers' licenses. 237

The vague and practically useless guidelines make it unclear under what conditions a person may be disqualified from operating a car. As in almost every other


situation where a person loses certain rights and
privileges, certain questions remain unanswered. Some
of the questions that need to be examined are: 1) is the
opinion of the person's physician necessary or taken into
consideration?; 2) is the person in a psychiatric facility
and is that person a formal or voluntary patient?; 3) is
the person deemed incompetent to manage his own personal
affairs? Are all of these points measured into the dis-
qualification? People can be bad drivers for many other
reasons other than mental illness. One may compare the
question of whether the province disqualifies the alcoholic
from driving a car just on the grounds that he drinks and
disqualifies a mentally ill person because he has a mental
illness.

In recapitulation, the major issues of concern re-
garding legislative statutes in Ontario, may affect the
legal and civil rights of mental patients. The major
difficulty lies in establishing the identity of these
people. Research in this area has typically shown that
these types of statutes usually:

1. not only neglect to say whether a person's rights
are suspended upon entering a mental hospital
and becoming a patient there, but also fails to
differentiate voluntary from compulsory hospital-
ization;
2. fails to state whether a formal legal adjudication
of mental disability is required before personal
and property rights are restricted;
3. does not say whether non-hospitalized mentally
ill persons are prohibited from exercising
particular rights;
4. is silent to the rights of a person who, although adjudged incompetent, does not need hospitalization;
5. fails to indicate whether the prohibition applies to a person who is in fact incompetent but who has not been so adjudicated;
6. neglects to spell out administrative procedures enforcing the suspension of rights;
7. is unclear about whether the denial of rights is based on the premise that any person who is in need of hospitalization is incapable of exercising them . . . ;
8. fails to specify when or how reinstatement of any suspended rights occurs.238

Summary

The review of the literature has examined the status of the mentally ill person or a person assumed to be mentally ill under three major sections.

The first major section offered a historical overview of man's view of pathology, man's concept of mental illness, and his attitude towards the mentally ill person. A general review of the evolution of "parens patriae," or right to treat, and the development of legal statutes in Ontario designed to control and treat the mentally ill person have been outlined.

The section on psychiatric admission procedures in Ontario's present Mental Health Act examined the ways and means of psychiatric hospitalization and treatment of the province's people deemed to require such treatment.

238 Frank T. Lindman and Donald M. McIntyre, eds., The Mentally Disabled and the Law, p. 263.
The last major section of the review of the literature extensively investigated the rights and privileges that may be restricted, revoked, or infringed upon when a person is assumed to be mentally ill. Since due process of the law is not afforded to these citizens, the constitutionality of such statutes, how they are enforced, and who is responsible for enforcement has been questioned.
CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

The choice of the research design of the study clarified for the researcher the step-by-step approach to conducting his research in a systematic and orderly fashion. This planning phase led to the following selection (classification of research design, research hypotheses, working definitions, the population and sample, method of data collection and data analysis) being formulated. These selections make up the logical strategy of the study.

Classification of Research Design

Once the researcher had formulated and refined the nature of the problem he wished to investigate, a review of the material associated with the classification of the research design indicated that the characteristics of his own study fell within the realm of Quantitative-Descriptive Studies guidelines. Research that comes under guidelines of quantitative-descriptive studies have as their purpose the seeking of knowledge through the testing of hypotheses or the description of quantitative relationships between
specific variables. The researcher's study is designed to test five hypotheses which state the existence of a measurable relationship between two or more variables. Furthermore, the hypotheses only suggest an association between two variables and do not forecast the direction of the relationship.

Of the four sub-categories of quantitative-descriptive studies, the researcher believes that his study resembles the research objectives of the third sub-type, which describes the characteristics of a population. Researchers refer to a study which attempts to accurately describe the characteristics of a population as a "Population Descriptive Study." The main goal is the accurate depiction of measurable traits of a selected population. This type of study frequently employs survey procedures and may describe its population's attitudes.

It is the researcher's main objective in the study to detail the attitudes possessed by a specific group of

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241 Tony Tripodi et al., The Assessment of Social Research, p. 42.
Windsor social workers regarding specific variables. The researcher feels positive in assessing his study as a population description study. Since the study claims to accurately describe quantitative characteristics of a selected population, these exclusive qualities advance the choice of a Quantitative-Descriptive Study, sub-categorized as a "Population Descriptive study."

Problem Formulation and Research Hypotheses

This study examines the attitudes that a specific group of Windsor social workers hold toward the legal and civil rights issue of the psychiatric patient. As discussed in a previous chapter, the lay community, on the average, is prejudiced against a person who is deemed mentally ill or is suggested to have a mental health problem. In comparison, mental health professionals have a more favourable view relating to mental illness and the mentally ill and see it as less of a threat to society than does the general public. However, the response to clients by mental health professionals can be affected by their rank within the hierarchy of the health profession, patient hospital status (formal or voluntary), circumstances which surround the decision of the psychiatric patient to enter the hospital, and whether there is a judiciary process which challenges the clinical judgment for hospitalization. These events
seem to have a negative impact on mental health professionals toward the patient and his care and may ultimately deprive the patient of his rights.

It is the intent of this study to determine the answer to five research hypotheses. They are as follows:

1. Social workers do not possess a knowledgable understanding of Ontario's Mental Health Act.

2. Social workers who score low on the test questionnaire in their knowledge of Ontario's Mental Health Act will also score low on the test questionnaire in their knowledge of the psychiatric patient's legal and civil liberties.

3. Social workers do not believe that the statutes as outlined in the Mental Health Act, Revised Statutes of Ontario, 1970, safeguard and protect the legal and civil liberties of psychiatric patients.

4. Social workers do not inform psychiatric patients about their hospital status (formal commitment or voluntary admission) and how the nature of the admission may, in turn, affect their legal and civil liberties.

5. Social workers do not believe that it is a right or a necessity for a certified psychiatric patient to receive "due process of law" or be represented by legal counsel in civil commitment proceedings.

The first and second hypotheses provide the opportunity to determine a correlation, if any, between
social workers' knowledge of the Mental Health Act and their knowledge of the psychiatric patient's legal and civil rights. The correlation will be derived from the scores obtained by each social worker who participates in the study and completes the two test questionnaires. The Mental Health Act will become the control and each respondent will receive a score of one for each correct answer he obtains on the questionnaire based on the mental health statutes. Hypotheses three to five are descriptive hypotheses and will provide quantitative and qualitative information.

Working Definition

To further clarify this study, it is necessary to distinguish the concepts that emerge within the construct of the hypotheses. Certain terms must be defined. "The operational definition stipulates which specific indicators (or observations) are to be assigned which specific meanings."²⁴²

As defined in the opening chapter, social work is a profession "which endeavours to foster human welfare through professional services and activities aimed at

²⁴² Claire Selltiz et al., Research Methods in Social Relations, p. 40.
enhancing, maintaining, or restoring the social functioning of persons." 243 Until recently, the Ontario Association of Professional Social Workers was inclined to limit its membership to those individuals who possessed a Bachelor of Social Work degree or its equivalent. 244 Since this study is focusing on a small cluster of social workers, to restrict it even further by accepting the limitation of only those people who hold a professional social work degree from a university confines the concept of social worker for this study. Therefore, the study depends on a broader definition of the term social worker to increase the number of respondents.

For the purpose of this study, a "social worker" is defined as an individual who works on a full-time basis and fulfills at least four out of the following six criteria:

1. has employment in a recognized social service agency (a recognized agency means that the agency is listed in the Directory of Social Services of Essex County);
2. has face-to-face contact with clients or client groups (psychiatric patients);
3. holds a B.S.W., M.S.W., D.S.W., or Ph.D. degree;


4. has a job description which includes social work functions that meet the C.A.S.W. definition of social work;
5. maintains a belief that he or she has social work functions that meet the C.A.S.W. definition;
6. carries social work functions which in the researcher's opinion meet the C.A.S.W. definition. 245

The second operational definition concerns the concept Mental Health Act. The Mental Health Act are those statutes which have been passed as law by the legislature of Ontario and establishes the rules governing mental health in this province. These statutes may be found in the Mental Health Act, R.S.O., 1970, c.269, plus Regulation 576 and Regulation 577. For the purpose of this study, the formal and operational definition will be based on the exact wording of the statutes found under this Act.

The next concept which needs to be defined is "psychiatric patient." The Mental Health Act describes a patient as "a person who is under observation, care and treatment in a psychiatric facility." 246 The definition is sufficient for the operational definition of this study.

The concept of "legal and civil liberties" which arises in the second research hypothesis is difficult to define precisely and lucidly. Tarnopolsky writes on

245 Andrzej B. Michalski, "Essex County Social Workers: Their Attitudes Towards Women," M.S.W. thesis, University of Windsor, Windsor, Ontario, 1976. This researcher has accepted all six criteria presented in this M.S.W. thesis as the standard needed to define his own definition of a social worker.

246 The Mental Health Act, R.S.O., c.269, s.1, ss.(i).
The Canadian Bill of Rights that:

A 'right' may be said to be a claim or an advantage possessed by a person or persons, which is conferred or protected by law, and which implies a corresponding duty on the part of another.247

In addition, he classifies civil liberties under four subcategories of political liberties, economic liberties, legal liberties and egalitarian liberties which encompass the classes of human rights and fundamental freedoms.248

For the purpose of this study, "legal and civil liberties" include all those rights and privileges classified by Tarnopolsky which may be withdrawn, revoked or suspended arbitrarily, haphazardly and, at times, unconstitutionally from psychiatric patients. For the most part, all Ontario citizens assume they possess and usually take these rights for granted.

Another concept which needs to be defined is the term "hospital status." Webster's dictionary defines status as, "position; rank; position of affairs,"249 thus indicating hospital status to represent hospital position or hospital rank. This formal definition, however, does not meet the


248 Ibid., p. 3.

requirements for this study due to its lack of clarity. For this study, "hospital status" will indicate a psychiatric patient admission status as provided for by the Mental Health Act. Under the statutes of the Act, a psychiatric patient may be admitted under three proceedings and each procedure, in turn, affects the patient's legal and civil liberties to different degrees.

For the purpose of this study, "hospital status" is defined as the admission procedure under which a patient entered hospital (formal commitment as provided for by medical or criminal procedures or voluntary admission) and the rights and privileges so accorded to the admission.

The final concept that requires a definition arises from the fifth hypothesis. The concept of "due process of law" is defined as: the right of any citizen to have decision concerning his life, liberty, or property made in an open session of court. Before he can lose his legal and civil liberties he must be notified of the specific charge against him and have the opportunity to challenge, with the assistance of legal counsel, any adverse evidence through the introduction of his own witnesses.

Assumptions

The researcher made several assumptions which have a bearing on the research hypotheses and the research methodology. These assumptions are based on events which
the researcher has accepted to be true for the length of this study. These assumptions are that:

1. Psychiatric hospital admission carries with it a certain status associated to the type of admission procedure the patient entered under which, in turn, grants or restricts certain hospital rights or privileges as well as specific legal and civil rights.

2. A psychiatric patient's legal and civil liberties are directly related to his hospital status.

3. The statutes as outlined in the Mental Health Act have a direct bearing upon the status of a psychiatric patient due to the admission procedure.

4. The statutes as outlined in the Mental Health Act have a direct bearing upon the legal and civil liberties of a psychiatric patient.

5. The mental health profession (especially physicians, psychiatrists, psychiatric nurses) believe that they have the right to treat the mentally ill person even against his own expressed wish not to be treated due to parens patriae or the State's right to treat the mentally ill.

6. Many mental health professionals still equate mental illness with incompetency.
Major Population

The population of this study is derived from all social workers in Essex County who meet limits made explicit by the researcher. To be considered eligible for this population a social worker had to:

1. Meet the criteria of the definition of a social worker as already outlined in this chapter.

2. Be employed as a social worker in any one of the four city of Windsor hospitals, or a recognized social agency that has direct contact with psychiatric patients.

3. Have face-to-face contact with psychiatric patients in a client/worker counseling relationship.

4. Be categorized under terminology or considered a social worker employed by a social agency in the mental health field.

Twenty-two social workers in Essex County could meet these criteria standards.

Major Sample

The sample is a nonprobability sample which can be further interpreted as a "purposive sample." A purposive sample allows the researcher to hand pick the cases to be
included in the sample. In turn, this provides for the development of a sample that is satisfactory in relation to the researcher's needs. A common strategy is to choose cases which are judged to be typical of the population in which one is interested. 250 The selection of a purposive sample permitted the researcher to select only those social workers who met the designated standards, trusting that these particular social workers would provide insight into the area being investigated.

An essential qualification of any sample is that it attempts to achieve representativeness. This means that the sample should reflect a miniature edition of the whole study population in all major respects. Yeakel and Ganter suggest the degree of sample representativeness establishes the legitimate claim that the study's findings approximate what may have been found if the entire population had been studied. 251

Owing to the limitations placed by the researcher on the population, he feels that the study's population cannot be assumed to be representative of the general population of psychiatric social workers in Ontario.


Nevertheless, the researcher believes that the study has the advantage of being highly representative of Essex County social workers who work directly with psychiatric patients, since all of the social workers who composed this group were personally sent a letter and phoned by the researcher to seek their cooperation in participating in the study.

Sample Size

Since the population sample in Essex County was small, the researcher's investigation was limited. However, Isaac and Michael argue that samples with small numbers between 10 and 30 have the advantage of being quick and convenient sample sizes with which to work. The small size facilitates calculations and lessens the chance of producing errors in the preparation and processing of data. The small sample size is, nevertheless, still large enough to test the null hypothesis, although small enough to overlook any weak treatment effects.\footnote{252}

Letter of Transmittal

Once the major population and sample were classified and defined, all the cases which met the population criteria were sent a letter of transmittal.\footnote{253} The letter contained


\footnote{253}Ibid., p. 94.
a clear, brief statement about the purpose and value of the study. The intent of sending this introductory letter was to present the study and elicit the receiver's assistance in participating in the study. (See Appendix C for a copy of the letter of transmittal.)

The letter of introduction was followed up with a personal telephone call to each member of the sample. At this time, the researcher introduced himself to the prospective respondent, reiterated the purpose of the study and asked for their assistance in participating in the research. Furthermore, at this time, the researcher arranged for a personal interview with the respondent at their convenience.

Comparison Population and Sample

The researcher felt that he should establish two comparison samples to review the findings associated only to the questionnaire. To fulfill this aspect two more populations were required.

The first comparison population was derived from all social workers in Essex County who met the criteria of the definition of a social worker, defined earlier in this chapter.

The sample for this comparison group of social workers was a nonprobability sample further known as an "accidental" sample. The researcher made contact with a
number of social workers in area agencies and asked this contact person to distribute and collect a number of the study questionnaires within their agency. The researcher personally delivered and retrieved the questionnaires from the contact person and accepted the first number of cases back that responded and represented the same number of cases in the major sample.

Although not considered a representative sample of social workers within Essex County, the researcher believes that this sample of social workers does allow for a comparison of two groups of social workers' scores (those who do and those who do not work directly with psychiatric patients) on the test questionnaire.

The second comparison population was gleaned from the general lay public in Windsor city itself.

For this comparison, a nonprobability accidental sample was established. The researcher went to a shopping mall in Windsor and asked people who walked by if they would be willing to respond to the test questionnaire. This process was stopped once the researcher had exactly the same number of respondents as he had in the other two sample groups.

The researcher is well aware that this last sample cannot be considered representative of the citizens of Windsor. This sample was drawn, however, only to provide a comparison of scores on the test questionnaires between
the three groups: 1) the scores of social workers who work directly with psychiatric patients; 2) the scores of social workers who do not work directly with psychiatric patients; 3) individual citizens who do normally not have contact with psychiatric patients.

Method of Data Collection

Since descriptive studies are not limited to any one method of data collection, any or all of the methods employed in research may be used. The benefit of choosing a variety of research formats in a descriptive study is to maximize the chance of fully measuring the social processes operating within any particular setting. Due to the information the researcher was seeking, two major methods of data collection were employed in this study: 1) a questionnaire; 2) an interview. Each respondent of the major sample group was asked to fill out a three-part questionnaire and then respond to the researcher all within the interview session. These two particular methods were chosen because:

In the interview and questionnaire approach, heavy reliance is placed on 'verbal reports' from the subjects for information about the stimuli or experiences to which they are exposed and for knowledge of their behavior.

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255 Ibid., p. 292.
Though each of these methods has particular advantages and disadvantages with regard to their use in research, the utilization of both measures was the only means that the researcher felt would gain the required information sought in the study. Employing both a questionnaire and an interview was implemented in an attempt to take advantage of the special qualities of each method and to lend further credence to the study.

The study relied upon the use of a questionnaire to collect data in the first part of the research because, "its standardized wording, its standardized order of questions, its standardized instructions for recording responses—might lead one to conclude that it offers some uniformity from one measurement situation to another." The questionnaire, therefore, seemed the most acceptable manner of obtaining each respondent’s test score. The use of a questionnaire would allow for an equal opportunity for every respondent to reply to the same questions in the exact same order as every other respondent. The use of the questionnaire allowed for the standardization of the instrument as well as made it possible to precode the answers.

The researcher also used an interview schedule in the study. The person-to-person interview provided the

256 Ibid., p. 295.
researcher the opportunity to examine in some depth an assumed sensitive subject area with the respondents. Jenkins states that:

The flexibility of the in-person situation allows for probes and exploration of respondents' experiences. A better percentage of responses is usually secured from personal interviews than from questionnaires.257

The interview schedule in this study was used to collect information from the respondents on a number of definite questions associated with their views or attitudes regarding the issue of psychiatric patient's legal and civil liberties. The use of the interview allowed the researcher to establish rapport with the respondents and elicit responses on this complex and emotion-laden subject. The interview also allowed the respondents a chance to explain their personal views and opinions much more fully.

Type of Questionnaire

Since the first portion of the study was aimed at determining the respondents' actual knowledge of the Mental Health Act, as well as their knowledge of the psychiatric patient's legal and civil rights, a three-part standardized questionnaire was designed by the researcher. (See Appendix A.) This self-administered, standardized

257 Shirley Jenkins, "Collecting Data by Questionnaire and Interview," in Social Work Research, p. 133.
questionnaire was based on a structural approach that provided all the respondents an equal chance to answer the questions in a similar fashion. The exact same questionnaire was completed by all respondents. Wording and sequence of questions was always in the same order. Directions were provided with the questionnaire and there was no opportunity for a respondent to seek clarification. 258

The first portion of the three-part questionnaire consisted of fourteen questions which sought to obtain general demographic and descriptive data.

The second segment was a test containing fifteen questions designed by the researcher to determine the respondent's basic knowledge and understanding of the statutes of Ontario's Mental Health Act. All questions in this section were worded from a "fixed-alternative" approach. The use of such questions limits the response of the subject to stated alternatives such as "yes" or "no." In some questions the respondent is asked to pick which one response of those provided is the correct answer to the question. 259

For each correct answer, the respondent scored one point. A perfect score was fifteen points. The scoring

258 Ibid., p. 135.

259 Claire Selltiz et al., Research Methods in Social Relations, p. 310.
was done to allow for the analysis of data and the computation of a correlation coefficient.

The third segment of the questionnaire was also based on "fixed-alternative" questions. The researcher designed a test containing fifteen questions to determine the respondents' basic knowledge and understanding of issues associated with the psychiatric patient's legal and civil liberties. A fifteen-point scoring system was used with one point given for each question answered correctly. The score obtained on this test furnished statistical information and the other half of the data needed for the correlation.

It should be mentioned here that all respondents, and this included those individuals who composed the two comparison groups, responded to all three portions of this questionnaire. Certain questions in the first section of the questionnaire were crossed out for members of the comparison samples, however. It was felt that they were not relevant to those respondents.

Type of Interview

As with the questionnaire, the researcher selected a standardized structured interview schedule. (See Appendix B.) The interview followed a well-defined set of questions of both open and closed structure. The format did permit the respondent to seek clarification or elaborate
on questions asked by the interviewer to a certain extent. In an attempt to establish rapport with the respondent and elicit brief replies which would be factually orientated and offer specific information, the researcher used a "funnelling" technique in arranging the interview questions. This "funnel" technique consisted of opening with broad general questions and then filtering down to more factual and specific questions. The technique is also considered an excellent way of establishing initial rapport and gaining the confidence of the respondent, so that he will be more comfortable and more likely to answer honestly the more difficult and specific areas of questioning.

Interspersed within the interview schedule were four questions which asked the respondents to indicate their level of agreement or disagreement. This scale, known as the "Likert-type scale," required the subject to respond to the statement in terms of several degrees of agreement or disagreement (see Appendix B, question numbers 15, 27, 35, and 50). Each item on the scale is considered equal in value or attitude. The score may be summed and averaged for each respondent to yield an individual's attitude score


261 Shirley Jenkins, "Collecting Data by Questionnaire and Interview," in Social Work Research, p. 141.

or summed and averaged to obtain the total sample's attitude score.

It must be noted here that only the major sample members were asked to participate in the face-to-face interview with the researcher. In the interview, the researcher asked each respondent a total of 52 questions.

Recording the Interview

In each interview, the researcher carefully followed a detailed interview schedule and attempted to record verbatim the subject's responses.\textsuperscript{263} The researcher did not endeavour to edit comments for content or meaning. The researcher also tried to make it a practice, whenever time allowed, to go directly from the interview and write out in more detail the individual's responses while the material was still fresh in his memory. It was at this time that the researcher would record any qualifying facts regarding the interview and his personal judgment of the respondent's overall attitude and behaviour.

Pretest of Questionnaire and Interview Schedule

The pretest of a questionnaire or interview is a means of trying out the instrument to see how it works.

and whether changes are necessary before using it in the actual study. Both Isaac and Michael and Selltiz et al. emphasize the importance of conducting a pretest as a means of catching and solving unforeseen problems in the administration of the instrument. They suggest that the people interviewed in pretests should be as similar in characteristics as those who will make up the final study. The pretest also provides valuable feedback to the researcher from the respondents in the way that they answer the questionnaire, or respond in the interview, or offer their own opinions and suggestions about certain items.

To fulfill the requirement and purpose of the pretest phase, the researcher sought the assistance of four graduating social work students from the School of Social Work, University of Windsor. The researcher was aware that each of these students met the criteria established for determining the population and sample group of this study. As well, each of the students' graduating field practicum was in a department of social work in two Windsor hospitals, and a large portion of their clients were psychiatric patients, which further qualified them to assist in the pretest.

These students consented to fill out the questionnaire and, in turn, be interviewed by the researcher preceding the test. The researcher, in conducting the interviews, had the opportunity to become familiar with levying the questions to a respondent based on an interview schedule.

In discussion with these students after conducting the pretest and reading the suggestions and comments that they had written beside certain questions, the researcher changed ten questions and added the four "Likert-scale" questions due to a weakness in the interview schedule.

Other changes came about due to suggestions offered by the researcher's committee members and an independent outside reader. Their help was particularly useful during the construction phase of the questionnaire.

Limitations and Biases

A major limitation of the study existed due to the fact that the researcher confined the population by using strict criteria for selection. This narrow selection process restricted the sample size to a maximum of twenty-two cases. The small sample size could affect the study's sampling errors, the power of the statistical instrument applied to the data, as well as the general reliability of the study itself.

Another limitation of the study was the acceptance
of the sample members to participate in the study itself. It has been the researcher's experience that the subject of the psychiatric patient's legal and civil liberties has been a taboo area of discussion among mental health professionals. Therefore, the researcher fully expected that the way this study was introduced to the sample would ultimately dictate whether these social workers would be comfortable enough to cooperate with the researcher.

Another limitation of the study, in conjunction with the one mentioned above, was that the study might cover sensitive material. There was the possibility that the respondents would reply in a less than honest fashion. The respondents might have encountered emotional influences within the interview which, in turn, would lead them to falsify their answers or resist, evade, and possibly deceive the researcher about their own personal views.

A fourth limitation of the study was present in its question content. The researcher believes the introductory letter, the questionnaire and interview schedule composition outlined the major purpose of the study in a very glowing way. This, at times, may have caused respondents to reply in a socially acceptable manner. The respondents may have expressed only appropriately favourable comments and withheld negative expressions about their own viewpoints regarding their professional
Bias was a problem which the researcher felt warranted some consideration. The researcher was fully aware of his own personal bias to the whole issue surrounding formal commitment of a person to a psychiatric facility without due process of law and the loss, by that individual, of his legal and civil liberties. With open acknowledgement of this bias, however, the researcher felt that he was responsible enough not to allow it to affect the outcome of the research data.

In an effort to minimize subjective bias on the part of the researcher, several steps were taken.

1. All questions constructed for the questionnaire and the interview schedule were examined by the researcher and a member of his research committee for clarity of meaning, wording bias, form of response, and placement of the question in sequential order (funnel technique).

2. The questionnaire and interview schedule were pretested and changes were made based upon suggestions of respondents or members of the research committee.

3. All interviews were recorded verbatim by the researcher as much as possible at the time of the interview.
4. A standardized structured interview form was used by the researcher to minimize subjective bias.

Data Analysis

The researcher gleaned information from three specific areas: 1) demographic and descriptive data; 2) experiential and behavioural data; 3) attitudinal and feeling data. The analysis of such information necessitated a number of statistical procedures.

Within the process of reporting demographic features, the researcher used frequencies and percentage tables along with cross-tabulations associated with the respondents' education, the reading of the Mental Health Act, and employment.

To describe the data related to quantitative and qualitative information pertaining to the ideas of the study, statistical inferences and association were used. The Pearson's Product Moment Correlation test was used to determine the degree of association between the respondents' knowledge of the Mental Health Act and his knowledge of the psychiatric patient's legal and civil liberties.

The measures of control tendencies were used to ascertain the median on all ordinal scales used in both the questionnaire and the interview schedule. The four
Likert-type scale had to be individually and group summed and averaged to yield individual and group attitudinal scores.

Summary

This study was classified as a Quantitative-Descriptive study and sub-categorized as a population-description study. The goal of the research was to draw conclusions on five research hypotheses and describe accurately the attitudes possessed by the sample.

The sample came from Essex County social workers who were directly involved in client/worker relationships with psychiatric patients. Each case of the sample was sent an introductory letter and then telephoned later on to arrange for a personal interview at their convenience with the researcher. Within the interview, each respondent filled out a three-part, self-administered questionnaire of forty-four questions. The remainder of the interview session consisted of a face-to-face interview with the researcher asking another additional fifty-two questions. The responses were tabulated and statistical information derived from the data collected.
CHAPTER IV

PRESENTATION AND DISCUSSION OF DATA

This chapter discusses the analysis of data procured from all the instruments used in this study:
1) demographic-descriptive data from the questionnaire;
2) the Mental Health Act test questionnaire; 3) the psychiatric patient's legal and civil rights test questionnaire; 4) interview schedules used to record respondents' replies in the direct interview with the researcher.

Data analysis of questionnaire number one provided the basic characteristics of the respondents based on demographic and descriptive findings. Analysis of questionnaire two and three furnished test scores for each respondent, documenting their knowledge and understanding of the Mental Health Act, and the psychiatric patient's legal and civil rights. The examination of the interview schedule revealed attitudinal data concerning the attitudes of social workers towards the issue of the psychiatric patient's legal and civil rights.

Owing to the nature of the criteria applied to the constituents of the population by the researcher, a total of twenty-two social workers employed in six social agencies 217.
in Windsor met the standards. An introductory letter was sent to these twenty-two social workers which described the purpose of the study as well as asked for their assistance. The researcher followed up the initial letter approximately three or four days later with a personal phone call to each case member of the population. At this time, the researcher introduced himself, again explained the purpose of the study, and arranged to interview the person within a specified three-week time span.

Through the use of this procedure, the researcher obtained acceptance by twenty of the twenty-two social workers to be interviewed for the study proposal, a 91 per cent acceptance or response rate. This response rate would have been even higher except one respondent became ill before the interview and no suitable or convenient time was left available to reconduct the interview within the specified time schedule. The 91 per cent response rate does mean that the sample data results were highly representative of this particular population of Essex County social workers.

Characteristics of the Respondents

Demographic Features

In regard to agency orientation, 15 respondents, or 75 per cent, were employed as social workers in the social
work departments of Windsor's four city hospitals. Mental Health/Windsor-Essex accounted for 4, or 20 per cent, of the sample; the remaining cases, or 5 per cent, came from Legal Assistance Windsor.

There were 3 women for every male respondent in the study. Eighty per cent of the sample was age 40 or less. With regard to age, 53.3 per cent of the women were in the 21-30 age range, 40 per cent were in the 31-45 age range, and one woman respondent, or 6.6 per cent of their group, was over 55. In fact, in the sample, women dominate the age range from 21-30 by a margin of 8 women to 1 male, thus accounting for the young age of the study's sample.

For the male respondents, one, or 20 per cent of that group, was age 26-30, 40 per cent were between 36 and 40 years of age with one male respondent in the age ranges of 41-45 and 51-55 (see Table 5).

Every member of the sample held a university degree and 5 of the respondents held two degrees. For the analysis of data, however, only the higher of the two degrees was considered. Eighty per cent of the sample possessed a professional social work degree. Nine respondents, or 45 per cent of the sample, held a B.S.W. degree, 7, or 35 per cent, held a M.S.W. degree. Of the four other respondents, one held a general B.A. degree and the remaining three possessed registered nurses degrees from a university (see Table 6).
Table 5
Age of Respondents by Sex

<table>
<thead>
<tr>
<th>Age Range of Respondents</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Under 20</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>21-25</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>26-30</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>31-35</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>36-40</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>41-45</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>46-50</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>51-55</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Over 55</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Totals</td>
<td>5</td>
<td>25</td>
</tr>
</tbody>
</table>

N=20
Males = 5
Females = 15
Table 6
Educational Level of Respondents

<table>
<thead>
<tr>
<th>Frequency of response by respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>45</td>
</tr>
<tr>
<td>8</td>
<td>35</td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>15</td>
</tr>
</tbody>
</table>

Note: 80% of the respondents hold a social work degree. All respondents hold at least one university degree.

N=20
+ The three respondents who indicated that they held a degree other than the ones already listed all held a B.Sc. in nursing.
A cross-tabulation of educational level to sex of respondents indicates one male and eight females of the sample had a B.S.W. degree. Of the seven respondents who possessed a M.S.W. degree, the representation was four males and three females. Thus, 80 per cent of the male respondents held M.S.W. degrees; only 20 per cent of the female respondents held M.S.W. degrees. All of those who held degrees other than a professional social work degree were female.

Descriptive Features

Fourteen, or 70 per cent of the sample, answered that they had read the Mental Health Act, Revised Statutes of Ontario, 1970. Table 7 offers a graphic representation of the reading of the Mental Health Act and the reason(s) behind the respondents reading it. As illustrated, 50 per cent of the respondents read the Act of their own volition. The other 30 per cent did so to meet certain requirements placed on them. A question arises here: would the other six respondents read the Act? As they had not read the Mental Health Act up to this point in time, it is very unlikely that they would in the near future, unless specific circumstances arose which would have required them to do so.

In replying to this question, three respondents gave more than one reason for reading the Act and in each of these cases their reply was: 1) own interest; 3) employer
Table 7
Reasons Given by Respondents for Reading
the Mental Health Act

<table>
<thead>
<tr>
<th>Reason for Reading Mental Health Act</th>
<th>Yes</th>
<th></th>
<th>No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Own interest</td>
<td>10</td>
<td>50</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Course requirement</td>
<td>1</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Employer requirement</td>
<td>2</td>
<td>10</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Did not read</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Totals</td>
<td>14</td>
<td>70</td>
<td>6</td>
<td>30</td>
</tr>
</tbody>
</table>

N=20
required it. The researcher, however, showed only their first response, "own interest" in Table 7.

Of the fourteen respondents who answered "yes," ten cases in this group, or 71.4 per cent, replied that they read the Act out of their own interest because of their work with psychiatric patients. One person, 7.1 per cent, read the Act as part of required reading for a university course. Another five cases, 35.7 per cent, responded that their employer required that they read the Mental Health Act, and one person, 7.1 per cent of this group, read the Act due to a specific client situation to obtain a necessary understanding of the client's circumstance in relation to the Act.

The questionnaire further asked respondents to reply to three questions regarding their university courses and whether their field practicum was in a psychiatric setting. Only five, or 25 per cent, of the respondents replied that they had taken a course while at university which dealt with the Mental Health Act. Furthermore, fifteen, or 75 per cent, indicated they had taken a university course which dealt with the specific problems of the mentally ill.

Cross-tabulation of the sample's answers in response to their university education signifies that 25 per cent of the respondents took a university course that dealt with the problems of the mentally ill as well as a course that reviewed the Mental Health Act (see Table 9). Fifty
Table 8
Courses Taken by Respondents with Regard to Mental Illness and the Mental Health Act

<table>
<thead>
<tr>
<th>Took Course on Mental Illness</th>
<th>Took Course Dealing with Mental Health Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes Number</td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>6</td>
</tr>
</tbody>
</table>

N=20
per cent of the respondents had taken a course on mental illness although they did not have a university course that covered the Mental Health Act. Interestingly, five respondents, which represents 25 per cent of the total sample, neither took a university course that dealt with the problems associated with mental illness or inspected the Mental Health Act. This lack of specific educational programs at the university level, on a large part of the sample, is an important factor to note, since 25 per cent of the respondents indicated that they had been employed in the mental health field in their present position for one year or less.

With regard to field practicum, nine cases, which represents 45 per cent of the sample, responded positively to the question of whether any of their field placements were in a psychiatric setting. Of these nine replies, one respondent indicated that both their B.S.W. and M.S.W. field placement were in a psychiatric facility. One-half of this group noted that their field placement was at the B.S.W. level of their educational program; over 50 per cent placement came during the M.S.W. program level. Furthermore, two respondents that had not been in a social work program at university indicated that they had a field placement in a psychiatric setting as part of their practical field training.

Table 9 presents a graphic representation of the
Table 9
Respondents Who Had Read the Mental Health Act and Had Also Taken a University Course which Dealt with the M.H.A.

<table>
<thead>
<tr>
<th>Read the Mental Health Act</th>
<th>Had a University Course which Dealt with the M.H.A.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes Number</td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>6</td>
</tr>
</tbody>
</table>

N=20
sample in cross-tabulation of those who had read the Mental Health Act and had also taken a course at university which reviewed the Mental Health Act. The table shows that 25 per cent of the sample had read the Mental Health Act and had also taken a course while at university which dealt with the Act. Forty per cent of the sample had read the Mental Health Act, but had not taken a course in university dealing with the Act. Thirty per cent of the sample had neither read the Mental Health Act nor taken a course about it in their university career.

Though the sample possessed a very high percentage of respondents who held a professional social work degree and 70 per cent indicated that they had read the Mental Health Act, it certainly appears that few of these respondents had the professional training through university educational courses and practical field training to prepare them to enter into the mental health field of social work and their present employment situation. The researcher is left to speculate about the content of professional education that the majority of these social workers received during their university education and their professional ability to operate competently on behalf of psychiatric patients and not infringe upon or overstep their clients' legal and civil liberties.

In light of these findings, the researcher must further question whether this aspect reflects upon the
students themselves not accepting the responsibility for the direction of their professional education or whether it is caused by the social work education being provided by Schools of Social Work to students which, in fact, does not meet the reality of the actual employment situation, or is it a combination of both.

The researcher, through the use of the questionnaire, gathered information pertaining to the respondents' length of time in present employment, previous work experience with psychiatric patients, percentage of time spent with patients in direct client/worker relationships, and any in-service training received by present employees. The following findings represent the data obtained by these questions.

Regarding the respondents' length of time in their present employment situation (see Table 10), 80 per cent of the respondents had been employed from one to five years. Ten per cent of the respondents had been employed in their present agency from 6-10 years; the remaining 10 per cent had been employed 11-15 years in their agency.

Seventy per cent of the sample indicated that before coming to their present employment, they had previously worked with psychiatric patients. Those who answered that they had had previous work experience with psychiatric patients, five of these fourteen cases, 35.7 per cent of this group, had only worked one year or less. Another
Table 10

Length of Time in Present Employment

<table>
<thead>
<tr>
<th>Frequency of responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 year or less</td>
<td>25</td>
</tr>
<tr>
<td>2-3 yrs.</td>
<td>25</td>
</tr>
<tr>
<td>4-5 yrs.</td>
<td>30</td>
</tr>
<tr>
<td>6-8 yrs.</td>
<td>5</td>
</tr>
<tr>
<td>9-10 yrs.</td>
<td>5</td>
</tr>
<tr>
<td>11-15 yrs.</td>
<td>10</td>
</tr>
<tr>
<td>16-20 yrs.</td>
<td></td>
</tr>
<tr>
<td>20 years or more</td>
<td></td>
</tr>
</tbody>
</table>

Note: 80 per cent of the sample has been in their present employment situation of working with psychiatric patients for five or less years. Average length of employment is 4-9 years.

N=20
four, or 28.6 per cent, had from 2-3 years experience, while another 28.6 per cent had from 4-5 years. The remaining respondents had 9-10 years of previous work experience with psychiatric patients before entering their present employment. Therefore, of the fourteen respondents who indicated previous work experience, 92.9 per cent of them had five or less years of previous work experience (see Table 11).

Not only was this sample a young one (as illustrated by Table 5), but it was also a fairly unseasoned one in total employment years of working with psychiatric patients (see Tables 10 and 11). By calculating the topmost years in each time category (Tables 10 and 11) and by multiplying this by the number of cases in each category, the researcher was able to evaluate the average length of employment for the sample.

The average length of employment for present work situation was 4.9 years. Pre-employment with psychiatric patients averaged out to be 3 years. Therefore, the average total experience computed to 6.5 years, which was on the "high" side because the researcher allowed for the highest number of years in each category to be counted.

Half of the respondents claimed that they spend from 61-100 per cent of their time in actual direct face-to-face contact with psychiatric patients. The remaining 50
Table 11

Previous Work Experience with Psychiatric Patients

Before Coming to Present Employment

<table>
<thead>
<tr>
<th>Frequency of responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 year or less</td>
<td>35.7</td>
</tr>
<tr>
<td>2-3 yrs.</td>
<td>28.6</td>
</tr>
<tr>
<td>4-5 yrs.</td>
<td>28.6</td>
</tr>
<tr>
<td>6-8 yrs.</td>
<td>7.1</td>
</tr>
<tr>
<td>9-10 yrs.</td>
<td></td>
</tr>
<tr>
<td>10 years or more</td>
<td></td>
</tr>
</tbody>
</table>

Note: 13 out of the 14 respondents had 5 or less years of previous work experience with psychiatric patients. Average length of pre-employment is 3 years.

N=14
per cent of the sample's time spent in direct service was in the lower percentage categories. Five respondents, or 25 per cent of the sample, expended from 1-20 per cent of their time in direct patient/worker contact. Another five per cent of the sample was directly involved with patients for approximately 21-40 per cent of their time, while the remaining four respondents, or 20 per cent of the sample, were involved with clients for 41-60 per cent of their time schedule (see Table 12).

Some very interesting figures materialized when the researcher cross-tabulated the sample replies to, "have you read the Mental Health Act?" with "percentage of actual time spent in direct service with psychiatric patients." (See Table 13.) Stated earlier, six respondents, or 30 per cent of the sample, had not read the Mental Health Act. Of this group, one member was involved with psychiatric patients approximately 1-20 per cent of his time schedule. Another member was in direct service contact from 41-60 per cent of his time. Amazingly, a total of 15 per cent of the whole sample group who indicated that they spent anywhere from 61-80 per cent of their time in direct service contact with psychiatric patients had not read the Mental Health Act.

Furthermore, another respondent, or five per cent of the sample, revealed that she also had not read the mental health statutes, and she indicated that she spent approximately
Table 12

Percentage of Time Spent in Actual Direct Service with Psychiatric Patients

<table>
<thead>
<tr>
<th>Percentage of time Spent with Psychiatric Patients</th>
<th>Frequency of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-20</td>
<td>25</td>
</tr>
<tr>
<td>21-40</td>
<td>5</td>
</tr>
<tr>
<td>41-60</td>
<td>20</td>
</tr>
<tr>
<td>61-80</td>
<td>25</td>
</tr>
<tr>
<td>81-100</td>
<td>25</td>
</tr>
</tbody>
</table>

Note: 50 per cent of the respondents indicated that they spend from 61-100 per cent of their time in direct contact with psychiatric patients.

N=20
### Table 13

#### Percentage of Time Spent with Psychiatric Patients:

<table>
<thead>
<tr>
<th>Read M.H.A.</th>
<th>1-20%</th>
<th>21-40%</th>
<th>41-60%</th>
<th>61-80%</th>
<th>81-100%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4-20</td>
<td>1-5</td>
<td>3-15</td>
<td>2-10</td>
<td>4-20</td>
<td>14-70%</td>
</tr>
<tr>
<td>No</td>
<td>1-5</td>
<td>-</td>
<td>1-5</td>
<td>3-15</td>
<td>1-5</td>
<td>6-30%</td>
</tr>
<tr>
<td>Totals</td>
<td>5-25%</td>
<td>1-5%</td>
<td>4-20%</td>
<td>5-25%</td>
<td>5-25%</td>
<td>20-100%</td>
</tr>
</tbody>
</table>

N=20

**Note:** 3 respondents who spend anywhere from 61-80 per cent of their time with psychiatric patients had not read the *Mental Health Act*. Furthermore, one respondent who indicated that they spent 81-100 per cent of their time in direct service contact with psychiatric patients had not read the *M.H.A.*
81-100 per cent of her time dealing directly with psychiatric patients.

What this researcher finds astonishing about this data is that under the province's present mental health legislation, psychiatric facilities and their employees are obligated to follow the statutes contained within the Mental Health Act in carrying out their duties, and failure to do so is a punishable offense. Statute sixty of the Act reads:

Every person who contravenes or is a party to the contravention, directly or indirectly, of any provision of this Act or the regulations is guilty of an offense and on summary conviction is liable to a fine of not less than $25 and not more than $500.265

Aside from the offense and penalty, the researcher questions the ability of these social workers to interpret the provisions of the statutes contained within the Mental Health Act accurately and appropriately on behalf of their psychiatric patient clients. The researcher speculates as to whether these social workers who have not read the Act are aware of their client's legal and civil liberties. Since these workers are not knowledgeable of the Act, does this lead to violations of the client's legal and civil rights due to neglect, abuse, or infringement?

The researcher also questions why these social workers have not read the Mental Health Act since, by

265 The Mental Health Act, R.S.O., 1970, c.269, s.60.
provincial statute, they are supposedly practicing from it. Are social workers in the mental health field not required by their employers to read the Act? Is it not part of a prerequisite for employment or a requirement after employment? Is it, in fact, just laziness on the part of those social workers who do not read the Act, or is it ineffectiveness or a lack of concern on the part of this particular group of social workers?

As a social worker who has worked in the field of mental health, the researcher surmises that although some of the reasons he has suggested regarding this issue may enter into the picture, the main factor is due to laziness on the part of these workers. Re-evaluation of the statistical findings on the questionnaire appears to suggest that this group of social workers may not take their work seriously and, therefore, have not really involved themselves wholeheartedly. According to the data, those who had not read the Act were, in the majority, female, young, and unseasoned social workers in the mental health field, who had little agency training in the Mental Health Act or in the problems associated with being a psychiatric patient.

Most of the respondents, in fact 75 per cent of the sample, reported that their present agencies have not offered or provided any in-service training seminars which dealt specifically with the Mental Health Act. Of those
who answered "yes" to the question, two cases, or 10 per cent, said their agency gave specific instructions on admission procedures, discharge procedures, and legal and civil rights issues of patients. Another 10 per cent indicated their agency gave training in all areas the researcher listed as topics of concern covered. One respondent replied that their agency had covered the new proposals of Bill 19 introduced by Health Minister Dennis Timbrell.

Scores on the Mental Health Act Test Questionnaire

The respondents were asked to mark their personal responses to a fifteen-question test based on their knowledge and understanding of the statutes contained within the Mental Health Act. Each respondent was asked to mark what they believed to be the correct response to a question from a number of fixed alternative answers provided by the researcher. The correct answer was always provided among the fixed alternative answers offered. For each question answered correctly, the respondent was given a score of one thus a maximum score of fifteen was possible for a perfect test questionnaire.

Table 14 shows the frequency and percentage of respondents who scored in the numerical categories available as well as the range of scores in relation to the total scoring for all participants.
Table 14
Respondents' Scores on Mental Health Act Questionnaire

<table>
<thead>
<tr>
<th>Frequency of response</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>20</td>
</tr>
</tbody>
</table>

Scores on Mental Health Act Questionnaire

Note: 16 respondents or 80 per cent of the sample scored 9 or less on knowledge and understanding of the M.H.A. A score of 9 out of 15 represents 64.3 per cent or a "C" grade on a university exam.

N=20 =151

Mean: 7.55
Median: 8.0
Mode: 5/9
Range: 4–12

Male scores N=5
Mean: 7.20 =36
Median: 6.0
Mode: 5.0

Female scores N=15
Mean: 7.66 =115
Median: 7.32
Mode: 8–9
As depicted by the Table, the sample scores range from a low of four out of fifteen to a high of twelve. In reviewing the graph data, the researcher noticed that 16 respondents scored 9 questions or less correctly on the test questionnaire. Placing the respondents' scores into letter grades based on university standards, the researcher determined that 80 per cent of the sample would have received a letter grade of "C" or below. In fact, 40 per cent of the sample scored below a "D" grade which is certainly considered a failing grade.

Of the four respondents which scored above the 64.3 percentage score level, one respondent had 10 questions correct for a 71.4 per cent average. Two respondents scored 78.6 per cent for having answered eleven out of fifteen questions correctly. The remaining respondent had a score of 85.7 per cent for twelve correct answers.

The respondents' mean score was 7.55. For male respondents, the mean score computed to be 7.20 while the female respondents' mean score was 7.66.

Some interesting facts surfaced when the researcher examined the total scoring patterns of every question in the Mental Health Act test questionnaire. For instance, 85 per cent of the sample chose "dangerous to self and others," as the correct answer to question number 11 (see Appendix A, Questionnaire No. 2), when they should have chosen "competent to manage his estate."
this answer is substantiated by part III, statute 32 of the Mental Health Act, which reads:

Forthwith upon the admission of a patient to a psychiatric facility, he shall be examined by a physician to determine whether he is competent to manage his estate.266

" Dangerous to self or others" is the legal documentation needed in order to have a person admitted to a psychiatric facility by civil commitment. It appears that those individuals who answered this question incorrectly may have interpreted that as the requirement of the physician. However, "dangerous to self or others" is what gets a person admitted. Upon admission though, he has to be examined to see if he is mentally capable of managing his personal affairs.

Another response of interest was that only one-half, or 55 per cent of the sample, knew that a physician could, upon his own discretion, fill out a certificate of renewal and keep a patient in the facility for more than the originally specified thirty days.

Furthermore, only four individuals, or 20 per cent of the sample, knew that the first renewal certificate was for sixty days and not thirty days, which 65 per cent of the respondents believed. With regard to the question of police power and the mentally ill (see Appendix A,

266The Mental Health Act, R.S.O., 1970, c.269, s.32.
Questionnaire No. 2, question 15), eight respondents, or 40 per cent of the total sample, did not know that the police, upon their own discretion, could detain a person for a psychiatric examination.

Scores on Psychiatric Patients' Legal and Civil Rights Test Questionnaire

Questionnaire Number 3 asked each member of the sample to respond to a fifteen-item test. Although designed and marked the same as the Mental Health Act test questionnaire, this questionnaire attempted to determine the respondents' knowledge and understanding of psychiatric patient's legal and civil rights. All of the questions were verified by the researcher for authenticity by examining the statutes to which the questions related. 267

The graph of the scores obtained on Questionnaire Number 3 (see Table 15) illustrate a skew dispersal of scores ranging from a low of three to a high of eleven out of fifteen. Particularly significant is the fact that 95 per cent of the total sample, which represents nineteen out of twenty cases, scored eight or less questions correct on the questionnaire. A score of eight out of fifteen is 53.5

267 To verify the questions used, the researcher surveyed the following provincial Acts: the Mental Health Act, R.S.O., 1970, c.269; the Marriage Act, R.S.O., 1970, c.261; the Election Act, R.S.O., 1970, c.142; Highway Traffic Act; as well as all the Acts contained in Table 4 and the writing of Stewart Page and the Committee on Legislation and Psychiatry, The Law and Mental-Disorders, Vol. 2.
Table 15
Respondents' Scores on Psychiatric Patients' Legal and Civil Rights Questionnaire

<table>
<thead>
<tr>
<th>Scores on Psychiatric Patients' Legal and Civil Rights Questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>%</td>
</tr>
</tbody>
</table>

Note: 19 respondents or 95 percent of the total sample scored 8 or less on knowledge and understanding of psychiatric patients' legal and civil rights. A score of 8 out of 15 represents 53.3 per cent or a "D" grade on a university exam.

N=20  
\( z = 1.11 \)

Mean: 5.55  
Median: 5.85  
Mode: 5.0

Male scores N=5  
Mean: 6.40  
Median: 7.0  
Mode: 7.0

Female scores N=15  
Mean: 5.27  
Median: 5.65  
Mode: 5.0
per cent or less and a letter grade of "D" or less, which is a failing grade if compared to university test standards.

The one individual who did score above the 53.3 percentile rank answered eleven out of fifteen questions correctly for a 73.3 per cent score.

For the sample, the mean score was 5.55 which is two less than the mean score on Questionnaire Number 2, (7.55). The male respondents' mean was 6.40, while the female respondents obtained a mean of 5.27.

The researcher personally believes that this sample of social workers does not possess a knowledgeable understanding of psychiatric patient's legal and civil liberties. When asked to respond to questions outside of the area of "admission" the sample scored very poorly. On questions relating to other provincial Acts which have statutes within them pertaining to mental illness or the mentally ill, the sample's scores were fairly low. Usually less than 40 per cent of the cases chose the correct answer in these questions.

To substantiate this claim, the researcher found that only 25 per cent of the sample were aware of a statute contained within the Marriage Act which restricts a mentally ill person or a person thought to be mentally ill from marriage. Six cases, or 30 per cent of the sample, realized that the Ontario Election Act restricts a person from voting, if the person is institutionalized. Of the six respondents
who answered this question correctly, only 4 of them were able to answer question number 4 regarding whether a person is disqualified from voting in either a provincial or federal election. Furthermore, one respondent in the sample who scored incorrectly on question number 2 scored correctly on question number 4. These scoring patterns suggest a hit and miss approach—"guessing" with a one in four chance of being correct.

Another interesting fact was that 30 per cent of the sample answered correctly that the Ontario Highway Traffic Act restricts a mentally ill person or a person thought to be mentally ill from operating a motor vehicle. Only 20 per cent of the sample knew that a person could be restricted under certain statutes governing the practice of trades and professions from working in their trained employment because of mental illness. Also, only 10 per cent of the sample knew that there was a six-month time limitation placed upon a patient who wished to bring litigation against a person or a psychiatric facility for wrongful doing under the Mental Health Act.

Correlations of the Test Score

Through the plotting of each respondent's scores on Questionnaire Numbers 2 and 3, the researcher obtained a graphic illustration which helped him to interpret the correlation between the two sets of scores (see Table 16).
Table 16

Scatter Diagram Illustrating the Obtained Scores by the Respondents on Test Questionnaires Number 2 and 3

Note: Each mark (1) represents the score obtained by a respondent on each questionnaire.

(line of regression)

Scores Obtained by Respondents on Test Questionnaire No. 3

<table>
<thead>
<tr>
<th>Scores Obtained by Respondents on Test Questionnaire No. 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
</tr>
</tbody>
</table>

Scores Obtained by Respondents on Test Questionnaire No. 3

N=20

Correlation coefficient = -0.123

T-test = -0.526

<table>
<thead>
<tr>
<th>Questionnaire No. 2</th>
<th>Questionnaire No. 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean: 7.55</td>
<td>Mean: 5.55</td>
</tr>
<tr>
<td>Median: 8.0</td>
<td>Median: 5.85</td>
</tr>
<tr>
<td>Mode: 5-9</td>
<td>Mode: 5.0</td>
</tr>
</tbody>
</table>
The Pearson Product Moment Correlation (r) formula was used to calculate the reliability between the two sets of scores.

The scatter diagram appears to depict a negative association between the scores obtained on the Mental Health Act test questionnaire and the scores obtained by each respondent on the psychiatric patient's legal and civil rights test questionnaire. The slope of the regression line moves from left to right. The size of the coefficient and the direction of the regression line denotes the strength of the relationship between the two sets of scores.

The correlation between the two sets of scores was calculated at -0.1234 and, therefore, suggests no association between the two test scores. In fact, the scatter diagram depicts that those respondents who scored low on the Mental Health Act questionnaire did not necessarily score low on the psychiatric patient's legal and civil rights questionnaire. Actually, those respondents who scored high on one questionnaire tended to score low on the other questionnaire.

Summary of Data

In relation to determining the sample's knowledge and understanding of the statutes contained within the present Mental Health Act, the research questionnaire established the following: thirty per cent of the sample had not read the Mental Health Act at the time of the investiga-
tion. Of this group, two-thirds indicated that they spent anywhere from 61-100 per cent of their time in direct face-to-face service contact with psychiatric patients. Fifteen respondents, or 75 per cent of the sample, replied that they had not taken a university course during their education which dealt with the Mental Health Act. Also, 75 per cent of the sample had not received any in-service training seminars by their agency on the Mental Health Act.

Reiterating the Mental Health Act questionnaire data, 80 per cent of the sample scored nine questions or less out of fifteen, a 64.3 percentage rate or less. The mean score for the sample was only 7.55, and scores ranged from 4 to 12 out of a possible 15.

Based on these findings and the others already presented at the beginning of this chapter, the researcher feels justified in stating that, on the whole, this sample of social workers did not possess well informed and comprehensible judgment of the statutes contained in the province’s mental health legislation.

The statistical data obtained by the research questionnaire, therefore, allows the researcher to state that the data substantiates the first research hypotheses of the study: that is, Social workers do not possess a knowledgeable understanding of Ontario’s Mental Health Act.

On the other hand, the scatter diagram and the calculation of the Pearson Product Moment Correlation to
determine the degree of association for the scores obtained by the respondents on the Mental Health Act test questionnaire and the psychiatric patient's legal and civil rights test questionnaire depict no association. The correlation coefficient of -0.1234 causes the researcher to accept the position that the second research hypothesis could not be supported by statistical data and has not been confirmed. Thus, social workers who did score low on their knowledge and understanding of the Mental Health Act did not necessarily score low on their knowledge and understanding of psychiatric patient's legal and civil rights.

Characteristics of Comparison Samples

Due to the low scores obtained on the two questionnaires by the sample respondents, the researcher decided to further evaluate the test questionnaires on two contrast groups. The comparison was done in an endeavour to check the reliability and validity of the questionnaires, because the researcher believed that the sample respondents had scored very low. The researcher also wanted to determine if the two contrast groups who did not have direct agency contact or any contact at all with psychiatric patients possessed similar knowledge and understanding of the Mental Health Act, as did the original sample.
In order to carry out a comparison of scores, the researcher secured two contrast groups based on non-probability accidental samples. The first contrast sample was composed of social workers who worked in various Windsor social agencies. Upon contact, the researcher introduced himself and explained the purpose behind his study and the assistance the researcher needed in his effort to obtain a contrast sample of social workers. The contact persons agreed to distribute and collect the completed questionnaires (the exact same questionnaire given to the original group). The researcher then gathered the questionnaires from the contact person. The first twenty questionnaires received were considered and used as the contrast sample. From this point on, this contrast sample will be referred to as group B in this study.

The second contrast group was obtained by the researcher through a nonprobability accidental sample mean. The researcher went to a large plaza in Windsor and approached people, explaining the nature of his research and asking for their assistance to volunteer and respond to the questionnaire. Like group B, once the researcher procured twenty cases of lay respondents, this was considered and used for statistical data as the contrast sample. This contrast sample will be referred to as group C in the rest of this study.
Demographic Features

Group B was composed of eight males, or 40 per cent, and twelve female respondents for 60 per cent of the total sample. Group C had six male and fourteen female respondents which represented a 30 per cent and 70 per cent split. Seventeen respondents of group B, or 85 per cent, were under the age of 40. This was 5 per cent higher than the original sample of social workers and also indicated a young age range of social workers in the various Windsor social agencies. These figures are comparable to the ones found in a study that surveyed 171 social workers in 34 social agencies in Windsor and Essex County.268

For group C, 16 cases, or 80 per cent of that sample, were 40 years old or less. The researcher accepts responsibility for attempting to secure sample groups based on age. However, in only one sample, group C, was the researcher directly in a position to control and account for those people who constituted the sample respondents. The original sample and group B age representativeness was due to sampling procedures and not manipulation on the part of the researcher. Table 17 illustrates the frequencies and age range of the respondents in all three comparison samples.

Table 17
Age of Respondents in the Three Comparison Samples

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>under 21</td>
<td>5</td>
</tr>
<tr>
<td>21-25</td>
<td>10</td>
</tr>
<tr>
<td>26-30</td>
<td>15</td>
</tr>
<tr>
<td>31-35</td>
<td>20</td>
</tr>
<tr>
<td>36-40</td>
<td>30</td>
</tr>
<tr>
<td>41-45</td>
<td>35</td>
</tr>
<tr>
<td>46-50</td>
<td>40</td>
</tr>
<tr>
<td>51-55</td>
<td>35</td>
</tr>
<tr>
<td>over 55</td>
<td>20</td>
</tr>
</tbody>
</table>

original sample 80 per cent under age 40

---

---

---

---

group B 85 per cent under age 40

---

---

---

---

group C 80 per cent under age 40
Descriptive Features

In examining the descriptive features of group B some interesting points emerged. For instance, nineteen respondents, or 95 per cent of the sample, held a professional social work degree. Of this group, 14 respondents held a B.S.W. degree while 5 persons possessed a M.S.W. degree. In the original sample, 80 per cent of the respondents possessed a professional social work degree. These sample figures are somewhat higher than the 75.5 per cent rate found in the Michalski study. 269

Only 20 per cent of group B had read the Mental Health Act and only two cases indicated that they had taken a university course which dealt with mental health legislation. Interestingly, though, 6 respondents, or 30 per cent of the sample, had had a social work field placement in a psychiatric setting. Furthermore, 35 per cent, or 7 respondents of group B, had previously worked with psychiatric patients. Of those who had worked with psychiatric patients, 4 persons had worked for only one year or less. Two respondents had worked from 2 to 3 years, while another individual had previously worked with psychiatric patients for 10 or more years.

This statistical information is provided to offer

269 Ibid., pp. 112 and 115.
the reader a flavour of the descriptive characteristics of the contrast group of social workers. In comparison, the original group and group B are similar in makeup in regard to respondents' sex, age, and educational makeup. With regard to other factors, these two samples obtained similar response rates, though usually in reverse order, such as their response rate to the question, "Have you read the Mental Health Act?". In the original sample, 70 per cent responded "yes" to this question and 30 per cent reported "no." On the other hand, for group B, 20 per cent replied "yes" while 80 per cent answered "no."

Since group C was comprised of lay people secured by accidental sampling procedures, the researcher asked these respondents to respond only to the demographic features of age and sex. This sample was really only asked to answer Questionnaires Number 2 and 3 in order to obtain test scores for the process of doing a correlation coefficient between their knowledge and understanding of the statutes of the Mental Health Act in comparison to their knowledge and understanding of psychiatric patient's legal and civil rights.

Scores on Mental Health Act Test Questionnaire

Table 18 depicts the comparison scores procured by all three samples with regard to their scores on Questionnaire Number 2.
Table 18
Comparison of Samples’ Scores on
Questionnaire Number 2

<table>
<thead>
<tr>
<th>Score</th>
<th>Original Sample</th>
<th>Group B</th>
<th>Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>7.55</td>
<td>6.40</td>
<td>5.15</td>
</tr>
<tr>
<td>Median</td>
<td>8.00</td>
<td>6.75</td>
<td>4.85</td>
</tr>
<tr>
<td>Mode</td>
<td>5.0 and 9.0</td>
<td>6.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Range</td>
<td>4/12</td>
<td>4/10</td>
<td>3/9</td>
</tr>
</tbody>
</table>

N=20 for each sample
As illustrated by Table 18, the mean scores for the contrast groups are fairly similar to the scores obtained by the original group. The original sample, composed of social workers in direct contact with psychiatric patients, only answered an average of one question more than did group B which featured a sample of social workers who were not in direct service contact with psychiatric patients. Group C, made up of community people, scored on a whole, only 2-4 questions less on the test questionnaire than did the original sample.

The dispersion range between the highest and lowest scores obtained on the Mental Health Act questionnaire are fairly consistent. The original sample has the largest dispersion of 9 points ranging from a low of 4 to a high of 12. Group B range was the lowest with only a 7-point spread, while group C fell in between these two samples with a spread of 8.

Scores on Psychiatric Patients' Legal and Civil Rights Test Questionnaire

The mean sample scores of the three comparison groups produce some alarming facts when the scores on Questionnaire Number 3 are compared. (See Table 19.)

The mean scores secured by each sample fell within .25 points of one another. There is a wider dispersion range between the low and high mean scores compared to
Table 19
Comparison of Samples' Scores on
Questionnaire Number 3

<table>
<thead>
<tr>
<th>Scores</th>
<th>Original Sample</th>
<th>Group B</th>
<th>Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>5.55</td>
<td>5.75</td>
<td>6.05</td>
</tr>
<tr>
<td>Median</td>
<td>5.85</td>
<td>6.23</td>
<td>6.28</td>
</tr>
<tr>
<td>Mode</td>
<td>5.00</td>
<td>6.00</td>
<td>6.00</td>
</tr>
<tr>
<td>Range</td>
<td>3/11</td>
<td>1/8</td>
<td>3/12</td>
</tr>
</tbody>
</table>

N=20 for each sample
Questionnaire Number 2 scores. However, this time the low mean score belonged to the original sample and the high mean score to group C or the lay community members. The researcher believes this to be of significance. The scores obtained on Questionnaire Number 3 indicate that, on the average, lay community members seem to possess a better knowledge and understanding of psychiatric patient's legal and civil rights compared to a group of social workers in general and a particular group of social workers in direct service contact with these patients.

These low scores obtained by the two social work samples leave the researcher to speculate about how much social workers violate psychiatric patient's rights and privileges because they are not well versed on the subject. The question still remains: "Why are they not aware of those rights and privileges?" This applies especially to the original sample, since psychiatric patients compose the major portion of their clientele.

Correlation of Test Scores

In assessing the scatter diagrams of each sample which depicts the scores obtained by all respondents on the test questionnaire, the plotting indicates a negative regression line for the original sample and positive regression lines for group B and group C. The wide dispersal of the tabulation points away from the regression lines
however, which suggests a very weak or non-existence of association between the two scores and test questionnaires.

Table 20 presents the correlation coefficients and t-test figures of the three samples.

As the correlation coefficient figures in Table 20 show all three coefficients are very low, which indicates a very low degree of association. The low degree of association between the two variables, the scores on the Mental Health Act test questionnaire, and the scores obtained on the psychiatric patient's legal and civil rights test questionnaire leads the researcher to reject his second research hypothesis. Social workers who score low on the test questionnaire in their knowledge of Ontario's Mental Health Act will also score low on the test questionnaire in their knowledge of the psychiatric patient's legal and civil liberties. The correlation coefficient of the samples suggest that just because a person scores low on the Mental Health Act test questionnaire does not mean the person will necessarily score low on the psychiatric patient's legal and civil rights test questionnaire.

Summary of Data

In summary, the original sample and the two contrast groups are similar in certain demographic features. In particular, the original sample and group B, composed of social workers, are very representative of one another
Table 20
Correlation and t-test Data of all Samples

<table>
<thead>
<tr>
<th></th>
<th>Original Sample</th>
<th>Group B</th>
<th>Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correlation</td>
<td>-0.1234</td>
<td>-0.1479</td>
<td>+0.0297</td>
</tr>
<tr>
<td>t-test</td>
<td>-0.526</td>
<td>-0.6346</td>
<td>0.1262</td>
</tr>
</tbody>
</table>

Correlation coefficient were obtained using Pearson Product Moment Correlation Coefficient (r)
t-test: were obtained by (n-2) for 18 degrees of freedom
with regard to sex, age, and education. These two samples also approximate one another in six other categories, percentage-wise, though in a reverse order.

The original sample procured a mean score of 7.55 on Questionnaire Number 2. Group B's mean score was 6.40 while group C's mean score figured out to 5.15. The statistical data indicate that a sample of social workers who have direct contact with psychiatric patients have a better general knowledge and understanding of the statutes of Ontario's mental health legislation than do their contrast group members.

Nevertheless, the original sample obtained the lowest mean score on Questionnaire Number 3 which dealt with psychiatric patient's legal and civil rights. In fact, the sample composed of lay community people scored the highest mean score of 6.05 compared to group B's score of 5.75 and the original sample's mean score of 5.55.

The two contrast samples received positive but very low correlation coefficient scores which suggest "no" or "very little" association between Questionnaire Number 2 and Questionnaire Number 3. These correlation scores differed slightly from the original sample although it received a very low correlation coefficient and its regression line was a negative one compared to the positive ones obtained by the two contrast groups.

Owing to the similarity of statistical data obtained
by all three samples on Questionnaires Number 2 and 3 and the low correlation coefficient figures, the researcher feels comfortable in stating that the research questionnaire was a very reliable and valid questionnaire.

Interview Schedule

In an effort to obtain a better feel and understanding of the respondents' views held on the major issue of psychiatric patient's legal and civil liberties, the researcher conducted a personal interview with each respondent who was a member of the original sample. Since the researcher felt that the issue being examined might be a sensitive subject for the respondents, he used the personal interview technique to better explore their opinions. Not wishing to stray too far from the question at hand, the researcher followed a fixed interview schedule. The researcher attempted, in all interview sessions, to query each respondent in a similar manner and the interview schedule forced the researcher to read the same question in the same order to each respondent. In the interview itself, the researcher sought to obtain each respondent's personal opinions or beliefs on six topics based on responses to fifty-two questions.
Respondents' Awareness of the Review of the Mental Health Act

The researcher opened the interview with a general inquiry into the respondent's awareness of a social movement afoot to attempt to have the province's present mental health legislation reviewed and modernized. Ninety per cent of sample A told the researcher that they were aware that within the last year and a half, Health Minister Dennis Timbrell had been requested to review the Mental Health Act. Of those questioned, seventeen respondents, or 85 per cent of the sample, personally believed that the present M.H.A. was in need of review and revision.

Though the majority of the respondents stated their awareness of this issue, only 50 per cent could provide the name of at least one organization that they believed had lobbied for the review. Canada's Mental Health Association was the most frequently named organization, followed by the Canadian Civil Liberties Association, Ontario Psychological Association and civil rights lawyers.270

Besides naming of the lobbying organizations, only

270 All of these organizations have presented briefs to the Council of Health who reviewed the present Mental Health Act, R.S.O., 1970, c.269 and who, through Health Minister Dennis Timbrell, designed Bill 19, An Act to Amend the Mental Health Act. However, the Canadian Civil Liberties Association has been the most critical and has received the most press coverage regarding their persistent request for revision of the M.H.A. on the grounds that it restricts individual freedoms through the civil commitment process.
half of the respondents could provide one reason used by these organizations to support their demands for review of the present mental health statutes. Those who replied to the question indicated reason(s) falling into six broad topics. The violation of psychiatric patients' civil rights and the vagueness of the wording contained within the statutes themselves received the most responses. Other reasons cited by the respondents were: admission criteria used, time limitation and the issue of renewal of certificate, the lack of proper Review Board procedures, and detention based on unwarranted reasons.

Even though half of the respondents were able to provide a reply to questions number 2 and 3 of the interview schedule, the replies were hesitant in a fair percentage of the sample and many were often accompanied by, "I think," or "I'm not sure." The researcher gained the distinct impression that many members of the sample who provided answers to the above questions were guessing at an answer. That is, some respondents were providing a response on the hope that they might be correct or thought the response they gave was correct, even though they possessed no factual knowledge or proof of their own.

When each respondent was asked if they felt there was a need for a review and possible amendments to the M.H.A., all respondents listed several areas where they felt change should occur. Some of the areas of concern
mentioned were: 1) use of terminology is vague and leaves professionals to interpret for themselves the basic legal and civil rights of patients—questions were raised as to whether professionals are homogeneous in their definitions; 2) admission procedures and the use of civil commitment was questioned; 3) discharge and Review Board procedures were also viewed as restrictive; 4) many respondents felt more than one physician should be required to sign a commitment certificate and a general practitioner should not have this authority except under extreme conditions; 5) many respondents stated that they considered the 30-day period of first commitment too long and felt that it should be reduced; 6) a couple of respondents believed that the least restrictive method of treatment or the use of other alternatives should be explored before procedures contained within the M.R.A. were used which might violate the person's civil rights and privileges. One respondent even commented that he personally viewed civil commitment as a trial without jury and a direct contradiction of the Canadian Bill of Rights.

On the other hand, another respondent indicated that her major concern was that it is very difficult to get a person living in the community into a psychiatric hospital. The respondent felt that physicians were not carrying out their responsibility as provided for under the M.H.A. in admitting certain individuals into psychiatric hospitalization.
The respondent suggested that physicians were reluctant to use civil commitment by a physician's certificate as a method of hospitalizing an individual in need of psychiatric care and treatment, even though their action had not come to the attention of other citizens in the community.

These two cases represent the extremes of the areas the respondents felt needed a review and possible amendment in the Mental Health Act. Most respondents provided the researcher with at least two issues of concern which they felt were in need of updating. Most of their concerns fell within the six topics outlined previously, though some respondents did discuss specific areas of concern, such as the two outlined above and the issue of psychiatric patients' rights. The distress associated with patients' rights seemed to focus on the aspect of the patient's right to refuse or accept psychiatric treatment. The issue of the "right to refuse treatment" appeared to be a very perplexing area and one that does not have a consensus among mental health professionals.

Chadoff writes that medical model psychiatrists believe in the state's power under the doctrine of parens patriae to arrange for psychiatric hospitalization and treatment of the assumed mentally ill person even though coercion is involved and the person is deprived of certain
civil liberties. The Ontario division of the Canadian Mental Health Association in their brief to the Ontario Council of Health Committee states that under present law, valid consent must be obtained for every type of treatment given and there is no mention of distinguishing between whether the patient's status is formal or voluntary. The brief further suggests that some mental facilities' administrators apparently believe that involuntary status gives them legal authority to treat psychiatric patients without obtaining their consent, even if it goes against the patient's will.

There does not appear to be a consensus among mental health professionals regarding a psychiatric patient's "right to refuse treatment." It is generally conceded by these professionals that very few psychiatric patients are deemed mentally incompetent and unable to decide the consent issue. Test cases in Ontario Courts are needed in which the question of the "right to refuse treatment" is adjudicated. The civil rights of the psychiatric patient must be clearly defined in statutory law.


272 An Interim Brief presented by the Canadian Mental Health Association, Ontario Division to the Ontario Council of Health Committee on Mental Health Services Legal Task Force, April 1, 1978, pp. 38-42.
Respondents' Personal Views of Civil Commitment

Until the passage of the 1967 Mental Health Act, any person committed to an Ontario psychiatric hospital was considered "ipso facto" to be incompetent. The Rosenhan study\(^{273}\) suggests that there is a tendency on the part of psychiatric facility's staff to view patients as being sick, rather than normal. Stewart Page writes that:

In mental institutions, a chief expectation on the part of staff is that anyone who appears there (who isn't "staff") must therefore be a mentally ill individual.\(^{274}\)

Due to these implied tendencies, the researcher asked the respondents, "If a person is committed to a psychiatric facility, does that mean that the person is incompetent?". Seventy per cent of the sample answered in the negative, stating that commitment did not necessarily relate to or imply incompetency. Five respondents, or 25 per cent, replied not necessarily, thus seeming to denote that it may or may not, depending upon the circumstance and the events associated with the admission and the type of admission. Only one respondent believed commitment to a psychiatric facility was grounds enough to indicate a person's mental incompetency.


When asked if they had any concerns about civil commitment, all respondents immediately responded with a "yes." Regarding the assumption that certified psychiatric patients may lose certain rights and privileges once they are committed to a psychiatric facility, the sample had no general areas of consensus. The answers provided by some respondents offered the various outlooks of this issue held by social workers. These views were very divergent and ran the whole spectrum from positive to negative beliefs. The gist of some of the respondents' personal statements were:

1. Some of these patients do lose certain rights. However, these loses can be explained to them.

2. Often the loss is justifiable.

3. In some cases, the loss of some rights should happen. However, the respondent believed the loss of rights should be based on each individual case.

4. One respondent was surprised that it was happening.

5. One respondent stated that the loss of rights is not an assumption, it is a fact.

6. Another said that from their experience they are not really that concerned with the issue. Any errors made are made on the side of caution and besides the 30-day commitment period is
not all that long anyway.

7. Another respondent stated that the assumption that patients lose rights and privileges is not an assumption. Under the present M.H.A. they do lose certain rights. In fact, the loss of certain legal and civil rights is built into the Act.

There was not a consensus on the above assumption. Nevertheless, the majority of the respondents were in agreement; 85 per cent believed that civil commitment does affect an individual's personal freedom and, at the same time, violates certain of his legal and civil rights.

The statistical data procured by these two questions leaves doubt in the researcher's mind about the accuracy of the replies offered. In further examination of the replies pertaining to the above mentioned assumption and using as wide a latitude as possible for determining and defining a positive response, the researcher feels that only 8 respondents, or 40 per cent of the respondents, replied with a positive "yes" response regarding the assumption question. If 85 per cent of the respondents believe that commitment interferes with the legal and civil rights of a patient, then surely more than 40 per cent of the same respondents would accept the assumption that certified psychiatric patients lose certain legal and civil rights once they have been committed to a psychiatric
facility.

The above discrepancy may be accounted for because social workers may believe that civil commitment does affect a patient's rights and privileges. However, just because they accept such a statement does not necessarily mean they support the assumption with their actions. It appears to the researcher that those social workers who fell within the 40 per cent response bracket were the ones who would be more likely to become involved in patient's issues.

On the whole, persons in the sample possessed a belief that civil commitment is a necessary social mechanism required by society to deal with specific cases of mental illness at certain times. However, all respondents further qualified their replies by suggesting some criteria which must be mentioned. The researcher has compiled these suggestions into three guidelines:

1. It should be defined with greater accuracy who can commit and under what circumstances and situations civil commitment is an acceptable process.

2. If utilized, civil commitment should be the last alternative employed. All other possible means should be explored and the least restrictive one accepted. Should none of these alternative means prove to be an acceptable avenue, then and
only then should civil commitment be adopted as the last resort.

3. Review of the person's admittance process and mental status should be investigated automatically within the first week of admission and preferably weekly thereafter.

4. Some respondents even suggest that the civil committed patient should be provided the opportunity to challenge, through a court of law, if necessary, their impending commitment to a psychiatric facility.

The respondents were also aware of some of the abuses and evils of the civil commitment process. The majority of the respondents discussed what they personally believed to be injustices contained within the mechanism of civil commitment, and offered various alternative procedures to rectify the situation.

When asked whether they were concerned about the issue of psychiatric patient's legal and civil rights, nineteen respondents, which represents 95 per cent of the sample, responded "yes." Furthermore, all respondents of the sample replied that they were conscious of and aware of not overstepping the legal and civil boundaries of their clients in their patient/worker relationships.

In review, a large portion of the sample believed that civil commitment did affect a psychiatric patient's
legal and civil rights. A much smaller percentage, however, accepted the assumption that certified patients lose certain legal and civil rights once committed to a psychiatric facility. Every respondent in the sample had a personal concern about civil commitment and most suggested alternative guidelines to help offset the abuses of this process. Furthermore, 95 per cent of those interviewed were concerned with the issue of the psychiatric patient's loss of rights and privileges and were conscious of not overstepping patient's legal and civil boundaries.

Respondents' Attitudes Associated with the Mental Health Act

The researcher was interested to learn the respondents' attitudes with regard to whether they personally believed the statutes contained in the present Mental Health Act protect and safeguard the legal and civil liberties of psychiatric patients. The interview schedule included ten specific questions designed to probe the respondents' beliefs associated with this issue. Table 21 provides a graphic representation of the statistical data based on the replies for seven of those questions.

Only 45 per cent of the sample accepted the position that Ontario's present Mental Health Act protects the legal and civil rights of all citizens within the province. Ten respondents, or 50 per cent of the sample, did not
Table 21
Respondents' Replies to Interview Schedule Questions
Regarding the Mental Health Act

<table>
<thead>
<tr>
<th>Questions posed by the researcher to the respondents in the interview</th>
<th>Respondents' Replies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>7. Does the M.H.A. protect the legal and civil rights of the hospitalized psychiatric patient?</td>
<td>5-25%</td>
</tr>
<tr>
<td>8. Should any physician in Ontario have the authority to commit a person to a psychiatric facility?</td>
<td>5-25%</td>
</tr>
<tr>
<td>9. Accept the fact that the police have the authority to detain any person for a psychiatric examination?</td>
<td>10-50%</td>
</tr>
<tr>
<td>10. Is it necessary for the police to have this power at this time?</td>
<td>11-55%</td>
</tr>
<tr>
<td>12. Does the M.H.A. provide sufficient safeguards for discharge of psychiatric patients?</td>
<td>2-10%</td>
</tr>
<tr>
<td>13. Does the M.H.A. provide sufficient safeguards for review procedures by the Review Board?</td>
<td>4-20%</td>
</tr>
<tr>
<td>14. Is it appropriate for the Lieutenant Governor to have authority to exempt psychiatric facilities from the application of the statutes of the M.H.A.?</td>
<td>3-15%</td>
</tr>
</tbody>
</table>

Totals
40-200% 77-385% 23-115% 140-700%

Note: See Appendix B for the exact wording of these questions.
agree with this statement, while one respondents indicated they were not exactly sure where they stood on this issue. Only five respondents, or 25 per cent of the sample, felt that the Act actually protected the legal and civil rights of psychiatric patients while residing in a psychiatric facility. However, 45 per cent of the respondents answered with a definite "no" that they personally did not believe that the M.H.A. protected psychiatric patients' rights. Another 30 per cent of the respondents were not exactly sure if they could accept or reject the question (see Table 21, question 7).

These statistics may indicate that there is a serious concern by a large segment of the sample to question whether the Mental Health Act has the capacity in its statutes to protect any individual in the province from the loss of his personal freedom due to civil commitment procedures.

When questioned about their opinion of the police authority to arrest persons for a psychiatric examination and whether this general power of authority is a necessity, approximately one-half of the sample responded positively. Fifty per cent of the sample accepted the fact that Ontario's police could detain any citizen for a psychiatric examination based solely on their opinion about the arrested person's mental status (see Table 21, question 9).
Those respondents who personally could accept the authority provided to the police by statute 10 of the Mental Health Act tended to suggest specific stipulations necessary to validate this process. Of those who responded favourably, some believed this process was acceptable as long as it was not abused on the part of the police. Others stipulated they could accept the process only if, in the opinion of the officer, the person was felt to be in immediate need of psychiatric treatment or was considered dangerous to self or others at the time of apprehension and detention.

While 50 per cent of the sample of social workers want Ontario's police to have the authority to detain a suspected mentally ill person for a psychiatric examination, the Fox, Erickson study determined, through direct discussion with Toronto police officers, that the majority of the police interviewed did not want this power.

For their part, most police interviewed, while accepting the disposition of suspected mentally ill persons as part of their work, did not particularly like it and would have been pleased if others assumed their function in this area.275

The Fox, Erickson findings seem to suggest that the police have accepted this role as part of their function and as a social requirement placed on them by citizens of

275 Richard G. Fox and Patricia G. Erickson, Apparently Suffering from Mental Disorders, p. 171.
the province.

The respondents who replied with a "no" response, however, did so factually and bluntly with little retort offered. Almost all of these ten respondents answered with an abrupt "no" and advanced no further data to support or defend their attitude on this matter.

On question 9, 55 per cent of the sample also considered it necessary for the police to have this special power of authority at the present time in determining who may or may not be mentally ill. Thirty-five per cent of the sample, nevertheless, did feel that it was unnecessary for the police to have this power. The other ten per cent of the sample was not sure whether or not the police required the authority in this day and age to ascertain if a person was mentally ill. Once again, those respondents who replied in the affirmative provided several reasons to support their answers. One respondent indicated that the policies and procedures police officers are allowed to take are clearly outlined. Other respondents felt that the police were the only persons in many situations who could restrain a person deemed to be dangerous to himself or others in the community. There was also the retort, "Who else could do it?". However, those respondents who appeared to take displeasure with the question, challenged the wide discretionary power offered to the police in this area. Under the mental health legislation:
The officer, if he is satisfied that,
c) the person should be examined in the interest of his own safety or the safety of others; and
d) the circumstances are such that to proceed under section 9 would be dangerous,
take the person to an appropriate place where he may be detained for medical examination.\textsuperscript{276}

It is the discriminatory power contained within statute 10, subsection (c) and (d) that allows police officers to use their own personal judgment to determine a person's mental status that upset those respondents who challenged this power. Those who questioned special police authority did so on the grounds that, on the whole, physicians are not very good judges of a person's mental condition, nor can they accurately predict dangerous tendencies in a person. Therefore, if physicians who are presumably trained in this area cannot accurately diagnose an individual's mental condition, how can police officers do it, especially when they rarely receive any special training in this area?

While 50 per cent of the respondents accepted the fact that the police had the authority to take any person for a psychiatric examination, only 5 respondents, or 25 per cent of the sample, believed that any physician in Ontario should possess the authority to commit a person to a psychiatric facility. The remaining 15, or 75 per

\textsuperscript{276}The \textit{Mental Health Act}, R.S.O., 1970, c.269, s.10, ss. (c) (d).
cent of the respondents, did not accept the present mental health statute which allows any physician to sign a "Physician's Application for Involuntary Admission" form which forces psychiatric hospitalization (see Table 21, question 8).

Of the 15 respondents who indicated that they do not believe that any physician in Ontario should be invested with the authority to commit a person, 80 per cent of that group suggested that only psychiatrists should have this power. Of the 12 respondents who made up this 80 per cent, three indicated that only one psychiatrist's signature was necessary on the commitment form. Six respondents, however, suggested that two or more psychiatrists conduct independent examinations of the person and that all psychiatrists who examined the person be required to sign the certificate of admission. Another three respondents of this group stated that they felt a team of different mental health professionals should have the responsibility in determining whether a person should be committed to a psychiatric facility. The respondents who discussed this aspect further suggested that this assessment team be composed of individuals who represented the various mental health professions.

One-half of the sample did not believe that there were sufficient safeguard measures contained in the Mental Health Act to provide for the discharge of psychiatric
patients. Only two out of the 20 persons interviewed held the opinion that the M.H.A. possessed the essential statutes which authorized measures for the dismissal of a patient from a psychiatric facility. A large segment of the sample, 40 per cent, were not sure whether they personally could indicate agreement or disagreement with this question (see Table 21, question 12).

In addition to the above, 50 per cent of the sample also expressed the opinion that the M.H.A. does not provide sufficient safeguards for review procedures by the Review Board. This high percentage of the sample gives credence to the concerns discussed by Reitsma on this particular issue. She indicates that Review Board proceedings are not open to the public, nor are their findings made public. Therefore, under these circumstances it is very difficult to really determine how thoroughly and effectively Review Boards safeguard psychiatric patients' liberties.\(^{277}\)

Although 50 per cent of the respondents believed there was really no protection provided to patients in the process of review procedures, 20 per cent of the respondents thought that there was. Six respondents were in the "middle of the road," not sure whether they could accept or reject the question posed to them (see Table 21, question 13).

\(^{277}\)Marge Reitsma, "Civil Liberties and the Mentally Ill," p. 11.
Eighty per cent of the respondents were in complete agreement with the McRuer Report\(^{278}\) when they indicated that they could not accept the provision contained in the Mental Health Act which allowed the Lieutenant Governor in Council to exempt any psychiatric facility in Ontario from the application of any provisions or statutes in the M.H.A. The data appear to suggest that the majority of the sample believes that the special provisions provided to the Lieutenant Governor undermine the whole Act, and therefore provide little protection for psychiatric patients' rights.

McRuer states in his inquiry into civil rights that:

> It is the designation of an institution as a psychiatric facility by regulation that confers the powers provided under the Act, and likewise confers on the patients the safeguards provided by the Act. The safeguards of review, etc., are contained in Part II of the Act, but the Lieutenant Governor in Council may by regulation exempt any psychiatric facility or class thereof from the application of Parts II and III of the Act.\(^{279}\)

It is interesting that the high proportion of respondents (80 per cent) who rejected the statutes afforded to the Lieutenant Governor did not reply in proportional numbers to the belief that the Mental Health Act does not protect the legal and civil rights of psychiatric patients, nor does it offer the patient sufficient safeguards for


\(^{279}\)Ibid., p. 1238.
review procedures. In re-examining the statistical data, the researcher found that a higher percentage of the respondents believe a psychiatric patient's legal and civil rights were better protected by the M.H.A. than were his opportunity to receive the necessary and required review procedures regarding his hospital status.

This portion of the interview schedule was used to investigate the respondents' attitudes towards specific statutes in the M.H.A., regarding the Act's ability to protect patients' rights and provide standards for discharge or case review. The researcher asked each respondent to state what they personally believed to be the percentage of certified psychiatric patients detained within the community hospitals and the province's psychiatric facilities, as a whole. Table 22 illustrates the sample's reply to this question.

Sixty per cent of the sample estimated that from 1-10 per cent of the community's hospitalized psychiatric population are certified psychiatric patients. Seventy per cent of the total sample suggested that no more than 20 per cent of the psychiatric patient population is composed of certified patients. However, when estimating province-wide figures, 40 per cent of the sample believes that 20 per cent or less of the total psychiatric patient population consists of formal admission patients. Another 45 per cent of the
Table 22
Respondents' Speculation of the Percentage of Certified Psychiatric Patients Contained Within the Hospitalized Psychiatric Patient Population

<table>
<thead>
<tr>
<th>Percentage of Certified Psychiatric Patients Assumed by Respondents to be Found in the Psychiatric Patient Population</th>
<th>Psychiatric Facilities</th>
<th>Community</th>
<th>Provincial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>1-2</td>
<td>5</td>
<td>25</td>
<td>1</td>
</tr>
<tr>
<td>3-5</td>
<td>3</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>5-10</td>
<td>4</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>11-15</td>
<td>1</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>16-20</td>
<td>1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>21-25</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>26-50</td>
<td>2</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Over 50</td>
<td>1</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>No response</td>
<td>3</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Totals</td>
<td>20</td>
<td>100</td>
<td>20</td>
</tr>
</tbody>
</table>

N=20
sample nevertheless assumed the proportion ranged from 21 to
over 51 per cent of the total patient population.

The researcher compared the respondents' figures to
governmental mental health statistics on the provincial-wide
population of psychiatric patients. Over 25 per cent of
the admissions to the province's psychiatric facilities in
1977 were conducted through formal admission procedures.
Thus, the majority of the respondents were fairly accurate
in their speculation about the percentage of certified
patients. The researcher was unable to find data giving
community admission rates in Windsor, however he accepts
the assumption that the percentage is fairly low, probably
below the 10 per cent mark.

To complete this section of the interview schedule,
the researcher asked each respondent to rate on a seven-
point scale their agreement or disagreement with research
hypothesis number three expressed to them as a statement.
As illustrated in Table 23, 8 respondents, or 40 per cent
of the sample, disagree to various extents with the state-
ment, "The statutes as outlined in the Mental Health Act
do not protect and safeguard the legal and civil rights of
psychiatric patients." Ten per cent of the sample were un-
deided as to where they stood in regard to this statement.
The remaining 55 per cent of the sample, however, responded
in agreement and therefore denote that they personally be-
lieved the M.H.A. does not protect psychiatric patients'
Table 23
Respondents' Agreement or Disagreement to the Statement: "The Mental Health Act does not protect the legal and civil rights of psychiatric patients."

<table>
<thead>
<tr>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
</tr>
</tbody>
</table>

Disagreement / Agreement

1) strongly disagree
2) disagree
3) mildly disagree
4) undecided
5) mildly agree
6) agree
7) strongly agree

Note: Categories 1-3 contain the reply of 8 respondents or 40 per cent of the sample who disagree with the statement. Categories 5-7 contain the reply of 11 respondents or 55 per cent of the sample who agree with the statement.
rights and privileges. Thus, this 40/50 split among the respondents demonstrates that the respondents did not express a positive attitude about this statement in one direction or the other.

Respondents' Attitudes Toward the Issue of Informing Psychiatric Patients about their Legal and Civil Rights

In an endeavour to determine to what extent the respondents became involved in discussing with patients their legal and civil rights, the researcher asked each respondent twelve questions regarding their experience in this area. Table 24 provides a detailed description of the respondents' replies to six of those twelve questions.

Only 35 per cent of the respondents attested to the fact that they discussed, on a regular basis with psychiatric patients, the legal aspect of their hospital status. Another 30 per cent of the respondents did signify that, on occasions, they too approached this matter and did discuss this situation with certain psychiatric patients. The remaining 35 per cent, however, replied that this was not in any way, shape, or form a part of their regular counselling sessions with their clients. (See Table 24.)

One-half of the respondents said that they personally informed all psychiatric patients that they counsel of any privileges that may be withheld or restrictions that may be
Table 24
Respondents' Replies to Interview Schedule Questions Relating to Social Workers Informing Patients of their Rights

<table>
<thead>
<tr>
<th>Questions Posed to the Respondents by the Researcher in the Interview</th>
<th>Respondents' Replies</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Do you discuss with psychiatric patients the legal aspect of their hospital status?</td>
<td>Yes: 7-35%  No: 7-35%  Other Replies: 6-30%  Total: 20-100%</td>
</tr>
<tr>
<td>17. Do you inform psychiatric patients of any privileges or restrictions that may or may not be given or placed upon them?</td>
<td>Yes: 10-50%  No: 3-15%  Other Replies: 7-35%  Total: 20-100%</td>
</tr>
<tr>
<td>19. Do you discuss with certified patients what their commitment entails and the length of time their commitment is for?</td>
<td>Yes: 8-40%  No: 5-25%  Other Replies: 7-35%  Total: 20-100%</td>
</tr>
<tr>
<td>20. Do you inform certified patients what procedures are available to them to seek discharge from hospitalization?</td>
<td>Yes: 7-35%  No: 8-40%  Other Replies: 5-25%  Total: 20-100%</td>
</tr>
<tr>
<td>22. Do you inform all psychiatric patients that they have the right to refuse psychiatric treatment?</td>
<td>Yes: 6-30%  No: 4-20%  Other Replies: 10-50%  Total: 20-100%</td>
</tr>
<tr>
<td>25. Do you personally address the above questions in every patient situation or only when certain events arise and become an issue?</td>
<td>Yes: 2-10%  No: -  Other Replies: 18-90%  Total: 20-100%</td>
</tr>
</tbody>
</table>

Totals: Yes: 40-200%  No: 27-135%  Other Replies: 53-265%  Total: 120-600%

Note: See Appendix B for the exact wording of these questions.
placed on them due to their hospitalization. A further 30 per cent of the respondents replied that there were times when they did discuss this issue with their clients. The matter of privileges and restrictions was examined by these seven respondents only when the psychiatric patient asked specifically about it. These same respondents further attested that they personally would not initiate the discussion of patient's rights and privileges in their counselling sessions.

As civil commitment can entail at least a 30-day stay in a psychiatric facility, the researcher questioned the respondents as to whether they discussed this time aspect with certified psychiatric patients. Some 40 per cent of the respondents told the researcher that they did talk with these patients about what their civil commitment entailed or the length of their commitment. However, as stated before in this study, the time period can be shortened or extended at any time at the discretion of the physician. A further seven respondents stated that they informed certified patients of the 30-day commitment period only if the patient asked about their length of stay.

In association with the above question, 35 per cent of the sample informed certified patients that they counsel of the procedures available to them to seek release from psychiatric hospitalization. This small percentage indicates that of twenty respondents, only seven social workers
took it upon themselves to inform certified patients about procedures that are available to them to make application to the Review Board. One-quarter of the respondents stated that they only informed certified patients of their rights to seek discharge through Review Board procedures if the patient's initial request for discharge had been denied. These same respondents further stated that they do so only when they are approached by the patient himself and the patient initiates the discussion in seeking information about release. (See Table 24.)

It is interesting to note that the largest percentage (40 per cent) who responded to the question replied that they did not volunteer information to certified psychiatric patients about their civil right to seek discharge from psychiatric hospitalization if they wished. In fact, it was one of the few questions in this segment of the interview schedule that received a higher percentage rate in the "no" category than in the "yes" category. Such a situation may stem from the respondents' inadequate comprehension of patient's rights and privileges associated with review proceedings.

In re-examining questions 10 to 13 of the psychiatric patient's legal and civil rights test questionnaire, it was evident that only a small percentage of the respondents were able to select the correct answers to each of these questions, all of which dealt with specific aspects of.
review proceedings or policies. For question ten, only 20 per cent of the sample answered the question correctly; 45 per cent responded correctly to question number eleven, while only 35 per cent of the sample was able to choose the correct answer for question twelve (see Appendix B for these questions). These statistics suggest that a large portion of the sample had little personal knowledge or awareness of the legal and civil rights of certified psychiatric patients.

This supposition is further substantiated by the fact that only four respondents, or 20 per cent of the sample, said they personally explained to patients that certain of their basic civil rights may be affected by psychiatric hospitalization. A further 40 per cent of the sample stated that they discuss this situation with certain patients on different occasions, but not on a regular basis. The remaining respondents, or 40 per cent of the sample, said they never approached these subject matters with any psychiatric patients. (See Table 24, question 25.) These respondents felt that a certified psychiatric patient was in no condition to understand the legal aspects of their hospitalization due to their mental condition. Such a response appears to suggest, at least in the minds of these respondents, that a person is incapable of comprehending the various aspects of his hospitalization if he is an involuntary patient.
The respondents' inability to answer correctly the questions on the questionnaire attest to the fact that the majority of the respondents were in no position to be discussing, let alone offering advice to psychiatric patients in these areas. For instance, on the psychiatric patient's legal and civil rights questionnaire, the two questions dealing with the right to vote received only 30 and 25 per cent respectively, correct response rates from the study's sample. On the question regarding restricting the mentally ill person's right to drive, only 30 per cent of the sample answered the question correctly. As for the respondents' knowledge about provincial trade and professional statutes restricting an assumed mentally ill person from practicing law or medicine, only 20 per cent of the respondents were able to answer this question correctly. Furthermore, the mean score of 5.55 (see Table 14) obtained by the study's respondents on the psychiatric patient's legal and civil rights questionnaire shows that, on the whole, this particular sample of social workers did not fully comprehend psychiatric patients' civil liberties.

To explore the issue of patients' rights further, the researcher asked several more questions touching upon controversial areas. Concerning a patient's right to be involved in the assessment of their own physical and emotional needs, 70 per cent of the respondents replied that
they personally informed all psychiatric patients they counselled that the patient was entitled to this privilege, even if the medical staff did not accept this position. A further 20 per cent of the respondents stated that they had informed certain patients of this aspect, if they felt the patient's circumstances warranted it. Ten per cent of the respondents did not discuss this situation with psychiatric patients.

The researcher asked each respondent whether they informed all psychiatric patients they counsel (formal or voluntary) that they have the right to refuse psychiatric and medical treatment. Interestingly, six respondents, which accounts for 30 per cent of the sample, talk about this matter with all of their psychiatric patients. Another 50 per cent of the sample stated, in one form or another, that on occasions they had personally talked to specific patients and informed them of this right. The other 20 per cent of the sample indicated, however, that they had never discussed with patients their right to refuse treatment while hospitalized.

There is no specific statute within the present provincial Mental Health Act which stipulates that a psychiatric patient (formal or voluntary) must accept psychiatric or medical treatment while they are residing in a psychiatric facility. Thirty-five per cent of the respondents indicated (see Appendix A, Questionnaire number 3, question 7) that
they believe a formal psychiatric patient has the right to refuse psychiatric treatment.

In general, a sizeable percentage of the respondents stated that they informed psychiatric patients of their legal and civil liberties as a normal procedure in their client/worker counselling sessions. However, only two of the twenty social workers interviewed were able to say that they personally discussed all of the issues mentioned with every one of their psychiatric patient clients. The other eighteen respondents signified that they approached the discussion of legal and civil rights with patients as the need arose. These eighteen social workers appeared to be suggesting that if psychiatric patients initiated a conversation about patients' rights, then and only then would these respondents follow up the discussion and advance additional information on rights, privileges and obligations.

To see whether the respondents' departmental policies reinforced or hindered their performance in informing patients of their civil rights, the researcher questioned each respondent. Every respondent in the study refuted the question stating that their department or agency policies and procedures did not, in any way, restrict or interfere with their work in this area.

The opinion that social workers were not hindered by department policy was further supported by two chief social workers who headed social work departments in two of Windsor's
hospitals. In responding to eight additional questions, these individuals thought that if their department had no formal written policies associated with the issue of psychiatric patients' rights, they personally believed that social workers would inform patients of their rights anyway, when the situation called for it.

To end this portion of the interview schedule, the researcher posed the fourth research hypothesis as a statement and asked every respondent to rate their level of agreement or disagreement with the statement. As Table 25 depicts, one-quarter of the respondents were in disagreement and rated the statement that, "Social workers do not inform psychiatric patients how the nature of their admission to psychiatric hospitalization may or may not affect their legal and civil rights." On the other side though, thirteen respondents, or 65 per cent of the sample, accepted the statement to various degrees. Only two respondents were undecided on their position.

The somewhat negative attitude held by the majority of these social workers, in the almost 3:1 response rate, appears to indicate that this particular sample of social workers was not really that interested in informing psychiatric patients of any restrictions or infringements on their legal and civil rights.
Table 25

Respondents' Agreement or Disagreement on the Statement:

Social Workers do not Inform Psychiatric Patients how Their Admission May or May Not Affect Their Legal and Civil Rights

<table>
<thead>
<tr>
<th>Frequency</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>7</td>
<td>35</td>
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<tr>
<td>6</td>
<td>30</td>
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<tr>
<td>5</td>
<td>25</td>
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<tr>
<td>4</td>
<td>20</td>
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<td>3</td>
<td>15</td>
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<td>2</td>
<td>10</td>
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<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

1) strongly disagree  
2) disagree  
3) mildly disagree  
4) undecided  
5) mildly agree  
6) agree  
7) strongly agree

**Note:** Categories 1-3 contain the reply of 5 respondents or 25 per cent of the sample who disagree with the statement. Categories 5-7 contain the reply of 13 respondents or 65 per cent of the sample who agree with the statement. This represents almost a 3 to 1 response rate difference.
Respondents' Attitudes Toward the Issue of Due Process of Law for Psychiatric Patients

In accordance with one of the major issues of the study, the researcher felt it was appropriate to investigate the attitudes held by persons in the sample about the controversial topic of "due process of law." This guarantees the right for a judicial hearing for psychiatric patients before their civil freedom can be taken away through the process of civil commitment. A set of questions was included in the interview which would provide information associated with the fifth research hypothesis. Five of the questions and the respondents' replies are represented in Table 26.

Eighty per cent of the respondents replied affirmatively that there was a need for psychiatric patients to have legal aid service. The remaining 20 per cent felt that there may be a need occasionally. Fourteen respondents indicated that they personally told all psychiatric patients they counseled that legal assistance was available to them through the Ontario Legal Aid Program. Five respondents answered that when they thought it was necessary for a patient to have legal counsel, then and only then did they inform a patient that legal assistance was available to them (see Table 26).

These data are supported by findings of Page in a
Table 26
Respondents' Replies to Interview Schedule Questions Relating to the Issue of Due Process of Law

<table>
<thead>
<tr>
<th>Questions Posed to the Respondents by the Researcher in the Interview</th>
<th>Respondents' Replies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>28. Do psychiatric patients have a need for Legal Aid Service?</td>
<td>Yes 16-80% No - Other 4-20%</td>
<td>Total 20-100%</td>
</tr>
<tr>
<td>18. Do you inform psychiatric patients that Legal assistance is available to them?</td>
<td>Yes 14-70% No 1-5% Other 5-25%</td>
<td>Total 20-100%</td>
</tr>
<tr>
<td>32. Do you feel a person should receive &quot;due process of law&quot; if they are about to be committed to a facility against their will?</td>
<td>Yes 14-70% No 6-30% Other -</td>
<td>Total 20-100%</td>
</tr>
<tr>
<td>33. Do you feel a person should be represented by legal counsel in a case where a person is about to be committed to a facility against their will?</td>
<td>Yes 15-75% No 3-15% Other 2-10%</td>
<td>Total 20-100%</td>
</tr>
<tr>
<td>34. Do you feel a person should be represented by legal counsel to challenge and attempt to avoid commitment?</td>
<td>Yes 7-35% No 9-45% Other 4-20%</td>
<td>Total 20-100%</td>
</tr>
<tr>
<td>Totals</td>
<td>Yes 66-330% No 19-95% Other 15-75%</td>
<td>Total 100-500%</td>
</tr>
</tbody>
</table>

Note: See Appendix B for the exact wording of these questions.
study conducted at a large psychiatric hospital in Toronto. Page presents information that indicates that of 76 professional staff members (about equal numbers of psychiatrists, psychologists, physicians, head nurses, and social workers), 86 per cent of this sample "felt there was a 'significant,' or a 'very great' need for patients to have provision of legal counsel." 280

The Windsor social workers were questioned as to what kind of psychiatric patient (formal or voluntary) could best make use of legal counsel, 65 per cent of the respondents suggested that either could, though it would depend upon their particular situation. Five respondents, or 25 per cent of the sample, however, believed the formal patient (by civil or criminal commitment) could best make use of legal assistance. The respondents were split regarding what problems psychiatric patients might need legal assistance for in their view. Forty per cent of the respondents listed various aspects associated with psychiatric patients' legal and civil liberties. The most frequent of those legal and civil right topics discussed were: 1) the process by which the person was admitted, especially if it was a civil commitment; 2) dismissal or seeking discharge through a Review Board proceeding;

3) abuse of patients' rights due to civil commitment; and
4) control by Public Trustee over the incompetent patient's estate.

Sixty per cent of the respondents thought social conditions were the major reasons why a psychiatric patient might need legal counsel. Social conditions usually represent problems connected to family or community relationships. The issues associated with marital and family problems seemed to focus around separation and divorce proceedings, maintenance and support, and child custody. As for the community problems, the predominant topics discussed by these respondents concerned the issue of employment. The majority of the respondents felt that the psychiatric patient was discriminated against when the person sought employment because of their hospital background. These respondents further suggested that a person stood a very good chance of losing his "employment rights" if he should be hospitalized while he is working. These respondents were implying that many psychiatric patients found themselves without their job when they attempted to re-enter their previous employment after their discharge from a psychiatric facility.

Exploring the theme of "due process of law," the researcher found that 70 per cent of the respondents believed that in a case of an individual about to be committed to a psychiatric facility, the person should
receive the benefit of "due process of law."\textsuperscript{281} The remaining members of the sample did not believe that this was a valid liberty for these people to have. Many of the respondents who represented both sides of this position promoted the concept of a tribunal.\textsuperscript{282} These social workers thought that the process of civil commitment was not strictly a medical or legal matter and should be handled in a somewhat different framework than a court proceeding. Those who advanced the idea of a tribunal process favoured either a community or a provincial tribunal concept would benefit the assumed mentally ill person.

Seventy-five per cent of the respondents indicated that they believed that any person about to be committed to a psychiatric facility against their will should be represented by legal counsel (see Table 26, question 33). A further 10 per cent of the respondents signified that the

\textsuperscript{281} The issue of "due process of law" or the right to a judicial hearing is an issue that is beginning to receive much attention today in regard to psychiatric patients and their civil liberties. This issue is being advanced by numerous authors who are advocating on behalf of patients' rights. Many of these authors and their writings have been cited already in this study. Some of the more important ones are: Bruce Ennis (1973); Robert A. Farmer (1967); Nicholas N. Kittrie (1971); Stewart Page (1976); Thomas Szasz (1961), (1963), (1970), (1976); E. Fuller Torrey (1974).

\textsuperscript{282} The concept for the use of tribunals to be used in the social determinant of civil commitment has been advanced by: Alan Borovoy, "Borovoy: Doctors Have Too Much Power," Our Future 5 (May 1977):1, and "Insane Judgments," Weekend, The Windsor Star, 21 May 1977, p. 16; Nicholas N. Kittrie, The Right to be Different, pp. 95–97.
person about to be committed should have the option of being defended by legal counsel if he so chooses. Only three out of the twenty respondents did not believe that the right to legal counsel was a necessary option or civil right for a psychiatric patient.

Advancing the question a step further, the researcher posed the question of "... whether a person about to be committed to a psychiatric facility against their will, should be represented by legal counsel in order to challenge or attempt to avoid the possible commitment?" Only 35 per cent of the respondents were agreeable to this; whereas, before, 70 per cent thought the person should at least be represented by counsel. (see Table 27). The number of respondents who answered "no" in a very forceful manner was very high. These respondents' answers were often accompanied by: "not to challenge and get off;" "not until the first 30-day commitment period is up;" "this should not be the purpose of legal representation--they should be there only to explain the statutes." One individual suggested that a lay advocate well versed in the Mental Health Act may be a more appropriate person to represent the psychiatric patient than a lawyer.

Page writes of two studies conducted at a large psychiatric hospital in Toronto. One study interviewed 30 psychiatric patients and asked for their responses to 16
<table>
<thead>
<tr>
<th>Responses to the Issue of &quot;Due Process of Law&quot; and Representation by Legal Counsel</th>
<th>Number</th>
<th>%</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>14</td>
<td>70</td>
<td>15</td>
<td>75</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>30</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Not sure</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Have option</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Totals</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

N=20
questions regarding legal counsel. The other study evaluated attitudes of 76 psychiatric staff members, composed of various mental health professionals, toward legal aid assistance. In the study composed of psychiatric patients:

Almost all (68 per cent) indicated that legal counsel, in their view, would have been valuable to them prior to hospitalization for the purpose of challenging an impending involuntary admission.283

In the study regarding psychiatric staff members' opinions about legal counsel for patients:

Forty-nine point three per cent thought patients should be represented by legal counsel with which to contest impending civil commitment proceedings at the onset of such proceedings; forty-six per cent felt this protection would be undesirable.284

Thus, the above finding of 46 per cent of a sample of psychiatric staff members opposed to legal counsel for psychiatric patients is very compatible with the findings of this study in which 45 per cent of the sample also opposed legal assistance before commitment.

As with the third and fourth research hypotheses, the researcher converted the fifth hypothesis into a statement. All respondents were asked to indicate their agreement or disagreement with the statement. Just over one-half of the respondents (55 per cent) "strongly disagreed" or "disagreed" with the statement: "Social workers do not


284 Ibid., p. 8.
believe that it is a legal and civil right nor is it in fact a necessity for a person who is about to be committed to a psychiatric facility against his/her own will receive "due process of law". (See Table 28.)

However, 45 per cent of the respondents indicated various levels of agreement with the statement. The 55:45 split of the sample suggests that this particular group of social workers do not possess one dominant attitude towards the issue of "due process of law" for a person about to be committed against their will. This group of social workers is uncertain as to whether a person is entitled to a judicial hearing before he can be forcibly admitted to a psychiatric facility.

Respondents' Attitudes Toward the Issue of Advocacy and their Involvement

At the end of the interview the researcher examined the respondents' attitudes toward the issue of "advocacy" on behalf of psychiatric patients and their rights and the respondent's own participation in this area. Almost all of the respondents (eighteen, or 90 per cent) stated that they had made efforts to voice their concerns about civil commitment. The respondents usually voiced this concern only to a co-worker, though a number of them did say that they had also discussed the issue with their immediate supervisor or head of the department.
Table 28

Respondents' Agreement or Disagreement to the Statement:

Social Workers do not believe it is a legal or civil right for a psychiatric patient to receive due process of law

<table>
<thead>
<tr>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>5</td>
<td>25</td>
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<tr>
<td>4</td>
<td>20</td>
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<td>3</td>
<td>15</td>
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<td>2</td>
<td>10</td>
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<tr>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Disagreement / Agreement

1) strongly disagree
2) disagree
3) mildly disagree
4) undecided
5) mildly agree
6) agree
7) strongly agree

Note: Categories 1-2 contain the reply of 11 respondents or 55 per cent of the sample who disagree with the statement.
Categories 5-7 contain the reply of 9 respondents or 45 per cent of the sample who agree with the statement.
Forty-five per cent indicated that they had personally attempted to inform other mental health professionals about patients' rights. The other 55 per cent of the sample stated they had not taken it upon themselves to inform other professionals about restrictions placed upon psychiatric patients, owing to civil commitment.

Asked if they would be willing to become actively involved in an advocacy movement, only 30 per cent of the respondents replied with a definite "yes." A further 40 per cent of the respondents replied with a flat "no," that they would not join or actively participate. The remaining 30 per cent of the respondents indicated to the researcher that they were either: 1) not sure if they would join (15 per cent); 2) would join if they felt a need (5 per cent); and 3) if they had the time would join (10 per cent). Furthermore, all respondents felt that if they joined an advocacy movement, there would not be any repercussions or ill-will on the part of co-workers or supervisors towards them.

Within the interview, all the respondents appeared to possess a general attitude of concern and understanding and were interested to share their views and opinions on the issues surrounding civil commitment and patients' rights. Some of the respondents were very adamant in their replies when they identified their level of agreement or disagreement with the statement: "Social workers as
individuals, as well as members of a professional association, are not concerned about the legal and civil rights of psychiatric patients so affected by the present Mental Health Act."

As Table 29 illustrates, the respondents were 4:1 in disagreement with the above statement. Eighty per cent of the respondents disagreed in varying degrees to the statement that social workers (which would include themselves) are not interested in psychiatric patients' civil liberties. Only four respondents out of twenty rated themselves in some form of agreement with the statement. The 4:1 response rate clearly demonstrates a concern about the psychiatric patient's civil liberties affected by the province's Mental Health Act.

Although the majority of these social workers indicated that they and other members of their professional organization possessed an attitude empathic and socially concerned about patients' rights, less than half of the respondents were concerned enough to advocate on behalf of psychiatric patients. Reflecting on this point, the researcher believes that many of the respondents replied to the questions asked in the interview with socially desirable responses. That is, they provided a favourable picture of themselves\(^{285}\) and were unwilling to admit the real attitudes.

\(^{285}\) For an explanation of social desirability, see: Claire Sellittiz et al., p. 165; Stephen Isaac, William B. Michael, pp. 58-59.
Table 29
Respondents' Agreement or Disagreement to the Statement:
Social Workers are not Concerned About Psychiatric Patients' Legal and Civil Rights so Affected by the Present Mental Health Act

<table>
<thead>
<tr>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>35</td>
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<tr>
<td>6</td>
<td>30</td>
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<td>5</td>
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<td>15</td>
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<td>2</td>
<td>10</td>
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<tr>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Disagreement / Agreement

1) strongly disagree
2) disagree
3) mildly disagree
4) undecided
5) mildly agree
6) agree
7) strongly agree

Note: Categories 1-3 contain the reply of 16 respondents or 80 per cent of the sample who disagree with the statement. Categories 5-6 contain the reply of 4 respondents or 20 per cent of the sample who agree with the statement. This represents a 4:1 response rate difference.
they possessed on specific issues posed by the researcher.

At the very end of the interview, the researcher asked two questions. The first one referred to the topic of the review of the present Mental Health Act and amendments to it. Two-thirds of the respondents, 65 per cent, favoured the proposal to reduce from 30 days to 3 days the time period a person can be committed on a "Physician's Application for Involuntary Admission." 286 The other 35 per cent of the respondents did not wish to see the present 30-day commitment period changed.

As to whether a certified psychiatric patient should have to accept forced psychiatric treatment by the facility and its staff, 287 Table 30 illustrates that one-quarter of the respondents held the attitude that these patients should have to accept treatment. However, over half of the respondents, 55 per cent, stated that they held the attitude that just because a person was a certified patient, did not provide a psychiatric facility with an open treatment policy.

Summary

Nearly the entire population of the sample demonstrated

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286 Bill 19, An Act to Amend the Mental Health Act, 2nd Session, 31st Legislature, Ontario, 27 Elizabeth II (Toronto: Queen's Printer, 1978).

287 See, Ombudsman Service pamphlet statement, footnote 205.
Table 30
Should Certified Psychiatric Patients have to Accept Psychiatric Treatment

<table>
<thead>
<tr>
<th>Respondents' Replies</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reply</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
<td>Depend on Circumstance</td>
</tr>
<tr>
<td>Totals</td>
<td>5-25%</td>
<td>11-55%</td>
<td>2-10%</td>
<td>2-10%</td>
</tr>
</tbody>
</table>

N=20
an awareness of the mental health movement evolving within the province to obtain a review and update of the present Mental Health Act. There was a consensus among the respondents that civil commitment does affect psychiatric patients' legal and civil rights. This attitude has led this sample of social workers to be much more cognizant of psychiatric patients' liberties in their own client/worker therapeutic relationships. Also, the respondents voiced various degrees of concern about the question of civil commitment.

In general, the respondents held a slightly more favourable disposition toward the issue that the statutes in the Mental Health Act do not protect and safeguard the legal and civil rights of psychiatric patients. Concerning the question of whether or not social workers inform psychiatric patients that their civil liberties may be affected, depending on their psychiatric admission status, this group of social workers generally agreed that social workers do not inform patients of this problem.

The respondents were split on the decision of whether a person about to be committed to a psychiatric facility should receive "due process of law." A small majority of the respondents, however, held the attitude that social workers do believe that these persons should receive the right to a judicial hearing. On the other hand, a majority of the respondents believed that social workers
are concerned about the legal and civil rights of psychiatric patients that are affected due to provisions contained in the Mental Health Act.

Discussion of the Findings

Through the two test questionnaires, the study set out to ascertain the respondents' knowledge of and understanding of the statutes contained within the present Mental Health Act, and their knowledge and understanding of a psychiatric patient's legal and civil rights. The mean score of 7.55 on the Mental Health Act test questionnaire, out of a possible score of 15, indicates a less than adequate comprehension of the Mental Health Act on the part of the respondents in the study's sample. This finding coincides with one of the findings of the Laves and Cohen study which assessed various mental health workers' knowledge of the legal rights of mental patients as set down in the statutes of New Jersey. 288 Sixty per cent of the sample scored only 8 correct questions out of a possible 15, for 53 per cent or less correct responses. The data support this study's first research hypothesis which states: "Social workers do not possess a knowledgeable understanding of Ontario's Mental Health Act." The researcher feels that

the scores on the **Mental Health Act** questionnaire are so low that they may, in effect, reflect a basic ambiguity in the statutes themselves, rather than an absolute ignorance of the law on the part of the sample’s members.

The respondents’ mean score on the second questionnaire was 5.55 and also indicates a lack of comprehension of psychiatric patients’ legal and civil rights. The lack of understanding patients’ civil liberties is supported by the fact that 95 per cent of the respondents scored only 8 correct questions out of a possible 15, for 53 per cent or less correct responses on the questionnaire.

The Pearson Product Moment Correlation score of \( r = -0.1234 \) indicates that there is no association between the two test questionnaires to signify that if a social worker scored low on the **Mental Health Act** test questionnaire, he/she would also score low on the psychiatric patient’s legal and civil rights test questionnaire. The data obtained on the two questionnaires (mean scores of comprehension and the correlation coefficient) refutes the second research hypothesis of "Social workers who score low on the test questionnaire in their knowledge of Ontario’s **Mental Health Act** will also score low on the test questionnaire in their knowledge of psychiatric patient’s legal and civil liberties."

The study, in addition to determining social workers’ comprehension of the **Mental Health Act** and psychiatric
patients' civil liberties, further addressed the major question of social workers' attitudes toward the legal and civil rights issue of psychiatric patients.

Ninety per cent of the sample possessed prior awareness and information about a civil libertarian movement developing within the province requesting a review and revision of the province's mental health legislation by the Health Ministry. Examination of this particular issue further revealed that approximately one-half of the respondents could substantiate their claims of cognizance.

As already indicated, the researcher believes that a portion of the respondents were attempting to provide information on a subject matter that they were not fully knowledgeable of, thus introducing respondents' bias into the interview through the "halo effect" of socially desirable responses.

Eighty-five per cent of the respondents believed that civil commitment affects a psychiatric patient's civil liberties. All of the respondents openly discussed their concerns about civil commitment and made it known that they were careful not to overstep their psychiatric patient clients' legal and civil boundaries within their client/worker relationship. Nevertheless, the researcher questions the respondents' claim of not infringing on patients' civil liberties in light of the test scores received by this sample which depict a lack of knowledge and understanding
of civil liberties and the Mental Health Act.

One-half of the respondents held the opinion that neither does the present Mental Health Act protect the legal and civil rights of psychiatric patients, nor does it provide sufficient safeguards for discharge or offer adequate Review Board procedures. The response rate was split 45:55 with a slight favour toward the attitude that the present Mental Health Act does not protect and safeguard psychiatric patients' legal and civil rights. The data does support the third research hypothesis which states: "Social workers do not believe that the statutes as outlined in the Mental Health Act, Revised Statutes of Ontario, 1970, safeguard and protect the legal and civil liberties of psychiatric patients." However, this is not substantial support of the hypothesis if it is based on a 45:55 split.

For the most part, the majority of the respondents did not address the specific topic of patients' legal and civil rights in their counselling sessions with psychiatric patients. The majority of respondents did, however, indicate in the interview that they personally would handle and discuss any issue of concern presented to them by psychiatric patients regarding their civil liberties.

Furthermore, the attitudes possessed by the majority of the respondents in the study's sample was in favour of and supportive of the fourth research hypothesis which
suggests that: "Social workers do not inform psychiatric patients about their hospital status (formal commitment or voluntary admission) and how the nature of the admission may in turn affect their legal and civil liberties."

It should be pointed out that the majority of the respondents stated within the interview that they thought the responsibility of informing patients of their rights was really that of the medical staff. These social workers appeared to be suggesting that psychiatrists or psychiatric head nurses should be responsible for informing patients of their rights and privileges, not social workers. Furthermore, a number of the respondents were employed in a setting which had an Ombudsman designated to protect the rights of psychiatric patients, provide information on patients' rights and privileges, and the obligations while hospitalized. On the other hand, this issue may not have been dealt with as the test scores have already indicated that the majority of the respondents did not possess a good grasp of psychiatric patients' civil rights.

The sample was split 45:55 on their opinion of whether a psychiatric patient should receive "due process of law." Nevertheless, when queried on separate issues within the interview, 80 per cent of the respondents held the opinion that patients had a definite need for legal aid service. Also, 75 per cent of the respondents replied positively "yes" to the question of a judicial hearing for
psychiatric patients. Also, 75 per cent thought that these persons should be represented by legal counsel.

This 45:55 split in the respondents' attitudes toward the issue of "due process of law" negates the fifth research hypothesis: "Social workers do not believe that it is a right nor a necessity for a certified psychiatric patient to receive 'due process of law' or be represented by legal counsel in civil commitment proceedings." However, the respondents tend to contradict themselves in many of their responses in the interview.

The vast majority of the sample has voiced a personal opinion about civil commitment to co-workers and supervisors. However, only one-third of the respondents stated to the researcher a willingness to actively participate and advocate on behalf of psychiatric patients regarding the issue of civil liberties. The major attitude held by this sample of social workers is, social workers are concerned about the issue of psychiatric patients' legal and civil rights affected by the present Mental Health Act.

Through analysis of the interview schedule and a personal assessment of each respondent's interview session, the researcher believes that the respondents show a general attitude which is slightly favourable to the third, fourth and fifth research hypotheses of the study. The respondents, however, possess very negative feelings about the statement that social workers are not concerned about
the effect of the mental health legislation on psychiatric patients' civil rights. Though the researcher may be able to accept the fact that these respondents personally feel they are aware of and concerned about patients' rights, the findings and the respondents' replies during the interview appear to be indicating otherwise. The discrepancy would appear to be due to the "halo effect."
CHAPTER V

LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

The researcher engaged in this investigation to determine the attitudes held by a specific group of social workers on the issue of the psychiatric patient's legal and civil rights. The researcher also wished to ascertain the respondents' knowledge of and understanding of the statutes contained in the present Mental Health Act and their knowledge and understanding of the psychiatric patient's legal and civil liberties.

In order to accomplish these purposes, the researcher developed five research hypotheses, designed a three-part questionnaire, and structured an interview schedule to utilize in his personal meetings with twenty Essex County social workers.

In this chapter, the limitations of the study are examined, conclusions are drawn from the findings, recommendations are presented, and the implications for social workers are discussed, with special consideration being advanced for those social workers who work in settings that have direct client/worker counselling relationships with psychiatric patients.
Limitations of the Study

The sample of this study is composed of individuals whose educational and employment qualifications place them within the mental health worker category and are defined by the term social worker. The wide scope of the definition used by the researcher, as described in the methodology chapter, means that to locate a similar sample for replication might be a difficult task. The difficulty may arise because of differences of opinion about who is considered a social worker and the membership criteria advocated by professional social work associations.

The selection criteria used in determining what standards social workers were required to possess in order to be accepted into this study's population resulted in a small number of Windsor social workers meeting the standards. The choice of a specific population and the methods used for selecting a sample from that population can produce an unusual sample group which may bias the results.

The voluntary nature of the sample may tend to bias the findings. The "halo effect," and the "Hawthorne effect" enter into respondents' replies to produce socially desirable responses. It may be argued that those social workers who consented to answer the questionnaire as well as be interviewed, having advanced knowledge of the study,
possessed a positive attitude on their part toward the issue of psychiatric patients' legal and civil rights and their knowledge of the Mental Health Act.

Conclusions

The study set out to ascertain the knowledge and understanding of the Mental Health Act held by this sample of social workers. The sample's mean score of 7.55 out of a possible 15 on the Mental Health Act test questionnaire and their mean score of 5.55 out of 15 on the psychiatric patients' legal and civil rights test questionnaire provides credence and supports the study's first research hypothesis which claims that social workers do not comprehend the province's Mental Health Act.

The Pearson's Product Moment Correlation score of -0.1234 refutes the study's second research hypothesis which suggested that those social workers who scored low on their comprehension of the Mental Health Act test questionnaire would also score low on their comprehension of psychiatric patients' legal and civil rights. Statistical analysis indicates there is no association between the respondents' scores on the two questionnaires. Therefore, social workers who score low on one questionnaire will not necessarily score low on the other questionnaire.

Through the use of a structured interview schedule, the study determined the attitudes held by the sample's
respondents towards the issue of the legal and civil rights of psychiatric patients. For the most part, the respondents demonstrated a social conscience and were aware of and concerned about various issues associated with the legal and civil rights of psychiatric patients. In general, the respondents indicated a somewhat favourable attitude to all the facets surrounding psychiatric patients' rights and privileges, though some discrepancies entered into the interviews. These discrepancies cast a shadow of doubt over certain areas responded to by the sample. For instance, only one-half of the respondents could substantiate their claims of being aware of a civil libertarian movement in the province and what organizations were supporting it. Furthermore, many of the respondents contradicted their replies to questions regarding whether psychiatric patients should receive judicial hearings and their own rating of their personal agreement or disagreement to the issue of "due process of law."

The analysis of the interview schedule signified that this particular sample of social workers held a slightly favourable attitude toward the study's third research hypothesis. When questioned on this particular issue, the respondents' disposition suggested that they agreed that the statutes of the Mental Health Act do not safeguard and protect the legal and civil rights of psychiatric patients.
The respondents also held attitudes that supported the study's fourth research hypothesis which sought to determine if social workers inform patients that the nature of their admission may, in turn, affect their legal and civil liberties. The sample's feelings toward this issue was very much in agreement with the statement. That is, the respondents were in agreement that social workers do not inform psychiatric patients about their hospital status and this, in turn, may affect their rights.

The respondents' replies to questions based upon the fifth research hypothesis appear to refute the hypothesis. The respondents agreed to feelings of acceptance of the position that a person about to be committed to a psychiatric facility against their will should receive "due process of law." A slight majority of the respondents felt that those persons caught within the civil commitment process should, in fact, have a judicial hearing to determine whether they should be committed to a psychiatric facility or not, based on the presentation of legal and medical evidence.

There was some evidence present in the study that suggested that the respondents might have shown some respondent bias by providing socially acceptable replies to the researcher's questions. Some of the discrepancies appear to indicate that a number of respondents may have provided responses to the researcher based on opinions and beliefs they thought they should be indicating, instead of
actually providing their own personal responses.

Whether this particular sample of Essex County social workers possess a social conscience on the legal and civil rights issue of psychiatric patients has not been conclusively proven. An important result of the study, however, is that this sample of Essex County social workers postulated that they possess favourable attitudes towards the controversial issues surrounding psychiatric patients' civil liberties.

The attitudes held by this sample of social workers indicates ignorance on the part of these respondents rather than malice or goodwill. This conclusion is substantiated by the findings which reveal a lack of comprehension by a majority of the respondents regarding the Mental Health Act and psychiatric patients' legal and civil rights.

**Recommendations**

The researcher proposes the following recommendations for the profession of social work and for further study:

1. The University of Windsor, School of Social Work, should instruct their students in existing provincial legislation that will affect their role in future employment. Thus, graduating social work students entering the field of mental health would know existing mental health legislation and be better prepared to assist their clients.
2. Social agencies working in mental health should be required to practice from a standardized policy and procedural manual drawn from the province's Mental Health Act. Such a policy manual should outline the importance of agencies' employees adhering to and following the Mental Health Act in carrying out their duties, for failure to do so is a punishable offense under the Mental Health Act. Furthermore, the manual should require all employees to inform all psychiatric patients of their legal and civil rights, whether in or out of hospital.

3. Agencies in mental health fields that employ social workers who provide counselling service to psychiatric patients should be required to demand all employees to read and understand the Mental Health Act upon employment.

4. Social agencies in mental health services should provide in-service training for their employees in the Mental Health Act, so that their employees interpret the Act in the same manner.

5. Mental health agencies should be required to provide in-service training to their employees dealing with the issue of psychiatric patients' legal and civil rights. Such training programs could dispense factual information relating to specific problems of the mentally ill that affect their civil liberties whether in or out of psychiatric hospitalization. These training programs should
also investigate other provincial legislation, such as the Marriage Act, the Election Act, the Highway Traffic Act, and present statutes governing the practice of trades and professions.

6. It is imperative that social workers in mental health know and understand the legal and civil rights of psychiatric patients. Therefore, special training programs co-sponsored by the Canadian Mental Health Association and the Canadian Civil Liberties Association should be designed and offered to those professionals in contact with psychiatric patients.

7. Bill 19, An Act to Amend the Mental Health Act has been designed by the Ministry of Health to replace the present Mental Health Act sometime this year. In the same manner that mental health workers are introduced to psychiatric patients' rights through special training programs, these professionals could be informed about Bill 19. Early public discussion of the new mental health statutes could remedy the lack of inadequate knowledge of mental health legislation on the part of mental health workers.

8. Social workers in mental health facilities need to be aware of their attitudes towards mental illness and the issue of legal and civil rights of psychiatric patients. These social workers should be encouraged by their employers to investigate many of the books and journal articles that
discuss the controversy over civil commitment and psychiatric patients' legal and civil rights.

9. The Ontario Association of Professional Social Workers and the Canadian Association of Social Workers should investigate the issues of civil commitment and psychiatric patients' legal and civil rights. These associations should make reports and recommendations regarding acceptable standards of practice with psychiatric patients. Furthermore, these Associations should present their findings in a brief to the Ontario Council of Health Committee, which is investigating the revision of the province's present Mental Health Act. Through their brief, these associations could advocate on behalf of the professional community of social workers. If these organizations would become involved, their briefs could influence the revision of the Mental Health Act and thereby provide safeguards for the committed patient. Such a development may help set down clearly in law the rights and privileges that remain intact for individuals committed under civil commitment procedures.

Implication for Social Work

"The responsibility for knowledge and implementation of legal rights must fall squarely on the shoulders of those whom requests of this kind are addressed." 289 Since

some patients seek out social workers in an effort to understand their civil rights, social workers are held responsible for explaining the laws which govern the legal status of their clients. Social workers' awareness of the laws can protect the civil liberties of those committed to psychiatric facilities. When a social worker receives a request by a psychiatric patient for knowledge of and implementation of his rights, whether the request is granted or denied may depend solely on whether the social worker is adequately versed in the laws that govern those rights.

Furthermore, many of the rights that remain after psychiatric commitment may be indiscriminately revoked or ignored by mental health professionals. The machinery for the implementation of patients' rights cannot be set into motion without the support of the mental health professionals. Protection of these rights is based a great deal upon the discretion of the medical profession or others who find themselves in decision-making positions at a psychiatric facility. Subtle malice or disinclination by mental health professionals can render the guarantee of psychiatric patients' rights all but useless. If social workers believe in the democratic process of equal protection under the law, they will have to attempt to do everything in their power on behalf of psychiatric patients to guarantee their civil liberties.
Under the objectives of the Ontario Association of Professional Social Workers code of ethics and professional obligations, social workers are obligated to take action on issues relevant to the province's citizens and to inform the citizens of Ontario about such issues. Social workers should lead in bringing the attention of other mental health professionals and the lay community to the issue of civil commitment.

Social workers who possess expertise in understanding the mental health legislation and psychiatric patients' legal and civil rights would be the obvious people to involve themselves in cases of civil commitment. Since this is not exclusively a medical matter, the types of problems associated with psychiatric patients' civil liberties fall more within the realm of the social worker than that of members of the medical profession who have a vested interest in the hospitalization of people.

Social workers can act as advocates on behalf of psychiatric patients to guarantee their basic statutory rights. Social workers can inform other mental health professionals so that they are kept up-to-date in their comprehension of the present mental health legislation. This understanding would assure that patients' rights were not being ignored because of expediency or the philosophy of "the right to treat" by the medical profession. The
education of other mental health workers is a vital role that social workers can fulfill.

Social workers can also participate in the mediation between patients, family and the medical profession. There is often a conflict of interest between the rights of the psychiatric patient and the rights of his family and the side the medical profession decides to favour. The stress-producing procedures of civil commitment, whether family oriented or medically defined, produce an extremely difficult situation that may require a third impartial party to be properly watchful for abuse of the person's legal and civil rights. It would be the social worker's role to remind these other parties that the potential patient's civil liberties have precedence over their professional rights and concerns.

Recommendations for Further Research

From the data secured from the study, the following suggestions are made for further research into this area:

1. Further studies are needed regarding not only social workers, but other mental health professionals' comprehension of the province's Mental Health Act. It is imperative that such studies examine whether one's lack of knowledge of the Mental Health Act does or does not affect the professionals' work with psychiatric patients,
especially in the areas of civil commitment and psychiatric patients' legal and civil rights.

2. Further studies need to be carried out regarding other mental health professional's comprehension of psychiatric patients' legal and civil rights. Such studies should examine whether a professional lack of understanding of psychiatric patients' legal and civil rights leads to violations of patients' rights.

3. Further studies need to be carried out regarding not only social workers but other mental health professionals' attitudes towards the issue of psychiatric patients' legal and civil rights. The studies should examine whether the attitudes held by mental health professionals directly affect their work with psychiatric patients in the area of patients' rights and privileges. This and the above recommended studies should be province-wide and could be similar in design to this study or the Laves and Cohen study conducted in New Jersey. Research using much larger numbers of respondents would reveal more accurately the attitudes that mental health workers hold.

4. A comparison study will be needed after the introduction of Bill 19 to determine mental health professionals' comprehension of the health statutes as well as their understanding of psychiatric patients' legal and civil rights, as affected by the new legislation.
5. Social agencies' policies and procedures within the mental health setting need to be studied to determine what affect they have upon social workers' and other mental health workers' practice of informing psychiatric patients of their legal and civil rights.

Summary

In this chapter, the researcher presented what he believed to be the limitations of the study. He drew tentative conclusions and presented recommendations for social workers within the mental health field who deal with psychiatric patients. The researcher further discussed the implications of the results of this study for social workers and concluded with recommendations for further research in this area.

In conclusion, the researcher realizes that more reliable empirical research needs to be conducted on mental health professionals' attitudes toward the legal and civil rights issue of psychiatric patients. The greatest effect of this study has been to increase the awareness of those Essex County social workers who were tested on the Mental Health Act and their knowledge of psychiatric patients' civil liberties, and questioned on their attitudes toward the legal and civil rights issue of psychiatric patients.
Questionnaire No. 1

Please circle the correct number for each of your answers.

1. Sex: 1) Male 2) Female

2. Age: 1) Under 21 2) 21-25 3) 26-30
       4) 31-35 5) 36-40 6) 41-45
       7) 46-50 8) 51-55 9) over 55

3. Level of Education Attained:
   1) Bachelor of Arts degree
   2) Bachelor of Social Work
   3) Master of Social Work
   4) Doctor of Social Work
   5) Ph. D.
   6) Other (please specify) _____________________

4. Have you ever taken a course or courses in university dealing with the specific problems of the Mentally Ill?
   1) Yes 2) No

5. Was your Social Work field practicum in a psychiatric setting?
   At B.S.W. level 1) yes 2) no
   At M.S.W. level 3) yes 4) no

6. How long have you worked in your present employment situation of working with psychiatric patients?
   1) 1 yr. or less 2) 2-3 yrs. 3) 4-5 yrs.
   4) 6-8 yrs. 5) 9-10 yrs. 6) 11-15 yrs.
   7) 16-20 yrs. 8) 20 yrs. or more
7. Before coming to your present employment, had you worked with psychiatric patients before?
   1) yes  2) no

8. If you answered yes to question seven, how long previously had you worked with psychiatric patients?
   1) 1 yr. or less  2) 2-3 yrs.  3) 4-5 yrs.
   4) 6-8 yrs.  5) 9-10 yrs.  6) 10 or more yrs.

9. In your present employment situation of working with psychiatric patients, what is the percentage of your time spent in actual direct service (i.e., face-to-face work with clients)?
   1) 1-20  2) 21-40  3) 41-60
   4) 61-80  5) 81-100

10. Have you read the Mental Health Act, Revised Statutes of Ontario, 1970?
    1) yes  2) no

11. If you answered yes to question ten, for which of the following reasons did you read the Mental Health Act?
    1) your own interest
    2) course requirement
    3) your employer required you to read it
    4) other (please specify) ______________________

12. Have you taken a course at university that dealt with the Mental Health Act?
    1) yes  2) no
13. Has your present agency ever given any in-service training seminar(s) that dealt specifically with the Mental Health Act?
   1) yes    2) no

14. If you have answered yes to either question twelve or thirteen, what were the topic(s) of concern covered?
   1) admission procedures
   2) discharge procedures
   3) estates and public trust
   4) legal and civil rights of patients
   5) all of the above topics
   6) others (please specify) ____________________
Questionnaire No. 2

Please circle the correct number for each of your answers. Work quickly. It is important that you mark your first response to the question as your answer.

1. Name the two different hospital statutes pertaining to psychiatric patients.
   1) formal and involuntary
   2) informal and voluntary
   3) formal and informal

2. Under which means may a person enter a psychiatric facility?
   1) civil commitment
   2) criminal commitment
   3) voluntary commitment
   4) all of the above

3. May admission to a psychiatric facility be refused?
   1) yes
   2) no

4. Which key decision(s) does a physician need to answer in the affirmative to bring about civil commitment?
   1) is the person likely or is it possible that he will endanger his own life
   2) is the person likely or is it possible that he will endanger the safety of other people
   3) the person is not suitable for admission as a voluntary patient
4) all of the above

5) none of the above

5) May a general practitioner commit a person to a psychiatric facility?
   1) yes
   2) no
   3) only under certain circumstances

6) Physicians under present Canadian law are required to include a specific psychiatric diagnosis on the commitment certificate.
   1) yes
   2) no
   3) only when requested by the psychiatric facility

7) How many physicians' signatures are required on the commitment certificate for a formal admission?
   1) one
   2) two
   3) three

8) Physicians in authorizing a commitment, are required to answer how many questions regarding the patient on a Physician’s Application for Involuntary Admission form?
   1) one
   2) two
   3) three
4) four
5) five or more

9. Physicians signing an involuntary admission form have to complete the form within how many days after the examination?
   1) one
   2) seven
   3) fourteen
   4) no specific time period applies

10. No person shall be admitted to a psychiatric facility upon receipt of an involuntary form after how many days of the date on which the application was completed?
    1) seven
    2) fourteen
    3) twenty-one
    4) no specific time period applies

11. Upon admission of a patient to a psychiatric facility, a physician has to examine the patient to determine whether he is
    1) dangerous to self and others
    2) neurotic or psychotic
    3) competent to manage his estate
    4) none of the above

12. In Ontario, a person may be forcibly institutionalized and kept up to a period of how many days due to civil
commitment?

1) seven
2) fourteen
3) twenty-one
4) thirty
5) upon the discretion of the physician

13. May a physician at his own discretion keep a patient in the hospital longer than the specific legal period for informal admission?

1) yes
2) no
3) if he obtains a court order

14. The first renewal certificate authorizes an additional commitment for how many days?

1) seven
2) fourteen
3) twenty-one
4) thirty
5) sixty

15. Under the Mental Health Act, does a police constable or peace officer have the authority to detain any person fora psychiatric examination?

1) yes
2) no
3) only under court order
Questionnaire No. 3

Please circle the correct number for each of your answers. Work quickly. It is important that you mark your first response to the question as your answer.

1. Is there a provision within the Ontario Marriage Act which restricts a mentally ill person or a person who is thought to be mentally ill from marriage?
   1) yes
   2) no
   3) not applicable to the Marriage Act
   4) not sure

2. Is there a provision within the Ontario Election Act that restricts a mentally ill person from voting?
   1) yes
   2) no
   3) only if the person is institutionalized
   4) not applicable to the Election Act
   5) not sure

3. Does the Ontario Highway Traffic Act restrict a mentally ill person or a person who is thought to be mentally ill from operating a motor vehicle?
   1) yes
   2) no
   3) not applicable to the Highway Traffic Act
   4) not sure
4. Is a psychiatric patient who is in an Ontario psychiatric facility disqualified from voting in either a provincial or a federal election?
   1) disqualified only in a provincial election
   2) disqualified only in a federal election
   3) disqualified in both provincial and federal election
   4) not applicable to a provincial election
   5) not applicable to a federal election
   6) not applicable to either a provincial or federal election
   7) not sure

5. Under present Ontario statutes governing the practice of trades and professions, is a person who is mentally ill or thought to be mentally ill restricted from practicing and working within his trained professional employment (i.e., practicing law or medicine)?
   1) yes
   2) no
   3) no statutes in Ontario to this effect
   4) not sure

6. Under the Mental Health Act, does a voluntary patient have the right to leave psychiatric hospitalization any time he chooses to?
   1) yes
   2) no
   3) only when he has been signed out by his physician
7. Under the statutes of the Mental Health Act, does a formal patient have the right to refuse treatment procedures?

1) yes
2) no
3) not applicable to the Mental Health Act

8. Under the statutes of the Mental Health Act, does the officer in charge or persons acting under his authority have the right to hold a patient incommunicado?

1) yes
2) no
3) only under extreme circumstances

9. The officer in charge of a psychiatric facility or persons acting under his authority may open and examine communications written by a patient or sent to a patient under what conditions?

1) communication would be unreasonably offensive to the addressee
2) communication may prejudice best interest of the patient
3) communication may interfere with the treatment of the patient
4) communication may cause the patient unnecessary distress
5) any of the above
6) none of the above
10. When may a formal patient or any person on his behalf apply for a review under the Mental Health Act?

1) when a request for discharge of a patient has been denied
2) a new certificate of renewal comes into force
3) change from voluntary to formal status
4) at any time
5) all of the above
6) none of the above

11. When the request for discharge of a patient has been denied, does the Mental Health Act stipulate that the hospital authorities have to advise the patient of any rights he may have in making application for review to the Review Board?

1) yes
2) no
3) not applicable to the Mental Health Act

12. Are psychiatric facilities required to furnish forthwith to any person who requests them application forms and envelopes preaddressed to the chairman of the Review Board having jurisdiction in that area?

1) yes
2) no
3) not applicable to the Mental Health Act
13. If the estate of a psychiatric patient comes under Public Trustee does that void the power of attorney for that person?
   1) yes
   2) no
   3) not applicable to Ontario Law

14. Can a psychiatric patient whose estate is under Public Trustee make and enter into a will and contract(s)?
   1) yes
   2) no
   3) only under the direction of the Public Trustee
   4) not applicable

15. A patient who wishes to bring action, prosecutions or other proceeding against any person(s) or psychiatric facility for wrongful doing under the Mental Health Act has to commence litigation within how many months after the said act occurred?
   1) one month
   2) three months
   3) six months
   4) nine months
   5) twelve months
   6) no time period for litigation action
Interview Schedule Questions

1. Are you aware of there being a request to the Health Minister, Dennis Timbrell, within the last year or so, for a review of the Mental Health Act?

2. If so, are you aware of who or what organization asked for the review?

3. Are you aware of the reason(s) given by specific individuals or organizations to support their demands for a review of the Mental Health Act and new legislation?

4. Do you personally believe that the Ontario Mental Health Act needs to be reviewed and updated?

5. If so, in what areas do you feel there is a need for the Mental Health Act to be reviewed and possibly amended?

6. Do you personally accept the fact that Ontario's Mental Health Act protects the Legal and Civil rights of the province's people?

7. Do you believe that Ontario's Mental Health Act protects the Legal and Civil rights of the hospitalized psychiatric patient?

8. Do you personally believe that any medical doctor in Ontario should have the authority to commit a person to a psychiatric facility?

9. Do you accept the fact that Ontario's police have the authority to detain any person for a psychiatric
examination based solely on their own personal opinion and value judgment?

10. Do you feel that it is necessary in this day and age for the police to have this special power of authority in determining who is or is not mentally ill?

11. What percentage of the hospitalized, psychiatric patient population do you assume is made up of certified psychiatric patients?

12. Do you believe that the Mental Health Act provides sufficient safeguards for the discharge of psychiatric patients?

13. Do you believe that the Mental Health Act provides sufficient safeguards for review procedures by the Review Board?

14. Do you personally believe that it is appropriate for the Lieutenant Governor in Council of Ontario to have the authority which enables him to exempt any psychiatric facility from the application of any provisions or statutes of the Mental Health Act.

15. How would you rate yourself personally on a scale of one to seven indicating your agreement or disagreement with this statement: the statutes as outlined in the Mental Health Act do not protect and safeguard the legal and civil rights of psychiatric patients.

   1. strongly disagree
   2. disagree
3. mildly disagree
4. undecided
5. mildly agree
6. agree
7. strongly agree

16. In your personal counselling sessions with psychiatric patients do you discuss with them the legal aspect of their hospital status?

17. Do you inform psychiatric patients that you work with any privileges or restrictions that may or may not be given or placed upon them?

18. Do you inform psychiatric patients that legal assistance through legal aid is available to them?

19. Do you discuss with certified patients what their civil commitment entails and the length of time their commitment is for?

20. Do you inform certified patients what procedures are available to them in regards to seeking discharge from psychiatric hospitalization?

21. Do you personally inform all psychiatric patients you work with that they have a right to be involved in the assessment of their physical and emotional needs as well as the treatment program designed specifically for them?

22. Do you personally inform all psychiatric patients (formal and voluntary) that they have the right to
refuse psychiatric and medical treatment?

23. Do you discuss with psychiatric patients their Civil rights while in hospital as specified by the Canadian Bill of Rights and the Bill of Rights adopted by your hospital regarding patient care?

24. Do you personally inform all psychiatric patients that certain of their basic Civil rights may be affected during and after their psychiatric hospitalization, such as, the right to vote, drive a car, be excluded from practicing or holding a position in certain employment and professional occupations?

25. Do you personally address all the above questions in every patient situation or only when certain events arise and become an issue?

26. Does your department policy reinforce or hinder your work in this area of informing psychiatric patients of their Legal and Civil rights?

27. How would you rate yourself personally on a scale of one to seven indicating your agreement or disagreement with this statement: Social workers do not inform psychiatric patients how the nature of their admission to psychiatric hospitalization may or may not affect their Legal and Civil rights.

   1. strongly disagree
   2. disagree
   3. mildly disagree
4. undecided
5. mildly agree
6. agree
7. strongly agree

28. Do you feel that psychiatric patients have a need for legal aid service?

29. What status of psychiatric patient (formal or voluntary) do you personally believe could best make use of legal assistance?

30. What problems do you see for which psychiatric patients might have need or might best use legal counsel for?

31. What status of patient (formal or voluntary) do you feel might be able to advise and instruct legal counsel in an appropriate way?

32. In the case of a psychiatric patient committed or about to be committed to a psychiatric facility against his/her own will, do you feel that person should receive "due process of law"?

33. In the case of a person about to be committed to a psychiatric facility against his/her own will, do you personally feel that the person should be represented by legal counsel?

34. In the case of a person about to be committed to a psychiatric facility against his/her own will, do you personally believe that the person should or should not be represented by legal counsel in order to challenge
or otherwise attempt to avoid the possible commitment?

35. How would you rate yourself personally on a scale of one to seven indicating your agreement or disagreement with this statement: Social workers do not believe that it is a legal and civil right nor is it in fact a necessity for a person who is about to be committed to a psychiatric facility against his/her own will to receive "due process of law".

1. strongly disagree
2. disagree
3. mildly disagree
4. undecided
5. mildly agree
6. agree
7. strongly agree

36. In what situations do you personally believe that civil commitment is a necessary and justifiable procedure?

37. In your own opinion, if a person is committed to a psychiatric facility, does that mean that the person is incompetent?

38. In your opinion, how long should a person be detained under a civil commitment certificate?

39. What is your personal view in regard to the assumption that certified psychiatric patients lose certain legal and civil rights once they have been committed
to a psychiatric facility?

40. Do you believe that civil commitment affects an individual patient's legal and civil rights?

41. What is your personal opinion about civil commitment?

42. Do you have any concerns about civil commitment?

43. As a professional social worker, are you concerned about the legal and civil rights issue of psychiatric patients?

44. In your own work with psychiatric patients, are you constantly aware of not overstepping the legal and civil boundaries of your client?

45. Have you ever attempted to voice your personal opinion about civil commitment to co-workers, supervisor or the head of your department?

46. Have you ever become actively involved in an attempt to voice and make known to other Mental Health Professionals or the lay community any injustices that may afflict the committed psychiatric patient?

47. Would you be willing to join and actively participate due to your own initiative an advocacy committee for the reform of the Mental Health Act as it stands today?

48. Do you think there would be any repercussions on your part from co-worker, supervisor or department head?

49. Are there any other areas of concern that you may have with regards to the Mental Health Act?
50. How would you personally rate yourself on a scale of one to seven indicating your agreement or disagreement to this statement: Social workers as individuals as well as members of a professional association are not concerned about the legal and civil rights of psychiatric patients so affected by the present Mental Health Act.

1. strongly disagree
2. disagree
3. mildly disagree
4. undecided
5. mildly agree
6. agree
7. strongly agree

51. Do you agree with the new health proposal of reducing from 30 to 3 days the time a person can be committed for observation on the strength of one doctor?

52. Since it is not stated within the Mental Health Act itself that a certified patient has to accept psychiatric treatment, do you believe that it is legal for psychiatric facilities to force treatment and acceptance of psychiatric treatment on the certified patient?
Dear

Most citizens are only vaguely familiar with the laws surrounding mental illness. They are little aware of the specific incidents under which any individual may be committed to a psychiatric facility. Due to this, Mental Health specialists and especially social workers find themselves in a very difficult professional role. Often social workers may find it very hard to walk the fine line between the legal and civil rights of the person involved and the needs, desires and rights of the individual's family and his society. Lately there has been a growing concern from many quarters about the legal aspect of forced psychiatric hospitalization and how this may or may not affect the legal and civil rights of the hospitalized person.

As a Master's student at the University of Windsor School of Social Work, I am writing to you to seek your cooperation in conducting a study on professional social workers' attitudes towards the above issue. This study will examine whether social workers believe that the legal and civil rights issue surrounding psychiatric patients is of major concern with the Mental Health Service area.

I would greatly appreciate your assistance in this matter and within the next week will contact you by telephone to arrange an interview at your convenience.

Sincerely yours,

Lawrence Barrie
Friday, February 18, 1977

The Honourable Dennis Timbrell
Minister of Health
Hepburn Block, 10th Floor
Queen's Park
Toronto, Ontario

It is now approximately a decade since the Ontario Mental Health Act was subjected to its last major review. While the amendments which emerged from that review probably represented an improvement on the previous Act, The Canadian Civil Liberties Association has reason to believe that another major review would now be timely.

Among the matters requiring such review is the threat to personal freedom in the practice of involuntary civil commitment. Under the present Act, any person may be confined against his will in a mental hospital for as long as one month on the authority of one physician. For these purposes, it will suffice for the physician to certify his belief that the person suffers from a "mental disorder of such a nature or degree so as to require hospitalization in the interests of his own safety or the safety of others".

In recognition of the dangers to liberty which inhere in the exercise of so much power so vaguely conceived, the Act has required the physicians' certificates to set out the facts, observations, and allegations upon which the judgments
are based. This requirement was designed to reduce the risk of improper commitment. The need for documented demonstration tends to subvert the arbitrary inclination. Unfortunately, however, there is reason to doubt the effectiveness of this safeguard. In a recent Master's thesis written for the Psychology Department of York University, Burton T. Perrin analysed two hundred certificates on the basis of which persons in this Province actually suffered various periods of involuntary civil commitment between January 1972 and May 1973. After the completion of the thesis, the Canadian Civil Liberties Association examined the contents of these certificates (with names and identifying material deleted). In order to ensure maximum objectivity, we requested two senior counsel not involved in the leadership of our organization to provide us with legal opinions as to the adequacy of the documents concerned.

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

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

On the basis of all this, it seems fair to conclude that at least 70% of the certificates at issue violated the minimum safeguards of the Mental Health Act.
The certificates require the committing physician to provide the following written information.

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

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

005

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

024

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

084

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

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

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

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

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

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

As a first step, the Canadian Civil Liberties Association would appreciate an opportunity for an early personal meeting with the Minister in order that we may discuss more fully the issue of civil commitments and their accompanying safeguards. It is our intention to present a brief outlining a number of specific proposals for the reform of the Act in this area.

We look forward to hearing from you at your earliest convenience.

Sincerely,

A. Alan Borovoy

General Counsel
APPENDIX E
PUBLIC FORUM

THE PROPOSED AMENDMENTS

to

THE MENTAL HEALTH ACT OF ONTARIO

- Do you know what they are?
- How will they affect your right?

ATTEND A PANEL PRESENTATION:

THURSDAY, May 11, 1978
7:30 p.m.

WINDSOR PUBLIC LIBRARY
MAIN BRANCH AUDITORIUM
850 Ouellette

THE PANEL MEMBERS INCLUDE:

Mental Health Professionals
Legal Representative
Ministry of Health Representative
Legislative Consultant
Spokesperson for Consumers of Mental Health Services

CHAIRMAN: Judge Saul Nosanchuk

FOR FURTHER INFORMATION CONTACT
mental health/windsor-essex
254-2556
REQUEST FOR SUBMISSIONS

This Commission has been charged with the responsibility of inquiring into problems relating to the confidentiality of health records. Particulars of our terms of reference will be found in the enclosed extract from the Order-in-Council creating the Commission.

The Commission will hold hearings wherever necessary, and will accept briefs and submissions from interested persons and organizations. We are also enclosing a guide to the preparation of written briefs.

We are writing to invite you or your organization to offer to the Commission any assistance, views or opinions that you may be able to provide to us and, in particular, any information relating to the acquisition and confidentiality of health records in any form.

JACK R. COOPER
Under the terms of reference, the Royal Commission of Inquiry into the Confidentiality of Health Records in Ontario has been charged to:

1. review all legislation administered by the Minister of Health (for example, The Public Hospitals Act, The Health Disciplines Act, The Health Insurance Act and The Mental Health Act), together with any other relevant legislation administered by other Ministers, and any Regulations passed thereunder, to determine whether proper protection is given to the rights of persons who have received, or who may receive, health services, to preserve the confidentiality of information respecting them collected under that legislation;

2. review the legality of the administrative processes under the above Acts; and

3. to report thereon to the Minister of Health with any recommendations for necessary amendments to the legislation and the Regulations passed thereunder.
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VITA

Lawrence Duncan Barrie was born October 24th, 1946 in Toronto, Ontario. He received his secondary school education at Northview Heights Secondary School. After graduation he worked for seven years as a survey technician for J. D. Barnes Ltd., Toronto.

In 1971, Mr. Barrie entered into employment with Browndale International, a residential treatment centre for emotionally disturbed adolescents and trained as a therapeutic parent.

Mr. Barrie returned to school in 1972 and graduated with a Bachelor of Arts degree with a major in Psychology from York University in 1975, and received his Bachelor of Social Work degree from York University, Atkinson College in 1976.

He entered the M.S.W. program in 1976 at the University of Windsor, School of Social Work and had a field placement at Hotel Dieu Hospital in the Social Work Department. He plans to graduate in the Spring of 1980 with a M.S.W. degree.