INVOLUNTARY CIVIL COMMITMENT IN ONTARIO: THE NEED TO CURTAIL THE ABUSES OF PSYCHIATRY

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Introduction

The recent proclamation into force of Bill 19 marks the first time in over ten years that the Ontario Mental Health Act has been subjected to major review.[1] During the last decade a long-overdue appraisal of civil commitment procedures and criteria of confinement has led American commentators to call for a re-examination of the legal foundations, consequences and rights accompanying involuntary civil commitment. The primary goal of this movement has been to assure minimum natural justice requirements at commitment hearings and to require hospitals to obtain the informed consent of inmates before subjecting them to any type of psychiatric treatment.[2]

To a large extent, courts and legislatures have been responsive to these demands. It is noteworthy that recent statutory enactments, both in the United States and in Canada, indicate a trend toward restricting civil commitment to the dangerous mentally ill and toward limiting the type and increasing the severity of harm necessary to support a finding of dangerousness.[3] For in revising the criteria of commitment, recent law reform effects a partial confronta-

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[1] R.S.O., 1970, c. 269, as am. by the Mental Health Amendment Act, 1978 (Bill 19), proclaimed into force November 1st, 1978.

[2] Although the first reading version of Bill 19 had little to say about these important questions, a clause-by-clause review of the bill by the Standing Committee on Social Development and the Legislature as a whole resulted in significant improvements in both of these areas. Ss 28-30 of the Mental Health Act now provide for appeals from involuntary admission decisions to a Regional Review Board, and from there to a County Court Judge. The new section 31a prohibits psychiatric treatment without the consent of a competent patient except under the authority of an order of a Regional Review Board and outlaws psychosurgery altogether in the involuntary setting. On the other hand, the first reading requirement that the initial assessment with respect to involuntary admission be completed within 72 hours was relaxed by the Standing Committee to 120 hours.

[3] Levick and Wapner, Advances in Mental Health: A Case for the Right to Refuse Treatment (1975), 48 Temple L.Q. 354.

tion with the prior and more compelling question, which few lawyers and psychiatrists have addressed: given the present state of psychiatric knowledge and treatment, is civil commitment itself justifiable as a resolution of the competing claims of society and the individual?

It is important to realize at the outset that civil commitment represents the most significant deprivation of liberty without judicial process that is sanctioned by our society today. We have elected to leave the issue of involuntary commitment almost entirely to the discretion of psychiatrists. Criteria for incarceration have been left vague so as to provide "the widest possible latitude in programs that [are] largely experimental".[4] There has been little effort to set substantive limits on the exercise of therapeutic power because of the understandable reluctance to second-guess the expertise of the therapists in "their own field". Even where legislatures have attempted to condition the exercise of this power by insisting on specific findings of dangerousness, courts have been all too willing to accept the therapist's affidavit without testing the validity of the attestation.[5] Thus, even with the appearance of a social perspective, the ultimate standard remains nominally medical, its application dependent not on community judgment but on faith in the "professional expertise" of physicians.

All of this might be defensible as a delegation of authority by the community if the conceptual cornerstones of the psychiatric theory on which these practices are based held up under examination. In the following pages I shall argue that this assumption is unsupportable, and that involuntary psychiatry, whether under present or proposed commitment criteria in Ontario, must be rejected as an unreasonable incursion upon the autonomy of the individual.

A. *Criminal Law and the Therapeutic State.*

In seeking to maintain social order, the criminal law has functioned primarily as a system for assessing individual blame, and for meting out criminal penalties that fit the severity of the crime and the degree of guilt. The last century, however, has seen a transition from these criminal sanctions to the utilisation of a different model of social controls, described as "evil", "therapeutic" or *parens patriae* (a term derived from the English concept of the King's role as father of the country).

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[4] N. Kittrie, The Right to be Different (1971), p. 370.

[5] See, for example, the results of empirical studies based on commitments under new American statutes. *e.g.*, Hiday, Reformed Commitment Procedures: An Empirical Study in the Courtroom (1977), 11 Law & Soc. Rev. 651; Warren, Involuntary Commitment for Mental Disorder: Application of California's Lanterman-Petris-Short Act (1977), 11 Law & Soc. Rev. 629.

In the "therapeutic state"[6], little or no emphasis is placed on the individual's guilt of a particular crime; much weight is given to his physical, mental or social shortcomings. The state's role is not punishment, but change or socialization through treatment. In the realm of social defence, the goal is crime prevention rather than crime management: the power of the state to protect the peace and public welfare implies the right to restrain the violent.

Yet the *parens patriae* power was extended at an early stage beyond the goal of social defence. In line with its increasing intervention as provider for the needy, the welfare state assumed responsibility for care and treatment of the mentally ill:

> 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.[7]

The common characteristic of both paternalistic and protective commitments has been their effect of total social exclusion. Thus, a civil commitment results in a deprivation of liberty akin to that attendant upon a criminal conviction; indeed, since civil incarceration is indeterminate (the goal being successful treatment), its consequences may be more severe. Yet, in the *parens patriae* realm there is usually no consideration of whether a particular offence has been committed; therapeutic sanctions are exercised by a finding of the general social undesirability of one's condition or status. The absence of a requirement of an overt act, in addition to violating traditional concepts of criminal law,[8] raises several difficult questions. Who is to determine the acceptable balance between the state's right to protect and improve itself through preventive measures, and the individual's right to be left alone? Why should that determination be left to health professionals, as it clearly is under "psychiatric" criteria which disclaim the need for a demonstrated act, and instead fasten onto a status or condition? Absent clear legislative prescriptions, "how much of a social hazard must be demonstrated before society may step in and subject a deviant to therapy?"[9] The following dilemma emerges from the peculiar

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[6] Kittrie, *op. cit.*, footnote 4, p. 348.

[7] I.L. Shelford, A Practical Treatise on the Law Concerning Lunatics, Idiots and Persons of Unsound Mind (1833), p. 9.

[8] Specifically, the Anglo-American approach that dictates that the state may only act after an antisocial act has been committed or once "clear and present danger" has been demonstrated: *Schenck* v. *U.S.* (1919), 249 U.S. 47. See also Sharpe, Trends in Mental Health Legislation, presented at the Law and Psychiatry Symposium, Toronto, Feb. 26th, 1978: "The incarceration of an individual who has not committed a criminal act represents the most serious deprivation of liberty that we support in our democratic culture."

[9] Kittrie, *op. cit.*, footnote 4, p. 47.

juxtaposition of criminal law and the "therapeutic state": If involuntary psychiatry is "punishment", then it should only be invoked where accompanied by the substantive and procedural protections of the criminal law; and if it is "treatment", then it has no application to a non-consenting patient.[10] To deny the first of these propositions is to punish the status of "mental illness"; to deny the second is to remove the right to autonomy and self-determination of the individual.

Each of these steps involves the assertion of a compelling state interest which overrides the rights of the individual. In any society which values the liberty of its subjects, such an assertion should only be made with reluctance. I would go further, and set out three specific conditions which must be regarded as strict prerequisites to the exercise of the state power of civil commitment. It is only after these conditions are satisfied that the question of balancing the rights of the individual and the state can be meaningfully considered.[11]

The first requirement is the immediacy and severity of the social danger created by the group of persons whose status is described by the commitment criteria. The harmful conduct must not be remote in time or minimal in degree; it must be demonstrated that intervention is necessary in order to prevent the harmful behaviour and that voluntary therapy is unavailable as an effective means of abating the threat to society.

Secondly, we must evaluate the diagnostic technique that underlies the labelling of an individual as one falling within the commitment criteria. Psychiatrists play an extraordinary role in the determination of who shall be involuntarily committed; unless their judgments are both accurate and reliable, the effect of their influence must be to incarcerate many individuals for reasons which fall outside the statutory guidelines.

Thirdly, the reasonableness of state action based upon status is dependent upon the effectiveness of civil commitment to alter the status and prevent the harmful conduct. If incarceration is less than 100 percent effective in achieving these aims, there will clearly be some individuals whose lives have been interfered with for no demonstrable benefit.

In practice, of course, the importance of the first two conditions lies in the correlation between them. What interests us is not the immediacy and severity of harm caused by persons who are "immediately and severely harmful"; but rather, the immediacy and

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[10] See discussion of consent to treatment, *infra*, at footnotes 144 to 147.

[11] In the following formulation I have relied to a great extent on Kittrie's discussion, *op. cit.*, footnote 4, p. 381.

severity of harm of those who have been so labelled by the process of civil commitment, usually pursuant to a psychiatric diagnosis. Unless this correlation is very high, society is not justified in imposing commitment upon a large number of individuals in order to restrain some who will commit dangerous acts at some time in the future.

I. *Costs of Commitment: the Effectiveness of Psychiatric "Treatment".*

A. *The Concept of Mental Illness.*

1. *Can we Distinguish the Sane from the Insane?*

"At its heart, the question of whether the sane can be distinguished from the insane (and whether degrees of insanity can be distinguished from each other) is a simple matter: do the salient characteristics that lead to diagnoses reside in the patients themselves or in the environments and contexts in which observers find them?"[12]

With these words by way of introduction, a professor of psychology and law went on to describe a now-famous 1972 study in which he and seven colleagues gained secret admission to twelve different psychiatric hospitals. All of the eight pseudo-patients were normal, in the sense that they had never suffered symptoms of serious psychiatric disorders. They were admitted on the basis of complaints that they were hearing voices saying "empty", "hollow" and "thud".[13] Otherwise, no significant falsification of "person, history or circumstances" was made. Upon admission to the psychiatric wards, the pseudo-patients immediately ceased claiming to hear voices and simulated no other abnormal symptoms. With the exception of nervousness brought on by the circumstances of their commitment, their subsequent behaviour was perfectly normal.

All but one of the patients had been admitted with a diagnosis of schizophrenia, and all were discharged with a diagnosis of "schizophrenia in remission"; in other words, none was declared sane "nor, in the institution's view, had [any of them] ever been sane".[14] Only the other patients detected their sanity, and many refused to accept one pseudo-patient's explanation that he had once been sick but was fine now; they continued to believe that he was

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[12] D.L. Rosenhan, On Being Sane in Insane Places (1973), 179 Science 250, at p. 251.

[13] The significance of this complaint is that it did not correspond to any known psychiatric disease.

[14] Rosenhan, *op. cit.*, footnote 12, at p. 252.

sane throughout his hospitalization. Rosenhan concludes: "the normal are not detectably sane".[15]

2. *Diagnosis and Treatment of Mental Illness.*

"Illness" and "treatment" are terms which psychiatry has borrowed from the medical profession. Mental illnesses are regarded as similar to other diseases: the former, affecting the brain, manifest themselves by means of mental symptoms, while the latter, affecting other organ systems, manifest themselves by symptoms referable to those parts of the body. A growing number of psychiatrists argue that the application of these terms to psychiatry may be misleading, since it obscures vital differences between medical and mental ailments.[16] Even those who claim that most psychoses will be traced to physical abnormalities in the brain[17] agree that we know far less today about psychoses than about diseases like smallpox. Those who challenge the "myth of mental illness" do not, of course, deny the existence of functional disabilities and interpersonal human problems with no apparent organic origin. Their point is simply that there is no persuasive evidence that eccentric, bizarre or dysfunctional behaviour is the product of "mental disease" in the sense that organic disease is the product of a viral infection, for example.[18]

There is a general tendency in psychiatric diagnosis to locate the sources of aberration in the brain of the individual rather than in the environment and stimuli that surround him. Unexplained behaviour is blamed on the behaver rather than the environment that stimulated it.[19] Some commentators conclude that "mental illness may be more usefully considered to be a social status than a disease, since the symptoms of mental illness are vaguely defined".[20]

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[15] Similar results have been obtained in other studies. Akiskal and McKinney, for example, point out that many psychiatrists believe that a neurotic process is universal in the evolution of human culture. Thus, the diagnosis of schizophrenia has become fashionable, and we are witnessing a pseudo-epidemic of mental illness; Psychiatry and Pseudopsychiatry (1973), 28 Arch. Gen. Psychiat. 367, at p. 372. Other studies, focusing on the importance of context rather than pathology, conclude that "the initial set with which the interviewer begins the interview has considerable effect upon the outcome": Huguenard, Sager & Ferguson, Interview Time, Interview Set and Interview Outcome (1970), 31 Percept. Mot. Skills 831, at p. 834.

[16] See T. Scheff, Being Mentally Ill (1966); T. Szasz, Ideology and Insanity (1970), pp. 12-24; Albee, Emerging Concepts of Mental Illness (1969), 125 Am. J. Psychiat. 870. *Cf. Leland* v. *Oregon* (1952), 343 U.S. 790, at p. 803 (Frankfurther J., dissenting): "Sanity and insanity are concepts of incertitude. They are given varying and conflicting content at the same time and from time to time by specialists in the field."

[17] See, for example, S. Mark and R. Erwin, Violence and the Brain (1970).

[18] T. Szasz, The Myth of Mental Illness (1961), pp. 115-308.

[19] Rosenhan, *op. cit.*, footnote 12, at p. 254.

[20] Scheff, *op. cit.*, footnote 16, p. 128.

Even if we again assume the existence of mental illness that will some day be shown to be caused by brain abnormality, the fact that present-day classifications of mental illness represent descriptions of behaviour that tacitly assume an undiscovered cause has important implications.[21] First, a diagnosis of mental illness is more likely to be erroneous than one of physical illness. "If a patient expresses irrational fears, it is difficult to tell whether these anxieties represent a short-term reaction to environmental stress, which reaction will disappear within a few weeks, or the beginnings of a condition that will lead to much more bizarre behaviour in the future."[22] This fact is all the more significant because it has been shown that physicians generally operate with a strong bias toward "type 2 error"; they believe that "judging a sick person well is more to be avoided than judging a well person sick".[23] This tendency, in turn, must be given more weight in the field of psychiatry. While medical illnesses are not commonly pejorative, psychiatric diagnoses carry with them social, personal and legal stigmas.[24]

A second consequence of the lack of knowledge relating to the etiology of mental illness is that no behaviour of an individual is inconsistent with the hypothesis that the person is mentally ill. Referring to the pseudo-patient experiment described above, Rosenhan cites an example of how the factual background of one individual's personal relationship with his family members was "intentionally distorted by the staff to achieve consistency with a popular theory of the dynamics of a schizophrenic reaction".[25] The author concludes:[26]

> Once a person is designated abnormal, all of his other behaviours and characteristics are coloured by that label. Indeed, that label is so powerful that many of the pseudo-patients' normal behaviourisms were overlooked entirely or profoundly misinterpreted.

As a result, a person who has been wrongly diagnosed finds it very hard to demonstrate the error.

A third consequence is the tendency to assume that any gross deviance from moral or societal norms has an organic cause or is, in

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[21] Much of the following discussion benefits from Schwartz's treatment in In the Name of Treatment: Autonomy, Civil Commitment, and the Right to Refuse Treatment (1975), 50 Notre Dame L. Rev. 808, at pp. 810-812.

[22] Schwartz, *op. cit.*, *ibid.*, at p. 811.

[23] Scheff, *op. cit.*, footnote 16, p. 105. See also text accompanying footnotes 116-131, *infra*.

[24] Rosenhan, *op. cit.*, footnote 12, at p. 258. See also T. Szasz, The Rhetoric of Rejection, in Ideology and Insanity, *op., cit.*, footnote 16, where he labels psychiatric classifications "the language of social discrimination".

[25] *Ibid.*

[26] *Ibid.*, at p. 254.

some sense, a mental disorder. Both mental and bodily illnesses involve deviation from some clearly defined norm. But the norms of mental health are even more value-laden than those of bodily health.[27]

Examples abound of the tendency of psychiatrists to enforce professional, societal and moral norms. Within the Freudian group of psychoanalysts, breaking away from Freud's domination was interpreted as symptomatic of a "destructive psychosis".[28] The head of the psychiatric section of the Ontario Medical Association recently declared that "squandering finances", "ruining one's reputation in the community", and "thinking the Mafia is after him" are cogent reasons for the involuntary incarceration of an individual.[29] Homosexuality and other "unusual" sexual practices have been thought to be evidence of neuroses and subjected to "treatment".[30] Braginsky and Braginsky have shown that mental health professionals view patients who express radical political views as more disturbed than patients who voice the same psychiatric complaints, but whose political views are more conventional.[31]

Thus, while the standard against which mental illness is measured is a psychosocial, personal and ethical one, the remedy is sought in terms of medical measures supposedly free of ethical content. In effect, all of psychiatry has political implications:

> There is a strange and unfortunate tendency among psychiatrists to believe that professional activities designed to change the status quo are political and activities tending to strengthen the status quo are medical or neutral. This kind of thinking is illogical. By reinforcing the position of those who hold power, the psychiatrist is committing a political act whether he intends to or not. Once this fact is appreciated, the psychiatrist's search for political neutrality begins to appear illusory.[32]

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[27] Szasz, *op. cit.*, footnote 18, See also R.D. Laing, The Divided Self (1959), p. 36, where he states that "sanity or psychosis is tested by the degree of conjunction or disjunction between two persons where the one is sane by common consent". Studies have shown that psychiatrists' observations and perceptions of their patients tend to reflect their own personality structures and problems. See, for example, Raines & Rohrer, The Operational Matrix of Psychiatric Practice II: Variability in Psychiatric Impression and the Projection Hypothesis (1960), 117 Am. J. Psychiat. 133.

[28] Szasz, *op. cit.*, footnote 16, p. 64. Szasz goes on to note that when Ferenczi warned Freud of the need to flee Germany, Jones (one of the remaining group of Freudians) dismissed this as "method in his madness".

[29] Dr. Arthur Lesser, on the Toronto television show The Shulman File, Channel 79, 10 p.m., March 26th, 1978.

[30] For a statement of the orthodox Freudian position, see H. Fenichel, The Psychoanalytic Theory of Neurosis (1945), cited in Schwartz, *op. cit.*, footnote 21, at p. 812.

[31] Braginsky & Braginsky, Psychologists: High Priests of the Middle Class, Psychology Today, Dec. 1973, p. 15.

[32] S. Halleck, The Politics of Therapy (1972), p. 36.

In the above section I have provided a brief overview of the value-ridden and medically weak foundations of psychiatry. In my view, the available evidence, even at this preliminary stage in a survey of involuntary psychiatry, indicates that the proper attitude for freedom-minded individuals to take toward the institution is one of reluctance. I now turn to a particular example of the values underlying the theory and practice of psychiatry.

B. *Sex-Based Discrimination in Institutionalization.*[33]

Given the prevailing political and moral values underlying the practice of psychiatry, it should not be surprising to find indications that the accusation of "mental illness" has been applied in a discriminatory fashion against disadvantaged groups of all sorts.[34] But only in the case of women has the label of inferiority, derived from the historical and social context of psychiatry, been justified and perpetuated rather than challenged by psychiatrists. In short, subordination of women has been a hallmark of both the theory and the practice of psychiatry.

Women have traditionally been judged by psychiatrists on the basis of a different standard of normal behaviour than that used for men; this standard, as we have seen, is the key to the diagnosis and extent of mental illness. The scope of normal behaviour has been narrowed by the psychiatric belief that a woman's anatomy dictates her destiny. Freudian theory dictated that women's social and psychological needs were fulfilled by bearing and raising children.[35] Jung believed that a woman who undertook "a masculine calling, studying, and working in a man's way . . . is doing something not wholly in agreement with, if not directly injurious to her feminine nature".[36]

These ideas are still influential today in view of the pervasive influence of Freud in modern psychiatry.[37] Their ready acceptance by contemporary clinicians may also be explained by the above-

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[33] In outline, this section follows the exposition by Roth & Lerner, Sex-Based Discrimination in the Mental Institutionalization of Women (1974), 62 Cal. L. Rev. 789.

[34] On the relevance: of race, see S. Sillen & A. Thomas, Racism and Psychiatry (1970); of age, see Halleck, *op. cit.*, footnote 32, pp. 112-114; of economic class, see Weihofen, Mental Health Services for the Poor (1966), 54 Cal. L. Rev. 920; Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom (1974), 62 Cal. L. Rev. 693, at p. 725.

[35] S. Freud, Totem and Taboo, in Basic Writings of Sigmund Freud (A. Brill ed., 1938), p. 818.

[36] C. Jung, Contributions to Analytical Psychology (1928), cited in Roth & Lerner, *op. cit.*, footnote 33, at p. 793.

[37] K. Millett, Sexual Politics (1971), p. 241.

noted tendency of psychiatrists to trace behavioural aberrations to the brain of the individual rather than the environment that surrounds him.[38] Thus:

> Because the constricting social milieu in which women have existed has not adequately been taken into account, it has been common to see women's social behaviour as the manifestation of a rigidly limited potentiality, rather than as a consequence of limited social opportunity.[39]

Studies have shown that such stereotypes, although devoid of a medical or scientific basis, are held equally by male and female practitioners.[40]

Sex-based psychiatric discrimination finds practical application in all three phases of commitment, admission, treatment and release. Experience in the United States shows that it is harder for men to get into a hospital, but easier for them to get out.[41] Factors cited as causes of this discrepancy include: the numerical and hierarchical dominance of men in mental institutions; professional views that discriminate against women; the traditional lack of resistance by women to pressure from male authority figures; the inclination of psychiatrists to give greater credence to the perceptions of father, husband or policeman seeking a woman's commitment than to the facts as related by the woman; and attitudes of "protectiveness" or "sympathy" toward women that militate in favour of institutionalization.[42]

Many of these factors, of course, exert a similar influence in the area of discharge from an institution. Attributes which have been found to improve a female patient's chances of release include limited education, possession of domestic skills *only*, having a spouse or immediate family, and length of stay. Medical diagnosis and treatment had little effect on the rate of release.[43]

Since social adjustment is the goal of therapy, treatment in mental institutions is aimed at encouraging "appropriate" social roles.[44] In the case of women, such roles are dictated by the stereotypes mentioned above. Thus, women may be encouraged to

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[38] See text accompanying footnote 19, *supra*.

[39] Roth & Lerner, *op. cit.*, footnote 33, at p. 794.

[40] B. Friedan, The Feminine Mystique (1963), pp. 126-135; Szasz, *op. cit.*, footnote 18, pp. 1-8.

[41] Observation by Dr. David Abrahams, psychiatrist and Director of the Psychiatric Programme at Herrick Memorial Hospital in Berkeley, California, quoted in Roth & Lerner, *op. cit.*, footnote 33, at p. 797.

[42] Roth & Lerner, *op. cit.*, *ibid.*, at pp. 797-798.

[43] Orr, Anderson, Martin & Philpot, Factors Influencing Discharge of Female Patients from a State Mental Hospital (1955), 111 Am. J. Psychiat. 576.

[44] See text accompanying footnotes 62-96, *infra*.

make the beds in men's wards, perform housekeeping chores, or wear girdles.[45] Electroshock therapy[46] has been used to help female patients remember how to cook. While submissiveness and obedience are demanded of both male and female patients, a different standard of aggressive behaviour is used in each case: mildly aggressive behaviour is punishable in women because they depart from psychiatric expectations for "normal" women. Similarly, women are more likely than men to be punished for satisfying their sexual impulses while confined in an institution.[47] Finally, three times as many women as men have received psychosurgery.[48] It has been observed that after a lobotomy "women do the dishes better, are better housewives and comply with the sexual demands of their husbands. . . . It takes away their aggressiveness".[49] Psychosurgery has accordingly been termed "the final solution to the woman problem".[50]

The above summary of the available evidence indicates that sex-based discrimination is an integral and on-going aspect of the commitment process. Such evidence as there is thus confirms and makes more specific the preliminary conclusion reached earlier that individuals should only be subjected to the mechanism of civil commitment with the greatest reluctance. Fundamental deprivations of liberty are only exacerbated by their discriminatory application. I now return to the general exposition on civil commitment, and consider the stage of incarceration itself.

C. *The Effects of Institutionalization.*

Since the Middle Ages, Western societies have exhibited a great intolerance for deviation. "In Europe, the mad were often executed as witches, chained, or thrown into gatehouses and prisons, where they might furnish horrible diversion for the other prisoners."[51] Even today, our perceptions of "mental illness" (itself a relatively new term) have not changed much since the psychologically

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[45] Roth & Lerner, *op. cit.*, footnote 33, at p. 802.

[46] For a description of this treatment, see text accompanying footnotes 87 to 90, *infra*.

[47] Roth & Lerner, *op. cit.*, footnote 33, at p. 804.

[48] Breggin, The Return of Lobotomy and Psychosurgery (1972), 118 Cong. Rec. 5567, at p. 5571. For a description of these treatments, see text accompanying footnotes 92-100, *infra*.

[49] R.D. Laing, quoted in Stein, The Maverick Therapist Shatters "Mad" Image, San Francisco Chronicle, Dec. 7th, 1972, p. 41; cited in Roth & Lerner, *op. cit.*, footnote 33, at p. 806.

[50] Roberts, Psychosurgery: The Final Solution to the Woman Problem, Rough Times, Sept. 1972, p. 16.

[51] Kittrie, *op. cit.*, footnote 4, p. 57.

disturbed were thought of as witches and crazies. There is still the lingering view that while a broken leg is something one recovers from, mental illness endures forever.[52] This attitude, unfortunately, is just as prevalent among health professionals as among the general public, and results in institutions with several common and oppressive characteristics.

1. *Segregation.*

In the hierarchical organization of the hospital, those with the most power have least to do with the patients.[53] Staff and patients are strictly segregated; each group has its own living space and dining and bathroom facilities. There is little mingling among staff and patients; in Rosenhan's study, the average time spent by attendants outside their quarters was 11.3 per cent of working hours, and this figure included time spent on housekeeping and supervisory chores. "It was the relatively rare attendant who spent time talking with patients or playing games with them."[54] The hierarchical structure among staff members exacerbates this situation: in emulating the behaviour of their superiors, even attendants spend as little time with patients as they can. In this environment, psychotropic medication often takes the place of personal contact by convincing staff that treatment is taking place and further patient contact may be unnecessary.[55]

2. *Depersonalization and Powerlessness.*

In studies dealing with staff response to patient-initiated contact, Rosenhan began with the premise that "the amount of time a person spends with you can be an index of your significance to him". Self initiated contact by pseudo-patients with psychiatrists, nurses and attendants was compared to contact with faculty at a university campus and physicians at a university medical center. The studies showed that while groups outside the psychiatric hospital context were likely to respond by "stopping and talking", or at least "pausing and chatting", psychiatric staff inside the hospital were far more inclined to "make eye contact only" or to "move on, head averted".[56] After citing examples of patients being beaten or berated

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[52] Rosenhan, *op. cit.*, footnote 12, at p. 255.

[53] A. H. Stanton and M.S. Schwartz, The Mental Hospital: A Study of Institutional Participation in Psychiatric Illness and Treatment (1954), cited in Rosenhan, *op. cit.*, footnote 12, at p. 255.

[54] Rosenhan, *op. cit.*, *ibid.*, at p. 255. These observations are confirmed by the facts of *O'Connor* v. *Donaldson* (1975), 422 U.S. 563, in which the involuntarily incarcerated patient spent 14½ years in Florida State Hospital; during that time he spoke to psychiatrists for an average of fourteen minutes per year.

[55] *Ibid.*, at p. 258. [56] *Ibid.*, at p. 256.

for approaching an attendant and initiating verbal contact or simply saying "I like you", Rosenhan concludes:[57]

> Neither anecdotal nor "hard" data can convey the *overwhelming sense* of powerlessness which invades the individual as he is continually exposed to the depersonalization of the psychiatric hospital.

Patients in psychiatric hospitals have their credibility removed by virtue of their psychiatric label. Their freedom of movement and expression is restricted; they cannot initiate contact with staff, but may only respond. Privacy is minimal; personal possessions and quarters may be examined for whatever reason, and toilet cubicles, for example, often have no doors.

The oppressive circumstances of institutionalization have important implications for questions of civil commitment and treatment. In such an environment, it is doubtful whether an "informed and voluntary consent", as generally understood in the medical-legal context, can ever be given; I shall return to this point below.[58] For our present purposes, however, this doubt should be recorded alongside the obvious fact that any psychiatric treatment is most likely to be effective when the patient accepts it voluntarily,[59] and that:

> . . . efforts to increase the patient's awareness of a social situation are not merely an ethical necessity but are also an essential part of good psychiatric treatment. The patient's capacity to understand and then either to try to accept or to change his environment may in the long run be a greater force in promoting his psychological well-being than the sometimes temporary comfort he might obtain from symptomatic treatment.[60]

Such efforts seem incompatible with the above context of mental hospitals. Indeed, studies have shown that notwithstanding the best intentions, institutionalization *per se* may be harmful to the patient. "Most mental illness can be treated more effectively . . . when the positive relationships between the individual and his family, his job and his community are not severed."[61]

The other major point that emerges from an inquiry into the effects of institutionalization is the extreme hardship in terms of

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[57] *Ibid.*, at p. 257.

[58] See text accompanying footnote 155, *infra*.

[59] Sullivan, The Involuntarily Confined Mental Patient and Informed Consent to Psychiatric Treatment (1974), Loyola U.L.J. 578, at p. 593.

[60] Halleck, Legal and Ethical Aspects of Behaviour Control (1974), 131 Am. J. Psychiat. 381, at p. 385.

[61] Dr. S. Kieffer testifying in Hearings before the Senate Committee on Human Rights (1969-70), p. 319. See also H.I. Eysenck, The Effects of Psychotherapy (1969) and Scheff, *op. cit.*, footnote 16, cited in Arthurs *et al.*, Submissions to The Honourable Dennis Timbrell *re* Involuntary Civil Commitment, unpublished paper by the Canadian Civil Liberties Association, Toronto, March 28th, 1977.

individual liberty and human dignity that accompanies commitment to mental institutions. This factor must weigh heavily in any decision as to the appropriateness of civil commitment.

D. *Techniques of Behaviour Control.*

Most psychiatric treatments are designed to change the patient's behaviour. Behaviour control can be viewed as a special form of behavioural change; it has been defined as:

> . . . treatment imposed on or offered to the patient that to a large extent is designed to satisfy the wishes of others. Such treatment may lead to the patient's behaving in a manner which satisfies his community or his society.[62]

The techniques of behaviour control will be discussed in approximate order of "coerciveness", the least coercive treatments being considered first. Coerciveness can be gauged according to several factors, including (1) the nature, extent and duration of the primary and side effects; (2) the extent to which a non-consenting inmate can avoid the effects of the technique; and (3) the degree of physical intrusion.[63] Each of the techniques described below is employed in at least one of the mental institutions in Ontario to which individuals are involuntarily committed.[64]

1. *Milieu Therapy.*

Milieu therapy consists of the "scientific manipulation of the environment" in which the patient lives, with the aim of producing changes in his personality.[65] It includes the structuring of elements such as the physical characteristics of the treatment facility (for example, there should be no conspicuous locks and window grills which convey to patients that they are sick or dangerous), the personal relationships between staff and patients, and the facilitation of orientation by prominently displaying clocks and calendars.[66] Many writers are skeptical of its efficacy because it seems hospitals often "record the treatment given to a psychotic patient who has received little more than three meals a day and a bed as milieu therapy".[67]

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[62] Halleck, *op. cit.*, footnote 60, at p. 381.

[63] Note, Conditioning and other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients (1972), 45 So. Cal. L. Rev. 616, at p. 619. The author goes on to place psychotherapy and lobotomy on the continuum of coerciveness, the former being less coercive than the latter.

[64] Conversation with Dr. Jerry Cooper, Chief Psychiatrist, York-Finch General Hospital, Toronto, on March 7th, 1978.

[65] J. Cumming & E. Cumming, Ego and Milieu (1962), p. 2, cited in Note, *op. cit.*, footnote 63, at p. 621.

[66] Note, *op. cit.*, *ibid.*, at p. 621.

[67] Cumming & Cumming, *op. cit.*, footnote 65, p. 1.

2. *Psychotherapy*.

Psychotherapy is the process by which a patient-therapist relationship is created. It has been defined as "a means of attacking personal problems and trying to solve them largely by talking and related processes, whether they are called psychotherapy, psychoanalysis, counselling or guidance".[68] This treatment can be conducted either individually or in groups. Although there is a tendency to use group therapy to solve the problem of low staff-patient ratios, some patients find acceptance and support in a group which they could not obtain through individual psychotherapy.[69]

3. *Psycho-drama*.

Psycho-drama is a therapy technique by which personal problems of a patient are elucidated by role playing in a group setting.[70]

4. *Chemotherapy*.

The drugs most often used to treat mental disorders are major tranquilizers, minor tranquilizers and antidepressants. Major tranquilizers, such as thorazine and chlorpromazine, "have been responsible for revolutionary changes in the treatment of psychotic disorders . . . combativeness disappears, and relaxation and cooperativeness become prominent".[71] Prolonged use causes irreversible brain damage; other common negative side effects include hypertension, dizziness and muscle spasms.[72] Major tranquilizers are very intrusive, in that the patient cannot resist the massive change that overcomes his mood, temperament and thinking.[73]

Minor tranquilizers, such as valium, are useless for treating psychoses, but relieve the "excessive anxiety" of neuroses. Side effects include frequent impairment of ego function and intellectual abilities, as well as somnolence.[74]

Antidepressant drugs, most prominently tofrinal and flavil, are useful in the treatment of many types of depression. Although not

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[68] S. London & A. Rosenhan, Foundations of Abnormal Psychology (1968), p. 571, cited in McGovern, Mental Health—The Right to Refuse Drug Therapy under "Emergency Restraint" Statutes (1976), 11 New Eng. L. Rev. 509, at p. 526.

[69] A. Noyes & L. Kolb, Modern Clinical Psychiatry (6th ed., 1963), pp. 515-516, cited in Note, *op. cit.*, footnote 63, at p. 623.

[70] McGovern, *op. cit.*, footnote 68, at p. 526.

[71] Goodman & Gilman (eds), The Pharmacological Basis of Therapeutics (4th ed. 1970), p. 167, cited in Schwartz, *op. cit.*, footnote 21, at p. 812. Thorazine is the treatment of choice for psychotic patients: McGovern, *op. cit.*, footnote 68, at p. 526.

[72] McGovern, *op. cit.*, footnote 68, at p. 526.

[73] *Ibid.*, at p. 528.

[74] Schwartz, *op. cit.*, footnote 21, at p. 813.

completely understood, they are believed to alleviate depression by increasing electrical activity in the brain. These drugs often cause confusional states, disturbed concentration, disorientation, delusions, anxiety and nightmares.[75] Antidepressants are experimental in the sense that it is not known whether prolonged use causes permanent damage. When dealing with resisting patients, both antidepressant and tranquilizing medication must be administered intra-muscularly; they thereby constitute a substantial intrusion upon the body of the patient.[76]

E. *Behaviour Modification Techniques.*

Behaviour modification involves "the use of learning theory principles to teach adaptive behaviour or alter maladaptive behaviour".[77] The basic method of the three major techniques is to arrange contingencies between the patient's behaviour and the consequences of that behaviour.[78]

1. *Classical or Pavlovian Conditioning.*

Pavlov found that he could cause a discrete stimulus (a bell) to elicit the same response (salivation) as an original stimulus (food) by constantly pairing the discrete stimulus with the original stimulus. Similarly, Watson and Rayner conditioned an eleven-month-old child to fear a rat by pairing it with a loud noise which had been found to elicit fear.[79]

2. *Operant Conditioning.*

This procedure involves following a particular behaviour by positive or negative consequences. In the usual example, a rat pressing a lever in its cage is either rewarded by a food pellet or punished by an electric shock.[80]

3. *Aversion Therapy.*

Aversion therapy is an attempt to associate an undesirable behaviour pattern with unpleasant stimulation, under either the operant or the classical models.[81] This technique has been used to control

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[75] McGovern, *op. cit.*, footnote 68, at p. 526.

[76] *Ibid.*, at pp. 528-529.

[77] Whitman, Behaviour Modification: Introduction and Implications (1975), 24 DePaul L. Rev. 949, at pp. 952-953.

[78] H. Schaefer & P. Martin, Behaviour Therapy (1969), p. 5, cited in Note, *op. cit.*, footnote 63, at p. 626.

[79] Whitman, *op. cit.*, footnote 77, at p. 952.

[80] Note, *op. cit.*, footnote 63, at p. 628.

[81] *Ibid.*, at p. 629.

aggressive behaviour, sexual disorders, alcoholism, drug addiction and gambling.[82]

Perhaps the best example of aversion therapy is the procedure which led to the United States case of *Knecht* v. *Gillman*.[83] Apomorphine was administered to patients with "behaviour problems" which consisted of not getting up in the morning, giving cigarettes against orders, talking, swearing or lying. Any inmate or staff member could report these violations, and a nurse would forcibly administer the injection. The result of this treatment was a period of vomiting lasting fifteen minutes to one hour and a feeling of drowning or suffocation which some inmates likened to "death itself".

Several characteristics may be mentioned which are common to all forms of behaviour modification.[84] They are usually simple and straight forward, and can easily be taught to hospital attendants and others not formally trained in therapy; similarly, they can be used with a wide group of patients. Their success becomes most probable when the behaviour modifier has firm control over the patient's environment; hence, they have frequently been implemented in mental hospitals.

Finally, it seems clear that often, the ultimate beneficiary of such treatment is the institution; manageability rather than beneficial therapy is the goal.[85] The types of undesirable behaviour sought to be extinguished by behaviour modification techniques can be an expression of frustration with an oppressive environment rather than an autonomous, inner occurrence of the person's mind. We must consider the political and social implications of narrowing free choice when the assaultive tendencies aimed at by such "therapies" may be politically or socially motivated. By eliminating such behaviour, the psychiatrist's work takes on a wider meaning; it tends to suppress protest and preserve the stability of our social system. Psychiatric decisions, especially in this area, are not individual and socially neutral; psychiatrists "risk becoming agents of the *status quo*".[86]

4. *ECT.*

In electroconvulsive or electroshock therapy, electric currents are applied to the front part of the patient's head, thus producing

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[82] Conversation with Dr. Coulthart at the Clarke Institute of Psychiatry, Toronto, on March 28th, 1978.

[83] (1973), 488 F. 2d 1136 (6th Cir.).

[84] See generally, Whitman, *op. cit.*, footnote 77, at pp. 953-954.

[85] *Ibid.*, at p. 962.

[86] Halleck, *op. cit.*, footnote 60, at p. 385; see also T. Szasz, Psychiatric Justice (1965); Kittrie, *op. cit.*, footnote 4; S. Halleck, *op. cit.*, footnote 32.

unconsciousness and a convulsion.[87] The drug anectine is often used in conjunction with electroshock treatment to prevent the risk of fractured bones as a result of this convulsion.[88] It is clear that ECT causes at least temporary impairment of memory; some have suggested that this is the basis of its therapeutic effects. Whether the treatment causes permanent brain damage is more controversial; recent studies have shown that the harm done to memory and perception is evident "a relatively long time" after the administration of ECT.[89] ECT has beneficial effects with some forms of depression; its results are less well established in the case of other psychoses.[90]

5. *ESB.*

Electronic stimulation of the brain is an experimental technique which is used to control human aggression. A tiny electric drill is used to bore the skull so that electrical conductors may be placed in the brain. When charged, these conductors stimulate certain sensations associated with the particular part of the brain.[91]

6. *Psychosurgery.*

Psychosurgery has been defined as "brain surgery that has as its primary purpose the alteration of thoughts, social behaviour patterns, personality characteristics, emotional reactions, or similar aspects of subjective experience in human beings".[92] It represents a supposedly more refined successor to the lobotomy, which involved removal or severance of the frontal lobes of the brain, and resulted in impaired memory, diminished sexual contacts and a suppression of reflective thought; in short, the creation of "semivegetables".[93]

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[87] London & Rosenhan, *op. cit.*, footnote 68, at p. 562.

[88] In *Farber* v. *Odhan* (1953), 40 Cal. 2d 503, 254 P. 2d 520, both of the patient's legs were broken as a result of the procedure; the malpractice action was dismissed.

[89] Schwartz, *op. cit.*, footnote 21, at pp. 813-814.

[90] *Ibid.*, at p. 813. In *New York City Health & Hospitals Corp.* v. *Stein* (1972), 325 N.Y.S. 2d 461 (Sup. Ct), the court, in upholding the right of an involuntarily committed patient to refuse ECT, noted that there was great controversy as to its efficacy and its dangers. The court listed, among the ailments caused by ECT, pulmonary edema and bone fractures, and pointed out that in rare cases it has resulted in death.

[91] Note, *op. cit.*, footnote 63, at p. 632.

[92] Chorover, Psychosurgery: A Neuropsychological Perspective (1974), 54 B.U.L. Rev. 231.

[93] Schwarz, *op. cit.*, footnote 21, at p. 814. The inventor of the lobotomy, Dr. Egas Moniz of Portugal, described the operation in 1937 as "simple . . . always safe . . . and not prejudicial to either physical or psychic life of the individual". During the next twenty years, 50,000 lobotomies were performed in the United States

Psychosurgery today still involves the destruction or removal of brain tissue. The problem is that there is no conclusive evidence correlating specific brain structures with particular forms of behaviour. The psychosurgeon cuts out a part of the brain thought to cause the patient's emotional problem and in the process he irreversibly blunts a whole host of functions associated with that part of the brain.[94] Again, manageability is the goal: success is measured in terms of whether the patient becomes "quiet and manageable".

As with other psychotechnological treatments, psychosurgery cannot be viewed in a social vacuum. It has continually been used to deal with troublesome individuals, who are variously described as "aggressive", "assaultive", "acting-out", "disruptive", or "dangerous".[95] The possibility that deviant behaviour may be justifiable is generally ignored; "homosexuals have allegedly been turned straight, for example, through destruction of part of the brain called Cajal's nucleus—the supposed 'sexual switch-board'".[96]

The severe and often irreversible side effects of these forms of treatment, together with their "shocking" and "frightening"[97] social implications, must be considered in conjunction with their likelihood of effectiveness. As one author points out:

> One of the main reasons why many therapies retain an image of much greater effectiveness than they actually have is that there is a tremendous medical literature attesting to their efficacy. The scientific utility of much of that literature, however, is at best weak, and the image it propels is maintained by bulk rather than by substance. Its main shortcomings consist in (1) the failure to employ control groups and (2) the failure to employ a double-blind design.[98]

It is significant that in justifying the cost-benefit ratio of psychosurgery, one of its main proponents relies on a comparison with nonsurgical forms of treatment; in so doing, he presents a startling indictment of all forms of psychiatric treatment:

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alone. Later studies proved Moniz's claims to be erroneous: side effects were severe, and only a small proportion of the lobotomies helped the disorders for which they were performed.

[94] Schwarz, *op. cit.*, *ibid.*, at p. 816, cites the work of Chitanondh in Thailand. Incipient schizophrenics sometimes manifest their self-hatred by smelling an unpleasant odor on their bodies. Chitanondh treats this by destroying the part of the brain responsible for smelling.

[95] The writings of some psychosurgeons suggest that they assume an organic cause for any breach of society's moral codes. See examples cited in Schwartz, *op. cit.*, footnote 21, at p. 816.

[96] Note, *op. cit.*, footnote 63, at p. 633. The effect, of course, is to render the person entirely devoid of sexual sensation.

[97] U.S. Rep. Gallagher said that these terms "are too mild to describe my reaction": (1972), 118 Cong. Rec. 5567, cited in Schwartz, *op. cit.*, footnote 21, at p. 817.

[98] London & Rosenhan, *op. cit.*, footnote 68, at p. 561.

> [N]o valid statistical data indicate that any particular form of psychotherapy is more effective in treating seriously ill mental patients than any other form of treatment or even chance alone.[99]

On the basis of the above evidence, the most reasonable conclusion on the costs of institutionalized treatment seems to be that reached by Kittrie:

> Professing at times to cure what is incurable, . . . emphasizing psychological factors while ignoring environmental dynamics, and all along failing to provide adequate supportive therapeutic facilities, society has under the therapeutic mantle assumed too much power without enough knowledge or resources.[100]

II. *Validity of Commitment: the Presumption of Psychiatric Expertise.*

In recent years there has been a gradual realization that the "costs of civil commitment" discussed above represent substantial threats to individual freeedom. Many jurisdictions have amended their statutes to require more than the status of "mental illness" as a basis for certification.[101] In this respect, Ontario's Mental Health Amendment Act incorporates a typical solution. The new section 8 requires:[102]

> . . . mental disorder of a nature or quality that likely will result in
> (d) serious bodily harm to the person;
> (e) serious bodily harm to another person; or
> (f) imminent and serious physical impairment of the person.

Thus, as in Alberta's unproclaimed Mental Health Act of 1972, the criterion is essentially "mental disorder . . . presenting a danger to himself or others".[103]

The critical unstated premise behind such criteria is the expertise of medical professionals in diagnosing mental illness and predicting dangerous behaviour. The belief in such expertise was put

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[99] Mark, Psychosurgery versus Anti-Psychiatry (1974), 54 B.U.L. Rev. 217, at p. 225. He goes to point out the significant hazards of psychotherapy.

[100] Kittrie, *op. cit.*, footnote 4, p. 395.

[101] Nevertheless, several provincial statutes retain the criterion of need for "care, supervision and control for his own . . . welfare": Mental Health Acts, S.B.C., 1964, c.29, s.23; R.S.S., 1965, c.345, s.11; S.A., 1964, c.54, s.8 (S.A., 1972, c.118, not yet proclaimed); or "health and security of the patient": Mental Patients Protection Act, S.Q., 1972, c.44, s.2. The Ontario, P.E.I., Newfoundland and New Brunswick statutes include the requirement of "hospitalization in the interests of their own safety" as a criterion: R.S.O., 1970, c.269, s.8; R.S.P.E.I., 1968, c.37, s.10; S.Nfld., 1971, c.80, s.6; R.S.N.B., 1973, c.M-10, s.8. The Nova Scotia Municipal Mental Hospitals Act, R.S.N.S., 1967, c.202, s.11, requires nothing more in terms of psychiatric assessment than a statement that "the person is mentally disordered". I have benefited from the research into Canadian mental health statutes done by Ms. Elena Hoffstein for the Law and Health Program, University of Toronto, during the summer of 1977.

[102] Bill 19, *supra* footnote 1, s.2.

[103] *Supra*, footnote 101, s.25.

forward by Ontario's Deputy Minister of Health and his senior solicitors in 1963:

> We believe that psychiatry has advanced to the point where a skilled and competent psychiatrist can, without undue difficulty, assess the majority of persons suffering from psychiatric disorders and make a prognosis as to his [sic] probable conduct.[104]

Since commitment in Canada requires nothing more than the certificate of one or two medical practitioners, it is important to determine whether the underlying premise of faith in psychiatric judgment is a well-founded one.

A. *The Diagnosis of Mental Disorder.*

Psychiatric diagnoses using the accepted diagnostic categories[105] have been found to be both unreliable and invalid. Reliability refers to the frequency of agreement when two or more observers answer the same question; validity signifies the accuracy of their judgments.[106]

In a lengthy review of major studies up to 1968, Zubin observed:[107]

> The degree of overall agreement between different observers with regard to specific diagnoses is too low for individual diagnosis. The overall agreement on general categories of diagnosis, although somewhat higher (64-84%), still leaves much to be desired. The evidence for low agreement across specific diagnostic categories is all the more surprising since, for the most part, the observers in any one study were usually quite similar in orientation, training and background.

In one study since then, forty-three experienced psychiatrists diagnosed an individual after viewing a filmed interview. Seventeen psychiatrists thought he was psychotic, and twenty-six believed he was not.[108]

Disagreement is prevalent not only as to broad diagnostic categories, but also in the perception of the presence, nature and severity of symptoms. In the film study mentioned above those psychiatrists who diagnosed schizophrenia saw more severe and

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[104] Brown & Walker, Mental Hospitals Legislation in Ontario (1963), 15 U.T.L.J. 208, at p. 212.

[105] Organic psychoses, functional psychoses, neuroses, and character disorders. (Conversation with Dr. Coulthart, *supra*, footnote 82.)

[106] Ennis & Litwack, *op. cit.*, footnote 34, at p. 697. Thus "if every psychiatrist in the world agrees that Smith would commit a dangerous act if released from the hospital, that judgment would be 100 percent reliable. But if Smith were released and does not commit a dangerous act, the judgment would be invalid".

[107] *Ibid.*, at p. 703.

[108] Katz, Cole & Lowery, Studies of the Diagnostic Process (1969), 125 Am.J.Psychiat. 937, cited in Ennis & Litwack, *op. cit.*, footnote 34, at p. 704.

different symptoms than the others. In the level of specific diagnoses, psychiatrists disagree more often than not.[109]

Infrequency of agreement has important consequences. For although "psychiatric diagnosis is at present so unreliable as to merit very serious questions when classifying, treating and studying patient behaviour", treatment programmes differ significantly according to the patient's diagnosis. Thus diagnosis by one psychiatrist might result in tranquilizing medication, while diagnosis by a different clinician might mean subjection to shock therapy.[110]

Although there are few studies of the validity of psychiatric diagnoses, the available literature indicates that it is limited. In one study, thirty-four relatively complete formulations were drawn up describing the patients' history, emotions and motivations. Each patient was designated as falling within one of seven diagnoses; psychiatrists and laymen were asked to study the formulations and to predict the correct diagnoses. The psychiatrists were found to predict the correct diagnoses only slightly better than chance would dictate, and no better than the laymen.[111]

On the basis of an extensive review of the literature, Frank concluded that "save perhaps the grossest kind of psychotic behaviour", there was little correlation between diagnoses and behaviour patterns.[112] Thorne, noting "that many clinicians are unable to make better than chance judgments", reiterates that we "can no longer take for granted the validity of any clinician's judgment".[113]

These findings, together with the results of the Rosenhan study discussed earlier,[114] add additional urgency to the words of Lord Atkin in 1920:[115]

> Grievous as is the wrong of the unjust imprisonment of an alleged criminal, I apprehend that its colours fade into utter insignificance before the catastrophe of unjust imprisonment of an unfounded finding of insanity . . . it is the effect

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[109] Ennis & Litwack, *op. cit.*, *ibid.*, at pp. 703-704.

[110] Pasamanick, Dinitz & Lefton, Psychiatric Orientation and its Relation to Diagnosis and Treatment in a Mental Hospital (1959), 116 Am. J. Psychiat. 127, cited in Ennis & Litwack, *op. cit.*, *ibid.*, at p. 707.

[111] Goldsmith & Mandell, The Dynamic Formulation: A Critique of a Psychiatric Ritual (1969), 125 Am. J. Psychiat. 1738, cited in Ennis & Litwack, *op. cit.*, *ibid.*, at p. 710.

[112] Frank, Psychiatric Diagnosis: A Review of Research (1969), 81 J. Gen. Psychol. 157, at p. 164, cited in Ennis & Litwack, *op. cit.*, *ibid.*, at p. 711.

[113] Thorne, Clinical Judgment, in Clinical Assessment in Counseling and Psychotherapy (1972), pp. 30-31, cited in Ennis & Litwack, *op. cit.*, *ibid.*, at p. 711.

[114] See text accompanying notes 12 to 15, *supra*.

[115] *Everett* v. *Griffith*, [1920] 3 K.B. 163, at p. 211 (C.A.).

> on the mind sane, even if feeble, that knows itself wrongly adjudged unsound, that produces the most poignant suffering.

B. *The Prediction of Dangerousness.*

Difficulties with the prediction of dangerousness begin with the lack of a uniform definition of the term. Given the wording of the criteria in Bill 19, the problem should not arise of whether the reference is to violent crimes, assaultive behaviour, property offences or other minor crimes; this vagueness was evident in the previous statutory criterion of "safety",[116] and was amply exploited by psychiatrists to commit individuals in the interests of family stability and economic well-being.[117] Problems, however, remain with respect to standards of magnitude, seriousness, imminence, likelihood and frequency. The insertion of a requirement of imminence in clause (f) only is anomalous; as the Canadian Civil Liberties Association has urged, there should be such a test throughout.[118]

The next hurdle is deciding how a clinical judgment of dangerousness should be made; what symptoms are predictive of dangerousness? Several writers have reported the association of certain groups of "premonitory signs and symptoms" with the later existence of aggressive behaviour.[119] Yet all of these results have certain common characteristics:

> . . . some are simply tautological statements that the individual is dangerous, and others are characteristics so widespread that they lose all predictive value in discriminating between the dangerous and the harmless.[120]

Recent research has shown that the factor exhibiting the greatest correlation with a psychiatric prediction of dangerousness is the offence, if any, with which the individual is charged. Rubin's report on the so-called Menard patients describes how seventeen men were labelled as dangerous as a result of an original accusation of a violent crime, rather than on the basis of any realistic appraisal or clinically competent examination.[121] This finding is disturbing, since first, it

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[116] Mental Health Act, *supra*, footnote 1, ss 5, 8(1)(a).

[117] Statement by Dr. Morton Shulman, on The Shulman File, *op. cit.*, footnote 29. Similar remarks were expressed by Dr. Arthur Lesser on the same show, and by Dr. Coulthart in conversation, March 28th, 1978, *op. cit.*, footnote 82.

[118] Letter from Canadian Civil Liberties Association to the Ministry of Health, Feb. 20th, 1978, p. 2.

[119] These studies are reviewed in Diamond, The Psychiatric Prediction of Dangerousness (1975), 123 Penn. L. Rev. 439, at pp. 440-443. For example, Hellman and Blackman described a triad of symptoms in Enuresis, Fire-setting and Cruelty to Animals: A Triad Predictive of Adult Crime (1966), 122 Am. J. Psychiat. 1431.

[120] *Ibid.*, at p. 443.

[121] Rubin, Prediction of Dangerousness in Mentally Ill Criminals (1972), 27

renders nugatory the presumption of innocence, and secondly, it implies that psychiatric expertise is unnecessary to make such predictions.

Statistical evidence on the expertise of psychiatrists in predicting dangerousness points clearly to two conclusions: (1) they are inaccurate, both in an absolute sense and when compared to other health professionals and actuarial devices such as experience tables; and (2) they are particularly prone to type two error: overprediction.[122]

Perhaps the most striking illustration of the problem of false positives is provided by a study of the so-called *Baxstrom* patients. In *Baxstrom* v. *Herold*,[123] the Supreme Court of the United States ruled that those persons remaining in hospitals for mentally ill prisoners after their prison terms had expired must be released, and committed civilly, if at all. Baxstrom and 968 other prisoners, who were considered to be among the most dangerous persons in the state, were transferred to civil hospitals and were expected to display their dangerousness both there and in the community, upon release. Four and one-half years after the transfer, one-third of the patients were free in the community; of the entire group, only twenty-six committed acts serious enough to warrant their return to a hospital for the criminally insane.[124] As Ennis has said:[125]

> In statistical terms, Operation Baxstrom tells us that psychiatric predictions are incredibly inaccurate. In human terms it tells us that but for a Supreme Court decision, nearly 1000 human beings would have lived much of their lives behind bars . . . all because a few psychiatrists, in their considered opinion, thought they were dangerous, and no one asked for proof.

Diamond concludes that psychiatrists tend to overpredict dangerousness by "somewhere between ten and a hundred times the actual incidence of dangerous behaviour".[126]

Arch. Gen. Psychiat. 397, at p. 401, cited in Diamond, *op. cit.*, footnote 119, at p. 445. This observation is confirmed by Dr. Coulthart of the Clarke Institute of Psychiatry, Toronto, and by Cocozza & Steadman, The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence (1976), 29 Rutgers L. Rev. 1084, at p. 1096.

[122] Dershowitz, The Psychiatrist's Power in Civil Commitment: A Knife that Cuts Both Ways, Psychology Today, Feb. 1969, p. 47, cited in Ennis & Litwack, *op. cit.*, footnote 34, at p. 712.

[123] (1966), 383 U.S. 707.

[124] See Diamond, *op. cit.*, footnote 119, at pp. 745-747; Cocozza & Steadman, *op. cit.*, footnote 121, at p. 1090; Ennis & Litwack, *op. cit.*, footnote 34, at pp. 712-713.

[125] Ennis, The Rights of Mental Patients, in The Rights of Americans (Dorsen ed., 1970), p. 487.

[126] Diamond, *op. cit.*, footnote 119, at p. 747.

Subsequent studies have confirmed the lesson of the *Baxstrom* patients.[127] In a recent project, the authors of the *Baxstrom* findings, monitored the application of the New York Criminal Procedure Law of 1971 under which accused persons found unfit to stand trial were channelled into civil or criminal hospitals according to the criterion of dangerousness. The two groups were in the same facility during their initial detention and experienced very similar lengths of hospitalization prior to their release into the community or return to court. Their results showed that those predicted to be dangerous were not more dangerous than those evaluated as not dangerous. The author concludes: "There is *no* empirical evidence to support the position that psychiatrists have any special expertise in accurately predicting dangerousness."[128]

This should not be surprising, since psychiatrists are not even trained in the assessment or prediction of dangerousness. Medical schools do not offer courses on this topic, and there are no textbooks explaining the methods of making such assessments.[129] As noted above,[130] no traits or symptoms have been identified which are useful predictors of dangerous behaviour. In particular, the condition of "mental illness" *per se* is a poor predictor. Data on the arrest rates of mental patients indicate that there is no foundation for the assumption that the mentally ill are more dangerous than the general population. Studies tend to negate the existence of a relationship between mental illness and violence, although they show a higher rate of convictions for certain offences among those found to be mentally ill.[131]

Conclusion: Balancing the Interests of Individual and State.

The tendency of psychiatrists to overpredict violence by a factor of at least ten[132] seriously calls into question a statutory standard of civil commitment based solely on such a criterion. There is no doubt that psychiatric judgments are far less reliable and valid than polygraph

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[127] See generally, Diamond, *op. cit.*, *ibid.*, at pp. 444-447; Cocozza & Steadman, *op. cit.*, footnote 121, at pp. 1091-1098; Ennis & Litwack, *op. cit.*, footnote 34, at pp. 711-716.

[128] Cocozza & Steadman, *op. cit.*, *ibid.*, at p. 1099.

[129] Rappeport, for instance, conducted an exhaustive survey of the literature and found "no articles that could assist (psychiatrists) to any great extent in determining who might be dangerous". Rappeport, Lassen & Hay, A Review of the Literature on the Dangerousness of the Mentally Ill, in The Clinical Evaluation of The Dangerousness of the Mentally Ill (J. Rappeport ed., 1967), pp. 72, 79.

[130] See text accompanying footnotes 120-121, *supra*.

[131] Cocozza & Steadman, *op. cit.*, footnote 121, at pp. 1087-1088.

[132] See text accompanying footnotes 116-131, *supra*.

tests.[133] Yet even with the safeguards of the criminal justice system with trial by jury, few courts have received polygraph reports in evidence, and then usually for limited purposes. The Supreme Court of Canada, in *R.* v. *Philion*,[134] ruled that polygraphy is not yet sufficiently exact to be considered a science, and consequently a polygraph expert was not qualified to give opinion evidence.

It is therefore anomalous that psychiatric judgments are accorded great weight in criminal trials; but it is more than anomalous that they should be used untested to confine an individual against his will in a civil commitment case. And this situation is rendered no less startling by bolstering the criterion of dangerousness by a requirement of mental illness. Psychiatric diagnosis is scarcely more accurate than predictions of dangerousness;[135] in addition, those diagnosed as mentally ill are no more dangerous than the general population.[136] Thus, the standard of dangerousness, in its application to the "mentally ill", is a wholly arbitrary one; the number of potentially dangerous individuals "caught" by the present and proposed Ontario criteria is directly proportional to the number certified, but is the same as if doctors (or laymen) randomly certified one in every ten or so members of the population, "sane" or not. In other words, present results could be achieved using a net and a crowded city street. Even if impervious to attack as "arbitrary detention" under the Canadian Bill of Rights,[137] such a provincially-enacted standard cannot be sound legislative policy.

Thus far in my conclusion I have spoken only of the detentive aspects of civil commitment. But psychiatrists as a group are impatient with the claims of civil libertarians; their function is to treat, and one of the premises of the therapeutic state is that individuals need no protection against the benevolent and paternalistic influence of *parens patriae* treatment. According to this rationale, no one should complain if more individuals receive therapeutic attention than is absolutely necessary.

It is to counter such assertions of benevolent treatment that I spent some time reviewing the uncertain foundations of the art of psychiatry and the substantial costs of civil commitment. Like the Canadian Civil Liberties Association, I would "impute nothing but benevolent motives to the greatest number of physicians";[138]

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[133] Evidence indicates that an experienced polygraph examiner can detect truth or deception about 80 to 90 percent of the time: Ennis & Litwack, *op. cit.*, footnote 34, at p. 736.

[134] (1973), 10 C.C.C. (2d) 562, 21 C.R.N.S. 169.

[135] See text accompanying footnotes 105-115, *supra*.

[136] See text accompanying footnotes 130-131, *supra*.

[137] S.C., 1960, c.44, s. 2(a). The Bill applies only to federal enactments.

[138] Letter to the Minister of Health, *supra*, footnote 118, p. 2.

nevertheless, the facts show that there is little basis for a delineation of the mentally ill from the mentally healthy;[139] the determination that is made is replete with social and moral assumptions that have no place in a therapeutic treatment programme;[140] institutionalization involves substantial stigma and dehumanization[141] and is permeated by sex-based discrimination in its theory and application;[142] and the specific forms of treatment offered are highly intrusive, largely experimental, and often ineffective.[143]

Mention of the forms of treatment conducted in mental institutions raises another point used in justification of present-day commitment procedures. Proponents of the present system will argue that treatment is given only with the informed and voluntary consent of the patient, and so assertions of the intrusive, experimental or ineffective nature of the therapies are *nihil ad rem*.

First, this argument is not supported by the facts. Physicians in Ontario have claimed the right to impose treatment on confined patients in varying degrees: some have asserted the right to treat in order to prevent the injuries for which certification was executed;[144] others have held that it was implied by the fact of certification itself.[145] This situation has been alleviated to some extent by the amendments, which afford the competent patient a right to refuse treatment unless the Regional Review Board decides otherwise.[146] But this is clearly not the case throughout Canada; in fact, a recent Nova Scotia statute removes the requirement of informed consent in certain circumstances.[147]

Secondly, if there is indeed a right to refuse treatment, then presumably many, if not all, individuals who are committed involuntarily are being admitted solely for the purpose of segregating them from the rest of society. In effect, they are being incarcerated for their status as "certifiable", just as others are incarcerated for their status as "criminals". As noted above,[148] the need for

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[139] See text accompanying footnotes 12-15, *supra*.

[140] See text accompanying footnotes 16-32, *supra*.

[141] See text accompanying footnotes 51-61, *supra*.

[142] See text accompanying footnotes 33-50, *supra*.

[143] See text accompanying footnotes 62-99, *supra*.

[144] For example, Dr. Arthur Lesser, *supra*, footnote 29. Strangely enough, he is supported, although somewhat ambivalently, by the Canadian Civil Liberties Association; see its letter to the Minister of Health, *supra*, footnote 118, p. 4.

[145] For example, Dr. Jerry Cooper, *supra*, footnote 64; and see Brown & Walker, *op. cit.*, footnote 104, at p. 211.

[146] Mental Health Amendment Act, *supra*, footnote 1, adding s. 31a.

[147] Public Hospitals Act, R.S.N.S., 1967, c.249, as am. by S.N.S., 1973, c.45, s.46.

[148] See text accompanying footnotes 7-11, *supra*.

safeguards to protect the rights of an accused person has long been recognized in Anglo-Canadian law. The requirement of natural justice stems from the proposition that it is better that several guilty men go free than that one innocent man be convicted. The analogy to the indeterminate commitment of individuals is inescapable:

> Should we not be willing to accept these limitations to preserve human variation and pluralism in the same way that we have been willing to accept limitations on the exercise of the police powers in order to preserve liberty at the expense of more crime, delinquency, and offensive behaviour?[149]

So we move from detention of the individual, to the interests of physicians in treating illness, and back to detention of the individual. In truth, the question of civil commitment is one for society in general rather than for any one professional group, such as physicians or lawyers. Psychiatrists never tire of repeating this statement; yet in doing so they intend something completely different from what I mean by it. Psychiatrists contend that the legislature should set the relevant standards of commitment, and then leave them alone to interpret and apply them. But to do this would be to leave great power in the hands of a professional group "whose members feel a greater sense of responsibility to their peers than to the public as a whole".[150] Psychiatrists are the natural adversaries of persons faced with involuntary commitment. As such, they cannot be allowed to pass judgment on whether such persons should be incarcerated. Natural justice requires that an impartial arbiter be interposed between the players before one of them is banished indefinitely.

This conclusion can be arrived at simply on the basis of abstract notions of natural justice. But when the conditions of banishment are weighed—the costs of commitment as I designated them above—the balance shifts heavily in the direction of Szasz's solution:[151] abolish

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[149] Kittrie, *op. cit.*, footnote 4, p. 394.

[150] Neville, Pots and Black Kettles: A Philosopher's Perspective on Psychosurgery (1974), 54 B.U.L. Rev. 340, 351. In this regard, the united opposition of the Ontario psychiatric establishment to the relatively limited changes effected by the 1978 amendments is noteworthy in two respects. First, the Ontario Medical Association's section of psychiatry was alone amongst provincial psychiatric bodies in its disapproval of the Ontario amendment bill: see Moser, Ontario's bid to change mental health act backed, Ottawa Journal, March 13th, 1978. This phenomenon seems to suggest that the widespread discontent among Ontario psychiatrists had its origins in concerns outside the medical context. A second characteristic of this opposition front has recently emerged as a result of a survey conducted in late 1978 by the Citizens' Commission on Human Rights. Responses to a questionnaire by doctors in London, Kingston, Windsor, Hamilton, Kitchener, Toronto, Barrie, and Ottawa showed that 37 per cent were unaware of the contents of Bill 19, and only 22 per cent had in fact read the bill. (Overall, only 24 per cent of the respondents declared themselves in favour of the amendments.)

[151] Szasz, *op. cit.*, footnote 18.

civil commitment altogether. And the imbalance reaches grave proportions when the ability of psychiatrists to deal with criteria of commitment is added into the equation. Why permit psychiatrists to incarcerate individuals on the basis of a ten percent chance of actually fitting within the commitment criteria, when criminal defendants are acquitted every day on the failure to prove guilt beyond a reasonable doubt?

One need not go far as Szasz's assertion that there is no such thing as mental illness, to arrive at the conclusion that civil commitment must be abolished. A similar position may be reached by considering the interests of the state in protecting individuals from themselves and others and the interests of the individual in self-determination.[152] In the United States, discussion regarding the right to refuse treatment has centred on the Bill of Rights.[153] The first amendment guarantee of freedom of speech has been used to establish a fundamental right of "mentation", which refers to the full range of one's mental processes, including thoughts, sensations and feelings. In conjunction with the right to privacy, the right of mentation has been used to ensure freedom from thought control, which is inherent in many behaviour control techniques.[154] Other relevant provisions have been the fourth amendment protection against "unreasonable searches and seizures" in the eighth amendment prohibition of cruel and unusual punishment.

Considered as a package, these amendments have been held to mandate protection of self-determination and bodily integrity; in sum, great value is placed on the freedom of the individual to choose his own values and goals and to shape his life in conformity with them. This freedom is not absolute; however, the more intrusive the state encroachment, the more compelling must be the state interest to justify it. On this analysis, and after examining the likelihood of informed and voluntary consent in an institutional setting and the effectiveness of psychiatric prediction and treatment, one commentator arrived at the conclusion that competent mental patients have the absolute right to refuse treatment.[155]

I would reach a similar result on the question of civil commitment; namely, that it must be abolished in the case of competent persons. Immunity from forcible treatment renders confinement nothing more than imprisonment; imprisonment is the

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[152] See Schwartz, *op. cit.*, footnote 21.

[153] See generally, Schwartz, *op. cit.*, footnote 21; McGovern, *op. cit.*, footnote 68; Levick & Wapner, *op. cit.*, footnote 3.

[154] See text accompanying footnotes 33-50, *supra*.

[155] Schwartz, *op. cit.*, footnote 21, at p. 841.

function of criminal law, and must be based on an overt act and attended by appropriate judicial safeguards.

This result is, in my view, independently mandated by the evidence presented above on the costs of civil commitment and the inability of psychiatrists to predict dangerousness. Those who support commitment in its present form argue that the interests of society in protecting its members must override the claims of the competent individual who prefers to remain at large and refuses treatment. They express concern for the liability of the psychiatrist for failing to restrain individuals who turn out to be dangerous, and cite the recent *Tarasoff* case[156] as an example of such an imposition of liability. But in fact, the California Supreme Court in that case found the therapist liable for failure to warn Ms. Tarasoff that his patient Poddar had threatened to kill her. The court expressly disavowed any finding as to whether the patient should have been incarcerated, and acknowledged the tendency of psychiatrists to overpredict violence. It held, however, that:[157]

> The risk that unnecessary warnings may be given is a reasonable price to pay for the lives of possible victims that may be saved.

It is my primary contention that the risk that unnecessary certification may be made is *not* a reasonable price to pay for the danger to society that may be obviated by present certification proceedings. Psychiatric standards are simply too capricious, and the results of confinement liable to be too devastating, to permit such an encroachment on the right of self-determination of a person who has committed no criminal act and is able to comprehend the choice of voluntary admission and treatment.

This leaves persons who are incompetent to make this choice. To be sure, this class of individuals is a small one; neither a diagnosis of mental illness nor a prediction of dangerousness implies incompetence, and a person may be incompetent for some purposes while perfectly capable for others.[158] In line with my earlier comparison of civil and criminal incarceration, I would recommend that civil commitment of mentally incompetent persons proceed under the following safeguards:

(a) a judicial hearing, beginning with a determination as to competence;

(b) court-appointed or other counsel to argue against commitment;

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[156] *Tarasoff* v. *Regents of Univ. of Calif.* (1976), 551 P. 2d 334.

[157] *Ibid.*, at p. 346.

[158] Damich, The Right against Treatment: Behaviour Modification and the Involuntarily Committed (1974), 23 Cath. U.L.Rev. 774, at p. 784; *Winters* v. *Miller* (1971), 446 F. 2d 65 (2nd Cir.).

(c) the requirement of proof beyond a reasonable doubt;[159] and

(d) a judicial mandate not to accept conclusory judgments by psychiatrists without factual substantiation.

All of these requirements are natural outgrowths of the care we must take in depriving individuals of their liberty on the basis of psychiatric advice. The fourth condition is a necessary corollary of studies which have shown that conversion from nonjudicial to judicial commitment has not lessened reliance on conclusory psychiatric pronouncements of dangerousness.[160] Indeed, the American Psychiatric Association has endorsed this rule:[161]

> It has been noted that "dangerousness" is neither a psychiatric nor a medical diagnosis, but involves issues of legal judgment and definition, as well as issues of social policy. Psychiatric expertise in the prediction of "dangerousness" is not established and clinicians should avoid "conclusory" judgments in this regard.

As Schwartz has noted: "The law governing civil commitment and treatment is grounded neither on logic nor on experience. It is based upon *a priori* assumptions and post hoc rationalizations which accord neither with the medical realities of mental illness nor with the way in which commitment and treatment operate in practice." It is hoped that adoption of rules such as the ones adumbrated above will serve these goals and at the same time fashion an acceptable reconciliation of the interests of individual and state in the area of civil commitment.

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[159] This requirement was imposed on the procedures governing commitment of mentally disordered sex offenders in California, in *People* v. *Burnick* (1975), 14 Cal. 3d 306, 121 Cal. Rptr. 488, 535 P. 2d 352. In approving this decision the *Tarasoff* court noted that it was predicated on the "uncertain character of therapeutic prediction". See *supra*, footnote 156, at p. 346.

[160] Warren, *op. cit.*, footnote 5; Hiday, *op. cit.*, footnote 5.

[161] A.P.A. Clinical Aspects of the Violent Individual (1974), p. 33.