McGill Centre for Human Rights and Legal Pluralism | Centre sur les droits de la personne et le pluralisme juridique de McGill

DISABILITY & THE LAW SEMINAR SERIES 2015-2016

Involuntary Confinement and Treatment: Seclusion and Restraint

Monday, 25 January 2016

Moderator: Professor Derek Jones (Member CHRLP, Lecturer in Psychiatry and Law, McGill University)

Panelists:

- *James Sayce is a lawyer at Koskie Minsky LLP in Toronto. The primary focus of his practice is plaintiff-side class action litigation*
- *Ella Amir has been Executive Director of AMI-Québec since 1990. Under her leadership the organization has become one of the principal resources in Québec for families struggling to cope with mental illness.*
- *Marie-Hélène Goulet est infirmière clinicienne et candidate au doctorat en sciences infirmières de l'Université de Montréal. Elle est boursière du RRISIQ et des IRSC.*

Resource Persons: Iñaki Navarrete (Seminar Series Coordinator), Alizeh Ladak (Seminar Series Coordinator), Bwighane Mwenifumbo (Rapporteur)

Organized by: McGill Centre for Human Rights and Legal Pluralism (CHRLP), in conjunction with the Human Rights Working Group - Disability and the Law Portfolio

Summary of Seminar

Professor Jones began by painting the context of the seminar. Since the heyday of the asylum era from the late 19th -mid 20th century, societies have based involuntary commitment to psychiatric institutions on such grounds as lunacy, socio-economic status, dangerousness, health needs, well-being. The modern human rights revolution that has unfolded since WWII has helped to challenge, narrow, eliminate and refine the process and standards for admission, conditions of stay, and departure. Beginning notably in the 1970s, that revolution helped fuel the deinstitutionalization movement, helped reform laws, helped empower some patients with rights, freedoms and non-custodial community options, notably in the US, Europe and Canada. The 2007 *UN Convention on the Rights of Persons with Disabilities* (CRPD) shall contribute to this (r)evolution, by its standards on human dignity, non-discrimination, liberty and treatment. Societies confront sundry post-deinstitutionalization issues implicating profound legal conflicts. Moreover, many domestic statutes still provide for involuntary confinement and/or treatment of persons with a mental condition, typically based on a finding of a serious danger to self or others. Professor Jones introduced this interdisciplinary panel on "Involuntary Confinement and Treatment." He invited the panelists to explore how such issues as equality, health and safety, personal autonomy, and dignity of the person may be better reconciled.

James Sayce spoke on his experiences as counsel in class actions involving incarcerated people with mental illness, focusing particularly on a class action on which he is acting, *Brazeau v Canada*. He explained that the *Corrections and Conditional Release Act S.C. 1992 c.20* requires prisons to provide reasonable access to essential healthcare within professionally accepted standards, including mental healthcare. It is, widely known that this standard is not met by correctional facilities in a variety of ways. Sayce mentioned three in particular: the over-reliance on administrative segregation, which can cause

mental illness and exacerbate pre-existing mental illness; a failure to treat mental illness, whether through therapy or pharmaceutically; and a denial of access to specific pharmaceuticals. Sayce provided a typical account of a patient arriving at a facility after sentencing, having no access to prescribed medication, having to wait a prolonged period before seeing a doctor, who then might be limited in what s/he prescribes by the rules of the particular facility. Prisoners are also regularly transferred within the correctional system, which then leads to a repeat of the challenges. As the language of the Act gives correctional facilities a lot of discretion over the administration of mental healthcare, there is incoherence throughout the system and administrators frequently make arbitrary medical decisions. Access to medication can be restricted and drugs can be withdrawn from a patient as a form of punishment. Sayce characterizes these failures as systemic negligence and breach of fiduciary duty by Canada. Sayce stressed the need to encourage class actions in such cases in order to pressure the government to enforce the standards set by the CRPD.

Ella Amir's presentation was on the community's experience with involuntary confinement and treatment, with special emphasis on the tension between notions of freedom and protection. Opinions on involuntary confinement are usually based on civil liberty arguments or based on getting the patient back to health. Not many opinions try to identify a balance that could reconcile these seemingly opposing points of view. Efforts have been made to involuntarily commit persons with mental illness in order to treat them and afterwards return them to their communities. However, it has been observed that this has not been successful and instead, has resulted in an increase in homelessness and repeated hospitalization. Danger to self or others has become the standard for involuntary commitment. Families are increasingly seeking court orders to involuntarily commit family members with mental illness, however, this often backfires as it strains relationships between the patient and their family. This in turn increases the chances of the patient reverting to their poor mental condition after discharge back into the community. Therefore, when families approach her and her organization for advice, involuntary commitment through court orders is not usually recommended, and then only as a last resort. Rather, families are encouraged to attempt different communication techniques with the patient to persuade them to get treatment. Focus is thus moved from the illness to the patient, a technique that has reported much success. Amir emphasized that there is a need to reduce the reliance on involuntary commitment and consider other available options; not all mental illness necessitates involuntary commitment.

Marie-Hélène Goulet amorça la discussion en précisant qu'elle présentait un point de vue psychiatrique au Québec. En se basant sur ses travaux de recherche, elle veut examiner les stratégies qui peuvent être mises en œuvre pour réduire l'utilisation des mesures de contrôle. Aux fins de la discussion, elle commença par rappeler les trois principales définitions utilisées en milieu psychiatrique (qui proviennent des *Orientations ministérielles* de 2002 qui découlent de la *Loi sur les services de santé et les services sociaux*). La **contention** implique l'utilisation d'une force humaine ou un moyen mécanique dans le but de restreindre la liberté de mouvement d'une personne. La **contention chimique**, quant à elle, limite cette liberté par l'administration d'un médicament. Enfin, **l'isolement** consiste dans le fait de placer une personne dans un lieu, seule, d'où elle ne peut sortir. L'article 118.1 de la LSSSS touche la question de l'utilisation de ces mesures de contrôle. Celles-ci peuvent être utilisées contre une personne « que pour l'empêcher de s'infliger ou d'infliger à autrui des lésions ». Sur ce point, Marie-Hélène constate qu'il existe une prévalence, au Québec comme en Ontario, de l'isolement et de la contention comparativement à la moyenne internationale. Quoique les *Orientations ministérielles* établissent des principes sur lesquels doit reposer l'utilisation de ces mesures, le tout demeure d'après elle

insatisfaisant. Les effets néfastes des mesures – tant pour les patients, les intervenants que les organisations – sont largement recensés. Mais lorsque Marie-Hélène a recherché quel programme de réduction des mesures était le plus efficace, elle s'est heurtée à un vide: il n'existe pas de méta-analyses ni même de recensions des écrits sur ce thème. Les données sont rares, ce qui l'a poussé à creuser la question. Ses recherches pointent vers plusieurs facteurs qui pourraient favoriser la réduction de l'utilisation de ces mesures. Le plus important d'entre eux est le leadership, soit la volonté des gestionnaires et cliniciens à appliquer une philosophie de réduction des mesures de contrôle. De plus, ses études montrent que réduire l'utilisation des mesures de contrôle améliore la santé de tous et n'a pas d'incidence sur la sécurité des professionnels de la santé.

When the floor was opened for discussion, questions included the conditions of solitary confinement (as raised by Sayce in discussion of the Ashley Smith case). It was noted that jurisdictions in the USA have limited or stopped solitary confinement for vulnerable populations like prisoners with mental illness or children, based on human rights claims and interdisciplinary studies documenting the ills of the practice. A question was raised as to why there have not been any *Charter* challenges raised against Canadian statutes and/or practices that seem to allow solitary confinement in the penal system. Sayce responded (i) that there were certain situations where solitary confinement is necessary, which makes it difficult to completely eliminate from the penal system; and (ii) there is little incentive for *Charter* litigation because the damages granted are usually very low; the latter leads such cases to be less effective than class actions in modifying government behaviour, and, more pragmatically, less attractive to potential counsel. Concerns were also expressed about whether doctors who refuse or limit treatment of prisoners with mental illness were liable for malpractice. Professor Jones noted that failure to provide essential medical care have been successfully raised in litigation for HIV-affected prisoners and that federal law and regulations require the provision of adequate care. On the other hand doctors' professional discretion is also framed by correctional facility practice, and individual prisoners seldom muster the resources to bring suits either against physicians, facilities or government.