YOU CAN'T GO OUTSIDE: INVOLUNTARY HOSPITALIZATION AND ACCESS TO THE OUTDOORS IN HEALTH CARE

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ABSTRACT

This paper will explore the practice of withholding a person's access to the outdoors while under involuntary hospitalization, or civil commitment, in the province of Ontario, Canada. Following a question from the author's clinical practice, the paper asks: Are we denying mental health patients a right that is protected for prisoners?

An overview of the structure of the Canadian legal system and the role of international human rights law in local legislation is offered to situate lack of outdoor access under civil commitment in a broad legal context. The intention of legal and ethical positions described in human rights and mental health law will be considered in light of how these support or negate current practices in health care. Key issues of civil commitment will be defined. Law and policy governing outdoor access in other institutions such as prisons and detention centers will be outlined as a point of comparison.

The purpose of this paper is to serve as a guide to thinking through the issue of institutional confinement without access to the outdoors when a person's independent freedom of movement is compromised, legally or otherwise. Should there be future interest in challenging this practice, this paper will be useful as a primer for how to approach legislation and institutional policy.

Key words: Canadian legal system; Mental Health Act (1990); Ontario; Deprivation of liberty; Ultra vires; Human rights; Psychiatric nursing; Hospital design; Outdoor spaces; Fresh air; Patient rights; Civil commitment

I. INTRODUCTION

> *From behind panes of plexiglas, a man knocks at the sliding window. I open it. He looks down at his hands, one cradling the other, and begins to count out his rights. "One shower, one change of clothes, one hour of fresh air. As a prisoner, that is what I am entitled to." He has been a prisoner before, but that is not his designation here. We are in a general hospital, in an acute care psychiatric unit, and I am his nurse not his warden. I answer, "You are welcome to all the showers and changes of clothes you would like, but I can't let you outside."*
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> - Vignette from the author's nursing practice -

Civil commitment is the involuntary confinement of a person to a hospital under the power of mental health legislation. Currently, in Ontario, Canada, the *Mental Health Act* (1990) (hereafter the MHA) permits involuntary hospitalization if a doctor determines that one of two alternative statements pursuant to section 20(1.1) and section 20(5), 'Conditions for involuntary admission,' are met. (On the ancillary Ministry of Health certificates, involuntary hospitalization is indicated under Box A criteria – the Serious Harm test – and involuntary treatment under Box B criteria (Queen's Printer for Ontario, 2000).) The MHA separates these two assessments. If a person is determined to be

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incapable of making decisions about their treatment due to their mental status, forced administration of psychiatric treatments are permitted under the Health Care Consent Act (1996) in conjunction with a substitute decision maker.) Under the statutory powers of the MHA, enactment of a certificate of involuntary admission by a doctor drastically alters a person's right to consent and suspends their freedom of movement. A certified patient cannot leave the hospital until the certificate expires or is lifted by their psychiatrist. Section 20(4) of the MHA explains that each certificate is time-limited and must be re-assessed at prescribed intervals.

Confinement on a locked mental health unit is recognized as a deprivation of liberty in that the MHA establishes minimum threshold criteria for civil commitment, so as to safeguard against abuses. Confinement is distinct, however, from 'restraint' in the terminology of the MHA and other bodies governing health care. 'Restraint' refers to an intervention "to prevent serious bodily harm to the person or another by the minimal use of force, mechanical or chemical means" – mechanical, like binding a person's wrists and ankles to a bed, or chemical, like administering a psychotropic medication to "intentionally inhibit a particular behaviour or movement" (MHA, Definitions, 1990). Restraints are interventions to protect safety, but they are openly the subject of debate, while confinement does not inspire similar contention or controversy.

In Ontario hospitals, a doctor's order is required to apply a restraint, but the recommendation to use a restraint is most often made by the nurse working directly with the patient. As such, the College of Nurses of Ontario (CNO) advises: "Restraints should be used only for the shortest time when prevention, de-escalation and crisis management strategies have failed to keep the individual and others safe" (Understanding Restraints, 2018). The Registered Nurses Association of Ontario (RNAO) developed a Clinical Best Practice Guideline entitled, *Promoting Safety: Alternative Approaches to the Use of Restraints,* in 2012 that articulates the concept of restraints as an intervention of last resort. What continues to be a challenge for inpatient mental health nurses is the limited resources available for meaningful alternatives to de-escalate and manage agitation, aggression, or threats of violence. An ethnographic study of restraint use in a Toronto hospital by Sandy Marangos-Frost and Donna Wells (2000) found nurses experienced an ethical dilemma when restraints were viewed to be "the best available option" in the situations in which they were used due to "the apparent lack of acceptable alternatives" as well as "unit factors" (366). Without concrete infrastructure to support alternatives, like an outdoor space, restraints continue to be used.

In addition to mechanical restraints placed upon a person's body, the CNO and RNAO describe 'environmental restraints' as controlling a person's mobility (CNO, 2018; RNAO, 2012: 19). In writ, the MHA does not authorize psychiatric facilities to detain or restrain an informal or voluntary patient, according to section 14. In practice, placement in a secure ward is the *de facto* disposition when a person is admitted for inpatient mental health care in Ontario. This is the case for both voluntary and involuntary admissions because inpatient mental health units are locked and are permitted only in hospitals designated by the Ministry of Health and Long-Term Care (MHOLTC) as Schedule 1 facilities (institutions where patients may be restrained if necessary according to the MHA.) There are 70 Schedule 1 facilities in Ontario, including forensic institutions for the treatment of those found Not Criminally Responsible for a crime due to a mental

disorder (MHOLTC Health Services in Your Community, 2012). Toronto, Ontario has 13 Schedule 1 facilities of which I have been to 7 - 2 had outdoor space for the general ward, none had outdoor access for their acute units (Personal experience.) A voluntary patient ostensibly has the right to exit the mental health unit, but in practice, the voluntary patient's right to exit the secure unit is mitigated by their physician's assessment of their safety. To leave the secure unit requires permission (the privilege of a "pass") and permission can be denied. If denied a pass, the voluntary patient can revoke their consent to hospitalization (opt for discharge against medical advice) or choose to stay inside the hospital and continue to receive treatment. Should the client meet criteria for involuntary admission at the time of their assessment for a pass and should the client opt to be discharged against medical advice, the physician can, of course, initiate a certificate of involuntary hospitalization.

According to the MHOLTC's communication group, there is no obligation for hospitals to provide secure outdoor space for patients (Personal Correspondence, September 26th, 2016).

> Ministry of Health and Long-Term Care does not have any policies or standards in place for design requirements. The board of directors of the hospital along with the architect they choose to hire determine the design of the facility;
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> Depending on the lot of the facility, there may or may not be outdoor space available to allow involuntary patients to access the outdoors (Personal Correspondence, September 26th, 2016).

This means that access to a secure outdoor area is arbitrarily dependent on the hospital's design. Architectural constraints and the lack of legislation in Ontario on the issue of outdoor access have created conditions across the province that make confinement without outdoor access permissible in general hospitals. This is so routine in practice that I was challenged in the writing of this paper to qualify whether human beings have a right to fresh air at all. The secure unit is a form of environmental restraint in that the person's mobility is limited to the hospital unit, but with the distinction in the MHA between custody and restraint, and with more visceral practices, like wrist cuffs or chemicals, confinement is taken as a simple fact of inpatient mental health treatment, not as a deprivation. Nursing documentation practices also illustrate the conceptual distinction between restraint and confinement. When mechanical restraints are implemented in Ontario, nursing protocols are typically triggered to monitor the restrained person to ensure the person is fed, toileted and ambulated. There are medical rationales for these – the body's need to void and the risk of deep vein thrombosis due to the immobility imposed by mechanical restraints – as well as the legal imperative to document the sensible use and monitoring of restraints should a legal complaint arise. However, no such protocols exist to reflect health considerations when a person is admitted to a secure unit, like daily outdoor access for bone health or sleep regulation. In the absence of cues to consider confinement to a secure unit as different from an open unit, confinement seems benign rather than exceptional.

Confinement as a feature of mental health care has been under examined and normalized as a result. This could change. An amendment not-yet-in-force as of 2019 to the *Long-Term Care Homes Act* (2007) is notable because in section 3, 'Residents' Bill of Rights', restraint is related to confinement:

> 3.13
>
> Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
>
> Note:
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> On a day to be named by proclamation of the Lieutenant Governor, paragraph 13 of subsection 3 (1) of the Act is amended by striking out "restrained" and substituting "restrained or confined". (See: 2017, c. 25, Sched. 5, s. 2 (2))

Positive strides in legislation have also been made for long-term involuntary patients in the wake of the landmark Ontario court case *PS v Ontario* (2014) that has opened "the door to a fuller recognition of the profound deprivation of liberty involved in civil commitments" by drawing comparison between provincial criminal Review Board jurisprudence and civil commitment Review Board jurisprudence (Grant & Carver, 2016: 999). Still, people in Ontario continue to be routinely deprived of outdoor access when admitted as an inpatient for mental health care, and, unfortunately, Ontario is not unique. A digital scan of all ten Canadian provinces' mental health acts using the search terms 'outdoor,' 'fresh air,' 'program,' 'access,' 'recreation' and 'privilege,' found that no province delineates outdoor access as an entitlement for involuntary patients. (Mental Health Act, Statutes of Nova Scotia 2004; Mental Health Care and Treatment Act, Statutes of Newfoundland 2006; Mental Health Act, Statutes of New Brunswick 1973; Mental Health Act, Statutes of Prince Edward Island 1994; An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others, Statutes of Quebec 1997; The Mental Health Act, Statutes of Manitoba 1999; Mental Health Services Act, Statutes of Saskatchewan 1984; Mental Health Act, Statutes of Alberta 2000; and Mental Health Act, Statutes of British Columbia 1996).

> If we don't even appreciate that consumers and staff are both feeling locked in, we may not even think that we need to do something about it (Arya, 2011: 165).

Nurses do hear patients say they feel cooped up and caged in and nurses themselves express ambivalence about the plexiglas nursing station that is both a measure for occupational safety and glass-walled box (Arya, 2011). The patient's statement that opened this paper took the everyday practice of confinement to a mental health unit without daily access to the outdoors and snapped it into focus. It looked strange. I understood the medico-legal rationale for the patient's confinement on the basis of safety, both the patient's and that of the community, but the assertion that an hour of fresh air would be permitted in prison prompted me to question what legal and ethical grounds there are, if any, for withholding a person's access to the outdoors when confined under civil commitment. What specific legal protections should apply to people whose liberty is restricted by a locked ward? Are we denying mental health patients a right that is protected for prisoners in the jurisdiction of Ontario? Are there arguments to be made for secure settings to have secure outdoor areas for all patients?

METHODOLOGIES

To fully explore the strangeness of involuntary confinement without access to the outdoors in Ontario hospitals, this paper presents a close study of Canadian mental health law and criminal law, and a comparison of local legislation to international human rights law. Semi-structured interviews carried out for this project with both legal experts

and health care practitioners explore interpretations of legislation and perceptions of confinement in practice. Interviews received ethics clearance from York University and informed consent was obtained from interviewees at the research stage and for this publication. Identities of interviewees have been anonymised with aliases. They are: "Leonard," a provincial court judge; "Martin," a lawyer practicing in public interest environmental law; "John," a lawyer practicing in the area of criminal law on behalf of the Ministry of the Attorney General; and "Rose," a registered nurse working in mental health in Ontario.

This is not a dispassionate paper.

To situate myself, I work as a registered nurse in Ontario where my professional experience includes psychiatric settings and refugee primary care. I care about mental health and nursing and, like many others in my field, I struggle against parameters of practices that are not obviously therapeutic. I am of the mind that questions raised in clinical practice are important for nurses and health care providers to investigate. I also feel aware that sometimes it feels risky to talk about these questions outside of the nursing station. There is a fear of violating the responsibility to protect a client and their privacy or a sense of limited professional autonomy to safely question ethically challenging practices outside of the hierarchy of the organizations in which we work, even when that hierarchy has failed to respond. This is an aspect that strains mental health nursing and maintains the acceptance of practices that may be ethically distressing to staff and non-therapeutic to patients.

For full transparency, where I rely on information gained from my own clinical practice, I have done so in a manner that would not reveal the identities of patients or colleagues. Personal medical information and identifying details are omitted as per Ontario's *Personal Health Information Protection Act* (2004). What I have done is grafted stories together to foreground the practice issues and critical themes.

This paper is not a critique of the dedicated staff that work in inpatient psychiatry. It is an acknowledgement of the constraints we work under. It is also an expression of interest to openly problematize those constraints outside the immediate pressures of daily work; including and especially the pressure felt when an involuntary patient persistently knocks on the nursing station window requesting to go out. This paper asks if everyone might deserve a little more breathing room.

I. CANADIAN LEGAL SYSTEM

To situate the MHA in the context of human rights law requires an overview of legal jurisdictions. In Canada, legislative responsibilities of the law were divided between the provincial and territorial, and federal governments with the *Constitution Act* (1867) (hereafter the Constitution). Each Province is responsible for the administration of both hospitals and civil and criminal justice related to provincially administrated powers (Constitution Act, 1867, s. 92(6, 7, 14)). Human rights in Canada were added to the Constitution in 1982 with the addition of the *Canadian Charter of Rights and Freedoms* (hereafter the Charter) (s 15, Part I of the Constitution Act; Foot, 2013). The very first section of the Charter establishes that all rights are subject to limits:

> The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

All Canadian provinces operate under the common law tradition with the exception of Quebec (which operates under the civil law tradition) (Department of Justice of Canada, 2016). Common law, described by the Department of Justice of Canada, is "a system of rules based on precedent" (About Canada's System of Justice, 2017: np). When there is a conflict or question around an ambiguity of the law, a case can be brought to the courts. A judge's decision will, subject to the rules of constitutional law (including that applicable to statutory interpretation), interpret the ambiguity of the law in question in keeping with the ways judges interpreted the same laws in previous cases. The rulings made by each judge sets new precedents for how those laws should be interpreted in future. This is the system of case law.

The day I met Justice Leonard at his wood-paneled chambers, he excused himself for requiring a few minutes before we stepped out to lunch. From behind his desk piled with papers, he scrolled through emails. "The rulings from the court of appeals are released at noon," he explained as he scanned through a list. "Sometimes," he said, "there will be a ruling related to the case you're hearing that very day." This is how dynamic laws are in the nucleus of their operations; daily the judge must check what laws have changed because they may affect rulings made for cases they hear in the afternoon.

Apart from the courts, federal and provincial legislatures can amend existing laws and write new laws. That new legislation then "takes the place of common law or precedents dealing with the same subject" (About Canada's System of Justice, 2017: np). Provincial governments are responsible for legislation relating to hospitals, including civil commitment. Conflicts related to provincial legislation, such as whether patients confined under civil commitment should be entitled to outdoor access, can be resolved in a superior court of the province or escalated to the Supreme Court of Canada.

II. INTERNATIONAL HUMAN RIGHTS LAW

Human rights are specifically defined as "the set of entitlements held to belong to every person as a condition of being human" (OED, 2009). When in 1948 the United Nations General Assembly passed the *Universal Declaration of Human Rights* (1948) (UDHR), the principle of universality became the crux of international human rights law (UN Human Rights Office of the High Commissioner, nd). This means that human rights are understood to be applicable to all people. The United Nations and other international bodies have created numerous documents that continue to define and refine human rights for specific populations, like prisoners, people with disabilities, or people with mental disorders. These are international human rights instruments, legal tools that may be used to interpret laws.

International instruments can be binding or non-binding (Arena Ventura, 2014). A non-binding document presents ideals that courts can use as examples for what a group of international legal experts agreed upon for a particular issue. A binding document is one that has been ratified or signed by a nation to endorse the contents of the document,

but neither a binding or non-binding law necessarily have attendant enforcement mechanisms until they are formally incorporated into domestic legislation. The absence of an enforcement mechanism is a vital point here. Lawyer Martin emphasized:

> Unless we have an enforcement mechanism by which people who are aggrieved by violations of those rights can have those rights addressed, like a court or a tribunal, it can be very difficult to enforce a right. The practical aspect is: how accessible is the enforcement mechanism? Do you have to run a court case to get it? In that case, it is inaccessible to a lot of people. Or is there a tribunal or a commission, like the provincial human rights commissions, that have some procedures in place to make it more accessible?

Legislation like the MHA should be interpreted so as to comply with human rights law (provincial and federal) and federal human rights law should be interpreted so as to comply with international human rights law. It is all well and good to refer to the 'rights' in these international instruments: but they need enforcement mechanisms, as lawyer Martin emphasized.

III. KEY ISSUES OF CIVIL COMMITMENT AND OUTDOOR ACCESS IN ONTARIO

1. Outdoor Access and Coercion

Under section 27(1) of the MHA, patients may be granted a leave of absence or "passes" off the unit by their physician. Pass policies are developed at the level of each individual hospital or institution and passes are negotiated between a patient and their psychiatrist. Importantly, passes are not universally implied for those admitted under voluntary status – voluntary patients must also negotiate passes with their doctor. If a team or doctor does not trust that a voluntary patient will return to a unit safely, the choice is: discharge yourself against medical advice or stay inside. This is, of course, not a choice in the true spirit of the word.

Pass policies are a source of great tension in the nurse-patient relationship, which is the very core of nursing and is the nurse's greatest, most powerful tool, especially in mental health (CNO, 2013: 3). Staff frequently debate pass policies, but Rose explained, "everyone understands the reasoning for it, from a safety perspective." She elaborated:

> There were sentinel incidents where patients had gone out on pass and committed suicide. And the hospital felt like they had to react. The pass policy became more strict. … It makes sense, but it doesn't make sense, if that makes sense. Sometimes we have involuntary patients who are there for years. Can you imagine not seeing outdoors for an entire year? Knowing that that's what people need to be mentally healthy, it's tough.

Safety is typically signaled by cues of cooperation from patients. Risk is generally assumed and assessed to be reduced based on measures such as medication compliance and patient participation in treatment; according to GD Glancy & G Chaimowitz (2005), these follow evidence-based practice principles (15). But, this can amount to well-intentioned coercion. For example, in settings that do not have courtyards, like most acute units, passes to the courtyard can be used as an incentive for patients to agree to take medications. Rose acknowledges that access to the outdoors is used as leverage in bargaining tactics with patients. "For example, it's: if you take your medication, you can have a pass." This is a practical example of the 'threat' implied in the most accepted definition of coercion articulated by Alan Wertheime as a conditional proposal where if the proposal is rejected, the person will be left "worse off according to a 'moral

baseline,'" which is defined as a liberty "one is normally entitled not to be deprived of" (Szmukler, 2015: 1).

I asked Rose how she feels about this:

> I do think you have to be creative in ways to treat people, unfortunately. And that might be a creative way to do so, even though it's coercive. But psychiatry struggles with coercion on a daily basis. Especially because it's [access to the outdoors] something that should just be a given right.

Indeed, informed consent as an aspect of ethical health care is challenged when a patient is not considered "safe" to access the outdoors without agreeing to take medication. Legal scholars have questioned whether free and informed consent is even possible under involuntary hospitalization where conditions enable 'soft coercion' (Gupta, 2003: 172).

I asked Rose how patients feel about the pass policy from her perspective. She answered:

> "A lot of remarks are that it's a human rights violation. You hear that a lot."

2. Prolonged Confinement

Though the MHA does not protect a person's ability to access the outdoors, it does make provisions for an accessible enforcement mechanism for inpatients to challenge involuntary hospitalization or incapacity via the Consent and Capacity Board (CCB). The CCB is an independent body created by the provincial government of Ontario to review MHA certificates. Every certified patient is entitled to a review if they so choose.

Under the MHA, a person hospitalized involuntarily or found incapable of making treatment decisions is automatically seen by a Rights Adviser (MHA, Rights adviser, s. 38(3)). The Rights Advisor explains the meaning of the certificates their psychiatrist has enacted and informs the patient that they may challenge the assessment at a hearing with the CCB (MHA, Rights adviser, s. 38(3)). If the CCB sides with the psychiatrist for either involuntary admission or a finding of incapacity, the patient does have one further mode of recourse. The CCB decision can be appealed to the Ontario Superior Court of Justice (MHA, Appeal to court, s. 48(1)). Though this is intended to honour the patient's autonomy and choice, an appeal to the Superior Court can result in a shockingly long hospitalization for a patient awaiting a court date. Between 2003-2004, the average wait for the court to return a decision from the time the appeal was filed was 8 months (Zuckerberg, 2007: 526). I mentioned this statistic to Rose who replied: "I think it's longer." The Ontario Superior Court could not offer more recent statistics than those quoted by Zuckerberg as of 2018. Indeed, we had both worked with clients who waited over a year for their day in court.

I asked each of the lawyers interviewed if they thought it was reasonable to keep a person in this particular quagmire confined to a mental health unit without access to the outdoors. Justice Leonard answered simply: "No." John sharply hammered the point: "Even Paul Bernardo [an infamous rapist and murderer] gets an hour a day outdoors. On his own. But he gets it."

Patients with dementia compounded by a mental health history are another population that endure long hospitalizations. Lack of supportive housing is widely recognized as a major bottleneck in the mental health care system. The 2016 Annual Report of the Office of the Auditor General of Ontario stated:

> We found that in the last five years approximately one in ten beds in specialty psychiatric hospitals was occupied by someone who did not actually need hospital care but could not be discharged due to the lack of available beds in supportive housing or at long-term care homes. Over the past five years this problem has become worse (Ministry of Health and Long-Term Care, 2016: 619).

General hospitals face the same barriers. Social workers require Herculean tenacity to find long-term care for clients with dementia and a mental health history, especially if that person has been violent. In my experience, these people are often held involuntarily in acute units because of the high level of care they require. They do not go outside until they leave feet first, to put it crudely.

In 2014, a man who had been detained at a psychiatric hospital for nineteen years brought a case to the Ontario Court of Appeals on the grounds that his Charter rights had been violated in his detention (Grant & Carver, 2016). The judge in *PS v Ontario* (2014) determined indefinite detention without review was unconstitutional in civil commitment. As such, Ontario's MHA was in contravention of section 7 of the Charter because "it provided for long-term commitment [detention of six months or longer] without adequate procedures to protect the liberty interests of the person committed" and "fail[ed] to give the CCB the necessary tools to protect the liberty interests of long-term detainees" (Grant & Carver, 2016: 1003, 1009). Bill 122*, Mental Health Statute Law Amendment Act* (2015), the result of *PS v Ontario*, empowers the CCB to order facility transfers; leaves of absence; change of security level or privileges; supervised or unsupervised access to the community; or vocational, interpretation or rehabilitative services (List of Board orders s. 2(1-5)). Prior to Bill 122, the CCB had no jurisdiction over the conditions of confinement. This is a very positive change.

Legal scholars Isabel Grant & Peter J. Carver (2016) highlight that this ruling has identified a shortcoming in mental health laws across Canada. With the exception of Ontario:

> no provincial mental health legislation in Canada provides the kind of jurisdiction envisaged by the Ontario Court of Appeal in PS to supervise the conditions of long-term commitment (Grant & Carver, 2016: 1013).

PS v Ontario gives lawyers and citizens a tool to challenge the lack of power other provincial tribunals have to make a meaningful impact on the treatment and conditions of care of detainees (Grant & Carver, 2016: 1014). Grant & Carver also acknowledge that:

> The decision, and Ontario's legislative response also leave open the pressing question of the scope of liberty interests guaranteed by section 7 for those who are civilly committed for shorter periods of time (999).

According to the Canadian Institute for Health Information (2018) the average stay for an inpatient on a mental health unit is 70 days, and many people who have had an inpatient psychiatric admission in Canada tend to cycle in and out of hospital. Between 2003 and 2004—the most recent data tracking patients for more than a month after

their discharges from hospital—37 percent of people treated for a mental disorder across the country were readmitted within one year (Madi, Zhao & Fang Li, 2007). Ninety-eight percent of people who are civilly committed are hospitalized for less than six months, meaning these new powers invested in the CCB affect only 2% of involuntarily hospitalized people (Grant & Carver, 2016: 1008). Only the 2% can seek an order affecting what is categorized as the privilege of having access to even a restricted part of the outdoors

The CCB is currently invested with the power to order outdoor access for long-term detainees, and so it should. However, without legislation requiring hospitals to have secure outdoor space, it could prove difficult to materialize this power. Further, the power to address such conditions of care should not be restricted to long-term detainees. Whether confined for six months, six weeks, six days or six minutes, liberties should be protected.

3. Long-Term Care

Confinement without outdoor access is also not exclusively restricted to mental health units; there are other hospital areas and institutions that are designated to have secure units where the exit doors are locked. Units in long-term care facilities where people with dementia live out their days are locked for safety. Recent reforms to Ontario's *Long-Term Care Homes Act* (2007) (LTCHA) include processes that mirror those of the MHA relating to confinement, and that carry the spirit of use of the least restrictive means required to mitigate risk posed by a person. Though not-yet-in-force at the date of publication and with no date yet named by the Lieutenant Governor for the commencement of these provisions, the reforms to the LTCHA will introduce providing the person with notice of confinement, contact with a rights adviser, and the ability to contest confinement via a CCB hearing (s.30(1-9) as amended by the *Strengthening Quality and Accountability for Patients Act* (2017). Since 2015, the *Long-Term Care Home Design Manual* dictates that:

> At least one outdoor space at grade level must be enclosed to prevent unauthorized entering or exiting from the home (Outdoor Space, 6.1).

This is an important measure towards better buildings, but this only applies to new constructions or renovations planned after February 2015. It does not require a retrofit to all long-term care homes. In the absence of legislation that requires outdoor access, it would not be a violation of rights to spend the rest of your entire lifetime indoors from the moment you are admitted to a dementia unit in a long-term care facility until the day you die. This is a future that current Ontario legislation makes possible.

4. Medical Considerations

Access to the outdoors is a component of both physical and mental health. Medical research on the importance of sunlight exposure for bone and dental health as a source of Vitamin D has led to the development of guidelines for the general public. The UK's National Institute for Health and Care Excellence (NICE) recommend at least 10 to 15 minutes of sun exposure without sunscreen to maintain adequate vitamin D supplies, for those confined indoors vitamin D supplements are recommended (NHS Choices, 2016). Sun exposure is also a vital element for good sleep hygiene. Exposure to sunlight

produces serotonin, a neurotransmitter that can effect positive mood and optimism; in darkness, serotonin is converted to melatonin, a neurotransmitter-like hormone that regulates sleep (Mead, 2008). A balance of serotonin can even effect positive mood and optimism (Mead, 2008). Because of the impact of sunlight on neurotransmitters and hormones that affect the circadian rhythm and mood, Russel J. Reiter, a professor in the department of cell systems and anatomy at the University of Texas Health Science Center, stresses that "it's important that people who work indoors get outside periodically" (Mead, 2008: np). Sleep hygiene is vital to good mental health for all and mental health settings should be designed to facilitate behaviours that support good mental health.

5. The Built Environment and Health Outcomes

The connection between mental health and the built environment has been widely researched. However:

> the weight of the evidence is relatively weak, relying principally on small convenience samples and cross-sectional study designs or short-term follow-up (Rugel, 2015: 1).

Despite multiple studies linking green space to improved mental health:

> in medical fields, a randomized controlled trial or experiment is considered the strongest research design for generating sound and credible empirical evidence (Ulrich, Zimring, Zhu, DuBose, Seo, Choi, Quan, & Joseph, 2008: 103).

Roger S. Ulrich, a professor of architecture, has researched the effects of nature on health in a manner consistent with the evidentiary regime of the randomized control trial.

In 1984, Ulrich wondered if a view to the outdoors would be therapeutic to patients and, accordingly, their recovery. Aided by the layout of a post-surgical unit in a suburban Pennsylvania hospital where patient rooms faced either a "small stand of deciduous trees or a brown brick wall," Ulrich was able to randomize participants to study the effect of nature on patients recovering from cholecystectomy (gallbladder removal) (Ulrich, 1984). His findings showed:

> the patients with the tree view had shorter postoperative hospital stays, had fewer negative evaluative comments from nurses, took fewer moderate and strong analgesic doses, and had slightly lower scores for minor postsurgical complications (Ulrich, 1984: 421).

Ulrich notes there is a constant pressure in health care to reduce costs and yet improve quality of care. To persuade hospital administrators and decision-makers to allocate resources to a courtyard garden, for instance, there are three kinds of convincing evidence: health outcomes, like decreased blood pressure readings; economic measures, like cost-saving on medications; or patient reported satisfaction. His 1984 study provided firm ground to defend the role of nature in healing and showed that sometimes clinical indications overlap with economic outcomes; for example, how decreased use of medications like analgesics or anxiolytics, or decreased length of stay can lower costs in patient care (Ulrich, 2002).

A literature search turned up numerous articles on outdoor exposure as a benefit to certain mental health disorders – anxiety and depression – but rarely were psychotic

disorders examined, even though this subpopulation are more likely to require inpatient hospitalization. (See, for example, Emily Rugel's (2015) excellent survey of research examining the impact of nature on health, *Green Space and Mental Health: Pathways, Impacts, and Gaps*.) More attention in health research in terms of non-medical interventions like outdoor access, exercise, and occupational engagement for psychotic disorders like schizophrenia is desperately needed.

IV. OUTDOOR ACCESS IN CIVIL COMMITMENT VS. HUMAN RIGHTS LAW

In Canada, if a lawyer were to make a legal claim for health and wellness, such as oa person needs sun exposure for bone health, the Charter would be the most useful piece of legislation to ground the claim. Martin is familiar with using the Charter in this way. He pointed me to section 7 of the Charter (life, liberty and security of the person), which he and his colleagues have used to build cases in the past.

> We have tried to link the idea that your health is an expression of security of the person. So, you can have threats to your life or threats to the security of the person through things that are damaging to your health. Environmental harms are harms to health, usually, but the case law in this area is limited and usually the threat to health has to be severe.

Martin added the sobering reminder: "There's no free standing constitutional right to be healthy."

To my knowledge, there have been no civil suits about outdoor access while under civil confinement in Ontario, but there have been cases that challenged civil commitment. Lawyer and legal scholar Joaquin Zuckerberg (2007) found in his review of case law pertaining to involuntary hospitalization without treatment that the practice is not inconsistent with interpretations of section 7 of the Charter, because:

> the legislation is designed to protect persons who pose a danger to themselves or to others (516).

Without a legal precedent to help explain outdoor access as a human right, I compared the MHA to international instruments that might give guidance, such as the UDHR, and the *UN Principles of the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (1991) (MI Principles), and to policies in other secure settings such as prisons for criminal commitment and detention centres for those found to be in violation of immigration law. Who gets to go outside?

Below is a list of international instruments and local legislation to show how local Ontario law fits within the federal and international legal contexts.

International Human Rights Instruments	
Binding	**Non-Binding**
International Covenant on Civil and Political Rights (1966)	UN Declaration of Human Rights (1948)
International Covenant on Economic, Social and Cultural Rights (1966)	UN Principles of the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991)
Convention on the Rights of Persons with Disabilities (2006)	UN Standard Rules for Equalization of Opportunities for Persons with Disabilities

	(1993)	
	General Comments 5 (1996) and 14 (2000) of the International Covenant on Economic Social and Cultural Rights	
	WHO's Mental Health Care Law; ten basic principles (1996)	
	WHO Guidelines for the Promotion of Human Rights of Persons with Mental Disorders (1996)	
Domestic Human Rights Instruments		
Constitutional	**Provincial**	**Related Commission**
Charter of Rights and Freedoms (1982)	Ontario Human Rights Code (1962)	Human Rights Tribunal of Ontario (HRTO)
Provincial Legislation Related to Involuntarily Hospitalized Persons		
	Related Commission	
Mental Health Act, RSO, 1990	Consent and Capacity Board	
Health Care Consent Act, S.O. c.2 Sched. A (1996).		
Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Sched. A	Information and Privacy Commissioner	

1. Freedom of Movement

The UDHR states:

> Article 13 1.
>
> Everyone has the right to freedom of movement and residence within the borders of each State.

Consistent with the above law, the Charter does include freedom of movement as a right; however, section 7 addresses deprivation of liberty.

> Section 7.
>
> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

And section 9 states:

> Section 9.
>
> Everyone has the right not to be arbitrarily detained or imprisoned.

These rights are subject to limits by section 1 of the Charter, which further necessitates the "least restrictive" principle of the MHA, which is obliged to be consistent with the Charter. The MHA does address this in section 41.1:

> *Factors to consider*
>
> (3) 6. Any limitations on the patient's liberty should be the *least restrictive limitations* that are commensurate with the circumstances requiring the patient's involuntary detention. 2015, c. 36, s. 10. (*italics mine*)

This consideration aligns with the MI Principles' Principle 9, which states:

> *Treatment*
>
> Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.

The MI Principles also include some detail on what the conditions of a treatment facility should be.

> Principle 13
>
> *Rights and conditions in mental health facilities*
>
> 2. The environment and living conditions in mental health facilities shall be *as close as possible to those of the normal life* of persons of similar age and in particular shall include:
>
> (a) Facilities for recreational and leisure activities … (*italics mine*)

There are no explicit inconsistencies between the MHA and these international instruments. Access to the outdoors is not explicit. However, might it be assumed that most people go outside regularly during their "normal life?" It did appear as though an argument could be made. I asked John if section 7 of the Charter might encompass freedom of movement. He replied, "I think it could. I think there's an argument to be made there." There appears to be reason to argue that outdoor access is implied as a human right in the Charter. I wondered if a civil suit brought before the courts about a person's right to outdoor time in hospital had any potential to change the legislation. John answered: "Oh I think that could happen. That's theoretically possible." Then, considering his work with the Ontario Review Board, (a tribunal that deals with people deemed Not Criminally Responsible by reason of mental disorder or unfit to stand trial), he added:

> But find me a lawyer who's going to take the time and energy required to bring that kind of suit on behalf of someone who's been charged criminally and detained. I mean, you could see it if someone were absolutely innocent, wrongfully imprisoned, and had deep pockets, and maybe, some sway in the community. But where's the money in that? Where's the benefit for the legal practitioners? And again, find me the political will to make conditions better for people who are accused of crimes. Or the mentally ill for that matter.

I asked: Might political will be lying nascent in Canada's aging population given that some will be affected by the lack of legislation for outdoor access especially in long-term care facilities? "Of course," John said, "but who in their right mind is worrying what happens if I get dementia?"

2. Equality and Accessibility

Another line of argument for outdoor access for patients in hospital could be based on equality rights. Section 15.1 of the Charter, entitled "Equality before and under law and equal protection and benefit of law," states:

Equality Rights

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Section 15.2, states:

Affirmative Action Programs

Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Section 15 of The Charter addresses accessibility for people with disabilities. Further, Rule 5.a in the non-binding *UN Standard Rules for Equalization of Opportunities for Persons with Disabilities* (1993) articulates the responsibility of states to create accessible buildings for those with disabilities:

Access to the Physical Environment

1. States should initiate measures to remove the obstacles to participation in the physical environment. Such measures should be to develop standards and guidelines and to consider enacting legislation to ensure accessibility to various areas in society, such as housing, buildings, public transport services and other means of transportation, streets and other outdoor environments

and

3. Accessibility requirements should be included in the design and construction of the physical environment from the beginning of the designing process.

It could be argued that a hospital providing mental health services ought to ensure outdoor space is accessible to involuntary patients on the basis that a mental disorder requiring involuntary hospitalization is considered a disability. Further, legislation ought to support this. Just as for other disabilities, consideration of access to the outdoors in the case of involuntary hospitalized patients should be part of the accessibility considerations of a hospital architect.

V. CANADIAN PRISONS AND DETENTION CENTRES

To follow the patient's assertion that he would be granted an hour of fresh air in prison, I reviewed the federal *Criminal Code* (1985). I found no mention of access to the outdoors for prisoners in this legislation. However, in May 2018, the *Correctional Services Transformation Act* was passed by the Ontario government. Included in this legislation is the introduction of Schedule 2: *Correctional Services and Reintegration Act* (2018) that defines conditions of custody for Ontario prisons, including outdoor access. It states:

Recreation

61 (1) Every inmate shall be offered the opportunity to participate in a minimum of one hour of recreation time each day.

Indoors or outdoors

(2) The inmate shall be allowed to choose whether to spend the recreation time indoors or outdoors.

Prior to this Act, Ontario law made no mention of outdoor access for inmates of provincial prisons. Documents provided by Correctional Service of Canada (CSC)[1] explained that daily fresh air is intended to be offered inmates in provincial and federal prisons. But both the *Inmate Information Guide for Adult Institutions* (2015) for provincial prisoners and the Commissioner's Directive 566-3 (2012): *Inmate Movement* for federal prisoners failed to indicate of the duration or frequency of access to the outdoors. These two documents, referred to outdoor access as the "Fresh Air Program." The *Correctional Services Transformation Act* (2018) provision for outdoor access for prisoners stands in contrast to the MHA which makes no such provision.

I asked interviewees if the MHA should likewise address conditions. John said:

> I think it should. Yes, I do. I think there should be a … basic minimum standard by which all institutions are held. Absolutely.

With regards to how much time should be given outdoors each day, Leonard said:

> In my view, I think everyone ought to be entitled to at least an hour a day.

Across Canada, each province has its own legislation governing provincial prisons. Of the ten provinces in the country, four have encoded outdoor access for prisoners in their law - Nova Scotia, Ontario, Alberta and British Columbia.

Province	**Law**	**Provision for Outdoor Access**
Nova Scotia	Correctional Services Act (2005)	57 (1) A superintendent shall ensure that every offender is allowed at least thirty minutes a day for outdoor exercise.
Newfound-land	Correctional Services Act (2017)	None.
New Brunswick	Corrections Act (2011) (Updated March 29, 2019).	None.
Prince Edward Island	Correctional Services Act (2017) Correctional Services Act Regulations (2004)	Neither of these documents address outdoor access.
Quebec	S-40.1 - Act respecting the Québec correctional system (Updated 10 December 2019)	None.
Ontario	Correctional Services and Reintegration Act (2018)	*Recreation* 61 (1) Every inmate shall be offered the opportunity to participate in a minimum of one hour of recreation time each day. *Indoors or outdoors* (2) The inmate shall be allowed to choose whether to spend the recreation time indoors or outdoors.
Manitoba	The Correctional Services Act (1998) (Updated January 31,	None.

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	2020).	
Saskatch-ewan	The Correctional Services Act (2012) as amended by The Statutes of Saskatchewan, 2013, c.27; 2014, c.E-13.1; 2016, c.28; 2017, c.P-30.3; and 2019, c.Y-3, c.18 and c.25.	None.
Alberta	Corrections Act (2000) (Updated 11 December 2018) Correctional Institution Regulation (2001)	No provision for outdoor access. Part 2: Inmates Exercise of inmate 26 An inmate is entitled to exercise daily in the open air, weather permitting, when staff, space and facilities are available.
British Columbia	Correction Act (2004) (Updated 22 January 2020.) Correction Act Regulation (2005)	No provision for outdoor access. *Inmate privileges* 2 (1) (b) a daily exercise period of at least one hour, in the open air if weather and security considerations allow

VI. ONE HOUR OF FRESH AIR A DAY – ORIGINS IN THE LAW

I asked each of the legal professionals I interviewed what they might recommend reading on the topic of "one hour of fresh air a day" for confined persons in the law. John suggested I look to the Geneva Convention for Prisoners of War. He advised:

> That is instructive because you're talking about wartime. It doesn't get more intense than war time.

Chapter V of *The Geneva Convention Relative to the Treatment of Prisoners of War* (1929) (ratified by Canada in 1933) does encode a standard for outdoor access (International Committee of the Red Cross).

> *Religious, Intellectual and Physical Activities*
>
> Article 31
>
> Prisoners shall have opportunities for taking physical exercise, including sports and games, and for being out of doors. Sufficient open spaces shall be provided for this purpose in all camps.

Further, the *Mandela Rules* adopted by the UN in 2015 defines a minimum standard for the amount of time a person ought to be permitted out of doors while a prisoner.

> *Exercise and sport*
>
> Rule 23 1.
>
> Every prisoner who is not employed in outdoor work shall have at least one hour of suitable exercise in the open air daily if the weather permits

In Canadian detention centres, the Canadian Border Services Agency states that:

> A minimum of one hour of suitable exercise in the open air on a daily basis, weather permitting, shall be made available to all detainees at facilities with a capacity of more than 24 detainees (Personal Correspondence, October 21, 2016.)

Though all human beings are entitled to all human rights, those detained by Border Services and Corrections in Canada are, upon paper, promised an hour of fresh air a day while those confined under the MHA are not. Whether daily access to fresh air is provided in practice is another question.

VII. LEGAL CHANGE FOR OUTDOOR ACCESS FOR MENTAL HEALTH SETTINGS IN THE USA

Access to the outdoors and fresh air programs of inpatient mental health services recently became part of state legislation in Massachusetts, in large part due to the committed work of Jonathan Dosick, a mental health advocate and service-user who began to investigate outdoor access in psychiatric settings in 2003 as a part-time employee with Massachusetts' Disability Law Centre (Mental Health Legal Advisors Committee, 2015). An article in *STAT* quoted Dosick's stand on fresh air as a fundamental right. He said:

> Prison inmates are allowed outside by law... Even organic livestock, they have laws protecting them. What does that say about people with psychiatric conditions?. (Bailey, 2016: np).

After a decade of dogged advocacy for the addition of outdoor access to the state of Massachusetts's Five Fundamental Rights for patients that protect access to telephones, mail, visitors, privacy and dignity, and legal council, Governor Deval Patrick signed off on the Fresh Air Bill which took effect April 6th, 2015 (Mental Health Legal Advisors Committee, 2015). There were not, however, any concrete guidelines for implementation and in July of 2016, approximately one-third of the state's hospitals were in search of waivers to the new rules "citing lack of space," or "concerns about safety, staffing, space and liability" (Bailey, 2016: np). It is still yet to be seen how the Bill will transform psychiatric services in Massachusetts, but "to those who have ever experienced life inside a psychiatric hospital or other inpatient facility, the promise of even temporary reprieve from the confines can have important implications for those persons' mental health and recovery prospects" (Mental Health Legal Advisors Committee, 2015).

VIII. SUMMARY

Ontario's mental health legislation is not unique for neglecting to include outdoor access. As mental health programs create their own hospital pass policies and the Ministry of Health and Long-Term Care does not require that those institutions be designed with secure outdoor space, there is no guarantee of access to the outdoors under civil commitment. While confinement is common to involuntary hospitalization and prisons, the carceral spaces in Ontario now protect a person's access to the outdoors while hospitals do not. Patients held under civil commitment for mental health treatment should, theoretically, be able to maintain their civil rights except for their right to leave the hospital. The 13th MI Principle of "the least restrictive environment" states conditions

of mental health care should be "as close as possible to those of the normal life" (MI Principles, 1991, 13.2.a). Access to the outdoors in civil commitment is a question of human dignity and civil rights. *PS v Ontario* has laid fertile ground to for those hospitalized involuntarily to question what liberties section 7 of the Charter ought to guarantee (Grant & Carver, 2016: 999). Patients on mental health units in general hospitals do not get to exercise freedoms patients on other hospital units can. Patients on other units can go outside for fresh air and a change of pace; but it is accepted that outdoor access cannot be offered to involuntary mental health patients due to architectural constraints. Confinement has been viewed by the medical community as an inconvenience of treatment rather than as a deprivation of freedom. From a disability rights perspective, as mental health disorders fit under the umbrella of disability, access to the outdoors for involuntary patients should be part of the accessibility considerations of a hospital board of directors and the architect they select to design a mental health unit.

Cor Wagenaar wrote in his introduction to *The Architecture of Hospitals* (2006) that hospitals:

> [R]eveal how society treats its citizens once they have fallen victim to illness and injury. They represent social and cultural values, and since the late eighteenth century, they have manifested the way science and philosophy conceives the origins, causes and cures of diseases (11).

What is revealed in both mental health legislation and health care practices is that our society believes that it is reasonable to restrict the freedoms of people with mental health disorders in ways we do not believe prisoners or prisoners of war should have their freedoms restricted. This may also reflect a modern neglect of the relationship between humans and nature as a component of health and a hierarchy for where attention is placed in health research. As Ulrich (2002) reminds us, without evidence upon which to base a change in health care practice, change is nearly impossible. As basic as a breath of fresh air may be to good mental health and communicating care for a whole person, the basis upon which to rest this claim is currently thin.

IX. CONCLUSION

We cannot compartmentalize how we think of mental health, physical health and safety, medicine and the law to such a point that we permit such blind spots in legislation and practice. The denial of outdoor access to involuntary mental health patients should receive attention from hospital decision-makers and ministry policy makers. Perhaps professional legislation must change. Perhaps the College of Nurses of Ontario's policy on restraints must change to include a subsection that says:

> You cannot deny your patients a right that through international law our government has agreed should be given to prisoners of war.

Perhaps the laws must change.

I have seen ways mental health professionals have conspired in hope to improve the quality of outdoor access for their patients. One unit fundraised for months among hospital staff to purchase greenery for their courtyard. These are great things, but they do not address the systemic problem – that our government does not protect a human's right to access the outdoors. While John warned of the unlikelihood that a lawyer would

take interest in building a case to change this, I am, as a nurse, aware of a further barrier: patients that are most acutely affected by limitations to outdoor access are often those least equipped to organize something like a legal challenge. Individuals with severe persistent mental illness or people with dementia awaiting a bed in long-term care are populations that endure the lengthiest admissions to hospitals. Beyond finding creative ways of convincing patients to comply with care plans so they may gain passes, there is little a nurse can do to prioritize their will to go outside. That will exists. Sometimes, that will is ferocious and expressed with fists pounding upon a plexiglas partition between the nurses and the patients. Sometimes that will is defeated after prolonged months of receiving the same answer: "I can't let you outside." Which of the two responses is most distressing to me as a nurse and as a person is a toss-up.

It is encouraging that laws do and have and will change. Nonetheless, the lengths one must go to in order to pursue the chance to change a law is daunting. Ontario has benefitted from the efforts of PS and his lawyers willingness to lodge a court challenge, Massachusetts has benefitted from a sympathetic politician willing to write a law from the legislature. Hopefully, this paper might be useful to others who care to ask if everyone might deserve a little more breathing room.

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